Health Services
LOS ANGELES COUNTY

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Los Angeles, CA 90012

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www.dhs.lacounty.gov

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August 08, 2023

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF AMENDMENT TO SOLE SOURCE AGREEMENTS WITH SUTHERLAND HEALTHCARE SOLUTIONS, INC. FOR FINANCIAL MANAGEMENT SERVICES AND WITH USCB AMERICA FOR FINANCIAL BILLING AND RECOVERY SERVICES
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request for approval authorizing the Director of Health Services (Director), or designee, to execute Amendments to extend the term of two sole source Agreements: (i) with Sutherland Healthcare Solutions, Inc. (Sutherland) for Financial Management Services (FMS) for the Department of Health Services (DHS) and the Department of Public Health (DPH); and (ii) with USCB America (USCB) for Financial Billing and Recovery Services (FBRS) for DHS; as well as a request for delegated authority to execute future Amendments to the Agreements to effectively adapt to changes in business needs and legal requirements and, if necessary, terminate the Agreements in accordance with the termination provisions set forth in the Agreements.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve and authorize the Director, or designee, to execute Amendment No. 14 (substantially similar to Exhibit I) to sole source Agreement No. H-703466 with Sutherland, effective upon execution following Board of Supervisors' (Board) approval to extend the term for the period October 1, 2023 through September 30, 2025, for the continued provision of FMS for DHS and DPH, with no change to the maximum reimbursement rates.

2. Approve and authorize the Director, or designee, to execute Amendment No. 14 (substantially similar to Exhibit II) to sole source Agreement No. H-702058 with USCB, effective upon execution following Board approval to extend the term for the period from October 1, 2023, through September 30, 2025, for the continued provision of FBRS for DHS, with no change to the maximum reimbursement rates.

3. Delegate authority to the Director, or designee, to execute future Amendments to the above Agreements to: (a) add, delete, and/or modify non-substantive terms and conditions as required by applicable law, Los Angeles County (LA County) policy, the Board, and/or the Chief Executive Office (CEO); (b) add/delete LA County facilities; (c) make any necessary changes to scope of services and to negotiate and adjust fees structure that do not exceed the existing maximum compensation rates specified in the Agreements; and, (d) if necessary, terminate the Agreement(s) in accordance with the termination provisions set forth in the Agreement(s), subject to prior review and approval as to form by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Background

Under the current Agreements, Sutherland and USCB provide a wide range of FMS and FBRS including commercial insurance billing, collection services, medical billing, and follow-up services, and Third-Party Resource Identification and Recovery Services (TPRIRS) to supplement DHS and DPH revenue recovery efforts.

Sutherland provides FMS to DHS and DPH which includes medical billing, collection, and TPRIRS. Sutherland has developed a proprietary system to accommodate DHS' medical billing operations and has fully integrated and interfaced its service platforms with DHS' revenue generating systems and operations in order to maximize revenue generating capabilities. Furthermore, Sutherland utilizes proprietary methodologies and possesses extensive knowledge and experience required to perform these specialized services that has assisted DHS in collecting approximately $1.1 billion in gross revenue and approximately $30 million in gross revenue for DPH annually.

USCB provides FBRS, including TPRIRS, Medicare bad debt recovery services, health plan, and commercial insurance billing services for DHS, which are unique and highly specialized financial services. USCB has also customized its operations to integrate with DHS' revenue operations and has assisted DHS in collecting approximately $128 million in gross revenue annually.

DHS has actively looked at its revenue operations, including an engagement with the consultants from Health Management Associates (HMA). In 2011, HMA reviewed DHS' revenue cycle operations and procurement strategies for outsourcing these services. HMA's report issued in October 2014 included specific recommendations for breaking out and reconfiguring the scope of Sutherland's services into multiple solicitations to enable DHS to obtain better financial pricing, higher performance standards, improved transparency and accountability, and make all resultant agreements easier to administer. Following these recommendations, DHS released a competitive solicitation for these services beginning with Electronic Data Interchange (EDI) services. Additional solicitations covering other revenue cycle services in the Sutherland Agreement were to be released on a phased basis. However, at the time, with the implementation of the Affordable Care Act, DHS's Electronic Health Record system known as the Online Realtime Centralized Health Information

Database (ORCHID), and creation of the former Health Agency impacted the timeline for the release of these solicitations.

On May 5, 2020, the Board approved the extension of these agreements for a two-year period to support DHS' efforts to perform extensive research and analysis to identify the various integrated service components, operational needs, system, and interface requirements to develop the appropriate solicitation to re-solicit these comprehensive and highly technical services.

Justification

The Public Health Emergency (PHE) caused by the COVID-19 pandemic in 2020 directly impacted the timeline for developing solicitations to replace these Agreements because DHS had to divert contracting staff resources to address urgent patient care contracting needs, and other finance related contracts that were approaching the end of their term. Consequently, a partial analysis was done which identified that the portion of the medical billing revenue services for Medi-Cal Managed Care and commercial insurance billing services could be carved out and solicited for through the Financial Revenue and Ancillary Services Master Agreement (FRASMA), under delegated authority. Additionally, given current managed care healthcare and Medi-Cal inpatient landscape and the need to itemize billing systems, LA County does not have the expertise to perform billing. Further, there is an intent for LA County to replace Affinity Revenue Cycle Only with a new revenue cycle management system.

DHS will continue to perform its analysis of these two Agreements, and gradually develop appropriate solicitations to address the full scope of revenue recovery services required to meet the needs of the departments. DHS has exhausted all of the extension options and both Agreements are scheduled to expire on September 31, 2023. The time extension is needed to preserve the revenue recovery practices and protect the financial sustainability of both LA County departments. Additionally, based on historical knowledge, the transition period to onboard a new vendor is expected to be lengthy and cumbersome.

Recommendations

Approval of the first and second recommendations will allow the Director, or designee, to execute Amendments to extend the term of the sole source Agreements with Sutherland and USCB, effective upon execution for a period of a two year term commencing from October 1, 2023 through September 30, 2025, for the continued provision of FMS for DHS and DPH, and FBRS for DHS, with no change to the compensation rates.

Approval of the third recommendation will give delegated authority to the Director, or designee to execute future Amendments to the above Agreements to effectively adapt to changes in business needs and legal requirements and, if necessary, terminate the Agreements in accordance with the termination provisions set forth in the Agreements.

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2, "Support the Wellness of Our Communities" and III.3, "Pursue Operational Effectiveness, Fiscal Responsibility and Accountability" of LA County's Strategic Plan.

FISCAL IMPACT/FINANCING

Sutherland and USCB receive a compensation rate ranging from 2% to 15% for FMS and FBRS based on actual revenues collected. The compensation rate is dependent on the type of payers and will remain unchanged during the extension period.

For Fiscal Year (FY) 2022-23 Sutherland is estimated to generate over $1.1 billion in gross revenues for DHS of which $39 million in fees is estimated to be paid to Sutherland by DHS, and approximately $7 million in gross revenues for DPH of which $1 million in fees is estimated to be paid to Sutherland by DPH upon reconciliation of invoices between Sutherland and DPH. For the same period, USCB is estimated to generate over $128 million in gross revenues for DHS of which $7.4 million in fees is estimated to be paid to USCB by DHS.

For FY 2023-24, DHS estimates that the gross revenues generated by Sutherland and USCB will remain at the FY 2022-23 levels. For the same period, it is estimated that approximately $4 million in gross revenues will be generated for DPH of which approximately $538,200 in fees will be paid to Sutherland.

DHS's funding is requested in FY 2023-24 Supplemental Budget Resolution (SBR), pending Board approval on October 3, 2023. DHS will request funding in future fiscal years, as needed. Funding for DPH is related to the Vaccine Revenue program and is included in DPH's operating budget.

There is no impact to net County cost for DHS.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On June 1, 1999, the Board approved an Agreement with Accordis, Inc., subsequently known as Apollo Health Street, Inc. (Apollo), and now known as Sutherland for FMS and an Agreement with USCB for FBRS both as the result of a solicitation process.

In subsequent years, Amendments have been executed to both Agreements to effectuate name changes for both contractors, as well as to extend the term and update various Agreement provisions to comply with State, Federal, and LA County rules and regulations, expand the scope of services to provide for efficiencies in FMS, FBRS, and TPRIRS; and to adjust the maximum contingency fee paid to the contractors. On December 1, 2005 and August 19, 2008, respectively, replacement Agreements were approved by the Board to do an overhaul and update all Agreement terms and conditions on both agreements. On May 5, 2020, the Board approved Amendments to extend the term of the Agreements through May 31, 2022.

The Board proclaimed a State of Emergency regarding COVID-19 on March 4, 2020. On March 4, 2022, DHS notified the Board of its intention to commence negotiations with Sutherland and USCB for the sole source Amendments; however, DHS determined that it was best to extend the contracts using the Board's delegated authority of March 15, 2022, which allowed DHS among other delegations, to amend the contracts that were slated to expire by September 30, 2022, both Agreements were extended on May 26, 2022, on a month-to-month basis for four months through and including September 30, 2022. This extension allowed DHS time to finalize the Information Security Requirements Exhibit required for these Agreements. Again, on September 26, 2022, using the same delegated authority, the Agreements were amended to extend the term for up to six months following the lifting of the Health Emergency Proclamation by the Board. The Board lifted the

declaration of the PHE on March 31, 2023; therefore, these agreements are set to expire on September 30, 2023.

Both Agreements are exempt from Proposition A (LA County Code Chapter 2.121) and not subject to the Living Wage Program (LA County Code Chapter 2.201). Sutherland and USCB services provided are very specialized and highly technical which cannot be provided by LA County staff. Further, DHS lacks the technological infrastructure required to perform financial billing and recovery services.

The Agreements include all Board's required provisions. County Counsel has approved the Amendments (Exhibits I and II) as to form.

CONTRACTING PROCESS

On May 1, 2023, DHS notified the Board via Attachment A of its intent to commence negotiations with Sutherland and USCB for the sole source Amendments with these entities in accordance with Board Policy No. 5.100. The Sole Source checklists are attached as Attachment B in compliance with the revised Board Policy 5.100, Sole Source contracts.

The requested extension to Sutherland and USCB Agreements will allow DHS to continue to conduct more analysis of the services being provided by both contractors. This will also allow DHS to continue to identify additional portions of the two Agreements that can be carved out and solicited for through the FRASMA and continue to minimize our dependence on these Agreements. To highlight the first major step in this direction, the DHS Contracts and Grants Division is already developing a completive solicitation for the portion of the medical billing revenue services that support Medi-Cal Managed Care and Commercial Insurance Billing Services through the FRASMA.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will permit DHS and DPH to continue medical billing, collecting, and identifying third-party payer resources without interruption, while DHS completes its competitive solicitation process, ultimately aiding the departments' financial sustainability.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:mr

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisor
Department of Public Health

Health Services
LOS ANGELES COUNTY

May 1, 2023

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

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"To advance the health of our patients and our communities by providing extraordinary care"

TO: Supervisor Janice K. Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **ADVANCE NOTIFICATION OF INTENT TO NEGOTIATE AN AMENDMENT TO SOLE SOURCE AGREEMENTS NO. H-703466 WITH SUTHERLAND HEALTHCARE SOLUTIONS INC. AND NO. H-702058 WITH USCB AMERICA**

This is to provide the Board of Supervisors (Board) with advanced notification of the Department of Health Services' (DHS) intent to enter into negotiations to extend the terms of Agreement No. H-703466 with Sutherland Healthcare Solutions, Inc. (Sutherland) for Financial Management Services (FMS), and Agreement No. H-702058 with USCB America (USCB) for Financial Billing and Recovery Services (FBRS), for a two-year period. These Agreements expire on September 30, 2023, six months after the lifting of the declaration of the Public Health Emergency (PHE) by the Board, which is effective as of March 31, 2023.

Board Policy No. 5.100 requires at least six months prior written notice to the Board of a Department's intent to enter into sole source negotiations for amendments to existing contracts, when the Department does not have delegated authority to execute such an amendment and allow four weeks for Board review of such notice prior to initiating contract negotiations.

Background

Sutherland and USCB provide a wide range of FMS and FBRS including commercial insurance billing, collection services, medical billing and follow-up services, and Third-Party Resource Identification and Recovery Services (TPRIRS) to supplement DHS and the Department of Public Health (DPH) revenue recovery efforts.

Sutherland provides FMS to DHS and DPH which includes medical billing, collection, and TPRIRS. Sutherland utilizes proprietary methodologies and possesses extensive knowledge and experience required to perform these specialized services that assists DHS in collecting approximately $1.05 billion in gross revenue annually and approximately $30 million in gross revenue annually for DPH. Sutherland has developed a proprietary system to accommodate DHS' medical billing operations and has fully integrated and interfaced its service platforms with DHS' revenue generating systems and operations.

USCB provides FBRS, including TPRIRS, Medicare bad debt recovery services, health plan and commercial insurance billing services for DHS, which are unique and highly specialized revenue billing and collection services that no civil service employees are qualified to perform. USCB has also customized its operations to integrate with DHS' revenue operations and assists DHS in collecting approximately $114.8 million in gross revenues annually.

On June 1, 1999, your Board approved an Agreement with Accordis, Inc., subsequently known as Apollo Health Street, Inc. (Apollo) and now known as Sutherland for FMS and an Agreement with USCB for FBRS both as the result of a solicitation process.

In subsequent years, amendments have been executed to the Agreements to effectuate name changes for both contractors, extend the term and update various agreement provisions to comply with State, Federal, and Los Angeles County (LA County) rules, and regulations, expand the scope of services to provide for efficiencies in FMS, FBRS, and TPRIRS; as well as to adjust the maximum contingency fee paid to the contractors. On August 19, 2008, the Board approved replacement Agreements to do an overhaul and update all Agreement terms and conditions. In 2011, HMA reviewed DHS' revenue cycle operations and procurement strategies for outsourcing these services and HMA's report issued in October 2014 included specific recommendations for breaking out and reconfiguring the scope of Sutherland's services into multiple solicitations to enable DHS to obtain better financial pricing, higher performance standards, improved transparency and accountability, and make all resulting agreements easier to administer. Following these recommendations, DHS released a competitive solicitation for these services beginning with Electronic Data Interchange services. Additional solicitations covering other revenue cycle services in the Sutherland Agreement were to be released on a phased basis. However, at the time, with the implementation of the Affordable Care Act, DHS's Electronic Health Record system known as the Online Realtime Centralized Health Information Database (ORCHID), and creation of the former Health Agency impacted the timeline for releasing of these solicitations.

On May 5, 2020, the Board approved Amendments to extend the term of the Agreements through May 31, 2022, to perform research and analysis to develop the appropriate contracting vehicle to solicit for these services. However, due to onset of the COVID-19 pandemic, these plans were not fully realized. Subsequently, on May 26, 2022, the Agreements were amended to extend the term for four months until September 30, 2022, using the delegated authority granted to the Director of DHS by

the Board on March 15, 2022. This extension allowed time to finalize the Information Security Requirements Exhibit required for these Agreements. Again, on September 26, 2022, using the same delegated authority, the Agreements were amended to extend the term for up to six months following the lifting of the Health Emergency Proclamation by the Board. The Board has since lifted the declaration of the PHE; therefore, these Agreements are set to expire on September 30, 2023.

Justification

Due to the PHE caused by the COVID-19 pandemic, the timeline for developing solicitations to replace these Agreements were directly impacted as DHS had to divert contract analyst staff to address urgent patient care contracting needs, and other finance related contracts that were approaching their end of term. Consequently, a partial analysis was done which identified that the portion of the medical billing revenue services for Medi-Cal Managed Care and Commercial Insurance Billing Services can be carved out and solicited for through the Financial Revenue and Ancillary Services Master Agreement (FRASMA). The solicitation is currently under development and is planned for release in the upcoming months. Additionally, given current managed care healthcare and Medi-Cal inpatient landscape and the need to itemize billing systems, LA County does not have the expertise to perform billing. Further, there is an intent for LA County to replace Affinity Revenue Cycle Only with a new patient accounting system. Lastly, DHS will continue to perform its analysis of these two Agreements, and gradually develop appropriate solicitations to address the full scope of revenue recovery services required to meet the needs of the Departments.

If these Agreements are not extended the revenue recovery practices for both Departments would be severely impacted. Without internal staffing resources and infrastructure to take over these operations, the $1.05 billion in annual gross revenue generated by Sutherland for DHS and the $30 million generated for DPH, and the $114.8 million in annual gross revenue generated by USCB for DHS would be lost, hindering the financial sustainability of both Departments.

Timeline

DHS intends to commence negotiations to extend the current sole source Agreements with Sutherland and USCB for the portions of the Agreements related to the FMS and FBRS services. DHS intends to return to the Board with a recommendation for the extension of the Agreements before the current terms expire on September 30, 2023. Concurrently, DHS will release a completive solicitation for the Medi-Cal Managed Care and Commercial Insurance Billing Services portion of the current Agreements through the FRASMA, with the intent to award and execute a successor agreement under existing delegated authority from the Board.

Conclusion

Sutherland and USCB are uniquely positioned to continue providing both Departments with revenue recovery services during the solicitation period which will permit both DHS and DPH to continue medical billing, collecting, and identifying third-party payor resources without interruption, ultimately aiding the Departments' financial sustainability. This extension will allow DHS to continue its analysis and gradually release FRASMA solicitations for replacement agreements. DHS will commence negotiations for extension of the current agreements no earlier than four weeks from the date of this memo with both Sutherland and USCB, unless otherwise instructed by the Board.

If you have any questions, you may contact me or your staff may contactmay contact Manal Dudar, Financial Operations Division Chief, at mdudar@dhs.lacounty.gov.

CRG:mr

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Department of Public Health

SOLE SOURCE CHECKLIST

Department Name: _____

☐ New Sole Source Contract

☐ Sole Source Amendment to Existing Contract:
Date Existing Contract First Approved: _____

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS AND AMENDMENTS **Identify applicable justification and provide documentation for each checked item.**
	➢ Only one bona fide source (monopoly) for the service exists; performance and price competition are not available. A monopoly is an "*Exclusive control of the supply of any service in a given market. If more than one source in a given market exists, a monopoly does not exist*."
	➢ Compliance with applicable statutory and/or regulatory provisions.
	➢ Compliance with State and/or federal programmatic requirements.
	➢ Services provided by other public or County-related entities.
	➢ Services are needed to address an emergent or related time-sensitive need.
	➢ The service provider(s) is required under the provisions of a grant or regulatory requirement.
	➢ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
	➢ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
	➢ Maintenance service agreements exist on equipment which must be serviced by the original equipment manufacturer or an authorized service representative.
	➢ It is more cost-effective to obtain services by exercising an option under an existing contract.
	➢ It is in the best economic interest of the County (e.g., significant costs and time to replace an existing system or infrastructure, administrative cost and time savings and excessive learning curve for a new service provider, etc.). In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Erika Bonilla
Chief Executive Office

Date

SOLE SOURCE CHECKLIST

JUSTIFICATION

Department Name: **DEPARTMENT OF HEALTH SERVICES**
New Sole Source Contract: **NA**

Sole Source Amendment to Existing Contract: **Agreement No. H-703466 Sutherland Healthcare Solutions, Inc.**
Date Existing Contract First Approved: **June 1, 1999**

JUSTIFICATION:

Sutherland provides Financial Management Services (FMS) to the DHS and DPH which includes medical billing, collection, and third-party resource identification and recovery services (TPRIRS). These services are very specialized and highly technical which cannot be provided by County staff. The Departments do not possess the technological infrastructure required to perform financial billing and recovery services. Sutherland has developed a proprietary system to accommodate DHS' medical billing operations and has fully integrated and interfaced its service platforms with Departments' revenue generating systems and operations in order to maximize revenue generating capabilities and to meet the unique operations and services needs of the DHS and DPH. Furthermore, Sutherland utilizes proprietary methodologies and possesses extensive knowledge and experience required to perform these specialized services that assists the Departments in collecting approximately $1.1 billion in gross revenue annually.

DHS will continue to perform its analysis of the Agreement, and gradually develop appropriate solicitations to address the full scope of revenue recovery services required to meet the needs of the Departments. DHS has exhausted all of the extension options and both Agreements are scheduled to expire on September 31, 2023. The time extension is needed to preserve the revenue recovery practices and protect the financial sustainability of both County departments. Additionally, based on historical knowledge, the transition period to onboard a new vendor is expected to be lengthy and cumbersome. Further, accessing the vendor's performance using the revenue cycle management system will take time, therefore in order to minimize any disruptions to DHS' revenue cycle, the option extensions are necessary.

SOLE SOURCE CHECKLIST

Department Name: _____

☐ New Sole Source Contract

☐ Sole Source Amendment to Existing Contract
Date Existing Contract First Approved: _____

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS AND AMENDMENTS **Identify applicable justification and provide documentation for each checked item.**
	➢ Only one bona fide source (monopoly) for the service exists; performance and price competition are not available. A monopoly is an "*Exclusive control of the supply of any service in a given market. If more than one source in a given market exists, a monopoly does not exist* ."
	➢ Compliance with applicable statutory and/or regulatory provisions.
	➢ Compliance with State and/or federal programmatic requirements.
	➢ Services provided by other public or County-related entities.
	➢ Services are needed to address an emergent or related time-sensitive need.
	➢ The service provider(s) is required under the provisions of a grant or regulatory requirement.
	➢ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
	➢ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
	➢ Maintenance service agreements exist on equipment which must be serviced by the original equipment manufacturer or an authorized service representative.
	➢ It is more cost-effective to obtain services by exercising an option under an existing contract.
	➢ It is in the best economic interest of the County (e.g., significant costs and time to replace an existing system or infrastructure, administrative cost and time savings and excessive learning curve for a new service provider, etc.). In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Erika Bonilla
Chief Executive Office

Date

SOLE SOURCE CHECKLIST

JUSTIFICATION

Department Name: **DEPARTMENT OF HEALTH SERVICES**

Sole Source Amendment to Existing Contract: **Agreement No. H-702058 with USCB America**
Date Existing Contract First Approved: **July 1, 2006**

JUSTIFICATION:

USCB America (USCB) provides Financial Billing and Recovery Services (FBRS) to the Department of Health Services (DHS_ which include medical billing and follow-up services, Third-Party Resource Identification and Recovery Services (TPRIRS) Medicare Bad Debt Recovery Services, and Identification and Billing Services for underpaid Accounts. To provide these services, USCB develops and maintains an integrated database to identify and process Medicare billing and collection information, bad debts associated with unpaid co-insurance and deductibles, and produce auditable Medicare Bad Debt reports.

Over the years, USCB has customized its services and system delivery to meet the unique operational and service needs of DHS and has become woven into DHS' revenue generation and recovery operations and infrastructure. DHS does not possess the technological infrastructure required to perform financial billing and recovery services to effectively bill for the large volume of patients served at our facilities and relies on USCB to meet its revenue objectives and maintain its fiscal sustainability. USCB assists DHS in collecting approximately $128 million in gross revenue annually.

This time extension will permit DHS to continue medical billing, collections, and identifying third-party payor resources without interruption, and enable DHS to continue to perform research and analysis to identify the various integrated service components, operational needs, system and interface requirements in order to gradually complete solicitations to address the full scope of these comprehensive and highly technical services.

Agreement No.H-703466

FINANCIAL MANAGEMENT SERVICES AGREEMENT
AMENDMENT NO. 14

THIS AMENDMENT is made and entered into this ___ day of_____, 2023,

By and between COUNTY OF LOS ANGELES
(hereafter "County"),

And

SUTHERLAND HEALTHCARE
SOLUTIONS, INC.
(hereafter "Contractor").

Business Address:

21061 South Western Avenue
Suite 100
Torrance, CA 90501

WHEREAS, reference is made to that certain document entitled “FINANCIAL MANAGEMENT SERVICES AGREEMENT", dated September 1, 2008, and further identified as Agreement No. H-703466, including any amendments and any other modifications thereto (cumulatively hereafter referred to as "Agreement"); and

WHEREAS, on (TBD) the Board of Supervisors delegated authority to the Director of Health Services, or designee, among other delegations, extend the term of the Agreement for the period October 1, 2023 through September 30, 2025; and

WHEREAS, it is the intent of the parties hereto to amend the Agreement to extend its term, to update certain terms and conditions to the Agreement, and to provide for the other changes set forth herein; and

WHEREAS, the Agreement, provides that changes in accordance to Paragraph 16, ALTERATIONS OF TERMS, may be made in the form of an Amendment which is formally approved and executed by the parties; and

WHEREAS, the Contractor warrants that it continues to possess the competence, expertise and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution.

2. The Agreement is hereby incorporated by reference, and all of its terms and conditions, including capitalized terms defined herein, shall be given full force and effect as if fully set forth herein.

3. The Agreement, Paragraph 1, TERM, is deleted in its entirety and replaced to read as follows:

"1. TERM

The term of this Agreement shall commence July 1, 2006, unless sooner cancelled or terminated as provided herein, and shall continue in full force and effect, through and including September 30, 2025 (“Term”).

In any event, this Agreement may be canceled or terminated at any time by either party, with or without cause, upon the giving of at least thirty (30) calendar days advance written notice to the other party. Further, County may also suspend the performance of services hereunder, in whole or in part, upon the giving of at least thirty (30) calendar days advance written notice to Contractor. County's notice shall set forth the extent of the suspension and the requirements for full restoration of the performance obligations.

Notwithstanding any other provision of this Agreement, the failure of Contractor or its officers, employees, agents, or subcontractors to comply with any of the terms of this Agreement or any written directions by or on behalf of County issued pursuant hereto shall constitute a material breach hereto, and this Agreement may be terminated by County immediately. County's failure to exercise this right of termination shall not constitute a waiver of such right, which may be exercised at any subsequent time.

The Contractor shall notify DHS when this Agreement is within three (3) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to the DHS at the address provided in Paragraph 18, NOTICES, of the Agreement."

4. The Agreement, EXHIBIT A-2, STATEMENT OF WORK, is deleted in its entirety and replaced by EXHIBIT A-3, STATEMENT OF WORK, attached hereto and incorporated herein by reference. All references to EXHIBIT A-2, STATEMENT OF WORK in the Agreement shall hereafter by replaced by EXHIBIT A-3.

5. The Agreement, EXHIBIT F, COUNTY’S ADMINISTRATION, is deleted in its entirety and replaced by EXHIBIT F-1, COUNTY’S ADMINISTRATION, attached hereto and incorporated herein by reference. All references to

EXHIBIT F, COUNTY'S ADMINISTRATION in the Agreement shall hereafter by replaced by EXHIBIT F-1.

6. The Agreement, EXHIBIT G, CONTRACTOR'S ADMINISTRATION, is deleted in its entirety and replaced by EXHIBIT G-1, CONTRACTOR'S ADMINISTRATION, attached hereto and incorporated herein by reference. All references to EXHIBIT G, CONTRACTOR'S ADMINISTRATION in the Agreement shall hereafter by replaced by EXHIBIT G-1.

7. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services, or authorized designee, and Contractor has caused this Amendment to be executed on its behalf by its duly authorized officer(s), on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By:_____for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

SUTHERLAND HEALTHCARE SOLUTIONS, INC.

By:_____
Signature

_____
Printed Name

_____
Title

APPROVED AS TO FORM:
DAWYN HARRISON
County Counsel

By:_____
Kelly Auerbach Hassel
Deputy County Counsel

EXHIBIT A-3

FINANCIAL MANAGEMENT SERVICES

STATEMENT OF WORK

FINANCIAL MANAGEMENT SERVICES

STATEMENT OF WORK

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FINANCIAL MANAGEMENT SERVICES

STATEMENT OF WORK

LISTING OF ATTACHMENTS

1.0 DEFINITIONS

The terms used throughout this Agreement and in this Exhibit A-3, STATEMENT OF WORK (SOW), unless otherwise stated shall mean the following:

1.1 Facility(ies): A Facility is a County of Los Angeles – Department of Health Services, Department of Public Health, and Department of Mental Health facility that provides health care services.

1.2 Confidential Information: All information, tangible or intangible, in whatever form or medium provided or obtained by a party or its representative, directly or indirectly, whether orally or in documents, through and by observation or otherwise, including any developed or learned information by an employee during the course of employment.

1.3 Document or Documentation: Any form or medium provided, including, but not limited to, writings, drawings, graphs, charts, photographs, phonographic records, tape recordings, discs and data compilations in whatever form recorded or stored from which information can be obtained and/or translated.

1.4 Referred Account: A Referred Account is an account that has been forwarded to Contractor by a Facility, in accordance with the provisions of this Agreement and as further identified in this SOW, for Contractor's assessment and acceptance or rejection.

1.5 Accepted Account: An Accepted Account is a Referred Account that has been referred to and accepted by Contractor for processing in accordance with the provisions of this Agreement.

1.6 Approved Account: An Approved Account is an Accepted Account that Contractor has requested outside of accounts typically referred to Contractor and received authorization from the referring facility to provide services in accordance with the provisions of this Agreement.

1.7 Other Third-Party Payer: Other Third-Party Payer is a payer source, other than Medi-Cal, Medicare, commercial insurance, or Health Care Plan, for an account, including but not limited to, certain government payers (e.g., Genetically Handicapped Person Program ("GHPP"), Child Health and Disability Prevention ("CHDP"), Family Planning, Access, Care and Treatment Program ("FPACT"), Children Medical Services ("CMS"), Cancer Detection Program).

1.8 County Project Monitor: County staff responsible for overseeing the day-to-day administration of this Agreement.

1.9 Clean Claim: A claim having all billing elements available in the County System (e.g., Affinity RCO, ORCHID) when reviewed to bill in a timely manner and within timely billing requirement by payer statute of limitations and County contract.

1.10 Billed Claim: A claim, or sometimes referred to as a "transaction", that has been billed to a third-party payer in accordance with the terms and conditions of this Agreement, and in accordance with all regulatory requirements, requesting payment for services provided by the County.

1.11 Paid Claim: A billed claim for which the County has received payment from a third-party payer.

2.0 SCOPE OF WORK

2.1 Contractor shall provide one or more of the following Financial Management Services of this Agreement: 1) Electronic Data Interchange and Clearinghouse Services, 2) Financial Billing and Follow-up Services, 3) Specialty Mental Health Billing, 4) Third-Party Resource Identification and Recovery Services, 5) Cost Report Recovery Services, and 6) Underpaid Account Identification and Billing Services, as further described in Paragraph 3.0, Specific Work Requirements of this Exhibit A-3. Each service above has various specific requirements which must be performed by Contractor, as detailed in 3.0, Specific Work Requirements, to satisfy the County's protocols, payer requirements, and governmental regulations.

2.2 Director may refer the following types of accounts within the categories listed above to Contractor: (1) self-pay accounts determined by the County to have partially or fully unpaid balances for eligibility determination; (2) non-self-pay accounts, whether billed or unbilled as having third-party coverage (e.g., Medi-Cal, Medicare, health care plan and commercial insurance), (3) non-self-pay accounts rejected for payment or otherwise not paid; (4) other types of accounts and/or from different automated systems than herein specified. Notwithstanding the above, Director reserves the right to discontinue any assigned service(s), or recall specific accounts or restrict specific accounts or account types from referral to Contractor. If an account is recalled, Contractor shall terminate services immediately and return the account to County within five (5) business days of notice, provided the recall is not solely for the purpose of denying contractor payment for services rendered on the recalled account.

2.3 In performing these services, Contractor shall readily accept County's patient financial, admission, eligibility, and other data in various formats (electronic media, magnetic tape, hard copies, and other formats that become available) as determined by the Director. The County Facilities utilize an all-inclusive charge; however, Contractor may be required to perform itemized billings when required by applicable law or payer requirements. All claims processed by Contractor shall comply with the Office of Inspector General (OIG) Program Guidance, State, Federal, HIPAA/HITECH Transaction Code Set (TCS) requirements.

2.4 Contractor shall maintain a comprehensive data warehouse of all accounts, claims, transactions. The database shall be cumulative and contain all accounts processed by Contractor as well as data provided by County and obtained by vendor in performing these services. Upon request by the Director, Contractor shall provide management reports, at no cost to County, as well as customized

reports or a system providing County with the ability to generate Ad Hoc reports in a timeframe agreed upon by Director and Contractor.

2.5 Contractor shall provide complete detailed written documentation of the systems, methods, and procedures employed in identification of claims (e.g., eligibility, under paid claims), claims billing, collection, account posting, claims denial and denial follow-up activities. Such documentation exclusive of software shall be provided upon expiration of the term of this Agreement, should County so notify Contractor.

2.6 Comprehensive Audit Trail and Appeal Support: Contractor shall maintain a comprehensive written audit trail and provide audit and appeal support to County, including but not limited to, responding to Auditor requests for documentation and information, packaging information according to Auditor requirements, and interfacing with the Auditors during document review. Contractor shall make available all audit supporting documentation in format and frequency as requested by the Auditor, and the County.

2.7 Additional Services: Contractor shall provide ongoing consultant and support services, at no cost to County, including recommendations relating to the future maintenance and updating of the systems, methods and procedures employed by Contractor. Contractor shall also provide recommendations as to how County billings and collections performance might be improved, and support services required to continue provision of those services to be performed by Contractor under this Agreement, at a comparable level of automation/efficiency, during any planned future financial accounting, patient registration, or any other Facility system procured by County and during any other system conversions or augmentations.

3.0 SPECIFIC WORK REQUIREMENTS

The following indicates the areas of services assigned to Contractor, subsidiaries, or subcontractors, as applicable. Contractor may be requested to perform the services below at individual or all Facilities, including but not limited to, Facilities listed in Attachment A – Facilities List. However, the County may, at any time during the term of this Agreement, add or delete services or Facilities in Attachment A –Facilities List. County shall provide Contractor with at least sixty (60) day notice for addition or deletion of services or Facilities which will result in a of greater than 10% in volume. Contractor shall process all claims timely and in compliance with applicable law and payer requirements. The County is due a “Penalty” as a result of Contractor’s failure to meet the Standard Performance Requirement identified in Exhibit A-3, Attachment B, Performance Requirements Summary. A Penalty shall apply in the event of Contractor’s failure to achieve the agreed upon Standard Performance Requirement during any measurement period. Contractor shall credit the County on the invoice following the month in which the failure, and resulting Penalty, occurs. In performing these services, Contractor shall readily accept County’s patient financial, admission, eligibility, and other data in various formats as determined by Facilities (e.g. HL7 data or other formats that become available). Contractor shall provide:

A. Electronic Data Interchange and Clearinghouse Services (EDICS);
B. Financial Billing and Follow-up Services (FBFS);
C. Specialty Mental Health Billing;
D. Third-party Resource and Identification and Recovery Services (TPRIRS);
E. Cost Report Recovery Services (CRRS); and
F. Underpaid Accounts Identification and Billing Services (UAIBS).

3.1 ELECTRONIC DATA INTERCHANGE AND CLEARINGHOUSE SERVICES (EDICS)

Contractor shall provide EDICS to Facilities, including maintaining a comprehensive data warehouse and revenue cycle management (e.g. eligibility verification, electronic remittance, claim status reports, rejection analysis), as directed by the County. In performing EDICS, Contractor shall:

3.1.1 Submit HIPAA/HITECH compliant Health Care Claim (837) transactions to Medi-Cal, Medicare and other third-party payers or its designated fiscal Intermediary. Data transmission shall utilize HIPAA/HITECH compliant transactions and code sets where such standards exist. Contractor shall enable Facilities to electronically transmit claims on at least a weekly basis or at other frequency requested. Contractor shall have the ability to receive Remittance Advices (835 transaction), Eligibility (271 transaction), and Claim Status (277 transaction) should those services be required. In submitting HIPAA/HITECH compliant Health Care Claim (837) transactions, the Contractor shall:

3.1.1.1 Incorporate detailed edits to identify potential errors, including but not limited to, duplicate claims, provider ID requirements, claim accuracy and coding verification and enable County personnel to make on-line corrections to claims. In addition, Contractor shall provide mechanisms to ensure follow-up notices/reports are provided on unpaid and underpaid claims.

3.1.1.2 Integrate electronic claims with hardcopy document submissions (i.e. medical records, authorizations) where appropriate or required by the payer(s) or its fiscal intermediary.

3.1.1.3 Provide County with real time interactive web-portal capability for direct data entry and editing, electronic claims tracking, file uploading, claim payment status (276/277 transaction) and verification, transaction logs and record history, and payer messaging.

3.1.1.4 Provide comprehensive billing details and summaries of all claims processed through Contractor's system including reports (i.e. aging report, average days to bill/collect, benchmark reports) for auditing or other management purposes.

3.1.1.5 Provide all programming changes for any customized and routine reports or customized claims processing, as requested by the County or as required by payer changes (e.g., State requirements, 5010 health claim format).

3.1.1.6 Contractor shall provide a secured system environment for data transfer and exchange. Contractor's system shall include, but not limited to, maintaining a secure portal, login and password security, and user authentication and verification. Contractor shall, at the Director's request, provide secured data transfer into the County's current electronic data capturing system in compliance with the County's specified format (e.g., HL7).

3.1.1.7 Provide technical support services during implementation and operations maintenance at no additional cost.

3.1.1.8 Provide training sessions to County staff at Facilities, as may be requested by the Facility. The subject matter shall include, but not be limited to, new or updated information concerning:

- Medi-Cal billing procedures.
- Medicare billing procedures.
- Medi-Cal Manage Care
- Commercial insurance billing procedures.
- Other Third-Party Payer billing procedures.
- Utilization of the reports generated.

3.2 Financial Billing and Follow-Up Services (FBFS)

3.2.1 Contractor shall provide FBFS as requested by Facilities for referred accounts. The County currently utilizes an all-inclusive charge, however, FBFS may include itemized billing where required by applicable law or payer requirements and encompasses the following third-party programs: Medicare, Medi-Cal, Health Care Plan and Commercial Insurance (i.e. HMO, HCP, and Medi-Cal Linked), and other third-party payers and may be specific to inpatient accounts or outpatient accounts or both. This includes billing and follow-up services, denial reprocessing, reviewing medical records for appeals, and using automated systems where available and appropriate or as requested by County.

3.2.2 Contractor shall request the necessary information (e.g., TARS, allocation of days (AOD) or patient discharge summaries) needed to develop valid reimbursement claims directly from the facility(ies) (e.g., Utilization Review, Medical Records, Patient Financial Services) including comprehensive chart review to access coding, development of clean claims necessary for itemized billing. Contractor shall provide personnel to assist in retrieving/photocopying documents. Contractor will provide personnel to assist in retrieving/photocopying documents as may be requested by the

Source Organizations and return all account documentation reviewed in the same condition and sequence in which they were originally received.

3.2.3 Contractor shall, within five (5) business days, bring to the attention of the Facility Patient Accounts Manager/CBO Manager, when the Contractor is having difficulty in obtaining information which prohibits the Contractor from billing or following-up on accounts.

3.2.4 If Contractor cannot obtain the necessary medical records coding from the Facility, the Contractor, at Contractor's own cost, may utilize its own coding staff or contracted coding vendor that has been approved by County as a subcontractor. Notwithstanding the foregoing, the Contractor may charge separately for "Special Accounts" identified under Change Order Number 9.

3.2.5 Contractor shall provide any one or all of the following services to Facilities as agreed upon between County and Contractor:

3.2.5.1 Research unbilled Inpatient and/or Outpatient accounts that have been classified as having third-party coverage on the Accounts Receivable (A/R).

3.2.5.2 Research all unbilled accounts on the A/R systems with discharge or service dates as requested by Facility to verify third-party coverage, except those assigned by County to other contract service providers. Contractor shall verify eligibility or recommend other appropriate disposition of these accounts to Facility staff, if no eligibility can be determined or non-matching eligibility.

3.2.5.3 Employ a claim edit system to review all data from Facility systems to create claims that are compliant with payer regulations and work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information, partial eligibility matches, and missing or incomplete medical record data). The updated information will be entered directly into the Contractor's billing processes. Contractor shall review medical record/chart as necessary where itemized billing is required.

3.2.5.4 Generate electronic or hardcopy of claims, including itemized claims where appropriate and necessary, and ensure claims are compliant with Federal, State, and other regulatory requirements and submit claims timely to the appropriate fiscal intermediary or other third-party payers. Contractor shall develop and bill Medicare, Medi-Cal, health care plan and commercial insurance, or other third-party payer, claims that meet the requirements of the applicable fiscal intermediary or

third-party payer, in electronic format where possible. Contractor shall generate electronic or hardcopy work queues of claims with invalid eligibility matches and research accounts on payer's on-line eligibility systems or with the Facilities' eligibility systems. If valid eligibility is identified, the information shall be entered directly into the billing system by Contractor. When necessary, Contractor shall review medical records to ensure all mandated codes exist prior to billing. The updated information will be entered directly into the Contractor's billing processes by Contractor staff.

3.2.5.5 Provide County updated demographic and third-party resources information at the time of billing to include third-party updates and third-party payer identification number (e.g., insurance code updates, Medi-Cal ID#), in electronic format–Insurance Change Reports. Provide updates for revised and/or corrected information obtained by vendor in electronic format.

3.2.5.6 Develop fully and submit, in a timely manner, completed Medi-Cal, Medicare, health care plan and commercial insurance, and/or any other third-party claims/billings, in electronic format where appropriate to fiscal intermediary for Medi-Cal or fiscal intermediary for Medicare, or the appropriate Independent Practice Association (IPA) /Participating Physician Group (PPG) or capitated Hospital and/or other third-party payers or fiscal intermediaries.

3.2.5.7 Follow-up on billed and unpaid accounts, according to the third-party payer timeline and follow appropriate processes, to determine claim status including usage of 276/277 transactions.

3.2.5.8 Follow-up on underpaid and denied claims, determine the cause of the denial, correct deficiency, and resubmit claims for payment unless the claim is determined to be uncollectible. When necessary, Contractor shall review medical records of denied or incorrectly paid claims to determine if an appeal is appropriate. If an appeal is appropriate, Contractor shall file the appeal with the appropriate payer (e.g., IPA/PPG, capitated hospital). Contractor shall document the reasons the account is uncollectible and report to the referring Facility(ies).

3.2.5.8.1 Respond within ten (10) business days from posting of remittance or correspondence, if information is available, to additional information requested (e.g., correspondence) by Medicare, Medi-Cal, health care plan and commercial insurance, other third-party payer or from applicable fiscal intermediary.

3.2.5.8.2. Research and resubmit claims billed by Contractor which are suspended or denied by the fiscal intermediary (e.g., complete and return resubmission turnaround documents, Claim Inquiry Forms (CIF)) and provide all follow-up services for denied claims and pursue third-party payments until the account is determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the Facilities.

3.2.6 Pursue full reimbursement for all commercial and managed care insurance accounts identified by the Facility(ies). Contractor shall submit in writing any proposed settlement/account compromise greater than 5% discount, with amount and reason for compromise, to County for approval prior to acceptance, in accordance with DHS' procedures. Contractor shall negotiate with the third-party payer to ensure that the compromise offer is fair and equitable. Contractor shall submit all compromise offers to County only when it has determined that the offered amount is the best offer that can be negotiated. For this purpose, Contractor shall provide County all information/documentation within three (3) business days. If County personnel are required to attend hearings and/or settlement conferences, Contractor shall notify County at a minimum of fifteen (15) business days in advance of the hearing/conference date.

3.2.7 Establish and maintain a claim/payment tracking system to identify by account, category, Facility, and in total, amounts billed, collected, pending, underpaid/denied, paid, and accounts referred back to Facilities. Contractor shall provide aging reports for accounts billed each month or as requested by referring Facility(ies).

3.2.8 Shall the County request, the Contractor will post (HIPAA/HITECH Compliant 835 transaction) the payments, denials, adjustments, and transfers, electronically, to all applicable Facility's A/R systems within four (4) business days. Contractor shall post, on a continuing basis, Medi-Cal, Medicare, health plan and commercial insurance and other third-party remittances and contractual allowances within four (4) business days after Contractor's receipt of Remittance Advices. Contractor shall provide payment posting detail for accounts that have been billed by Contractor and subsequently paid.

3.2.9 Establish a payment tracking process on the accounts billed by Contractor to identify amounts billed and amount collected and provide an accounts aging report for the accounts billed by Contractor and perform monthly review of all Accepted Accounts that were paid to ensure accounts are appropriately adjudicated.

3.2.10 Research credit balances on Accepted Accounts and billed accounts to ensure payments are correctly recorded. If overpayment is identified,

Contractor shall process either a corrected claim or a void claim where applicable. For those claims where corrected claim and/or voided claim is not applicable customer shall provide contractor with a notification process for customer to issue refund check. to the appropriate third-party payer(s) within the timeframe specified by the payer. Contractor shall provide monthly reports that identify overpayments and the appropriate actions taken to initiate refunds and/or corrections.

3.2.11 Provide Facilities with a listing of the accounts with amounts determined to be self-pay.

3.2.12 Provide payments, adjustments, and billing information transactions in electronic format.

3.2.13 Provide various management reports (i.e., eligibility identifications, claims billed, collections, remittance advice, underpayments, denials, and other reports, in formats, content, and frequency).

3.2.14 Return health care plan and commercial Insurance accounts to the County that have been billed but are unadjudicated two hundred seventy (270) calendar days after the last billing, except as otherwise instructed by the Facility. Contractor shall supply supporting documentation not available to the County upon request, in the format requested by the County.

3.2.15 Follow regulatory and DHS balance billing guideline for emergency services and other health care services.

3.2.16 Provide, develop, and maintain a database to accumulate patient data, charge information, billing statistics, payment information, and other data as necessary. Contractor shall allow County's staff to access the database for inquiries, reporting, and as otherwise necessary.

3.2.17 Provide automation of various management reports as specified and defined by the County.

3.2.18 Provide County with a quarterly assessment of each Facility's performance. Any concerns and recommendations to improve FBFS shall be included in such report.

3.3 Specialty Mental Health Billing

Contractor shall provide assistance to County in submitting HIPAA/HITECH compliant claims for specialty mental health Inpatient (IP), Inpatient Professional (IP Pro) Outpatient (OP), and Emergency Room (ER) services. Contractor shall also provide follow-up services, denial reprocessing, reviewing medical records for appeals, data collection and reporting, and using automated systems where available and appropriate or as requested by County, as specified further below. DHS provides mental health services which do not qualify as specialty mental health. Contractor's responsibilities for such non-specialty mental health services

are included in and subject to the provisions in Paragraph 3.2 (Financial Billing and Follow-Up Services (FBFS)).

- For purposes of this Paragraph 3.3, "DMH-Responsible Patients" include Medi-Cal beneficiaries who require specialty mental health services, including persons qualified for State-only Medi-Cal, and indigent and uninsured persons.

- For purposes of this Paragraph 3.3, "Non-DMH-Responsible Patients" include persons receiving specialty mental health services who are covered by Medicare or a third-party insurer.

3.3.1 Contractor shall provide the services under the terms and conditions set forth below in Paragraphs 3.3.2 through 3.3.8 for specialty mental health services provided to DMH-Responsible Patients. All claims shall be submitted to the Los Angeles County Department of Mental Health (LAC-DMH) in accordance with LAC-DMH's policies and procedures.

3.3.2 Contractor shall provide the services discussed in this Paragraph 3.3 to referred accounts for specialty mental health services. County shall generate referred accounts reports for DMH-Responsible Patients IP, IP Pro, OP and ER services once a month and will provide the reports securely.

3.3.3 Contractor shall request the information (e.g., TARS, allocation of days (AOD) or patient discharge summaries) necessary to develop valid reimbursement claims directly from Facility(ies) (e.g., Utilization Review, Medical Records, Patient Financial Services) including comprehensive chart review to access coding, and allow for the development of clean claims for itemized billing. At the County's request, Contractor shall provide personnel to assist in retrieving/copying documents and shall return all account documentation reviewed in the same condition and sequence in which they were originally received.

3.3.4 If Contractor cannot obtain the necessary coding from Facility, the Contractor, may utilize its own coding staff or a contracted coding vendor that has been approved by County as a subcontractor. Notwithstanding the foregoing, the Contractor may charge County separately for "Special Accounts" identified under Change Order Number 9.

3.3.5 Contractor shall provide any or all of the following services in connection with specialty mental health services to DMH-Responsible Patients as agreed upon between County and Contractor:

3.3.5.1 Research unbilled IP, IP Pro, OP and ER accounts that have been classified as having Medi-Cal on the Accounts Receivable (A/R).

3.3.5.2 Employ a claim edit system to review all data from Facility systems to create claims that are compliant with LAC-DMH rules, work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information, partial eligibility matches, and missing or incomplete medical record data). The updated information will be entered directly into the Contractor's billing processes. Contractor shall review medical record/chart as necessary where itemized billing is required.

3.3.5.3 Verify Medi-Cal eligibility for all claims designated as Medi-Cal.

3.3.5.4 If LAC-DMH requires encounters to be opened in its system in order to accept or process claims, Contractor shall open such encounters and input all necessary data into Integrated Behavioral Health Information Systems (IBHIS) using information from Affinity RCO or ORCHID.

3.3.5.5 Generate electronic (837 transaction) claims, and ensure such claims are compliant with Federal, State, LAC-DMH and other regulatory requirements and submit claims timely to LAC-DMH. All submitted claims, including but not limited to ER, must comply with regulatory and DHS balance billing requirements. All submitted claims must properly reflect whether they are for Medi-Cal beneficiaries or for the indigent and the uninsured. The County currently utilizes an all-inclusive charge; however, the referred specialty mental health service accounts may need itemized billing where required by applicable law or LAC-DMH's requirements. The updated information will be entered directly into the Contractor's billing platform by Contractor staff.

3.3.5.6 Have Contractor's supervisors review all billing reports to validate the accuracy and appropriateness of accounts billed to Medi-Cal.

3.3.5.7 Generate electronic work queues of claims with invalid eligibility matches and research accounts on payers' on-line eligibility systems or with the Facilities' eligibility systems. If valid eligibility is identified, the information shall be entered directly into the billing system by Contractor.

3.3.5.8 Provide County updated demographic and third-party resources information at the time of billing to include third-party updates and third-party payer identification number (e.g., insurance code updates, Medi-Cal ID#), in electronic format–Insurance Change Reports. Provide updates for revised and/or corrected

information obtained by Contractor or subcontractor in an electronic format.

3.3.5.9 Follow-up on billed and unpaid accounts, according to LAC-DMH's timeline and follow appropriate processes to determine claim status, including use of 276/277 transactions.

3.3.5.10 Follow-up on underpaid and denied claims, determine for each such claim the cause of the denial, correct the deficiency(ies), and resubmit claim for payment unless the claim is determined to be uncollectible. When necessary, Contractor shall review medical records of denied or incorrectly paid claims to determine if an appeal is appropriate. If an appeal is appropriate, Contractor shall file the appeal using LAC-DMH and/or Medi-Cal's appeal processes. If Contractor determines that the account is uncollectable, Contractor shall document the reasons the account is uncollectible and report to the referring Facility(ies).

3.3.5.10.1 Respond to additional information requests (e.g., correspondence) by LAC-DMH and/or Medi-Cal within ten (10) business days from posting of remittance or correspondence, if information is available.

3.3.5.10.2 Research and resubmit claims billed by Contractor which are suspended or denied by LAC-DMH (e.g., complete and return resubmission turnaround documents) and provide all follow-up services for denied claims and pursue payment until the accounts are determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the Facilities.

3.3.6 Contractor shall establish and maintain a claim/payment tracking and reporting system to identify by account, category, Facility, and in total, amounts billed, collected, pending, underpaid/denied, paid, and accounts referred back to Facilities. If requested by County, provide information included in such reporting system in an electronic format. Contractor shall further provide aging reports for accounts billed each month or as requested by referring Facility(ies). Additionally, unless County instructs to the contrary, Contractor will perform monthly review of all billed accounts that were paid to ensure accounts are appropriately adjudicated.

3.3.7 If the County requests, the Contractor will post the payments, denials, adjustments, and transfers, electronically to all applicable Facility's A/R systems within four (4) business days. Contractor shall post on a continuing

basis, Medi-Cal, and other LAC-DMH remittances and contractual allowances within four (4) business days after Contractor's receipt of Remittance Advices. Contractor shall provide payment posting detail for accounts that have been billed by Contractor and subsequently paid.

3.3.8 Contractor will research, based on data provided by County or otherwise known to Contractor, credit balances on referred and billed accounts to ensure payments are correctly recorded. If an overpayment is identified, Contractor shall process either a corrected claim or a void claim as appropriate. For those claims where a corrected claim and/or voided claim is not appropriate, the relevant Facility shall provide Contractor with a notification process for Facility to issue refund check to LAC- DMH or Medi-Cal within the timeframe specified by the payer. Contractor shall provide monthly reports that identify overpayments and the appropriate actions taken to initiate refunds and/or corrections.

3.3.9 As agreed upon by County and Contractor, Contractor shall provide any or all of the same services described in paragraphs 3.3.2 through 3.3.8 above to referred accounts for specialty mental health IP, IP Pro, OP and ER services provided to Non-DMH-Responsible Patients. For purposes of such services, any reference in paragraphs 3.3.2 through 3.3.8 to LAC-DMH or Medi-Cal shall be understood to mean the rules, systems, processes or procedures of the applicable non-LAC-DMH payer.

3.3.10 County shall bill deductibles, coinsurance or other copayment to the patient, unless the patient has other health coverage which is responsible for such amounts, in which case Contractor shall bill the other health coverage.

3.3.11 Contractor shall comply with all rules related to coordination of benefits in billing patients with multiple payers (e.g. patients who are eligible for both Medicare and Medi-Cal) and shall assure that all payments received by primary coverage are disclosed on claims to secondary coverage, as required by law or the payer.

3.3.12 Contractor will provide, develop, and maintain a database to accumulate patient data, charge information, billing statistics, payment information, and other data as necessary. Contractor shall allow County's staff to access the database for inquiries, reporting, and as otherwise necessary.

3.3.13 Contractor will provide various management reports (e.g., eligibility identifications, claims billed, collections, remittance advice, underpayments, denials, and other reports), in such formats, content, and frequency as shall be requested by County. Automate such management reports as specified by the County.

3.3.14 Contractor will provide County with a quarterly assessment of each Facility's performance in connection with the services described in this

paragraph 3.3. Any concerns and recommendations to improve the performance of services under this Paragraph 3.3 shall be included in such report.

3.3.15 Contractor will include information related to Non-DMH-Responsible Patients in the services provided pursuant to paragraphs 3.3.12 through 3.3.14.

3.4 Third-Party Resource Identification and Recovery Services (TPRIRS)

After DHS's best efforts have been exhausted, Contractor may review underpaid or unpaid accounts for third-party coverage identification and claim processing services provided that the Contractor has not performed FBFS. In performing TPRIRS, Contractor shall:

3.4.1 Provide all Facilities receiving TPRIRS with a monthly listing of accounts that are eligible for third-party reimbursement for which Contractor has conducted a review to ensure that no claim by County or another contractor has been paid or is pending adjudication by the third-party payer or its fiscal intermediary. The Facilities will exclude accounts from this listing, that are currently being pursued by the County or another contractor. The Contractor shall then pursue reimbursement only for accounts which have been approved by the Facility.

3.4.2 Provide all Facilities receiving TPRIRS with a monthly cumulative listing (electronic or paper) of Approved Accounts that are being pursued within five (5) calendar days of identifying third-party eligibility where payment was not received.

3.4.3 Contractor shall pursue Approved Accounts for full reimbursement within sixty (60) calendar days of the approval date.

3.4.4 If Contractor needs additional time to process Approved Account(s), additional time may be requested by Contractor and may be granted by the County, not to exceed one hundred and twenty (120) calendar days after Contractor initially received Approved Account from County.

3.4.5 Contractor shall request the necessary information (e.g., TARS, AOD or patient discharge summaries) needed to develop valid reimbursement claims directly from the facility(ies) (e.g., Utilization Review, Medical Records, Patient Financial Services) including comprehensive chart review to access coding, development of clean claims, necessary for itemized billing. Contractor shall provide personnel to assist in retrieving/photocopying documents.

3.4.5.1 Contractor shall notify the Patient Accounts Manager/CBO Manager within five (5) business days, when the Contractor is

having difficulty in obtaining information which prohibits the Contractor from billing or following-up on accepted accounts.

3.4.5.2 If Contractor cannot obtain the necessary medical records coding from the Facility, the Contractor may elect to utilize its own coding staff or contracted coding vendor if already approved by County as a subcontractor.

3.4.6 Utilize demographic, charge, and remittance data to construct a file of un-liquidated accounts that are unidentified by the Facility as having third-party coverage. The Contractor shall then apply remittance data to this file of un-identified accounts to identify and eliminate all previously liquidated services.

3.4.7 Employ a claim edit system to review all data from Facility systems to create a claim that is compliant with payer regulations and work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information, partial eligibility matches, and missing or incomplete medical record data). The updated information will be entered directly into the Contractor's billing processes.

3.4.8 Generate electronic or hardcopy of claims, including itemized claims when necessary, and ensure claims are compliant with Federal, State, and other regulatory requirements and submit claims timely to the appropriate fiscal intermediary and other third-party payers. Contractor shall develop and bill Medicare, Medi-Cal, health care plan and commercial insurance, or other third-party payer claims that meet the requirements of the applicable fiscal intermediary or third-party payer, preferably in electronic format where applicable. Contractor shall generate electronic or hardcopy work queues of claims with invalid eligibility matches and research accounts on payer's on-line eligibility systems or with the Facilities' eligibility systems. If valid eligibility is identified, the information will be entered directly into the Contractor's billing system. When necessary, Contractor shall review medical records to ensure all mandated codes exist prior to billing. The updated information will be entered directly into the Contractor's billing processes by Contractor staff.

3.4.9 Provide updated demographic and third-party resources information at the time of billing to include third-party updates and third-party identification number (e.g., insurance code updates, Medi-Cal ID#) in electronic format.

3.4.10 Develop fully and submit completed Medi-Cal, Medicare, health care plan and commercial insurance, and/or any other third-party claims/billings, preferably electronically to fiscal intermediary for Medi-Cal, or fiscal intermediary for Medicare, or the appropriate Independent Practice Association (IPA) /Participating Physician Group (PPG) or capitated Hospital and/or other third-party payers or fiscal intermediaries.

3.4.11 Follow-up on billed and unpaid accounts according to the third-party payer timeline and follow appropriate processes to determine claim status including usage of 276/277 transactions.

3.4.12 Follow-up on denied claims, determine the cause of the denial, correct deficiency, and resubmit claims for payment unless the claim is determined to be uncollectible. When necessary, Contractor shall review medical records of denied or incorrectly paid claims to determine if an appeal is appropriate. If an appeal is appropriate, Contractor shall file the appeal with the appropriate payer (e.g., IPA/PPG, capitated hospital). Contractor shall document the reasons the account is uncollectible and report to the referring Facility(ies).

3.4.12.1 Respond within ten (10) business days after posting of remittance or correspondence, if information is available, to additional information requested (e.g., correspondence) by Medicare, Medi-Cal, health care plan and commercial insurance, other third-party payer or from applicable fiscal intermediary.

3.4.12.2 Research and resubmit claims billed by Contractor which are suspended or denied by the fiscal intermediary (e.g., complete and return resubmission turnaround documents, CIF) and provide all follow-up services for denied claims and pursue third-party payments until the account is determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the Facilities.

3.4.13 Pursue full reimbursement for all commercial and managed care insurance account. Contractor shall submit in writing any proposed settlement/account compromise greater than 5% discount, with amount and reason for compromise, to County for approval prior to acceptance in accordance with procedures as follows: Contractor shall negotiate with the third-party to ensure that the settlement amount allocated to the County is fair and equitable. Contractor shall submit such compromise offers to County only when they have determined that the offered amount is the best offer that can be negotiated. For this purpose, Contractor shall provide County all information/ documentation within three (3) business days. If County personnel are required to attend hearings and/or settlement conferences, Contractor shall notify County at a minimum of fifteen (15) business days in advance of the hearing/conference date.

3.4.14 Establish and maintain a claim/payment tracking system to identify by account, category, Facility, and in total, amounts billed, collected, pending, denied, paid, and accounts referred back to Facilities or primary contractor(s). Contractor shall provide aging reports for accounts billed each month or as requested by referring Facility(ies).

3.4.15 Post (HIPAA/HITECH Compliant 835 transaction) the payments, adjustments, and transfers, preferably electronically, to all applicable Facility's A/R systems within four (4) business days. Contractor shall post on a continuing basis, Medi-Cal, Medicare and other third-party remittances and contractual allowances within four (4) business days after Contractor's receipt of Remittance Advices. Contractor shall provide payment posting detail for accounts that have been billed by Contractor and subsequently paid.

3.4.16 Establish a payment tracking process on the accounts billed by Contractor to identify amounts billed and amount collected and provide an accounts aging report for the accounts billed by Contractor and perform monthly review of all Accepted Accounts that were paid to ensure accounts are appropriately adjudicated.

3.4.17 Research credit balances on Accepted and billed accounts to ensure payments are correctly recorded. If overpayment is identified, Contractor shall process either a corrected claim or a void claim where applicable. For those claims where corrected claim and/or voided claim is not applicable customer shall provide contractor with a notification process for customer to issue refund check. repayment to the appropriate third-party payer(s) within the timeframe specified by the payer. Contractor shall provide monthly reports that identify over-payments and the appropriate actions taken to initiate refunds and/or corrections.

3.4.18 Provide Facilities with a listing of the accounts with amounts determined to be self-pay.

3.4.19 Provide payments, adjustments, and billing information transactions in electronic format.

3.4.20 Provide various management reports (i.e., eligibility identifications, claims billed, collections, remittance advice, denials, and other reports, in formats, content, and frequency).

3.4.21 Follow regulatory and DHS balance billing guideline for emergency services and other health care services.

3.4.22 Provide, develop, and maintain a database to accumulate patient data, charge information, billing statistics, payment information, and other data as necessary. Contractor shall allow County's staff to access the database for inquiries, reporting, and as otherwise necessary.

3.4.23 Provide automation of various management reports as specified and defined by the County.

3.4.24 Provide County with a quarterly assessment of each Facility's performance. Any concerns and recommendations to improve TPRIRS shall be included in such report.

3.5 Cost Report Recovery Services (CRRS)

At the County's direction Contractor shall provide CRRS to Facilities, including but not limited to:

A. If requested, Medicare Bad Debt Recovery Services;
B. Disproportionate Share Recovery Services; and
C. Indirect Medical Education Recovery Services.

3.5.1 Medicare Bad Debt Recovery Services (MBDRS)

Contractor shall maximize Medicare Bad Debt reimbursement costs by substantiating Medicare Bad Debts information and provide federally acceptable Medicare claims. Contractor shall develop an integrated database to identify and process Medicare billing and collection information, i.e., the amount of bad debts associated with co-insurance and deductibles and produce auditable Medicare Bad Debt Reports by Facility. Contractor shall:

3.5.1.1 Prepare a Medicare Bad Debt Report for each Fiscal Year (FY) as requested by Director. Each report shall include a listing, by Facility of Medicare Bad Debt accounts and account activity.

3.5.1.2 Create and compile a data warehouse of electronic Medicare payment data (Remittance) for County inpatient and outpatient accounts. Contractor shall match the Remittance data to County Facility Statistical Master file.

3.5.1.3 Obtain information from the County for Medicare accounts deemed uncollectible.

3.5.1.4 Analyze Medicare account(s) information to identify any coinsurance and deductible payments.

3.5.1.5 Analyze collection activities/data from Patient Accounts system and any ancillary files (received from the County and/or other County contractors) to a) identify collection activity, and b) examine write-off transaction and write-off timing.

3.5.1.6 Identify potentially qualifying accounts by various codes, indicating their characteristics as they pertain to Medicare Bad Debt claiming.

3.5.1.7 Create a listing of Medicare Bad Debt accounts by Facility for all accounts that qualify for Medicare Bad Debt claiming. Each listing shall comply with the requirements as outlined under the latest adopted regulation such as the Centers for Medicare and

Medicaid (CMS) Provider Reimbursement Manual (PRM) or Transmittal which includes but not limited to specific patient demographics, Medicare Health Insurance Claims (HIC) number, coinsurance amount, deductible amount, payments, write-offs, and Medicare Bad Debt allowable amount.

3.5.1.8 Provide this Medicare Bad Debt Report (by Facility) to the County within sixty (60) days following the end of each fiscal year (June 30), or as requested by the County.

3.5.2 **Disproportionate Share Recovery Services (DSRS)**

As requested by the County and with Contractor's concurrence, Contractor shall provide Medicare DSRS to Maximize County's Medicare Disproportionate Share Hospital (DSH) reimbursement in compliance with Medicare regulations. Contractor shall develop an integrated database to identify additional eligibility inpatient days, prepare necessary documentation, and secure acceptance from the Medicare fiscal intermediary for Medicare DSH claiming. Further, Contractor shall produce reports and compile detailed listing and claims for filing with Medicare, as required or as requested by County with concurrence of Contractor to provide claiming for eligible inpatient days. DSRS shall be provided by Contractor for all inpatient hospital Facilities, except as otherwise determined by the County. Contractor shall prepare Facility-specific listings and reports of eligible patient days and Medicare DSRS claims for dates of service as requested by County. Contractor shall:

3.5.2.1 Create and compile a data warehouse of electronic inpatient account information. Contractor shall reformat account information provided by County to standard Medicare DSH record types, creating records for all accounts.

3.5.2.2 Identify a universe of the potential Medicare DSH population by analyzing the compiled inpatient account information and segregating inpatient account information into potential Medicare DSH groups for each fiscal year as determined by County. To identify the universe of the potential Medicare DSH population, Contractor shall:

A. Match inpatient account records against Medi-Cal remittance data.
B. Match inpatient account records against eligible 1115 waiver days
C. Match inpatient account records against uninsured accounts
D. Perform self-pay conversion processing to identify potential incremental Medi-Cal and Medi-Cal Managed Care days.

E. Select accounts with patient days for dates of service for each fiscal year as requested by Director and categorize accounts by Medicare DSH type.
F. Accurately match inpatient account records to Medi-Cal eligibility dates.
G. Review days already claimed and paid by the fiscal intermediary and deduct these days from the Medicare DSH population.
H. Independently evaluate accuracy of the Medicare-assigned Supplemental Security Income (SSI) ratio for each fiscal year as determined by County, as follows:

1) Match the federal Centers for Medicare and Medicaid Services SSI file to inpatient account records;
2) Identify "dual-eligible" inpatient account records found on County system but not found on SSI file;
3) Research inconsistencies for non-matching instances to ascertain Medi-Cal coverage type, if any; and
4) Create a report of "dual eligible" inpatient account records not included in SSI ratio.

3.5.2.3 Prepare listings and reports by Facility as follows:

A. Medicare DSH exclusion report.
B. Payment status segregation report.
C. Reconciliation report of paid days to DSH listing, as necessary.
D. Plan code and service type summary report listing.
E. Medicare detail report (for filing with Medicare).

3.5.2.4 Additional Runs – Contractor shall perform up to three (3) additional runs after its initial Medicare detail report for filing with Medicare to potentially increase the Medi-Cal eligible days. The timing of the runs will be determined by the County. Contractor shall be paid a fee based on Paragraph 10.0, Provision For Payment of this Exhibit A-3, depending upon the issuance of the Revised Notice of Program Reimbursement (RNPR) reflecting these additional Medi-Cal eligible days.

3.5.2.5 For fiscal years where a final Medicare Cost Report settlement has been rendered, prepare claims for reopening or appeal, as appropriate and as determined by the County.

3.5.2.6 For fiscal years where a final Medicare Cost Report is pending, prepare claims for supplementing the pending Report.

3.5.2.7 Provide Medicare DSRS claims with dates of service to County upon request, where a final Medicare Cost Report settlement

has been rendered or pending. Contractor shall provide to County Medicare DSRS claims with dates of service as determined by the County, within two (2) years following the end of the fiscal year (June 30).

3.5.2.8 The parties also wish to clarify their intent with respect to the DSRS to be provided under the Agreement, including under SOW, Exhibit A-3.

3.5.2.8.1 The parties acknowledge and agree that, pursuant to Subsection 3.5.2, Disproportionate Share Recovery Services, Subsections 3.5.2.4 and 3.5.2.6, Sutherland will assist the County in filing amended cost reports by March 15, two years following the year covered by the cost reports to be amended. Such amended cost reports will reflect a revised claim of Medicaid eligible days based on an up-to-date determination of days for which Medicaid eligibility has been verified through the State's system.

3.5.2.8.2 The parties acknowledge and agree that the County is not required to ask Sutherland to perform, and Sutherland is not required to agree to perform DSRS in connection with the reopening of any cost report, or in connection with the appeal from any Notice of Program Reimbursement or revised Notice of Program Reimbursement. The County may, at its sole discretion, ask Sutherland to perform such services or may have them performed internally or by another entity.

3.5.2.8.3 Sutherland acknowledges and agrees that the Director of the County Department of Health Services or his delegate has only assigned to Sutherland, DSRS in connection with the filing, or amending of cost reports through and including FYE 6/30/20. If the Agreement is extended to May 31, 2022, or to subsequent years, DSRS in connection with FYE 6/30/2022, or subsequent years included in the extension period(s) will also be assigned to Sutherland. The County may assign DSRS associated with filing or amending cost reports for various fiscal years to other vendors.

3.5.3 **Indirect Medical Education Recovery Services (IMERS)**

At the County's discretion and with Contractor's concurrence, Contractor shall provide IMERS to Maximize County's Indirect Medical Education (IME) reimbursement in compliance with Medicare policies and regulations. Contractor shall:

3.5.3.1 Review the current impact of existing IME reimbursement and analyze the recovery rate. Develop, with Facility's approval, a processing flow to optimize IME reimbursement at Facilities.

3.5.3.2 Implement with Facility's approval, methodology for production of shadow billing, follow-up and collection.

3.5.3.3 Provide appropriate periodic reporting to County to document results.

3.6 Underpaid Account Identification and Billing Services (UAIBS)

Contractor shall identify underpaid accounts after these accounts have been closed by County or its primary contractor(s): Assign accounts will be based on protocol established and agreed upon between County and Contractor. Contractor shall:

3.6.1 Utilize demographic, charge, and payment data, Contractor shall identify and construct a file of underpaid accounts as having third-party coverage.

3.6.2 Apply appropriate fee schedules to determine if the claims were paid accordingly or if additional payment can be received due to errors or insufficient information and eliminate all accounts which were reimbursed appropriately.

3.6.3 Provide all Facilities receiving UAIBS with a monthly listing of accounts that are found to have been underpaid by the third-party payer (e.g. workers' compensation, commercial insurance), for which Contractor has conducted a review sufficient to ensure that no claim by County or its primary contractor exists. Facilities will delete accounts from the listing that are currently being pursued by the County or its primary contractor. Contractor shall then pursue reimbursement only for accounts remaining on the listing.

3.6.4 Provide all Facilities receiving UAIBS with a monthly listing (electronic or paper) of Approved Accounts which will not be pursued and no additional reimbursement was received, with an explanation of the reason(s) further efforts will not be pursued.

3.6.5 Employ a claim edit system to review all data from Facility systems to create a revised claim that is compliant with payer regulations and work with Facility staff to resolve all pre-bill edit failures (e.g., missing or incorrect patient demographic and charge information).

3.6.6 Provide County updated demographic and third-party resources information at the time of billing to include insurance information updates and third-party identification number (Carrier code updates, insurance billed) in electronic format.

3.6.7 Fully develop and submit, unless otherwise instructed by County, completed third-party revised claims/billings, preferably electronically, to the third-party payers or fiscal intermediaries.

3.6.8 Follow-up on denied claims, determine the cause of the denial, correct deficiency, and resubmit claims for payment unless and until the claim is determined to be uncollectible. Contractor shall document the reasons the account is uncollectible and report to the applicable Facilities.

3.6.9 Maintain a claim/payment tracking system to identify by account, category, Facility, and in total, amounts billed, collected, pending, denied, paid, and accounts referred back to Facilities or primary contractor(s). Contractor shall provide aging reports for accounts billed each month or as requested by applicable Facilities.

3.6.10 Post the payments and adjustments to all applicable Facility's accounts receivable systems within four (4) business days, as may be requested. Contractor's failure to post this information timely and accurately will result in fines/assessments as referenced in Attachment B – Performance Requirement Summary.

3.6.11 Provide (in electronic format) payments and adjustment transactions.

3.6.12 Provide various management reports regarding underpaid claims accepted, accepted claims not pursued and reason for not pursuing, claim billed, collections, remittance advice, denials, and other reports, in formats, content, and frequency to be determined by the County.

4.0 REQUIRED REPORTS

Contractor shall provide management reports, at no cost to County, provided the data is within Contractor's scope of services. All routine management reports (including Mental Health) must be provided timely per established due date.

From time to time, the County may request additional reports or one time only reports (i.e., new management reports, ad-hoc reports) created from Contractor's existing data fields. Contractor shall make such reports available to County within one week from Director's request or as otherwise agreed to by County and Contractor.

5.0 ADDITION/DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

5.1 Contractor shall provide one or more services listed in SCOPE OF WORK, Sub-Paragraph 2.1 as requested by each Facility listed in Attachment A, Facilities List.

5.2 The Contractor's awarded services may change as a result of deletion or addition of new Facility(ies), future consolidation of existing Facilities or as changes are required by law. Therefore, Contractor shall accept assignments or deletions of Facility(ies) and/or services deemed by the County to be in its best interest.

6.0 QUALITY CONTROL

The Contractor shall establish and maintain a written Quality Control Plan to ensure that the requirements of the Agreement are met. The Quality Control Plan may be in a chart format. An updated copy must be provided to the County's Project Director ten (10) business days after to the Agreement start date and within ten (10) business days when changes occur during the term of the Agreement. The plan shall discuss, but not be limited to, the following:

6.1 The Contractor's quality control or monitoring system covering each individual item listed in Paragraph 9.0, Performance Requirements Summary, of this SOW. It must specify the activities to be monitored on either a scheduled or unscheduled basis, how often monitoring will be accomplished, and the title of the individual(s) who will perform the monitoring.

6.2 The methods for identifying and preventing deficiencies in the quality of service performed before the level of performance becomes unacceptable and not in compliance with the Agreement.

6.3 The methods for documenting the monitoring results and, if necessary, the corrective actions taken.

6.4 The method for assuring that confidentiality of patient information is maintained while in the care of Contractor.

6.5 The method for assuring new Contractor employees will sign an Acknowledgement of Confidentiality Agreement prior to starting employment and will understand and abide by its terms upon starting employment.

On an ongoing basis, the Contractor's performance will be compared to the Agreement standards and Acceptable Quality Levels (AQLs) as referenced in Attachment B – Performance Requirement Summary. DHS may use a variety of inspection methods to evaluate the Contractor's performance, including but not limited to: random sampling; one hundred percent inspection of its output items on a periodic basis (daily, weekly, monthly, quarterly, semiannually or annually) as determined necessary to assure a sufficient evaluation of the Contractor's performance; review of reports and files; complaints from DHS; site visits; write off reports; and patient complaints.

7.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Agreement using the quality assurance procedures as defined in Section 14.0, County's Quality Assurance Plan, of the Additional Provisions of this Agreement.

7.1 Contract Discrepancy Report

Verbal notification of a Contract discrepancy will be made to the Contractor Project Manager as soon as possible whenever a Contract discrepancy is identified. The problem shall be resolved within a time-period mutually agreed upon by the County and Contractor. The County Project Monitor will determine whether a formal Contract Discrepancy Report shall be issued. Upon receipt of this document, the Contractor is required to respond in writing to the County Project Monitor within five (5) business days, with a plan for correction of all deficiencies identified in the Contract Discrepancy Report.

7.2 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Agreement at any time during normal business hours. However, these personnel may not unreasonably interfere with the Contractor's performance.

8.0 RESPONSIBILITIES

COUNTY

8.1 County Personnel and Records

8.1.1 County Administration

The Director shall have the authority to administer this Agreement on behalf of the County. The Director retains professional and administrative responsibility for the services rendered under this Agreement. A listing of all County Administration referenced in the following Sub-paragraphs is designated in Exhibit F, County's Administration, of the Agreement. The County shall notify the Contractor in writing of any change in the names or addresses shown.

8.1.1.1 County's Project Director

Person designated by the County with authority for the County on administrative matters relating to this Agreement that cannot be resolved by the County's Project Manager. Responsibilities of the County's Project Director include:

- ensuring that the objectives of this Agreement are met; and

- providing direction to the Contractor in the areas relating to County policy, information requirements, and procedural requirements.

8.1.1.2 **County's Project Manager**

8.1.1.2.1 The responsibilities of the County's Project Manager include:

- Meeting with the Contractor's Project Manager on a regular basis;
- inspecting any and all tasks, deliverables, goods, services, or other work provided by or on behalf of the Contractor; and.
- approving invoices.

8.1.1.2.2 The County's Project Manager is not authorized to make any changes in any of the terms and conditions of this Agreement and is not authorized to further obligate the County in any respect whatsoever.

8.1.1.3 **County's Project Monitor**

8.1.1.3.1 The County's Project Monitor is responsible for overseeing the day-to-day administration of this Agreement. The Project Monitor reports to the County's Project Manager.

8.1.1.4 County does not anticipate assigning any County employees to assist Contractor on a full-time basis regarding services to be provided by Contractor pursuant to this Agreement. However, County personnel will be made available to Contractor, if deemed necessary by the County, to provide input and assistance in order to answer questions and provide necessary liaison between Contractor and County departments.

8.1.1.5 The various operational/administrative records and statistics of County's health operations shall be provided to Contractor for review and evaluation whenever deemed appropriate and feasible by County, and as may be allowed by applicable law.

8.2 County Access to Information

8.2.1 In order for Contractor to perform the services described in this SOW, County shall cooperate with Contractor to allow access to such financial, medical and other operating data as may be allowed by Director and applicable law, including among other things the following:

8.2.1.1 Patient demographic, admission, and registration data from the respective Facility admission and registration system files, as available in format determined by Director.

8.2.1.2 Inpatient and ambulatory billing forms and billing folders for Medi-Cal, Medicare, and commercial insurance.

8.2.1.3 Affinity or other County patient accounting and accounts receivable information including all itemized and all-inclusive charges required for billing in format and timeframe determined by Director.

8.2.1.4 Medicare, Medi-Cal, and other third-party payer Remittance Files.

8.2.1.5 County patient medical records, for purposes of determining and verifying dates of patient service and other diagnosis information required for successful reimbursement.

8.2.1.6 File layouts, if necessary, for each of the files.

8.2.1.7 At Director's discretion, any additional files, documents, system access, or information deemed appropriate to Facilitate performance of the services described in SOW.

CONTRACTOR

8.3 **Contractor's General Responsibilities**

8.3.1 Contractor shall work independently on designated assignments in accordance with this SOW.

8.3.2 Notwithstanding any representation by County regarding the participation of County personnel in any phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities assigned in this Agreement.

8.3.3 Contractor(s) shall furnish all labor, materials, supplies, personnel, equipment, and administrative support necessary to perform the services under this Agreement. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee. At the County's sole discretion, the County may assign space, chairs, desks, and office equipment (e.g., telephones, fax machines, photocopying equipment) on a non-exclusive basis, for work area and related use by the Contractor. In the event the County assigns space and office equipment to the Contractor, Contractor shall use the space and office equipment only for the purpose of the performance of services hereunder. The Contractor is prohibited from use of such space and office equipment for the purposes other than for the performance of this Agreement

8.4 Contractor's Project Manager

8.4.1 Contractor shall provide a full-time Contract Project Manager or designated alternate. County must have access to the Contract Manager during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday except holidays, Contractor shall provide a telephone number where the Project Manager may be reached.

8.4.2 Manager shall act as a central point of contact with the County.

8.4.3 Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Agreement. Contract Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

8.4.4 Contractor shall respond to all County inquiries, including but not limited to, status and follow-up, telephonic, e-mail or facsimile inquiry, within one business day of initial inquiry. Failure to respond in a timely manner will result in fines/assessments as referenced in Attachment B – Performance Requirement Summary.

8.5 Contractor Personnel

8.5.1 Contractor shall assign a sufficient number of employees to perform the required work.

8.5.2 Background and Security Investigations

8.5.2.1 All Contractor staff performing work under this Agreement shall undergo and pass, to the satisfaction of the County, a background investigation as a condition of beginning and continuing to work under this Agreement. The County shall use its discretion in determining the method of background clearance to be used, which may include but is not limited to fingerprinting. The County shall perform the background check.

8.5.2.2 The County may request that the Contractor's staff be immediately removed from working on the County Agreement at any time during the term of this Agreement. The County will not provide to the Contractor nor to the Contractor's staff any information obtained through the County conducted background clearance.

8.5.2.3 The County may immediately, at the sole discretion of the County, deny or terminate facility access to the Contractor's staff that do not pass such investigation(s) to the satisfaction of the County whose background or conduct is incompatible with County facility access.

8.5.2.4 Disqualification, if any, of the Contractor's staff, pursuant to this Sub-paragraph 8.5.2, shall not relieve the Contractor of its obligation to complete all work in accordance with the terms and conditions of this Agreement.

8.6 Contractor Training

Contractor shall provide training programs for all new employees and continuing in-service training for all employees to perform the required work of this Agreement. Contractor's staff must be adequately trained and adhere to County Facility's information security policies and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) regulations in protecting the privacy and confidentiality of patient information at all times. Failure to comply with these requirements may result in fines/penalties, contract termination and/or legal prosecution.

8.7 Contractor's Office

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday except holidays, by at least one employee who can respond to inquiries and complaints which may be received about the Contractor's performance of the Agreement.

8.8 Additional Covenants of Contractor

In performing the services described in this SOW, Contractor shall:

8.8.1 Have no contact for collection with any of the patients of County's Facilities, without the prior written consent of the Director, during the course of Contractor's performance of any of the services in this Agreement.

8.8.2 Use reasonable care to avoid duplicate invoicing.

8.8.3 If so requested in advance by County, return all the material provided by County promptly and in the same condition and sequence in which is requested by the County.

8.8.4 Respect the confidential information with regard to County patient and Facility financial records. Contractor contractually recognizes the confidentiality of all County patient data and therefore, shall obtain/extract only that information needed to discover and generate required third-party billing information. All such collected information shall remain the property of County.

8.8.5 Upon termination of Agreement, if so requested by the Director, Contractor shall provide County, in a format designated by the Director, with the data

currently maintained in performance of services under this Agreement in accordance this SOW.

9.0 PERFORMANCE REQUIREMENTS SUMMARY

9.1 All listings of services used in the Performance Requirements Summary (PRS) are intended to be completely consistent with the Agreement and the SOW, and are not meant in any case to create, extend, revise, or expand any obligation of Contractor beyond that defined in the Agreement and the SOW. In any case of apparent inconsistency between services as stated in the Agreement and the SOW and Attachment B, the PRS Chart, the meaning apparent in the Agreement and the SOW will prevail. If any service seems to be created in this PRS which is not clearly and forthrightly set forth in the Agreement and the SOW, that apparent service will be null and void and place no requirement on Contractor.

9.2 The Contractor is expected to perform all services described herein. The PRS Chart describes certain required services which will be monitored by the County during the term of the Agreement, and for which Contractor may be assessed financial deductions from payment if the service has not been satisfactorily provided. The PRS Chart indicates the SOW and/or Agreement section of the performance referenced (column 1); the service and expected standard to be provided (column 2); the monitoring method that will be used (column 4); and the deductions/fees to be assessed for services that are not satisfactory (column 5).

10.0 PROVISION FOR PAYMENT

In accordance with the body of this Agreement, and as further set forth herein, County shall compensate Contractor as follows:

10.1 The fee payable to Contractor with respect to Medi-Cal, Medicare, health care plan and commercial insurance, and other third-party payer payments received by County as a consequence of this SOW Sections 3.1-EDICS, 3.2- FBFS, 3.4-TPRIRS, and 3.6-UAIBS shall be negotiated by the Director and the Contractor but not be greater than the amounts identified on Attachment C – Fee Schedule (Maximum Amounts). The negotiated fees will be incorporated into this Agreement via a written change notice. Fees may be renegotiated, or reduced in the event for which County's internal resources were used, and County's intervention were required for reimbursement of accounts, i.e. HCP Settlements.

10.2 Contractor shall be paid on a contingent fee basis for MBDRS provided to the county pursuant to SOW Section 3.5.1- MBDRS, and shall be negotiated by the Director and the Contractor but shall not, over the term of Agreement, be greater than twenty percent (20%) of the incremental Medicare Bad Debt settlement payments received by County as a direct result of Contractor's efforts.

10.3 Contractor shall be paid on a contingent fee basis for DSRS provided to the County pursuant to SOW Section 3.5.2 – DSRS, herein, and shall be negotiated by the director and the Contractor but shall not, over the term of the Agreement, be greater than twelve percent (12%) of the incremental (defined in Section 10.3.1 and 10.3.2 below) Medicare DSH reimbursements (an amount attributable to the Medi-Cal eligible days portion of the Medicare disproportionate share percentage) received by the County as a direct result of Contractor's efforts. The contingency fee paid to Contractor shall be calculated by each fiscal year, this amount is be calculated by dividing the Medi-Cal eligible and 1115 Waiver days ratio by the sum of the Medi-Cal, 1115 Waiver and SSI ratios. The resulting ratio will be applied to the total DSH reimbursement amount as per audit to determine the amount attributable to the Medi-Cal eligible days. The SSI ratio is provided by The Centers for Medicare and Medicaid Services ("CMS").

10.3.1 For FYE June 30, 1993 through the close of FYE June 30, 1997 - Incremental is defined as the additional Medi-Cal eligible days identified by Contractor and accepted by the Medicare Administrative Contractor that are greater than the days recognized in determining the DSH payment in the Notice of Program Reimbursement.

10.3.2 FYE June 30, 2002 and Forward – Incremental is defined as the additional Medi-Cal eligible days identified by Contractor that are greater than zero (0), due to Federal requirements of matching every Medi-Cal eligible day to the State Eligibility Verification Process or other State records that determines eligibility.

10.3.3 The amounts that Contractor will be paid for each phase of the claiming process are as follows:

10.3.3.1 Claiming submitted by Contractor based on Cost Reports

10.3.3.1.1 For patient care provided July 1, 2001 through September 30, 2013, County will pay Contractor a contingency fee of four percent (4%) determined by applying the formula calculated in Section 10.3 above to the final amount of DSH reimbursement determined in the Notice of Program Reimbursement or to the supplemental value reflected in any Revised Notice of Program Reimbursement issued after a non-appeal related reopening for which Contractor was responsible, except for patient care services rendered by provider Martin Luther King Jr./Drew Medical Center for July 1, 2001 through June 30, 2002 and Olive View-UCLA Medical Center for July 1, 2002 through June 30, 2003. For those two providers, for the designated period the County shall pay Contractor a contingency fee of 12 percent (12%) determined by

applying the formula calculated in Section 10.3 above to the final amount of DSH reimbursement reflected in these providers' Revised Notice of Program Reimbursements, regardless of whether the Revised Notice of Program Reimbursement was issued as a result of an appeal or a reopening request.

10.3.3.1.2 For patient care provided on or after October 1, 2013, County will pay Contractor ten percent (10%) determined by applying the formula in Section 10.3, to the final amount of DSH reimbursement determined in the Notice of Program Reimbursement. Notwithstanding the previous sentences, payment for DSRS related to Rancho Los Amigos National Rehabilitation Center's inpatient rehabilitation unit shall be four percent (4%) of amount received as a result of the adjustment for low income patients described in 42 C.F.R Section 412.624(e)(2), or any successor regulation.

10.3.3.1.3 Payment to Sutherland for DSRS related to patient care provided on or after October 1, 2013, shall not consider any reimbursement received by the County as uncompensated care payments pursuant to 42 C.F.R. Section 412.106(g), or any successor regulation.

10.3.3.2 Claiming for Additional Reimbursement Recognized after Audit

10.3.3.2.1 For purposes of this section, supplemental value reflected in a Revised Notice of Program Reimbursement means the difference between allowable DSH payment in the preceding Notice of Program Reimbursement, and the amount of allowable DSH payments in the Revised Notice of Program Reimbursement attributable to the Medicaid eligible days which the Contractor identified and the Medicare Administrative Contractor accepted. As reflected in Section 10.3, the Contractor shall not be paid for additional DSH reimbursement related to changes in the SSI Ratio provided by CMS.

10.3.3.2.2 County will pay Contractor a contingency fee of twelve percent (12%) of the supplemental value reflected in a Revised Notice of Program Reimbursement issued after reopening or appeal for

the service periods July 1, 1992 through June 30, 1997 for the following providers: LAC+USC Medical Center, Harbor-UCLA Medical Center, Martin Luther King Jr./Drew Medical Center, and Olive View-UCLA Medical Center.

10.3.3.2.3 County will pay Contractor a contingency fee of four percent (4%) of the supplemental value reflected in a Revised Notice of Program Reimbursement which is issued as the result of an appeal for all providers for the periods July 1, 2001 through September 30, 2013, except for Martin Luther King Jr./Drew Medical Center for July 1, 2001 through June 30, 2002 and Olive View-UCLA Medical Center for July 1, 2002 through June 30, 2003. Payment for those providers for those periods shall be governed by Section 10.3.3.1.

10.3.3.2.4 For patient care provided on or after October 1, 2013, County will pay Contractor ten percent (10%) determined by applying the formula in Section 10.3, to the supplemental value reflected in any Revised Notice of Program Reimbursement issued after a reopening or appeal for which Contractor was responsible. Notwithstanding the previous sentences, payment for DSRS related to Rancho Los Amigos National Rehabilitation Center's inpatient rehabilitation unit shall be four percent (4%) of amount received as a result of the adjustment for low income patients described in 42 C.F.R Section 412.624(e)(2), or any successor regulation.

10.3.4 **Interim Payment and Reconciliation**

10.3.4.1 At the request of Contractor, County shall make an interim payment of Contractor's contingent fee for each fiscal year in an amount not to exceed four percent (4%) related to services provided between July 1, 2001 and September 30, 2013, and not to exceed ten percent (10%) for services provided thereafter. Such interim payment shall be based on the incremental Medicare DSH reimbursement paid during the tentative settlement for each fiscal year by the Medicare Administrative Contractor. Interim payment made by the County to the Contractor shall relate only to the Medicaid eligible days portion of the claim only and may be paid in amount less than the full amount owed as agreed upon by County and Contractor. The Contractor shall not be paid for DSH reimbursement related to the SSI Ratio provided by CMS or if the Provider Statistical and

Reimbursement Group Appeal is resolved subsequent to the Medicare DHS-Medicaid eligible group appeal. If the Medicare Administrative Contractor has already made a tentative settlement for the fiscal year, the interim payment amount shall be based on the difference between the Medicare DSH reimbursement previously paid and the DSH amount paid during the most recent tentative settlement.

10.3.4.2 Upon issuance of a Notice of Program Reimbursement or a revised Notice of Program Reimbursement for a particular fiscal year that related to Medicare DSH-Medicare eligible days, the County will reconcile any interim payments for that fiscal year with the amount determined to be due pursuant to Section 10.3.3 above. If the County has not paid the full amount due, it will remit the difference to Sutherland. If the County paid Sutherland more than the amount due, Sutherland shall repay County within 15 days of receiving a notice of the overpayment or, with County's express written permission, may offset the overpayment against other amounts owed by Sutherland to County.

10.4 Contractor shall be paid on a contingent fee basis for services provided to the County pursuant to Section 3.5.3-IMERS, herein, and shall be negotiated by the Director and the Contractor but shall not, over the term of Agreement, be greater than twenty five percent (25%) of the incremental IMERS revenue received by County as a direct result of Contractor’s efforts.

10.5 All amounts payable to Contractor pursuant to this Paragraph 10.0, Provision for Payment, shall be paid by County to Contractor within a reasonable period of time following County's receipt of complete and correct payments for the billings generated by Contractor. At a minimum, Contractor shall submit monthly invoices detailing the payments received from all Third-Party payers during the prior month separated by facility, services, and payers. In no case shall County pay to Contractor any amounts pursuant to this Paragraph 10.0, Provision for Payment, for any Third-Party payments received by Facilities prior to date of commencement of this Agreement. Contractor shall be entitled to payments, pursuant to this Paragraph 10.0, Provision for Payment, for completed services provided by Contractor on accounts which were referred to and accepted by Contractor and not recalled by County.

10.6 All disputed accounts shall be resolved by County and Contractor as follows:

10.6.1 County will use a “Disputed Account Form” mutually agreed upon by County and Contractor.

10.6.2 Each disputed account may be returned to Contractor for additional information.

10.6.3 Contractor shall have thirty (30) days from receipt of a Disputed Account Form to respond to County's dispute.

10.6.4 County shall have thirty (30) days to accept or reject Contractor's response and process Contractor's invoice for the disputed claim. If County rejects Contractor's response and denies payment, Contractor must file an appeal to the Chief of Consolidated Business Office – Quality or designee for final disposition.

10.6.5 All invoices are assumed to be accurate unless County objects in writing within thirty (30) days of receipt of disputed invoice. If County in good faith disputes all or any portion of any invoice, County shall pay the undisputed amounts of such invoice when due and may, at its option, withhold the disputed portion pending resolution of the dispute or by mutual agreement. If County withholds any payment pursuant to this Section, County shall notify Contractor of the basis for such withholding. Upon resolution of the dispute, County shall pay to Contractor the unpaid portion, if any, of the disputed amount(s).

10.7 Contractor hereby agrees that any Payments made by County to Contractor for patient stays/visits originally approved by a Third-Party payer, but later disallowed in audit or otherwise recouped by the payer or its intermediary, except for Medi-Cal cost report settlements, shall be repaid/offset to County, provided however the disallowed payments are a result of the services supplied by the Contractor's under this Agreement The County is due a "Penalty" as a result of Contractor's failure to meet the Standard Performance Requirement identified in Exhibit A-3, Attachment B. A Penalty shall apply in the event of Contractor's failure to achieve the agreed upon Standard Performance Requirement during any measurement period. Contractor shall credit the County on the invoice following the month in which the failure and resulting Penalty occurs. All repayments/offsets of Payments to be made by Contractor shall be due and payable by Contractor upon Contractor's receipt of an itemized invoice indicating the specific nature and amount of the audit disallowance(s) and/or recoupment(s) and affirming County's intention to immediately repay any disallowances to the effective payer(s). If Contractor fails to immediately reimburse County following its receipt of such invoice, Director may, at his or her sole discretion, deduct such amount from future payments to Contractor.

10.8 Contractor hereby agrees that should it become necessary, due to temporary failure of Contractor to provide adequate EDICS, Contractor shall not be entitled to receive any fees specified in this Paragraph for claims submitted for payment through alternative means. Contractor shall be responsible for all lost revenue resulting from its failure to provide EDICS and if necessary, establish or subcontract with a qualified alternative third-party to provide EDICS.

10.9 Contractor also agrees to maintain records sufficient to document all billings submitted as part of this Agreement. Those records shall serve as the basis of the

computations required pursuant to Paragraph 10.0, Provision for Payment and shall contain the following information:

A. Accounts billed;
B. Invoice/control numbers of all billings submitted;
C. Dates of billings;
D. Amounts paid to County, by invoice/control number;
E. Dates of payments to County;
F. Amounts due to Contractor;
G. Dates of payments to Contractor by County; and
H. Account Notes.

10.10 County shall cooperate in providing Contractor with access to the information necessary for Contractor to maintain such ledgers and Contractor shall make such ledgers available to County for its inspection.

11.0 SPECIAL ACCOUNTS

From time to time, the County may designate accounts for processing based on County and Contractor mutually agreeing to established protocols or by referral of accounts as "Special" Accounts." Contingent fees on these accounts shall be set by the Director, or designee, with the written approval of the Contractor, but shall not be greater than the amounts identified on Attachment C - Fee Schedule (Maximum Amounts) in this SOW with any exception or additional terms set forth in writing by the Director. The written approval of reduced contingent fees by the Contractor for any and all special accounts (e.g., Disproportionate Share Hospital), shall be memorialized in the form of a written Change Notice pursuant to Paragraph 16, Alteration of Terms, of this Agreement and the fully executed Change Notice thereafter will be incorporated into and shall become part of the Agreement.

FACILITIES LIST

(DETAILED LISTING OF COUNTY FACILITIES BY FACILITIES, ACN's, and JUVENILE FACILITIES)

HEALTH SRVICES HEADQUATERS/ADMINISTRATION (HSA)	
FACILITY	**LOCATION**
Health Services Administration (HSA)	313 N. Figueroa St., Los Angeles CA 90012
Consolidated Business Office (CBO)	5555 Ferguson Sr. Commerce, CA 90022
Emergency Medical Services (EMS)	10100 Pioneer Blvd. Suite 200 Santa Fe Springs, CA 90670

DHS HOSPITALS	
FACILITY	**LOCATION**
Harbor/UCLA Medical Center	1000 W. Carson St. Torrance, CA 90509
Gardena High (School Based)	1301 W 182nd St, Gardena, CA 90248
Harbor-UCLA Family Health Center	1403 Lomita Blvd. Ste. 200, Harbor City, CA 90710
Los Angeles General Medical Center (LA General)	2051 Marengo St., Los Angeles CA 90033
Star Clinic	242 East 6th St., Los Angeles, CA 90014
Olive View-UCLA Medical Center	14445 Olive View Drive Sylmar, CA 91342
Rancho Los Amigos National Rehabilitation Center	7601 E. Imperial Highway Downey, CA 90242
AMBULATORY CARE NETWORK	
FACILITY	**LOCATION**
Antelope Valley Health Center	335 E. Avenue K-6, Ste B, Lancaster, CA 93535
Bellflower Health Center	10005 Flower St., Bellflower, CA 90706
Curtis Tucker Health Center	123 W. Manchester Blvd., Inglewood, CA 90301
Dollarhide Health Center	1108 North Oleander Ave., Compton, CA 90222
East Los Angeles Health Center	133 N. Sunol Dr. Ste 150, Los Angeles, CA 90063
East San Gabriel Valley Health Center	1359 N. Grand Ave., Covina, CA 91724
Edward R. Roybal Comprehensive Health Center	245 S. Fetterly Ave., Los Angeles, CA 90022
El Monte Comprehensive Health Center	10953 Ramona Blvd. Ste 221, El Monte, CA 91731
Glendale Health Center	501 N. Glendale Ave., Glendale, CA 91206
H Claude Hudson Comprehensive Health Center	2829 S. Grand Ave., Los Angeles, CA 90007

FACILITIES LIST

(DETAILED LISTING OF COUNTY FACILITIES BY FACILITIES, ACN's, and JUVENILE FACILITIES)

AMBULATORY CARE NETWORK	
FACILITY	**LOCATION**
High Desert Regional HC	335 East Avenue I, Lancaster, CA 93535
Hubert H. Humphrey Comprehensive Health Center	5850 S. Main St., Ste. 1127, Los Angeles, CA 90003
La Puente Health Center	15930 Central Ave., La Puente, CA 91744
Lake Los Angeles Community Clinic	16921 E. Avenue O, Ste G, Palmdale, CA 93591
Littlerock Community Clinic	8201 Pearblossom Hwy., Littlerock, CA 93543
Long Beach Comprehensive Health Center	1333 Chestnut Ave., Long Beach, CA 90813
Martin Luther King, Jr. Outpatient Center	12021 Wilmington Ave, Los Angeles, CA 90059
Mid-Valley Comprehensive Health Center	7515 Van Nuys Blvd., Van Nuys, CA 91405
San Fernando Health Center	1212 Pico St., San Fernando, CA 91340
South Valley Health Center	38350 40th St. East, Ste 100, Palmdale, CA 93552
Torrance Health Center	711 Del Amo Blvd., Torrance, CA 90502
West Valley Health Center	20151 Nordhoff St., Chatsworth, CA 91311
Wilmington Health Center	1325 Broad Ave., Wilmington CA 90744

JUVENILE CLINICS	
Central Juvenile Hall	1605 Eastlake Ave. Los Angeles CA 90033
Los Padrinos Juvenile Hall	7285 Quill Dr, Downey, CA 90242
Barry J. Nidorf Juvenile Hall	16350 Filbert St, Sylmar, CA 91342

FACILITIES LIST

**(DETAILED LISTING OF COUNTY FACILITIES
BY FACILITIES, ACN's, and JUVENILE FACILITIES)**

DPH - PUBLIC HEALTH CENTERS	
FACILITY	**LOCATION**
Antelope Valley Health Center	335 East Avenue K-6 Ste B., Lancaster, CA 93535
Central Health Center	241 N. Figueroa St., Los Angeles, CA 90012
Curtis Tucker Health Center	123 W. Manchester Blvd., Inglewood, CA 90301
Glendale Health Center	501 N. Glendale Ave., Glendale, CA 91206
Hollywood/Wilshire Health Center	5205 Melrose Ave., Los Angeles, CA 90038
Martin Luther King Jr. (South) Health Center	11833 s. Wilmington Ave., Los Angeles, CA 90059
Monrovia Health Center	330 W. Maple Ave., Monrovia, CA 91016
North Hollywood Health Center	5300 Tujunga Ave., North Hollywood, CA 91601
Pacoima Health Center	13300 Van Nuys Blvd., Pacoima, CA 91331
Pomona Health Center	750 S. Park Ave., Pomona, CA 91766
Ruth Temple Health Center	3834 S. Western Ave., Los Angeles, CA 90062
Burke/Simms/Mann Health Center	2509 Pico Blvd., Santa Monica, CA 90405
Torrance Health Center	711 Del Amo Blvd., Torrance, CA 90502
Whittier Health Center	7643 Painter Ave., Whittier, CA 90602
Central Satellite Clinic – The Leavey Health Center	522 S. San Pedro St., Los Angeles, CA 90013

OTHER PUBLIC HEALTH PROGRAMS	
Public Health Lab	12750 Erickson Ave., Downey, CA 90242
MCAH – Nurse-Family Partnership Program	600 S. Commonwealth Ave Ste 800., Los Angeles, CA 90005

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

CRITERIA 1: BILLING	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
A. Untimely Billing Exhibit A-3, Statement of Work (SOW), Sections: 3.2.5.1 3.2.5.2 3.2.5.3 3.2.5.4 3.2.5.5 3.2.5.6	Contractor shall timely bill a clean claim within the timeframe as specified in the Agreement and according to the payer contracts. A clean claim is defined as a claim(s) having all billing elements in the County System (e.g., Affinity/ORCHID) and all such elements have been provided to the Contractor via HL7 seven (7) business days prior to Payor's timeframe. <u>Timely billing is calculated as follows:</u> AQL shall be calculated as a percentage of the total undisputed number of accounts written-off divided by total number of billable accounts for the Fiscal Year (July-June), per facility, per category. Contractor will monitor and share reporting with the County on a monthly basis for tracking purposes only. No penalties shall be assessed until after the final Write-Off calculation is completed after the Fiscal Year closes. Penalties, if any shall only be assessed on those accounts that are written off after the AQL acceptable limit has been reached. Calculation shall start with accounts that are considered to be in the timely billing period on 07/01/2020. Applicable Write-off Adjustment Codes and Reason Codes: MMC: 20153 – 01, 34, 39, 43, 52 Commercial: 20072 – 01, 34, 39, 43, 52 Medi-Cal: 20073 – 01, 34, 39, 43, 52 Medicare: 20074 – 01, 34, 39, 43, 52 CCS: 20075 - 01, 34, 39, 43, 52	Monthly Write-Off Report	100% 97% 97% 97%	Inpatient Institutional: $1,500/Occurrence if Charge Amount > = $100K $1,000/Occurrence if Charge Amount < $100k Outpatient Institutional: $50/Occurrence Professional: $50/Occurrence

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

CRITERIA 1: BILLING	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
B. Untimely Follow-up SOW Sections: 3.2.5.7 3.2.5.8	Contractor shall timely follow-up and exert all efforts to resolve denied/unpaid or underpaid claims within the timeframe indicated in the Agreement. <u>Timely follow up is calculated as follows:</u> AQL shall be calculated as a percentage of the total undisputed number of accounts written-off divided by total number of billable accounts for the Fiscal Year (July-June), per facility, per category. Contractor will monitor and share reporting with the County on a monthly basis for tracking purposes only. No penalties shall be assessed until after the final Write-Off calculation is completed after the Fiscal Year closes. Penalties, if any shall only be assessed on those accounts that are written off after the AQL acceptable limit has been reached. Calculation shall start with accounts that are considered to be in the untimely follow up period on 07/01/2020. Applicable Write-off Adjustment Codes and Reason Codes: MMC: 20153 – 02, 33, 40, 44, 53 Commercial: 20072 – 02, 33, 40, 44, 53	Monthly Write-Off Report	100% 97% 97% 97%	Inpatient Institutional: $1,500/Occurrence if Charge Amount > = $100K $1,000/Occurrence if Charge Amount < $100k Outpatient Institutional: $50/Occurrence Professional: $50/Occurrence

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

CRITERIA 2: Payment & Adjustment Posting (as applicable to respective Contractors)	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
A. Duplicate Payment Batch Posting SOW Sections: 3.2.11 3.2.13 3.6.10	Contractor shall accurately post Payment Batches. Contractor shall solely use and post Batch Number(s) provided by County. In no event that Contractor shall create/rename/alter a Batch Number without prior approval from CBO General Accounting/Posting Unit.	Periodic Audit of Accounts through reconciliation of batches posted to Affinity RCO vs. Payments recorded by CBO General Accounting/Posting Unit.	97%	$1,000/Occurrence/Batch
B. Erroneous Posting of Recoupment/Refunds SOW Section: 10.7	All refunds/recoupments that are off-set by another account shall be posted in Affinity to both accounts affected provided the County has supplied Contractor with necessary account information to process such refunds/recoupments.	Periodic Audit of Accounts through reconciliation of batches posted to Affinity RCO vs. Payments recorded by CBO General Accounting/Posting Unit.	97%	$200/Occurrence/Account

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

CRITERIA 2: Payment & Adjustment Posting (as applicable to respective Contractors)	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
C. Untimely Processing of State Program Refunds SOW Section: 3.2.5.8	Create and timely process electronic CIFs for Medi-Cal OP denials or payments. Contractor shall within sixty (60) calendar days process CIF from County's initial notification. If CIF is not due to Contractors error, Contractor will process CIF and any fees charged for the original bill will not be refunded. Accounts must be identified with Carrier Code 465 – Credit Balance	Account Trial Balance (ATB)	97%	$50 /Account

CRITERIA 3: INVOICING	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
A. Duplicate Invoicing of Accounts SOW Section: 10.9	Contractor shall invoice County only once per payment per account with the proper batch number and account details on a monthly statement.	Monthly reconciliation of payments against accounts in previous invoices in the last 2 years.	97%	Inpatient Institutional: $100/Occurrence Outpatient Institutional: $100/Occurrence/Account Professional: $100/Occurrence/Account

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

CRITERIA 3: INVOICING	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
B. Failure to Respond to Request on Overpaid Fees SOW Section: 10.6.5	Contractor shall acknowledge County request within 1 business day and Contractor shall provide Agreement/disagreement to County's request within ten (10) business days from inquiry date. Upon mutual Agreement on funds to be reimbursed to the County, Contractor shall reimburse County on the next monthly invoice from the mutual Agreement date.	Monthly reconciliation of accounts against accounts in previous invoices.	97%	$500/Occurrence/Batch

CRITERIA 4: OTHER	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
A. Management Reports SOW Sections: 2.4 4.0	Contractor shall provide management reports, at no cost, as well as customized reports or a system providing County with the ability to generate ad hoc reports in a timeframe agreed upon with Director and Contractor.	Availability of Report	1 Business Day	$100/incomplete/inaccurate report $50 per report each day late
B. Maintain Written Quality Control Plan SOW Section: 6.1	Contractor shall establish and maintain written Quality Control Plan to ensure that the requirements of the Agreement are met.	Receipt and Review of Plan	1 Business Day	$1000 if plan is incomplete $50 per each day late.

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

CRITERIA 4: OTHER	STANDARD PERFORMANCE REQUIREMENT	MONITORING TOOL	Acceptable Quality Level (AQL)	ASSESSMENT
C. Respond to County Inquiries SOW Section: 8.4.4	Contractor shall respond to all County inquiries, including but not limited to, status and follow-up, telephonic, e-mail or facsimile inquiry, within one business day of initial inquiry. **County will adhere to Contractors Responsibility Matrix.**	Receipt of Response	1 Business Day	$100 per day when timeframe is not adhered to.
D. Confidentiality Agreement, County Confidential Information SOW Section: 6.1.5	Contractor and Contractor Employee Acknowledgement and Confidentiality Agreements signed and provided to DHS within three (3) business days.	None	Review of reports, complaints	$100 per day per employee when form not signed; $1,000 per unauthorized release of information

Penalty Cap:

1. County and Contractor agree to the Standard Performance Requirements (the "**SPRs**") measurement and expectations detailed in this Attachment B, Performance Requirements Summary. Any adjustments to the SPRs must be agreed upon by both County and Contractor.

2. Should Contractor fail to meet any of the SPRs listed in the Performance Requirements Summary during any measurement period, Contractor shall provide County with a written plan for improving Contractor's performance within five (5) business day of failing to meet SPR. Such plan shall be subject to County's approval, and such approval shall not be unreasonably withheld. Contractor shall promptly implement such plan (the "Improvement Plan") when it has received approval from County. Contractor shall provide feedback on selected errors discovered and, in consultation with County, make agreed upon changes to the issues causing the errors.

3. For the purposes of these SPRs and their associated penalties, the measurement will be recorded and monitored and the respective penalty shall be calculated as stated in this Attachment B, Performance Requirements Summary. Penalties, however, shall only be assessed based upon annual average of each measurement as determined at the anniversary of this Agreement.

4. The aggregate sum of the penalties assessed by the County on the Contractor for failed SPRs pursuant to the Attachment B, Performance Requirements Summary, for failed SPR(s) for a measured period shall not exceed five percent (5%) of the Contractor's average total invoiced amount for the Fiscal Year; the five percent (5%) constitutes the "Penalty Cap".

PERFORMANCE REQUIREMENTS SUMMARY
(EFFECTIVE JULY 1, 2020)

5. In the event the County assesses penalties on the Contractor in a measurement period in which the aggregate sum of assessed penalties equals the five percent (5%), the Penalty Cap shall automatically increase to ten (10%) for subsequent measurement periods.

6. The Contractor shall earn back the five percent (5%) Penalty Cap when the aggregate amount of penalty assessments per measurement period for the next six months are below five percent (5%).

FINANCIAL MANAGEMENT SERVICES

MAXIMUM CONTINGENTCY FEE SCHEDULE

CONTRACT PROVISION	MEDI-CAL	MEDICARE	CROSSOVER MEDI-CAL PORTION	INSURANCE	ALL OTHER PAYORS
Exhibit A-3, Statement of Work (SOW) Section: 3.1 EDICS	No greater than $5 for each transaction	No greater than $5 for each transaction	No greater than $5 for each transaction	No greater than $5 for each transaction	No greater than $5 for each transaction
SOW Section: 3.2 FBFS	No greater than $86 per I/P paid day No greater than $14 per O/P paid visit	All Inclusive Billing. No greater than 15.5 % of payments received Itemized billing is required. No greater than 25 % of payments received	No greater than $86 per I/P paid claim No greater than $7 per O/P paid claim	All Inclusive Billing. No greater than 14% of payments received Itemized billing is required. No greater than 25 % of payments received	All Inclusive Billing. No greater than 15.5% of payments received Itemized billing is required. No greater than 25 % of payments received

FINANCIAL MANAGEMENT SERVICES

MAXIMUM CONTINGENTCY FEE SCHEDULE

CONTRACT PROVISION	MEDI-CAL	MEDICARE	CROSSOVER MEDI-CAL PORTION	INSURANCE	ALL OTHER PAYORS
SOW Section: 3.4 TPRIRS	No greater than $345 per I/P paid day No greater than $28 per O/P paid visit	All Inclusive Billing. No greater than 25 % of payments received Itemized billing is required. No greater than 25 % of payments received	No greater than: $173 per I/P paid claim No greater than $14 per O/P paid claim	All Inclusive Billing. No greater than 25% of payments received Itemized billing is required. No greater than 25 % of payments received	All Inclusive Billing. No greater than 25% of payments received Itemized billing is required. No greater than 25 % of payments received
SOW Section: 3.6 UAIBS	No greater than $345 per I/P paid day No greater than $28 per O/P paid visit	All Inclusive Billing. No greater than 25_ % of payments received Itemized billing is required. No greater than 25 % of payments received	No greater than: $173 per I/P paid claim No greater than $14 per O/P paid claim	All Inclusive Billing. No greater than 25% of payments received Itemized billing is required. No greater than 25 % of payments received	All Inclusive Billing. No greater than 25% of payments received Itemized billing is required. No greater than 25% of payments received

- Contract Provision SOW Section 3.5 - Cost Report Recovery Services (CRRS): Contingency fees are provided in SOW Sections 10.2, 10.3 and 10.4.
- There is a CAP of $19,500 per paid account for FBFS and TPRIRS.
- The fees shall be negotiated by Director and Contractor but shall be no greater than the fees indicated on this Attachment C – Maximum Contingency Fee Schedule (Maximum Amounts).
- Department of Public Health
- Department of Mental Health

Notes: I/P = Inpatient; O/P = Outpatient; SOW = Exhibit A-3, SOW

COUNTY'S ADMINISTRATION

AGREEMENT NO. _____

COUNTY'S PROJECT DIRECTOR:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ Facsimile:_____

E-Mail Address: _____

COUNTY'S PROJECT MANAGER:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ Facsimile:_____

E-Mail Address: _____

COUNTY'S PROJECT MONITOR:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ Facsimile:_____

E-Mail Address: _____

CONTRACTOR'S ADMINISTRATION

CONTRACTOR'S NAME:_____

AGREEMENT NO: _____

CONTRACTOR'S PROJECT MANAGER:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

CONTRACTOR'S AUTHORIZED OFFICIAL(S)

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

Notices to Contractor shall be sent to the following:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

Agreement No.:H-702058

FINANCIAL BILLING AND RECOVERY SERVICES AGREEMENT
AMENDMENT NO. 14

THIS AMENDMENT is made and entered into this ___ day of _____, 2023,

By and between COUNTY OF LOS ANGELES
(hereafter "County"),

And

USCB INC. dba USCB AMERICA
(hereafter "Contractor").

Business Address:

3333 Wilshire Blvd., 7th Floor
Los Angeles, CA 90010

WHEREAS, reference is made to that certain document entitled “FINANCIAL BILLING AND RECOVERY SERVICES AGREEMENT", dated July 1, 2006, and further identified as Agreement No.: H-702058, including any amendments thereto (all hereafter referred to as "Agreement"); and

WHEREAS, on (TBD) the Board of Supervisors delegated authority to the Director of Health Services, or designee, among other delegations, extend the term of the Agreement for the period October 1, 2023 through September 30, 2025; and

WHEREAS, it is the intent of the parties hereto to amend the Agreement to extend its term, to update certain terms and conditions to the Agreement, and to provide for the other changes set forth herein; and

WHEREAS, the Agreement, provides that changes in accordance to Paragraph 14, AMENDMENTS, may be made in the form of an Amendment which is formally approved and executed by the parties; and

WHEREAS, the Contractor warrants that it continues to possess the competence, expertise and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution.

3. The Agreement is hereby incorporated by reference, and all of its terms and conditions, including capitalized terms defined herein, shall be given full force and effect as if fully set forth herein.

2. The Agreement, Paragraph 1, TERM, is deleted in its entirety and replaced to read as follows:

"1. TERM:

The term of this Agreement shall commence July 1, 2006, unless sooner cancelled or terminated as provided herein, and shall continue in full force and effect, through and including September 30, 2025 (“Term”).

In any event, this Agreement may be canceled or terminated at any time by either party, with or without cause, upon the giving of at least thirty (30) calendar days advance written notice to the other party. Further, County may also suspend the performance of services hereunder, in whole or in part, upon the giving of at least thirty (30) calendar days advance written notice to Contractor. County's notice shall set forth the extent of the suspension and the requirements for full restoration of the performance obligations.

Notwithstanding any other provision of this Agreement, the failure of Contractor or its officers, employees, agents, or subcontractors to comply with any of the terms of this Agreement or any written directions by or on behalf of County issued pursuant hereto shall constitute a material breach hereto, and this Agreement may be terminated by County immediately. County's failure to exercise this right of termination shall not constitute a waiver of such right, which may be exercised at any subsequent time.

The Contractor shall notify DHS when this Agreement is within three (3) months from the expiration of the term as provided for hereinabove. Upon occurrence of this event, the Contractor shall send written notification to the DHS at the address provided in Paragraph 16, NOTICES, of the Agreement."

3. The Agreement, EXHIBIT E, COUNTY’S ADMINISTRATION, is deleted in its entirety and replaced by EXHIBIT E-1, COUNTY’S ADMINISTRATION, attached hereto and incorporated herein by reference. All references to EXHIBIT E, COUNTY’S ADMINISTRATION in the Agreement shall hereafter by replaced by EXHIBIT E-1.

4. The Agreement, EXHIBIT F, CONTRACTOR'S ADMINISTRATION, is deleted in its entirety and replaced by EXHIBIT F-1, CONTRACTOR'S ADMINISTRATION, attached hereto and incorporated herein by reference. All references to EXHIBIT F, CONTRACTOR'S ADMINISTRATION in the Agreement shall hereafter by replaced by EXHIBIT F-1.

5. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services, or authorized designee, and Contractor has caused this Amendment to be executed on its behalf by its duly authorized officer(s), on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By:_____for
Christina R. Ghaly, M.D.
Director of Health Services

CONTRACTOR

USCB Inc. dba USCB America

By:_____
Signature

_____
Printed Name

_____
Title

APPROVED AS TO FORM:
DAWYN HARRISON
County Counsel

By:_____
Kelly Auerbach Hassel
Deputy County Counsel

COUNTY'S ADMINISTRATION

AGREEMENT NO. _____

COUNTY'S PROJECT DIRECTOR:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ Facsimile:_____

E-Mail Address: _____

COUNTY'S PROJECT MANAGER:

Name: _____

Title: _____

Address: _____

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E-Mail Address: _____

COUNTY'S PROJECT MONITOR:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ Facsimile:_____

E-Mail Address: _____

CONTRACTOR'S ADMINISTRATION

CONTRACTOR'S NAME:_____

AGREEMENT NO: _____

CONTRACTOR'S PROJECT MANAGER:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

CONTRACTOR'S AUTHORIZED OFFICIAL(S)

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-Mail Address: _____

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