MEDI-CAL PHYSICIAN SERVICES PROVIDER AGREEMENT, FEDERALLY QUALIFIED HEALTH CENTER

between

COUNTY OF SANTA BARBARA

and

CENCAL HEALTH

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**MEDI-CAL PHYSICIAN SERVICES PROVIDER AGREEMENT,
FEDERALLY QUALIFIED HEALTH CENTER**

THIS MEDI-CAL PHYSICIAN SERVICES PROVIDER AGREEMENT, FEDERALLY QUALIFIED HEALTH CENTER ("Agreement"), is hereby executed by and between **County of Santa Barbara**, an organization approved by the State Department of Health Care Services as a Federally Qualified Health Center (FQHC) (hereafter "County"," as defined below") and **Santa Barbara San Luis Obispo Regional Health Authority**, a body corporate and politic, (formerly Santa Barbara Regional Health Authority), dba CenCal Health, ("CenCal Health") (County and CenCal Health are jointly the "parties"). This Agreement will be effective January 1, 2012 (the "Effective Date").

RECITALS

A. CenCal Health and County have previously entered into Physician Services Provider Agreements, which have been amended from time to time. This Agreement will restate the relationship between the parties and replace all prior Medi-Cal agreements.

B. CenCal Health directly administers one or more health benefit products and wishes to arrange for the provision of medical services to Members as specified in this Agreement.

C. County is comprised of or contracts with one or more Physicians capable of meeting the credentialing criteria of CenCal Health.

D. CenCal Health desires to engage County to deliver or arrange for the delivery of medical services to the Members of its Plans and County is willing to deliver or arrange for the delivery of such services on the terms specified herein.

E. County was granted an expansion in scope from a Federally Qualified Healthcare Center (FQHC) to a Community Health Center (CHC) in September 2010. To coincide with the change in scope, County of Santa Barbara changed the name of site-specific County FQHC Clinics to "Health Care Centers" and said change is set forth in this Agreement as "County Health Care Centers".

F. CenCal Health has been administering the Medi-Cal Program in San Luis Obispo County since March 1, 2008. This Agreement, as written, will be deemed to include all Medi-Cal Members who reside in the CenCal Health Service Area, which is currently Santa Barbara (SB) and San Luis Obispo (SLO) counties, unless otherwise noted.

G. The parties agree and understand that while the County, as an FQHC, is legally required to be offered the same terms and conditions as other CenCal Health providers, because the County is a governmental entity, certain terms and conditions applicable to other providers are not appropriate or applicable to the County.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, the parties hereby agree as follows:

1. DEFINITIONS

As used in this Agreement, the following terms shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Additional definitions applicable to this Agreement are set forth in the contract definitions section of the overview section of the CenCal Health Provider Manual ("Provider Manual").

"Allied Health Provider" shall mean any qualified health care provider who has: (i) executed an agreement with CenCal Health to provide health care services to Members; (ii) who is not a Physician, Hospital, skilled nursing facility or intermediate care facility; (iii) accepted the compensation set forth in Allied Health Provider's Agreement with CenCal Health; and (iv) been credentialed or verified, if required.

"Attending Physician" shall mean: (i) any physician who is rendering medical services to meet the medical needs of the Member; or (ii) any physician who is, through delegation from the Member's PCP, actively engaged in the treatment or evaluation of a Member's condition.

"Board of Directors" shall mean the Board of Directors of CenCal Health.

"California Children Services Program" or "CCS" shall mean a public health program, which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR) § 41800, et seq.

CenCal Health currently does not administer the CCS Program in the Service Area, but is responsible for processing and payment of Claims for CCS authorized services in SB County, but does not have this responsibility in SLO County. Additional information about CCS is set forth in the Provider Manual.

"Capitation" shall mean a monthly payment in the form of a per capita (or per person) amount. CenCal Health is paid a per member per month rate by the California Department of Health Care Services (DHCS) for Medi-Cal patients and CenCal Health pays its contracted SBHI and SLOHI Primary Care Providers (PCPs), County, and others who have executed capitated agreements a capitation rate using the Capitation methodology set forth in Attachment A-2 of Exhibit A to the Agreement for member services. Whenever this term is used in the Agreement or in the Exhibits, it pertains only to payment to PCPs for County Case Managed Members, excluding Medi-Medi Members.

"Case Management" shall mean providing or approving Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services, coordination of Medically Necessary Covered Services; maintenance of a medical record with documentation of Referral Services, and follow-up as medically indicated; ordering of therapy, admission to hospitals, coordinated hospital discharge planning that includes necessary post-discharge care, and approval of referred services. Case Management includes the responsibility for organizing a pattern of supportive medical resources, so that Members may be appropriately served by medical advice and supervision seven (7) days each week and twenty-four (24) hours per day. May also be expressed as "Case Manager" or "Case Managed", i.e. County Health Care Center's Case Managed Members.

"CenCal Health Referral" shall mean an administrative authorization issued by CenCal Health Member Services or Provider Services Departments when PCP authorization is not possible due to

administrative problems as specified in the CenCal Health Referral, Authorization, and Utilization Management (UM) Process Policy and Procedure. The UM process is summarized in the Provider Manual and the Policy and Procedure is available upon request.

"CenCal Health Committees" shall mean the various committees as described in the Provider Manual.

"Children's Health and Disability Program" or "CHDP" shall mean California's version of the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The CHDP Program provides for payment of well child visits, screening procedures and immunizations for children (to age 21), which are also Covered Services. CenCal Health currently does not administer the CHDP Program. Additional information regarding the CHDP Program and CHDP Providers is set forth in the Provider Manual.

"Claim" shall mean a statement of services submitted to CenCal Health by County following the provision of Covered Services to a Member that shall include diagnoses and an itemization of services and treatment provided to Member. A Claim may be paper or electronic. See also Exhibit C, Encounter and Claims Billing Procedures, of this Agreement.

"Clean Claim" shall mean a properly completed billing form with complete Current Procedural Terminology (CPT)-4, International Classification of Diseases (ICD)-9 coding or Healthcare Common Procedure Coding System (HCPCS) coding where applicable, and which contains all the information specifically required in the Provider Manual, and/or the State manual.

"Clinical Privileges" shall mean permission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license and experience, competence, ability, and judgment.

"Confidential Information" shall mean specific facts or documents identified as "confidential" by law, regulations, or contract language.

"Copayment" shall mean a charge, if any, that may be collected directly by a Provider or its designee from a Member in accordance with the requirements of the Medi-Cal program administered by CenCal Health.

"County Health Care Center" or "County Health Care Centers" shall mean County's clinic sites at which CenCal Health Members receive Covered Services. Services may be rendered by County's Health Professionals or County's Physician Specialists. The parties agree that some services may be rendered outside of the County Health Care Center site, however for purposes of this Agreement, services are presumed to be primarily provided at the County Health Care Centers.

"County Health Professional" shall mean an FQHC Provider, Comprehensive Perinatal Services Program (CPSP) Practitioner, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker or visiting nurse. May also be referred to as "Health Professional".

"County Physician Specialist" shall mean a Physician who is a specialist and contracts with County to provide services within the County Health Care Centers and outside of its County Health Care Centers. When a County Physician Specialist delivers services outside of County Health Care Centers, that physician's services are Referral Physician services and may require Referral

Authorization Forms (RAFs), with the exception of non RAF required services including OB/GYN services, and which are billed using County's Physician Medical Group (PMG) provider number.

"Covered Services" shall mean the Medically Necessary (defined herein) health care services and benefits that Members are entitled to receive, provided by and through Providers contracted with CenCal Health. Currently, Covered Services for Medi-Cal Members as set forth in the State Medi-Cal contract ("State Contract") are all Medically Necessary services covered under the California Medi-Cal Program set forth in Chapters 3 and 4 of Subdivision 1 of 22 CCR, and certain health assessment and health screening services set forth in the Provider Manual, subject to the excluded services set forth in Section 2.3. Covered Services shall also include those FQHC services that are included in the State manual, as follows:

- Physician Services (includes acupuncturist services when the acupuncturist is a doctor of medicine)
- Nurse practitioner services
- Physician assistant services
- Certified nurse midwife services
- Visiting nurse services
- CPSP practitioner services
- Preventive Health Services (as defined in Exhibit A)

"Day" or "Days" shall mean calendar days, unless otherwise noted.

"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention, to result in: (i) placing the health of Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy; (ii) serious impairment to bodily function; or (iii) serious dysfunction of any bodily organ or part.

"Emergency Services" shall mean: (i) those health services needed to evaluate or stabilize an Emergency Medical Condition; or (ii) situations in which the Member has attempted to contact the Member's PCP and has found that no provisions for the prompt and proper rendition of Covered Services has been made on his/or her behalf and this is verified by the Attending Physician.

"Encounter" shall mean a Claim for which payment shall be made by either Capitation or by quarterly installments for Non-Capitated Services, in each case as described in Section 4 and or accompanying Exhibits to this Agreement.

"Family Planning Services" shall mean all services and supplies rendered by any Provider to an individual of childbearing age during a visit to said Provider for the purpose of family planning, including but not limited to contraceptive services, breast and cervical cancer screening, testing and treatment of sexually transmitted diseases and sterilization procedures. Family Planning Services do not include abortions and visits only for breast and/or cervical cancer screening or related ongoing treatment.

"Federally Qualified Health Center" or "FQHC" shall mean an entity that has been approved and its Prospective Payment System ("PPS") rates have been established by the Department of Health Care Services (DHCS), pursuant to the Federal OBRA of 1989 and 1990, as amended by the

Federal Beneficiary Improvement and Protection Act (BIPA) of 2000. An additional definition may be found in 42 USC § 1396d (L)(2)(B). FQHCs were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989. Each County Health Care Center is assigned a provider number for all physicians located in one site.

"Fiscal Year of CenCal Health" shall mean the twelve-month period beginning July 1, and ending June 30. This definition will also be referred to as “Fiscal Year” or “FY”.

“FQHC Provider” shall mean that the following practitioners are defined as "physicians":

- A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license;
- A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license;
- A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license;
- A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license;
- A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.

"Hospital" shall mean any licensed acute general hospital or limited service hospital that has a service agreement with CenCal Health.

"Limited Services" shall mean those services rendered by certain Allied Health Providers in accordance with the limitations and restrictions of the California Medi-Cal program and stated policy of the Board of Directors. Such Allied Health Providers include but are not limited to acupuncturists, audiologists, and chiropractors. Refer to the Provider Manual for specific information on authorization and payment for Limited Services providers.

"Medi-Cal Fiscal Intermediary" shall mean the entity that has a contract with the State to process claims for State Medi-Cal beneficiaries. State Medi-Cal manuals, which include all aspects of the Medi-Cal program for each Provider type, are referred to as the “State Manual” in this Agreement. County shall follow the State Manual that is applicable to the type of services provided by County unless otherwise directed by CenCal Health.

"Medi-Cal Rates" shall mean the schedule of Medi-Cal maximum fee-for-service allowances and rates of payment for health care services in effect for the State's Medi-Cal fee-for-service program at the time the services were rendered.

"Medical Director" shall mean the Medical Director employed by CenCal Health, or the Medical Director’s designee, who must be a licensed physician unless otherwise indicated.

"Medically Necessary” shall mean health care services or products that a prudent physician would provide to a Member for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with evidence-based, professionally and nationally recognized clinical criteria, as may be approved by the CenCal Health Medical Advisory Committee (comprised of physicians from the community), and which may include the following: *InterQual Criteria* or *Milliman Care Guidelines*; (ii) clinically appropriate in terms of type, frequency,

extent, site and duration; and (iii) not primarily for the convenience of the Member, physician, or other health care Provider. May also be referred to as "Medical Necessity."

"Medicare" shall mean the federally-administered program, begun in 1965, which covers basic medical and hospital services (but as currently administered not extended long term institutional care) for the elderly and disabled. Part A covers inpatient costs, Part B covers outpatient costs, and Part D covers most prescription medication costs. Part C is a Medicare managed care plan that covers inpatient costs, outpatient costs, and most prescription medication costs.

"Medi/Medi Member" shall mean SBHI or SLOHI Members who are also eligible to receive Medicare. When a Member is designated as Medi/Medi, Medicare is the primary payer and CenCal Health is the secondary payer of Claims. To be considered a Medi/Medi Member, a Member must have Medicare Part B or Medicare Part C. Members who are receiving only Medicare Part A or Medicare Part D are considered Other Health Care and are not considered Medi/Medi Members for the purposes of this Agreement nor any of the Exhibits or Attachments.

"Member" shall mean a general term used in this Agreement, to describe a Class 1 or Special Class Member (as defined under SBHI Member or SLOHI Member).

"NCQA" shall mean the National Committee for Quality Assurance. CenCal Health may elect to abide by NCQA standards in connection with this Agreement, and County agrees to comply by requirements of CenCal Health related to these standards.

"Non-Capitated Services" shall mean the following type of services when rendered in County Health Care Centers: (i) Covered Services rendered to Members not Case Managed by County; or (ii) Covered Services rendered to County's Case Managed Members that are not included in Attachment A-1; (iii) Services rendered to Medi/Medi Members; and (iv) County Physician Specialist services.

"Notice" shall mean a communication by CenCal Health to County informing County of the terms of or modification to the Medi-Cal program, and any other information relevant to the provision of Covered Services pursuant to this Agreement made in accordance with provisions of §15.9.

"Other Health Care" or "OHC" shall mean coverage by another private health plan, i.e. Blue Cross or Secure Horizons that also offers and reimburses for medical benefits. OHC plans are always considered the primary payers and CenCal Health would reimburse secondary. Claims for Members who have OHC are paid on a fee-for-service basis when applicable. OHC also includes Members who are receiving Medicare Part B or Part C.

"Physician" shall mean a Primary Care Physician, an Attending Physician, a Referral Physician or a County Physician Specialist.

"Primary Care Physician" or "PCP" shall mean a physician, group or clinic responsible for: (i) case managing, supervising, coordinating and providing initial and primary care to Members; (ii) initiating referrals for Referral Physician care; and (iii) maintaining the continuity of Member care. A PCP is a physician who practices primary care, and who has executed a medical service agreement with CenCal Health, a group, a clinic, or with County, agreeing to provide said services. Primary Care Physicians include family practitioners, internists and pediatricians.

"Primary Care Services" shall mean those services provided by a PCP or by County's PCPs to Members who are case-managed by that PCP or by County's PCPs or any physician with whom nighttime, weekend, or relief service has been arranged by the PCP or by County.

"Provider" shall mean an appropriately licensed and qualified health professional or any other entity or institutional health provider who has: (i) agreed in writing, either through this Agreement or through another written instrument, to provide Covered Services to Members; (ii) accepted the compensation set forth in applicable Exhibits attached to this Agreement; and (iii) who has been credentialed, if required. Credentialing shall be done by CenCal Health or duly appointed and authorized agent to which such responsibility has been delegated, pursuant to CenCal Health rules and procedures.

"Provider Information Form" or "PIF" shall mean a document on which County indicates pertinent information. Such information includes but is not limited to office and billing addresses, liability insurance coverage, handicapped accessibility, office hours, practice coverage by other qualified practitioners, access levels, and maximum number of Members as described in Exhibit A hereto. If subsequent changes to information on a PIF are necessary, an amendment to this Agreement is not required but changes must be submitted in writing by County to CenCal Health in a timely manner.

"Provider Manual" shall mean the CenCal Health manual which sets forth operational documents including but not limited to Provider obligations, authorizations; Claims and billing; Member services; quality of care, grievance system and CenCal Health policies and procedures pertinent to Providers. The Provider Manual may also contain sections for: overview materials; Provider's Agreement; Provider Bulletins; and the Contracted Provider List. The Provider Manual, titled "CenCal Health Provider Manual" prepared by the CenCal Health Provider Services staff, may contain provisions of the State Manual as specifically modified by CenCal Health. The information set forth in the Provider Manual is part of this Agreement and may, in the sole discretion of CenCal Health, be amended from time to time and is incorporated by reference into the Agreement as if set out herein in full. In the event that any provisions in the Provider Manual or any amendments thereto are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail. CenCal Health will give County advance notice and time to adjust to material changes to the Provider Manual. Notifications can be made through Provider Bulletins, substitution of pages, or other communications.

"Quality Assessment and Improvement Program" or "QAIP" shall mean a document that defines the CenCal Health organizational structure and clinical and non-clinical processes vital to implementation of continuous quality improvement in health care. The QAIP encompasses the quality of acute, chronic and preventive clinical care and service provided in both the inpatient and outpatient setting by primary care and specialty Physicians, ancillary providers and Hospitals. The QAIP also encompasses CenCal Health processes for monitoring and improving the quality of non-health care administrative services provided to Members by CenCal Health and its contracted Provider network as may be set forth in the CenCal Health Provider Manual.

The QAIP is an evolving document adopted by the CenCal Health Board of Directors and approved by appropriate State agencies pursuant to contractual and regulatory requirements. CenCal Health may, through Committee recommendations and/or at the direction of its Board of Directors, elect to include NCQA standards in the QAIP. Notice of any material changes to the QAIP shall be given to County no less than thirty (30) Days prior to the date the change is to take effect. The current QAIP is available on the CenCal Health website: www.cencalhealth.org/Ensuring Quality/Quality

Assessment and Improvement Program or upon request to the Health Services Department of CenCal Health.

"Referral Authorization Form" or "RAF" shall mean the required referral authorization form, or number, evidencing a referral by a PCP, the PCP's designee, or the Medical Director or his/her physician or non-physician designee, to render services.

"Referral Physician" shall mean any qualified physician or duly licensed group of physicians providing specialty services in California who has/have executed an agreement with CenCal Health to provide referral physician services, and to whom a Primary Care Physician may refer any Member for consultation or treatment. Referral Physicians may be also associated with County and unless otherwise specified, the term Referral Physician shall also apply to County Referral Physicians. See Exhibit B for Protocols for Referral Physicians.

"Referral Services" shall mean any services that are not Primary Care Services and that are provided on referral from the PCP or County.

"SBHI" shall mean the Santa Barbara Health Initiative, the Medi-Cal program administered by CenCal Health in Santa Barbara (SB) County.

"SBHI Member" shall mean any person who has been determined to be eligible to receive Medi-Cal benefits by the County of Santa Barbara Social Services Department, the State, or the Social Security Administration and who is a resident of SB County, who is assigned to Santa Barbara County Code Number 42, and whose aid code is included for capitation payment in the State Contract. A newborn of a SBHI Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a SBHI Member is covered under the mother's membership during the mother's first month of enrollment. SBHI Members are of two classes, as follows:

Class I Members shall include all SBHI Members who are case-managed by a Primary Care Physician and shall also include Special Case Members, as defined below**,** unless specifically excepted.

Special Class Members shall mean those SBHI Members who do not have an assigned PCP because they have been identified as non-case-manageable or because they are newly eligible with the health plan and are assigned to CenCal Health. Special Class Members also include, but are not limited to, SBHI Members who are eligible for Medi-Cal retroactively and those in skilled nursing facilities or outside SB County. Additional information on eligibility and membership is contained in the Provider Manual.

"Self-Referral Services" shall mean the services in addition to Emergency Services that Members are allowed to access without authorization, as set forth in State Contracts or in CenCal Health policies. Self-Referral Services currently include but are not limited to most obstetric services, Limited Services, Sensitive Services, basic prenatal services, minor consent services, nutrition education services (first visit) without a referral; and when the PCP has issued a "standing referral". Self-Referral Services are subject to utilization controls as specified under the Medi-Cal program and may change from time-to-time. Additional information is contained in the Provider Manual.

"Sensitive Services" shall mean services related to Family Planning Services, sexually transmitted disease, abortion and human immunodeficiency virus (HIV) testing.

"Service Area" shall mean the area that includes Santa Barbara County and/or San Luis Obispo County. For a PCP, the Service Area would be where the PCP has an office or normally sees patients and includes those contracted facilities, Physician offices, clinics and health professionals as set forth in the Contracted Provider List in either County. Service Area will be deemed to be limited to hospital(s) at which the Physician providing Covered Services to the Member has privileges, unless otherwise authorized.

"SLOHI" or "San Luis Obispo Health Initiative" shall mean the Medi-Cal program that CenCal Health administers in SLO County effective March 1, 2008 and forward.

"SLOHI Member" shall mean any person who has been determined to be eligible to receive Medi-Cal benefits by the County of San Luis Obispo Social Services Department, the State, or the Social Security Administration and who is a resident of SLO County, who is assigned to San Luis Obispo County Code Number 40, and whose aid code is included for capitation payment in the State Contract. A newborn of a SLOHI Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a SLOHI Member is covered under the mother's membership during the mother's first month of enrollment. SLOHI Members are of two classes, as follows:

Class I Members shall include all SLOHI Members who are case-managed by a Primary Care Physician, and shall also include Special Case Members, unless specifically excepted.

Special Class Members shall mean those SLOHI Members who do not have an assigned PCP because they have been identified as non-case-manageable or because they are newly eligible with the health plan and are assigned to CenCal Health. Special Class Members also include, but are not limited to those SLOHI Members who are eligible for Medi-Cal on a retroactive basis, and those residing in skilled nursing facilities or outside SLO County. Additional information on eligibility and membership is contained in the Provider Manual.

"Special Case Members" shall mean Members that are assigned a "medical home" with a PCP to coordinate all aspects of care. Said Members are: (i) children who are currently designated as California Children's Services (CCS) eligible; (ii) Members who receive organ transplants; and (iii) Members currently on renal dialysis. For the purpose of PCP Incentives Program calculations, Members will be classified in separate pools and their expenses and utilization will be compared only to each other within their established pool or pool subset, i.e. Members on dialysis against other Members on renal dialysis, unless excepted below, as follows in: (i) SB County: CCS, organ transplant, and renal dialysis Members; and (ii) SLO County: organ transplant and renal dialysis Members. All Special Case Members will be deemed to be Case Managed Members in the Agreement and Exhibits, unless specifically excepted.

Exceptions: SLO County CCS Members are not classified in separate Special Case pools and their expenses and utilization will be compared only to each other within their designated Peer Pool, (F1, M2 or P4) because expenses related to the CCS eligible condition are not the responsibility of CenCal Health.

"State" shall mean the State of California.

"Subcontract" shall mean a written agreement entered into by County with: (i) a qualified person who provides health care services and who agrees to furnish Covered Services to Members; and/or (ii) any other organization or person(s) that agree(s) to perform any administrative function or

service for County specifically related to fulfilling obligations of County to CenCal Health under the terms of this Agreement.

"Subcontractor" shall mean a person or any organization that has entered into a Subcontract with County. Subcontractors shall meet specified requirements as set forth in this Agreement. Notwithstanding the above, County Health Professionals and County Specialist Physicians who are under contract to provide medical care both within and outside of County Health Care Centers act as Providers of the FQHC and are thereby bound by this Agreement due to that status.

"Treatment Authorization Request" or "TAR" shall mean the document used by County to request authorization for coverage of services. The TAR is submitted to CenCal Health, and is reviewed by its Health Services Department. TARs are approved, denied, or deferred based on Medical Necessity.

"Utilization Management" or "UM" shall mean the process by which CenCal Health determines on a prospective, concurrent, or retrospective basis the medical appropriateness of Covered Services furnished to Members. CenCal Health may alternately delegate this responsibility to another duly appointed and authorized entity to which such responsibility has been delegated.

2. SERVICE OBLIGATIONS

2.1. Case Management. The Member may select or be assigned to one of County's County Health Care Center sites. County's PCPs at the selected site shall be the source of primary medical contact and advice for the Member and shall submit referrals to CenCal Health for approval for all health care services to be provided outside of the PCP's office, as required, except for Emergency Services, Self-Referral Services, Services that do not require a RAF, and excluded services. This concept of Case Managed Members is such that the County Health Care Center is the medical home of the Member. It is where the Member receives the majority of care; and where the Member's overall health status, need for care and services and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained. The PCP at the County Health Care Center shall coordinate Members' needs for Covered Services and provide other services, or initiate referral to other services, to assure Members receive all Medically Necessary care and services without regard to the party financially responsible for care and services. County shall be responsible for the Member's Case Management until the time such Member's PCP is changed in accordance with CenCal Health policies.

2.2. Case Management Services. County's PCPs or Physicians providing services at the request of County, shall:

2.2.1. Develop, implement, and maintain an adequate system for tracking all referrals and follow-up care.

2.2.2. Maintain procedures for coordination of care provided to Case Managed Members in all settings, including, but not limited to services rendered both within and outside of the Service Area.

2.2.3. Implement and maintain policies and procedures to follow-up on missed/broken appointments.

2.2.4. Ensure continuity of care from the ambulatory care setting to the inpatient care setting and all other care settings as needed.

Additional information on Case Management may be found in the Provider Manual.

2.3. Covered Services and Excluded Services. SBHI and SLOHI Covered Services are those services covered under the California Medi-Cal program as specified in 22 CCR Division 3, Subdivision 1, Chapter 3, Article 4, beginning with § 51301 (unless they are a CenCal Health-only benefit), which are included as Covered Services in the State Contract, and are Medically Necessary services. For purposes of this Agreement, Covered Services do not include services listed in the State Contract as excluded services and drug benefits for full-benefit Members eligible for Medi-Cal and Medicare who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC §1395w-101 et seq.), except as set forth in the State Contract. Additional information on Covered Services may be found in the Provider Manual.

Excluded services include but are not limited to the following:

Specialty Mental Health Services; Short-Doyle/Medi-Cal Mental Health Services; SLO County CCS eligible services; Alcohol and drug treatment services and outpatient heroin detoxification; dental services, as defined in 22 CCR § 51307; Adult Day Health Care, pursuant to 22 CCR § 54001; services rendered in any federal or State governmental hospital; CHDP services when provided in accordance with 17 CCR § 6800 et seq.; and childhood lead poisoning case management services provided by the local health department.

2.4. Provision of Covered Services to Members. County shall provide Covered Services that are set forth in Exhibits A and B to Members and County agrees as follows:

2.4.1. County shall make medical services available to Members in the same manner, in accordance with the same standards, and with the same availability, as to County's other patients;

2.4.2. County shall ensure that medical services provided under this Agreement are readily available and accessible, provided in a prompt and efficient manner without delays in terms of wait times or scheduling of appointments, consistent with professionally recognized standards of practice;

2.4.3. County shall provide medical services to Members in a culturally and linguistically appropriate manner, as set forth in this Agreement and in the Provider Manual;

2.4.4. County shall be available to provide to Members or arrange for Members to receive prompt urgent services within twenty-four (24) hours when Medically Necessary;

2.4.5. County shall be available to provide or case manage services that are Emergency Services twenty-four (24 hours) per day, seven (7) days per week;

2.4.6. County shall provide all Covered Services to Members that are the responsibility of County, consistent with the terms and provisions of this Agreement, any letters or bulletins from the State, Provider Manual, and CenCal Health policies;

2.4.7. County shall be liable for the provision of all Covered Services notwithstanding a delay in payment of any Capitation payment to County;

2.4.8. Without amending this Agreement, CenCal Health may incorporate any change in Covered Services mandated by federal or State law or regulation into the Agreement effective the date the change goes into effect. CenCal Health shall give County thirty (30) Days prior notice of any such change. CenCal Health shall determine the effective date of the change in Covered Services;

2.4.9. The actual provision of any Covered Service is subject to the professional judgment of County as to the Medical Necessity of the service, except that County shall provide assessment and evaluation services ordered by a court or legal mandate;

2.4.10. Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. County agrees and understands that all disputes between the respective Provider and Members about Medical Necessity can be appealed pursuant to CenCal Health policies; and

2.4.11. In no event, including but not limited to, non-payment by CenCal Health, insolvency of CenCal Health, or breach of this Agreement by County or CenCal Health, shall County or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State (except as permitted by FQHC PPS regulations), a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Agreement. This provision does not prohibit County or Subcontractors from collecting Copayments and deductibles, if any, as specifically provided for in this Agreement, in the Member's Evidence of Coverage (EOC), or as set forth in the State Manual, or for billing the Member and collecting fees for non-Covered Services from the Member if the Member agrees to the fees prior to the actual delivery of non-Covered Services. County further agrees that:

2.4.11.1. This sub-section 2.4.11 shall survive the termination of this Agreement for those Covered Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

2.4.11.2. This sub-section 2.4.11 shall supersede any oral or written contrary agreement now existing or hereafter entered into between County or Subcontractors;

2.4.11.3. This subsection 2.4.11 shall prevent County Subcontractors from pursuing compensation from Members.

2.5. Referral to Additional Providers. County's PCPs shall have the right to refer Member to any Referral Physician, or other referral Provider practicing within the Service Area who has previously executed a contract with CenCal Health. Prior to referral, the Provider must have expressed a willingness to serve Members and to undertake care in accordance with the provisions of this Agreement and the practices of CenCal Health. County PCPs may also make referrals to County Physician Specialists. Referral Authorization Forms (RAFs) are not required for services within the County network of care. However, for referrals to other FQHCs and to Physicians outside of the County network of care, County would be required to submit RAFs unless indicated as a selected service below. RAFs shall be submitted to CenCal Health for review and consideration when: services requested are not available or not sufficient for the Member population in the Service Area; for Member continuity of care; for Members who are under the age of 21 referred to specialty providers requiring prior review for potential or suspected CCS diagnoses; and/or in cases of Medical Necessity. Selected services that do not require RAFs (including but not limited to Emergency Services, Sensitive Services, Medi/Medi Members and most Self Referral Services) are set forth in the Provider Manual. RAFs are also not required prior to rendering services to Special Class and CCS eligible Members and any reference to RAF requirements for Members shall be deemed to exclude such requirement for Special Class and CCS eligible Members. Both the PCP and the requested provider will be notified either through email or fax of the status of the RAF. Referrals, other than referrals to County Physician Specialists, may require approval. More information is located in the Provider Manual.

2.6. Copies of Clinical Information. If County's PCPs render services to Members not assigned to County, or are providing Referral Services, County will promptly forward copies of consultation reports upon completion of the consultation, and summaries of Member care or Member results upon completion of Member care or discharge to the Member's PCP. County shall provide copies of such clinical information to the Member's PCP at no charge. Release of this information shall be in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations and requirements.

2.7. Prior Authorization. County shall obtain the following authorization, when required, prior to providing services to Members: (i) a Referral Authorization Form ("RAF") initiated by the Member's PCP or his or her designee and approved by CenCal Health for non-FQHC Services; (ii) a Treatment Authorization Form ("TAR") and based on a list of TAR required procedures and approved by CenCal Health; (iii) a prescription if required, i.e. for Durable Medical Equipment, (iv) a Medical Request Form (MRF), when required, for pharmaceutical services and prescribed drugs; (v) a Radiology Benefit Manager (RBM) consult to assist ordering physicians in selecting the best high tech imaging procedures consistent with the highest quality of medical care; or (vi) a Specialty Pharmacy Program (SPP) authorization, as may be required by the selected CenCal Health specialty vendor, for selected therapeutic classes.

Exceptions to the need for authorization include: Emergency, Self-Referral Services and when UM has been delegated in a written delegation agreement, up to two total Limited Services per month for SBHI and SLOHI Members, and for services indicated on "When RAFs are Not Required" in the Provider Manual and this Agreement.

The RAF and TAR/AR outline the scope of such medical services to be provided, and the MRF allows a prescribing provider to request non-Formulary drugs. Any such services must be authorized in advance, including tests, procedures, consulting services, supplies, drugs and hospital services not specifically described in the prescription, MRF, RAF, and TAR/AR.

Additional information for the RBM, under the RadConsult® program component, and the SPP for therapeutic classes including Hepatitis C, Growth Hormone Deficiency, Rheumatoid Arthritis, and Hemophilia, are further described in Provider Bulletins and on the CenCal Health web site at www.cencalhealth.org. SPP therapeutic classes may be amended or augmented from time to time.

Modifications to prior authorization requirements are material changes and, as such, notice will be provided to Provider as noted within this Agreement.

Except when services are those excepted services indicated above, compensation for services provided to Members is payable by CenCal Health only if such services are authorized Covered Services. County shall verify a Member's eligibility prior to rendering non-Emergency Services. Authorization procedures are further described in the Provider Manual.

Should the Member's non-County PCP refuse to authorize a service deemed by County to be Medically Necessary, County may contact either the CenCal Health Provider Services or Member Services Department to determine if a CenCal Health Referral (administrative authorization) can be issued.

2.8. Pharmaceutical Services and Prescribed Drugs. Providers who are authorized to issue prescriptions shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provisions of pharmaceutical

services and prescription drugs to Members. At a minimum, such pharmaceutical services and drugs shall be available to Members during normal business hours. Under emergency circumstances, providers contracted with CenCal Health shall provide a sufficient quantity of drugs to a Member to last until the Member can reasonably be expected to have a prescription filled. Further information about Pharmaceuticals is set forth in §5.3 (Formulary) of this Agreement and in the Provider Manual.

County will use best efforts to cooperate with CenCal Health's current and future quality programs including those in connection with prescribed drugs, diabetic supplies, specified injectable drugs and medications and high-tech radiology procedures, as they may be amended from time to time. These changes are considered "material changes" in which case notice by CenCal Health is required. More information is available in the Provider Manual.

2.9. Subcontracts. If County arranges for the provision of some medical services from other health care Providers, County shall require its Subcontractors to: (i) seek payment only from County and/or CenCal Health (where CenCal Health has a contract with Subcontractor or other obligation to pay Subcontractor directly), but not from the State or from the Member as set forth in §2.4.11; (ii) maintain and disclose records and other information as set forth in §8.1; (iii) abide by the nondiscrimination and Confidential Information provisions set forth in §§5.4 and 8.5, respectively; (iv) maintain insurance as set forth in §7.1; (v) comply with credentialing requirements, if required, as set forth in §3.1.2; (vi) comply with the grievance resolution provisions as set forth in §5.2 and in the Provider Manual; and (vii) comply with all other applicable provisions of this Agreement. Upon termination of this Agreement, such Subcontracts shall terminate with respect to Covered Services provided to Members. Upon request, County shall make such Subcontracts available to government officials for review and approval.

2.10. Coordination Regarding Non-Covered Services.

2.10.1. County Health Professionals and/or County Providers shall identify and refer all Members with possible CCS eligible conditions to the local CCS program. Such services must be authorized by the local program in order for payment to be made by CenCal Health for SB County CCS Members. Such services are not arranged for nor paid by CenCal Health for SLO County CCS eligible Members. Procedures for referral of said Members to CCS and payment of Claims for these services are set forth in the Provider Manual.

2.10.2. As part of their case management responsibilities, PCPs are responsible for providing or coordinating all Covered Services, including medical care related to mental health services within the scope of the PCP practice such as ruling out general medical conditions that may be causing or exacerbating mental health issues. County Health Professionals and/or County Providers shall refer SBHI Members who may need specialty mental health services back to their PCP for referral to the SB County Department of Alcohol, Drug, and Mental Health Services (ADMHS) and shall refer SLOHI Members who may need specialty mental health services back to their PCP for referral to the San Luis Obispo County Mental Health Department. If these Mental Health Departments do not cover the Member's diagnosis, the PCP shall attempt to refer Member to other appropriate community resources, coordinating services with the mental health provider, as appropriate. PCP will refer Member to CenCal Health's Member Services Department for assistance with referrals to community resources if initial referral attempts are unsuccessful. See Provider Manual for additional information on mental health coverage and specialty mental health providers.

2.10.3. County, when applicable, shall assist Members in obtaining services that are not Covered Services, including but not limited to, referring Members to public programs for which the Member may be eligible.

2.11. Fraud and Abuse Reporting. County shall report to CenCal Health all cases of suspected fraud and/or abuse, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services by County's Subcontractors, out of network Providers, Members, or County's employees. Said report shall be made within ten (10) business days of the date when County first becomes aware of or is on notice of such activity.

3. OBLIGATIONS OF PROVIDER

3.1. Licensed and in Good Standing.

3.1.1. County represents that its FQHC Providers shall remain licensed or registered, as applicable, to provide or arrange for the provision of those applicable Covered Services that are identified in Exhibits A and B, attached hereto and made part of this Agreement by this reference. County further represents, that it has, and will maintain and keep current all legally required licenses.

3.1.2. County agrees to cooperate in credentialing and recredentialing in accordance with the process set forth in the Provider Manual. County agrees that its FQHC Physicians who are required to be credentialed must be approved by appropriate CenCal Health Committees prior to rendering Covered Services to Members unless excepted below. Additionally, County shall ensure that all Subcontractors who furnish items and/or services to Members and/or submit Claims and/or receive reimbursement for Covered Services furnished to Members shall be qualified to provide Covered Services. County shall ensure that any Subcontractor who is required to meet these standards, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members unless excepted below.

The CenCal Health provider credentialing policy ensures that participating providers meet basic qualifications before providing services to CenCal Health Members. Proof of such qualifications is accomplished through the CenCal Health credentialing process. In consideration of necessity to ensure quality care for its Members, and upon recommendation of its Director of Provider Services, CenCal Health may expedite the initial credentialing process at County's written request demonstrating extenuating circumstances, and given an identified need in the network. An expedited file may be approved for credentialing by the Chief Medical Officer, in his sole discretion consistent with CenCal Health credentialing policies. Once so approved, credentialing will be effective as of the date of such approval. County will regularly and when changes occur, send CenCal Health a master file of their employed or contracted Providers.

3.1.3. County's FQHC Physicians who admit Members into the Hospital must maintain, at the admitting hospital, active medical staff privileges and all Clinical Privileges necessary to perform required services, or have executed a formal agreement with another Physician to admit and follow Members in said Hospital. Such arrangement must be acceptable to CenCal Health, acting reasonably.

3.1.4. County has received certification as a CHDP program provider in order to be assigned Members under nineteen (19) years of age. However, CHDP provider status is not required for each County Health Care Center in the network if County chooses not to offer CHDP services at a County Health Care Center site. Nothing in this section will preclude non-CHDP County Health Care Centers from being reimbursed for specialty care provided to Members under 19.

3.1.5. Covered Services that are provided by or arranged for by County shall be delivered by professional personnel qualified by licensure, training, or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted

standards in the industry. All Covered Services are to be provided at a place appropriate for the proper rendition thereof, within the constraints of the State Medi-Cal program regulations.

3.2. Laboratories. County shall require that each laboratory used by its County Health Care Centers or by its Subcontractor(s) to provide services complies with federal and State laws. County may also use a laboratory that has been issued a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration, and that has a CLIA identification number. CLIA waived laboratories shall provide only the types of tests permitted.

Any laboratory that does not comply with the appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare or Medi-Cal programs.

3.3. Patient Load. County shall designate on the PIF the maximum number of Members each County Health Care Center ("each site") shall serve, provided, however, that the maximum number of Members does not exceed the limits as set forth in the Case Management Protocols of the Provider Manual. County may additionally indicate its County Health Care Centers will accept SLOHI Members at their discretion. For example, for primary care, a County Health Care Center would initially open to fifty (50) SLOHI Members and then consider change to established patients only (EPO) to control the number of additional SLOHI Members. Specialty Care for SLOHI Members will be subject to availability that does not affect access for Santa Barbara County residents. These above provisions are applicable to all CenCal Health non-County PCPs and specialist physicians.

Notwithstanding the above, County reserves the right, in its sole discretion, to request reassignment of a SLOHI Member per the CenCal Health PCP Reassignment Policy.

County may request that only previous Members wishing to be re-assigned to a County Health Care Center be accepted (established patients only), or that the County Health Care Center is open to new patients. Unless County has indicated an established patients only or closed status on the PIF, County agrees to accept as patients for primary care services those who have selected or have been auto-assigned by CenCal Health according to its auto-assign algorithm aligned with County provider full time equivalents (FTE) resources rather than site quantities up to the maximum number of Members designated by County on the PIF, without regard to the health status or health care needs of such Members. In addition, County may not request Member assignment changes due to a Member's medical condition requiring increased care. Additional information on designating access and Member reassignment is in the Provider Manual.

3.4. Non-Physician Medical Practitioner Limits. Because County Health Care Centers provide medical services through non-physician medical practitioners, the number of the non-physician medical practitioners who may be supervised by a single Physician shall be limited as set forth in the Case Management Protocols in the Provider Manual.

3.5. Notification of Changes. If County decides to cease providing or suspend any Covered Service or reduce the hours at its County Health Care Centers, County shall notify CenCal Health in writing at least forty-five (45) Days prior to any such cessation, suspension or reduction. In the event of such a change by a County Subcontractor, County shall notify CenCal Health upon notification by Subcontractor. County will notify CenCal Health immediately of any changes in operation, Clinical Privileges, emergency conditions, or factors such as limited capacity that may significantly affect Covered Services provided to any Member or that may impair the ability of County to perform its obligations under this Agreement. County shall notify CenCal Health promptly of any material change in name, location, tax identification number, Medicare or Medi-Cal number or County National Provider Identifiers (NPI).

3.6. Provider Responsibility.

3.6.1. County's PCPs, and any Provider to whom its PCPs have delegated the authority to proceed with treatment or the use of resources, shall be responsible for all medical advice and Covered Services performed or prescribed through them for the Member. CenCal Health allows and encourages open communication between Providers and Members regarding appropriate treatment or treatment alternatives, and does not penalize Providers for discussing Medically Necessary or appropriate care with or for the Member, regardless of benefit coverage limitations.

County Health Professionals and/or County Providers shall also be responsible for providing information to Members on the proper use of health care services, and for providing health education, and preventive health information. Such educational offerings shall be noted in the Member's medical record and shall be documented in accordance with CenCal Health standards for medical recordkeeping as set forth in the CenCal Health current "Chart Quality Guidelines", if applicable.

3.6.2. CenCal Health will notify Members of their right to an initial health assessment to be performed within 120 Days of enrollment. County agrees to develop, implement, and maintain procedures for the performance of an initial health assessment for each new Member upon request for an appointment by Member, unless it is determined that the Member's medical record is adequate, as described in the Provider Manual.

County shall take all reasonable steps to ensure that Preventive Health Services, as more particularly defined in Exhibit A hereto, (well infant, well child, well adolescent visits and adult initial and periodic preventive medicine evaluations) are performed in accordance with requirements as may be set forth in the Provider Manual.

3.6.3. Nothing expressed or implied herein shall require the County's FQHC Physicians to provide to the Member, or order on behalf of the Member, Covered Services which, in the professional opinion of the said Provider, are not required for the control of present or future health impairment or are more costly and which are not of sufficient likelihood of being more effective in achieving these ends and/or seem inadvisable.

3.6.4. County agrees to cooperate with CenCal Health quality improvement activities and to provide access to medical, financial and administrative information: (i) as may be necessary for compliance by CenCal Health with State and federal law; and (ii) for CenCal Health program management purposes including, as appropriate: Utilization Management, grievance process, peer review, credentialing, Health Employer Data Information Set ("HEDIS") reporting, medical chart review and facility audits, as may be set forth in this Agreement or in the Provider Manual.

3.6.5. County agrees to comply with all final recommendations and determinations rendered by CenCal Health Committees appropriate to the issue in question.

3.6.6. County and/or its office staff is/are responsible to understand and adhere to the applicable requirements of the Medi-Cal program as set forth in the State Manual and the CenCal Health Provider Manual, as respectively amended from time to time by the State and CenCal Health.

3.7. Encounter Reporting. County submits Encounter information on a Claim form, indicating the service(s) provided by inserting the appropriate procedure code(s) as set forth in Exhibit C, Section 1, Encounter Billing Procedures, to the Agreement. Encounters with more than one County Health Professional and multiple Encounters with the same County Health Professional which take place on the same day and at a single location constitute a single visit, except for cases in which

the patient, subsequent to the first Encounter, suffers an illness or injury requiring additional diagnosis or treatment.

County shall submit Encounter data pursuant to standards defined by CenCal Health policies, as provided in Exhibit C to this Agreement, or as set forth in this Agreement and in the Provider Manual. Since County participates in the PCP Incentive Program, (as defined in Exhibit A hereto), the payout to County is subject to reduction if Encounter data does not meet the standards required pursuant to the Incentive Program. Additional information about the PCP Incentive Program is in the Provider Manual.

3.8. Other Reporting. County shall also supply CenCal Health, upon request, with other periodic reports and information pertaining to Covered Services provided to Members by County's FQHC Providers, Health Professionals or County's Subcontractors on such forms and within such times as requested by CenCal Health, and which will enable CenCal Health to meet all federal and State legal and contractual reporting requirements. County shall complete and return with this Agreement, Attachment 1, Disclosure Form, attached hereto.

3.9. Access to Care. County shall be held to the standards established by CenCal Health for accessibility to care. At least annually, CenCal Health will measure for compliance against applicable access to care standards that are contained in the Provider Manual.

3.10. Cultural and Linguistic Services. CenCal Health and County have joint responsibility in meeting needs and services as may be required by the State in an appropriate and applicable cultural and linguistic manner. Such services include, but are not limited to: (i) twenty-four (24) hour access to interpreter services, which may include face-to face encounters with County's FQHC providers, Health Professionals or staff, telephone language services, or the use of urgent care telephone lines, for all limited English proficient Members seeking health services from a Provider; (ii) referrals to culturally and linguistically appropriate community services programs; and (iii) use of translated signage and written translated materials appropriate for County Members. As County has indicated bilingual language capabilities, it shall ensure those providing such interpreter services are bilingually proficient at both medical and non-medical points of contact.

CenCal Health may provide training for County and its staff on the cultural and linguistic needs of Members. Additionally, materials on cultural and linguistic services are contained in the Provider Manual. CenCal Health may assess the cultural competence of County and its staff from time to time, and provide tools to assist County in cultural or linguistic competency.

3.11. Participation on Committees. County staff and/or Physicians, if requested by CenCal Health, and within reason, shall serve on a specified CenCal Health Committee for a two year term, unless excepted. A description of the membership and responsibilities of CenCal Health Committees is set forth in the QAIP and/or Provider Manual.

3.12. Utilization Management. Unless otherwise set forth in a written delegation agreement, County hereby acknowledges that: (i) CenCal Health conducts UM programs regarding the care provided to Members; and (ii) has indicated in the quality of care section of the Provider Manual affirmative statements regarding UM decisions and financial reward. County shall participate in and cooperate and comply with the provisions of the CenCal Health UM programs and its policies and procedures, including prospective, concurrent and retrospective review by CenCal Health UM committees and staff. Upon reasonable notification, County shall allow CenCal Health UM personnel, or their designees, or the entity who alternately oversees UM functions, physical and telephone

access to review, observe and monitor Member care and County's performance of its obligations under this Agreement. Additional information on UM is set forth in the Provider Manual.

4. PAYMENT AND BILLING

4.1. Payment of Compensation.

4.1.1. Case Managed Members. In accordance with the provisions of this Section 4 "Payment and Billing" and Exhibits A, B and C as may be provided with this Agreement, CenCal Health shall pay County the monthly capitation rates set forth in Attachment A-2, for Covered Services that are capitated services indicated on Attachment A-1 rendered to County Case Managed Members, excluding Medi-Medi Members. County will receive the Case Management list electronically as agreed to by the parties.

4.1.2. Non-Capitated Services. For Members receiving non-Capitated Services, compensation for these non-Capitated Services rendered after authorization, if required, by County's PCP shall be as follows:

4.1.2.1. CenCal Health shall pay County each year in equal quarterly installments of the current calculation as determined according to sections 4.1.2.2 through 4.1.2.4 for non-Capitated Services rendered in the months of the previous Fiscal Year as follows:

Date of Payment	**Months Covered**
February 15	January, February and March
May 15	April, May, and June
August 15	July, August and September
November 15	October, November, and December

4.1.2.2. In December, CenCal Health will calculate the value of medical care ("Value") that County provided for non-Capitated Services during the preceding period of January 1 through September 30 based on CenCal Health's prevailing reimbursement rate(s) to its contracted Medi-Cal Referral Physician network; and

4.1.2.3. If the Value is an increase or decrease by ten percent (10%) from the sum of the February, May, and August quarterly installment payments, then quarterly installment payments commencing on the subsequent February payment date will reflect one-quarter (1/4) of the Value. Otherwise, the amount of the quarterly installment payments will remain unchanged for the subsequent annual period.

4.1.2.4. Calculations as indicated above shall occur in subsequent years during the term of this Agreement, unless amended by the parties.

4.1.3. Services Provided Outside of County's Network of Care by County Physician Specialists and County Health Professionals. For non-capitated Covered Services rendered by County Physician Specialists and County Health Professionals outside of County's network of care, County shall submit Claim forms, bill electronically, or enter Claims on CenCal Health's website. Payment for these Covered Services is set forth in Exhibit B to this Agreement.

CenCal Health will generate Capitation payment to County on the fifteenth (15^{th}) day of each month, or if the 15^{th} falls on a non-business day, the first business day following the 15^{th}. The Case Management list is additionally available for County to confirm their assigned Members on the CenCal Health website at www.cencalhealth.org/For Providers Only.

4.2. Payment Prerequisites. As applicable to Provider, County compensation for services to Members shall be paid when all requirements have been met in accordance with the appropriate State Manual and the CenCal Health Provider Manual.

4.3. Copayments. When Members are required to make Copayments, County may collect such Copayments from the Member at the time of service, or as arranged with Member.

4.4. Payment to County. County agrees to accept the Capitation paid by CenCal Health, for Primary Care Services and quarterly installments for Non Case Managed Services for services rendered in County's Health Care Centers, as payment in full from CenCal Health, subject to applicable copayments to be collected from Member. County reserves the right to obtain its additional revenue up to its full FQHC PPS per visit rate from the State.

4.5. Claims and Encounters. County shall submit to CenCal Health all Claims and Encounters for Covered Services provided to CenCal Health Members. Claims and Encounters shall be on the currently accepted Claim form in use in the Medi-Cal program, and shall be submitted within one hundred and eighty (180) Days of service in order for full payment to be made, as set forth in the State Manual and/or as indicated in attached Exhibits, in accordance with the laws, regulations and billing procedures set forth in the State Manual, as applicable, and with the CenCal Health Provider Manual and policies. Unless an appropriate delay reason code is indicated, Claims submitted more than one (1) year from the date of Covered Service will not be considered for payment.

CenCal Health will process Encounters for Covered Services billed under County's FQHC provider numbers as set forth in Exhibit C to this Agreement. County agrees to submit most Claims and Encounters in an electronic format using industry standards as specified by the DHCS and/or HIPAA as agreed by the parties, or to enter Claims and Encounters on CenCal Health's website at www.cencalhealth.org. As applicable to Provider, additional information and requirements regarding submission of Claims and Encounters is set forth in the State Manual, the Provider Manual, and the FQHC Provider Claims Protocols.

Claim corrections, requests for adjustments and/or grievances/disputes regarding Claim payments or denials for SBHI or SLOHI Members, should be submitted as soon as feasible but must be received by CenCal Health no later than six (6) months after the date of the payment or denial of such Claim. These should be submitted on a CenCal Health dispute form (Provider Grievance Form). An acknowledgement letter will be sent to County within fifteen (15) business days, provided that any correction, request, grievance or dispute, is submitted on the dispute form. If an issue is not submitted on the dispute form, then no acknowledgement letter will be sent. Regardless of method of submission and whether or not an acknowledgement letter is sent, CenCal Health will respond within forty-five (45) business days from date of receipt of County's original submission of the correction, request, or grievance. If County disagrees with CenCal Health's response, or if County's correction, request or grievance/dispute is deemed untimely, County may appeal per CenCal Health policies, but the appeal must be received in writing no later than ninety (90) days after CenCal Health's response. If, from time to time, County requires an expedited review of a specific correction, grievance or request for adjustment, the expedited adjudication procedures described in Exhibit C will apply. Further information about Claims appeals is set forth in the provider grievance system policy in the Provider Manual.

4.6. Uncashed Checks. When checks issued to County remain uncashed beyond three (3) years of issuance, CenCal Health will make reasonable attempts to contact County's Chief Financial Officer by phone, email and/or US mail. If such contacts have failed, CenCal Health will void the check and the funds will be returned to the CenCal Health general fund.

4.7. Repayment. CenCal Health hereby agrees that Claims submitted for Covered Services rendered by the County Health Care Centers shall be presumed to be coded correctly. CenCal Health may rebut such presumption with evidence that a Claim fails to satisfy the standards set forth in the State Manual or in the Provider Manual. If an audit conducted by CenCal Health concludes that County owes monies to CenCal Health, CenCal Health reserves the right to require repayment or to deduct monies that may be due to County from subsequent payable Claims as per Medi-Cal regulations for FQHCs. Additionally, CenCal Health also reserves the right to take such action if: (i) County fails to meet its participation requirements; (ii) County fails to report services rendered in the manner specified herein; (iii) overpayment occurs; (iv) fraudulent billing by County has been discovered and substantiated; or (v) other such circumstances as determined in the sole and absolute discretion of CenCal Health, but acting reasonably and after notice to County. Should CenCal Health seek repayment or elect to deduct money from subsequent Claims, it is required to do so in accordance with CenCal Health established policies and procedures, and shall notify County in writing at the time of repayment or deduction. If County wishes to dispute such action, it shall do so in accordance with the processes set forth in CenCal Health grievance system policies and procedures in the Provider Manual.

4.8. Billing Other Sources. County may bill the Member in the following circumstances:

(i) For Copayments that are payable, if any.

(ii) Other Coverage. If a Member is entitled to benefits under other health benefits coverage and such coverage is primary, County will coordinate benefits as set forth in the Provider Manual.

(iii) Services After Coverage Exhausted or No Coverage. If a Member elects to continue receiving services after such Member's coverage has been exhausted, or CenCal Health determines in its sole discretion that such services are not Covered Services, then County shall seek compensation solely from such Member (or such Member's representative) for such services, or if the Member is not legally responsible for such services, County shall seek compensation from the legally responsible entity.

4.9. Coordination of Benefits. When CenCal Health is primary under applicable coordination of benefits ("COB") rules, CenCal Health shall pay to County, as set forth in this Agreement, the amount due for Covered Services rendered to Members. When CenCal Health is secondary under applicable COB rules, or another payor is primary to CenCal Health, then CenCal Health shall pay for Covered Services according to CenCal Health policies and procedures.

4.10. Medicare and Certain Other Recoveries. The State Manuals specify that certain other health programs (including Medicare and the Healthy Families program) for SBHI and SLOHI Members must be billed and recoveries made prior to billing the Medi-Cal program. Such rules shall also apply to CenCal Health administration of the Medi-Cal program. Most services billed initially to Medicare will be reported to CenCal Health as a Medi/Medi crossover, as set forth in the Provider Manual. CenCal Health shall process such Claims and reduce payment or deny Claims as appropriate, and notice of such reduction or denial will appear on an explanation of benefits (EOB) that County receives. County may qualify for and keep Medicare recoveries available after Claims have been processed.

County's Encounters for Covered Services rendered to Medi/Medi Members (crossovers) shall be processed as set forth in Exhibit C to this Agreement.

4.11. Notification of Member's Potential Tort, Casualty, or Workers' Compensation Awards. Since CenCal Health is under a contractual obligation to the State to notify the State of any potential tort, casualty insurance, Workers' Compensation award and uninsured motorists coverage for the value of Covered Services provided to any Member, CenCal Health must rely on its Providers to inform CenCal Health of such potential awards. Therefore, County agrees to notify CenCal Health that a potential tort, casualty insurance, Workers' Compensation award, or uninsured motorists coverage may cover any Covered Services provided by County whenever County discovers such potential awards.

4.12. No Reimbursement from State or Members. Except as specifically allowed as a direct result of County status as an FQHC Provider, County shall hold harmless the State and Members in the event that CenCal Health cannot or will not pay for Covered Services performed by County pursuant to this Agreement.

4.13. Payment Option. Should the State, through an Operating Instruction Letter (OIL) or otherwise, require CenCal Health to implement benefit changes that could result in reimbursement to County at a rate different than the rate indicated in any and all Exhibits and/or attachments, CenCal Health reserves the right, but does not have the obligation, to make said adjustments. In the event CenCal Health does elect to make such an adjustment, CenCal Health shall be obliged only to do so back to the beginning of the current Fiscal Year of CenCal Health. Notice to County will be provided.

4.14. Incentive Payments. CenCal Health, in its sole and absolute discretion and if it is financially feasible, may elect to pay Incentive Payments (as described in Exhibit A), to some Providers based on specific criteria. Such Incentive Payments, if any, shall not be deemed compensation for Covered Services under this Agreement and no Provider is entitled to any Incentive Payment. In no event shall any such Incentive Payment be a change requiring an amendment to this Agreement.

4.15. Confidentiality. The terms of this Agreement, including any Exhibits, Attachments, Provider Manuals, and any other Confidential Information, and in particular the provisions regarding compensation, are confidential and shall not be disclosed to any third party except as necessary for the performance of this Agreement unless required by federal or State law or regulation. Without limiting the foregoing, County agrees and understands that any rate or compensation set forth in this Agreement is proprietary to CenCal Health and may not be disclosed to any third party without the prior written approval of CenCal Health.

4.16. Deficit Reduction Act (DRA) of 2005. Pursuant to the DRA, section 6032, which created the new section of the Social Security Act § 1902(a)(68), County is hereby informed that CenCal Health makes its policy regarding false claims laws available for review. Such policy is available on the CenCal Health web site as follows: www.cencalhealth.org/For Providers/Manuals. The policy sets forth information about: (i) detecting and preventing fraud, waste and abuse; (ii) federal and State false claims laws; and (iii) protections available to whistleblowers. As a provider of health care services, who may additionally furnish or authorize furnishing of Medi-Cal health care services, County, in addition to CenCal Health employees and other agents and subcontractors, must adopt the policies as made available, and as they are updated from time to time.

5. ADMINISTRATIVE PROCEDURES

5.1. Deemed Notice of Provider Manuals, Rules, Policies and Procedures. County will comply with the State Manuals and with CenCal Health Provider Manuals and the policies and procedures established by CenCal Health, as applicable, and will be deemed to have accepted same,

to the extent County has been provided Notice thereof. As of the Effective Date hereof, the policies, rules and procedures applicable to County are set forth in CenCal Health Provider Manuals and other Exhibits attached hereto and incorporated by this reference. County is hereby notified that the Provider Manuals are available, as they may be updated and revised from time to time, on the CenCal Health web site: www.cencalhealth.org, and on the Medi-Cal web site: www.medi-cal.ca.gov. Changes to the language in the above referenced documents for SBHI and SLOHI Members and directions for acceptance of said changes will be indicated in a cover letter accompanying such proposed changes. County may provide specific names and addresses of those who should receive notification of changes.

5.2. Grievance System. County and any Subcontractors shall comply with the CenCal Health grievance system policy and procedures, and CenCal Health shall provide County a reasonable system for the resolution of disputes between County and CenCal Health. Additionally, County shall cooperate with CenCal Health in identifying, processing, and resolving all Member concerns and complaints pursuant to CenCal Health Member grievance procedures. CenCal Health grievance system policies are set out in full in the Provider Manual.

5.3. Formulary. County shall comply with the CenCal Health formulary and any associated drug utilization and disease management guidelines and protocols in effect now or that may become effective during the term of this Agreement. When required, the prescribing Physician shall be responsible for obtaining authorization through the Medical Request Form (MRF) process, and shall provide CenCal Health or its pharmacy benefit management company all information necessary to process MRFs.

Prescribing Physicians shall prescribe generic drugs if available instead of the brand name drugs whenever a therapeutically equivalent generic drug exists. See also Pharmaceutical Services and Prescribed Drugs, Section 2.8.

5.4. Non-Discrimination. During the performance of this Agreement, neither County nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including HIV and AIDS, AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. County and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. County and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code §12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR §7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code §12990, set forth in Chapter 5 of Division 4 of 2 CCR are incorporated into this Agreement by reference and made a part hereof as if set forth in full. County and Subcontractors shall give written notice of their obligations under this Section to labor organizations with which they have a collective bargaining or other agreement. County shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Agreement.

Neither County nor Subcontractors shall discriminate against Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC § 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code §11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code

§ 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

County shall take steps to ensure that all Members are provided Medically Necessary Covered Services without unlawful discrimination. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait and X-linked hemophilia. County shall act upon all complaints alleging discrimination against Members in accordance with CenCal Health Member grievance system and shall forward copies of all such grievances to CenCal Health within five (5) Days of receipt of same.

5.5. Notification. County will notify affected Members in writing of any substantial changes in the availability or location of Covered Services as may be provided by its County Health Care Centers at least thirty (30) Days prior to the effective date of such changes, or within fourteen (14) Days prior to the change in cases of unforeseeable circumstances. CenCal Health shall notify Members immediately if the County Health Care Center is terminated or closes so that the Member may choose a new PCP as soon as practicable.

CenCal Health will modify its Contracted Provider List (CPL) should a Provider who is either an individual or a member of a group no longer provide services to Members.

6. CENCAL HEALTH OBLIGATIONS

6.1. Plan Products and Benefit Information. CenCal Health shall include in the Provider Manual a description of the SBHI and SLOHI programs and shall promptly update the Provider Manual upon material changes to the program. CenCal Health shall advise and counsel its Members and Providers on the type, scope and duration of benefits and Covered Services to which Members are entitled pursuant to agreement among CenCal Health, County and Members.

6.2. Provider Network. County shall permit CenCal Health to include County in its CPL that is distributed to Members and Providers; provided however, that such rights shall not extend to listing of County in any newspaper, radio, or television advertising without the prior written consent of County. County shall notify CenCal Health of address changes pursuant to Section 15.9 of this Agreement, and such changes will be reflected in the CPL distributed to Providers and Members as set forth in §8.7.

6.3. Consultation with Medical Director. County may at any time seek consultation with the CenCal Health Medical Director or designee, on any matter concerning treatment of a Member.

6.4. Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of CenCal Health to intervene in any manner in the methods or means by which County renders health care services or provides health care supplies to Members. Nothing herein shall be construed to require County to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Members.

6.5. Reports. CenCal Health shall continue to provide to County the reports described in Exhibit C.

6.6. Data Reporting Oversight. County shall submit data to CenCal Health showing evidence of rendering Covered Services. County is required to submit Encounters for all services other than those referenced in Section 4.1.3, above and attached Exhibit B, for which County shall

submit Claims forms. Claims forms should be the most current form or accepted format if submitting online or electronically. Clean Claims should include the data elements required by CenCal Health as set forth in the Provider Manual. In order to comply with the CenCal Health QAIP, County must correct and resubmit data that is unacceptable within six (6) months after the date of denial of fee-for-service payment and within six (6) months after the request for additional data on Encounters.

In addition to supplying CenCal Health with required data within one (1) year from the date of service, after seven (7) days advance written notice by CenCal Health, County will allow CenCal Health to inspect and audit such data at the Provider's office at a mutually agreeable date and time. Additionally, County acknowledges that CenCal Health has the right to monitor County's timely submission of Claims in accordance with the relevant provisions of the Medi-Cal program or as set forth in the Provider Manual. County also understands that CenCal Health will publish reports obtained from the compilation of such required data for quality improvement purposes, but that the confidentiality of Members' identities shall be maintained in such publication.

6.7. Non Discrimination. CenCal Health shall not discriminate in the participation, reimbursement, or indemnification of any Provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification.

7. INSURANCE AND INDEMNIFICATION

7.1. Insurance.

7.1.1. County shall carry at County's sole expense professional liability insurance, or provide and maintain a self-insurance program. Insurance is against professional errors and omissions (malpractice) in providing services under the terms of this Agreement and for the protection of the interests and property of County, its employees, CenCal Health Members, third parties and CenCal Health. If applicable, each County driver shall be insured with automobile liability insurance. County shall also carry appropriate Workers' Compensation Insurance. Insurance may be provided in a form of blanket policy. All insurance shall be at limits reasonably required by CenCal Health.

7.1.2. CenCal Health acknowledges and accepts the County is self-insured for General, Professional and Auto liability losses up to $500,000 and purchases excess insurance with policy limits equal to or greater than $2,000,000 above its self-insured retention. The County purchases primary and excess Workers' Compensation insurance within statutory limits.

7.2. Indemnification. Each party to this Agreement agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorneys' fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicted shall have occurred prior to the effective date of termination or completion.

8. RECORDS AND CONFIDENTIALITY

8.1. Medical and Administrative Records. County shall establish and maintain a legible medical record for each Member who has received Covered Services from County's FQHC Providers or Health Professionals. Such medical record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of County, its qualified

employees, or County Subcontractor. Such medical record shall be in such a form as to allow trained health professionals, other than County, its employees, or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The medical record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR § 53284, and which permits effective professional review and facilitates a system of follow-up treatment.

8.2. Maintenance of Records. County, its employees, and any Subcontractors shall maintain books, charts, documents, papers, reports and records, whether in hard copy or in electronic format, (including, but not limited to: financial records; books of account; working papers; administrative records; patient medical records; laboratory results; prescription files; Subcontracts; management information systems and procedures; copies of current licenses and certifications for personnel legally required to be licensed or certified; and other documentation pertaining to medical and non-medical services for Members) related to medical services provided hereunder to Members, to the cost thereof, to payment received from Members or others on their behalf and to the financial condition of County ("Records"). Records also include those that are customarily maintained by County for purposes of verifying Claims information and reviewing appropriate utilization requirements, including privacy and confidentiality requirements and in accord with the general standards applicable to that book or record keeping. Records shall be legible, kept in detail: (i) consistent with appropriate medical and professional practice and prevailing community standards; (ii) which permits effective internal professional review and external medical audit process; and (iii) which facilitates an adequate system for follow-up treatment. The Member's medical record shall reflect whether the Member has executed an advance directive. County shall be fully bound by the requirements in 42 CFR § 2.1 et seq., relating to the maintenance and disclosure of Member records received or acquired by federally assisted alcohol or drug programs. County shall preserve Records for the longer of: (i) five (5) years after the close of the CenCal Health State Contract; or (ii) the period of time required by State and federal law, and by the Medicare and Medi-Cal programs, as applicable. Upon request, at any time during the period of this Agreement, County shall furnish any such Record, or copy thereof, to CenCal Health, which shall pay the cost of reproduction at the rate CenCal Health has in effect at the time of the request and mailing costs.

8.3. Records Retention. In order to comply with CenCal Health obligations under the State Contract, County shall retain, preserve and make available upon request all Records relating to the performance of its obligations under this Agreement, including Claim forms, for a period of not less than five (5) years from the date of the State's fiscal year in which the applicable Agreement between CenCal Health and County expires or terminates, except that, in the event County has been duly notified that the State, DHCS, DHHS, the Department of Justice or Comptroller General of the United States, or their duly authorized representative, or any other government entity (collectively "Government Officials") have commenced an audit or investigation of the Agreement or any Subcontract until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than five (5) years following the termination of litigation. Such provisions shall also apply to County Subcontractors.

8.4. Inspection Rights. County shall allow CenCal Health and Government Officials statutorily authorized to have oversight responsibilities over CenCal Health and its contracts and the successors and duly authorized representatives of the Government Officials, including DHCS' external quality review organization contractor, to inspect, monitor, or otherwise evaluate the quality, appropriateness and timeliness of services performed under this Agreement and applicable federal and State laws and regulations, and to inspect, evaluate and audit any and all books, records and facilities maintained by County and any and all of its Subcontractors pertaining to these services at

any time during normal business hours at County's normal place of business, or at such other mutually-agreeable location in California.

County shall provide, at the request of CenCal Health, reasonable facilities, cooperation and assistance to State and/or CenCal Health representatives in the performance of their duties. When permitted by law, and including but not limited to HIPAA regulations, to conduct health care operations, County shall promptly provide copies of requested records to allow inspection, monitoring, or evaluation of medical records by CenCal Health without patient consent.

8.5. Confidentiality of Information. Notwithstanding any other provision of this Agreement, the name of persons receiving public social services is Confidential Information and is protected from unauthorized disclosure in accordance with 42 CFR § 431.300 et seq., and California Welfare and Institutions Code §14100.2, and regulations adopted thereunder. Additionally, CenCal Health, County and any Subcontractors shall protect all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to individual Members from unauthorized disclosure. CenCal Health may release medical records in accordance with applicable law pertaining to the release of this type of Information.

With respect to any personally identifiable information concerning a Medi-Cal Member that is obtained by County, the County FQHC Providers and its Health Professionals and any Subcontractors will: (i) not use any such Confidential Information for any purpose other than carrying out the express terms of this Agreement; (ii) promptly transmit to CenCal Health all requests for disclosure of such Confidential Information; (iii) not disclose except as specifically permitted by this Agreement, any such Confidential Information to any party other than CenCal Health, without prior written authorization specifying that the information is releasable under 42 CFR § 431.300 and following, California Welfare and Institutions Code §14100.2, and regulations adopted thereunder; and (iv) at the expiration or termination of this Agreement, return all such Confidential Information to CenCal Health or maintain it according to written procedures sent to CenCal Health by DHCS for this purpose.

8.6. Member Request for Medical Records. County and its Subcontractors shall furnish a copy of a Member's medical records to another treating or consulting Provider regardless of whether the requesting Provider is a participating Provider or an out of network provider, at no cost to CenCal Health or to the Member when: (i) such a transfer of records facilitates the continuity of that Member's care; (ii) the Member is transferring from one Provider to another for treatment; or (iii) the Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

8.7. Use of Name. County and CenCal Health each reserves to itself the right to, and the control of the use of, its names, symbols, trademarks and service marks, presently existing or hereafter established, and, neither County nor CenCal Health shall use the other's names, symbols, trademarks, or service marks in any advertising or promotional communication of any type or otherwise without the prior written consent of the other party. Notwithstanding the above, CenCal Health may communicate County's name, address(es), telephone number(s), office hours, language capabilities, handicap access, specialty, affiliations and Subcontractors or other affiliates to Providers and Members.

9. AGREEMENT TERM AND TERMINATION

9.1. Term. This Agreement shall be effective as of January 1, 2012. The Agreement shall expire on December 31, 2017 unless terminated or amended as hereinafter provided in the Agreement.

9.2. Without Cause Termination. County may terminate this Agreement at any time for any reason or for no reason with at least sixty (60) Days prior written Notice to CenCal Health. CenCal Health may terminate this Agreement at any time for any reason or for no reason with at least thirty (30) Days prior written Notice to County.

9.3. With Cause Termination. If a party materially breaches this Agreement and fails to cure the material breach to the satisfaction of the non-breaching party within fourteen (14) Days after the non-breaching party gives written Notice of the material breach, the non-breaching party may terminate this Agreement immediately upon written Notice to the other party. Notwithstanding the above, CenCal Health may immediately suspend this Agreement pending completion of applicable termination procedures, if CenCal Health makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

9.4. Immediate Suspension and Termination.

9.4.1. County shall immediately notify CenCal Health and CenCal Health may immediately suspend this Agreement in the event there is a material adverse change in County's insurance coverage, or the County's FQHC Provider license(s), Medicare or Medi-Cal certification, accreditation (if applicable) or the credentialing status with CenCal Health is suspended or limited. If County does not provide adequate insurance coverage within thirty (30) Days of the material adverse change, or if the County's FQHC Provider's license(s), certification, accreditation (if applicable) or the credentialing status is not fully reinstated within thirty (30) Days of such suspension or limitation, CenCal Health may terminate this Agreement immediately. County shall immediately notify CenCal Health and this Agreement will terminate without further action of the parties if County insurance coverage is canceled, not renewed or expires, or if County fails to obtain insurance coverage as required by this Agreement, or if the County's FQHC Provider license(s), Medicare or Medi-Cal certification, accreditation (if applicable) or credentialing status with CenCal Health is revoked, not renewed or expires, if the County's licensure or certification is not obtained as required by this Agreement, or if County is excluded from participation in the Medicare or Medi-Cal programs. If this Agreement terminates without further action of the parties, the effective date of termination shall be the date of the occurrence of such event or, at the option of CenCal Health, such other date determined by CenCal Health in its sole discretion.

9.4.2. CenCal Health may immediately suspend this Agreement in whole or in part in the event CenCal Health does not receive funds or receives reduced funds from the State for health care services or the State determines that CenCal Health is no longer responsible to arrange for the provision of health care services to Members due to a catastrophic occurrence. In any event, this Agreement will automatically terminate at the termination of the CenCal Health State Contract.

9.4.3. County shall notify CenCal Health and CenCal Health may terminate this Agreement immediately upon written Notice to County if County files a petition in or for bankruptcy, reorganization or an arrangement with creditors, or has a case or proceeding commenced against it under any bankruptcy or insolvency law. County must notify CenCal Health, within twenty-four (24) hours, if County's FQHC Provider Clinical Privileges, membership, contractual participation or employment by any medical organization is denied, suspended, restricted, reduced, revoked, is subject to probationary conditions, or is not renewed for possible incompetence, improper professional conduct or breach of contract, or if any such action is pending. CenCal Health will review the issues and may terminate this Agreement immediately upon notification to County.

9.4.4. County shall notify CenCal Health if County provides services to Members through a Subcontractor and: (i) such Subcontractor's license to practice medicine in any state is

suspended, revoked, expired or not renewed; (ii) such Subcontractor's staff privileges at any Hospital is revoked, suspended, not renewed or significantly (in the judgment of CenCal Health) reduced for any medical disciplinary cause or reason (if Subcontractor is a physician); (iii) such Subcontractor is not or ceases to be covered by professional liability coverage as required under this Agreement; (iv) such Subcontractor is criminally charged with any act involving moral turpitude; (v) the credentialing information, if required, provided to CenCal Health with respect to such Subcontractor was materially false; or (vi) such Subcontractor no longer satisfies the credentialing standards, if required, of CenCal Health. In such case, County shall immediately suspend Subcontractor and work with CenCal Health to ensure that services to Members continue to be provided through other County Health Professionals. County shall be deemed to be on notice by CenCal Health that if the reason for the suspension is not remedied within thirty (30) days, County must terminate Subcontractor's contract with respect to Services to Members or this Agreement may be terminated by CenCal Health.

9.4.5. CenCal Health may terminate this Agreement immediately upon written Notice to County if: (i) County surcharges Members; (ii) County fails to comply with CenCal Health UM procedures; (iii) County fails to abide by CenCal Health grievance or quality assurance procedures; (iv) County rejects a modification pursuant to §12; or (v) there is any change to the composition of FQHC Providers, County Health Professionals and other health care providers providing Covered Services on behalf of County and such Providers have not been credentialed, if required, by CenCal Health.

9.5. Practice Closure. In the event County ceases to be a Provider, this Agreement shall be of no further effect, except insofar as moneys owed, either party shall remain a liability for the applicable party.

9.6. Assignment. This Agreement may not be transferred or assigned to any other person or entity unless prior written approval is obtained from DHCS.

10. RESPONSIBILITY UPON TERMINATION

10.1. Continuation of Covered Services. Upon termination of this Agreement, County shall continue to provide Covered Services to eligible Members under the care of County at the time of termination, and shall accept as compensation for such Covered Services, the rates set forth in this Agreement and in the applicable attached Exhibit(s) until County or CenCal Health has made reasonable and medically appropriate provision for the assumption of such Covered Services by a new Provider. County or CenCal Health shall use best efforts to make such alternate arrangements within ninety (90) Days of the termination of this Agreement. The terms and conditions of this Agreement will continue to apply to Covered Services provided to each such Member until completion or until transfer to a new Provider. County shall act in such a manner as to facilitate any new Provider's assumption of Covered Services**,** including County and its Subcontractors assisting in transfer of medical care and/or medical records as requested and needed. Upon termination, County will follow applicable processes for continuation of treatment/access including but not limited to Members undergoing active treatment for a chronic or acute medical condition, and care through the postpartum period for women in their second or third trimester of pregnancy, contained in the CenCal Health Continuity of Care Policy, which is set forth in full in the Provider Manual. Additionally, if a Member has requested a fair hearing, the Agreement shall continue until the decision is made, unless CenCal Health requests County to discontinue rendering Covered Services. In the event that CenCal Health ceases to administer the Medi-Cal program in Santa Barbara and/or San Luis Obispo County, County shall assist CenCal Health in meeting its pre-termination obligations to DHCS with respect to the transition of Members and continuity of care.

10.2. Turnover Requirements. Upon request by the Member, County shall assist the Member in the orderly transfer of the Member's medical care. In doing this, County shall make available to the subsequent Provider copies of medical records, patient files and any other pertinent information necessary for efficient medical case management of Members. Under no circumstance shall a Member be billed for this service.

10.3. Provisions Surviving Termination. Provisions of this Agreement including, but not limited to, §3.12 (Utilization Management), §5.2 (Grievance System), §7 (Insurance & Indemnification), and §8 (Records and Confidentiality) that are not fully performed or are not capable of being fully performed as of the date of termination will survive termination of this Agreement.

County further agrees that § 2.4.11 shall: (i) survive the termination of this Agreement regardless of the cause giving rise to termination; (ii) be construed to be for the benefit of the Members; and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into by the parties. Any modification to this §10.3 shall become effective only after proper State and federal regulatory authorities have received written notification of the proposed change.

10.4. Return of Funds. Upon termination of this Agreement, County shall, within thirty (30) Days, return to CenCal Health the pro rata portion of money paid to County which corresponds to the unexpired period for which payment has been received, if any.

11. HIPAA COMPLIANCE

County and CenCal Health shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

County shall comply with HIPAA requirements as currently established in the CenCal Health Provider Manual. County shall also take actions and develop capabilities as required to support CenCal Health compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats. County and CenCal Health agree and acknowledge that County and CenCal Health are covered entities who may disclose personal health information to carry out essential health care functions for treatment, payment and health care operations, as those terms are defined in HIPAA, in accordance with 45 CFR §§164.502(a) and 164.506.

12. AMENDMENT

CenCal Health may amend this Agreement by providing written Notice to County. The amendment shall become effective on the date stated in the Notice, which date shall be at least thirty (30) Days after Notice is given to County, unless County objects in writing within thirty (30) Days of receipt of said Notice of amendment. In that event, authorized County and CenCal Health representatives shall meet and confer to resolve any such objections. In the event they are unable to do so within a reasonable amount of time, County has the right to terminate this Agreement within five (5) Days of the inability of the parties to resolve their differences. Notwithstanding the foregoing, amendments required due to legislative, regulatory or other legal authority do not require prior approval of County and shall be deemed effective immediately upon County receipt of Notice.

13. AUTHORITY

All parties to this Agreement warrant and represent that they have the power and authority to enter into this Agreement: (i) in the names, titles and capacities herein stated; (ii) on behalf of any entities, persons, or firms represented or purported to be represented by such entity(ies), person(s), or firm(s); (iii) without the need for approval or agreement by any other person or entity. Each party further represents and warrants that it has complied with all formal requirements necessary or required by any State and/or federal law in order to enter into this Agreement.

14. DISPUTE RESOLUTION

14.1. Good Faith Efforts. Except for the right of either party to apply to a court of competent jurisdiction for a temporary restraining order or other provisional remedy to preserve the status quo or prevent irreparable harm, County and CenCal Health agree to attempt in good faith to promptly resolve any dispute, controversy or claim arising out of or relating to this Agreement, including but not limited to payment disputes, through negotiations between senior management of the parties and their designees. If the dispute cannot be resolved within fifteen (15) Days of initiating such negotiations or such other time period mutually agreed to by the parties in writing, either party may pursue its available legal and equitable remedies.

14.2. Continued Performance. County and CenCal Health agree that notwithstanding the existence of a dispute, they will continue without delay to carry out all their respective responsibilities under this Agreement.

15. MISCELLANEOUS

15.1. Independent Contractor. None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee, or the representative of the other.

15.2. Compliance with State and Federal Program. County shall comply with requirements established by State and/or federal programs relating to its performance under this Agreement. Compliance shall include but not be limited to provisions of the State Contract requirements for CenCal Health to maintain its Center for Medicare and Medicaid Services (CMS) waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and State and/or federal regulations regarding FQHCs.

15.3. Obligations Under Prior Agreement. County acknowledges and agrees that certain of its obligations and duties under the prior agreement as described in Recital A hereof, survive the expiration of the prior agreement and/or are measured following the expiration of the prior agreement (including, without limitation, financial requirements, corrective action plans, quality improvement and credentialing functions). County agrees to perform all such obligations and duties.

15.4. Approval by DHCS. This Agreement and any amendments hereto are subject to approval by DHCS. CenCal Health shall notify DHCS of any amendments to this Agreement.

15.5. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Agreement which such party believes is essential to the successful performance of this Agreement, said party may so inform the other party in writing, and the parties hereto shall

thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Agreement.

15.6. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Agreement shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained.

15.7. Severability. If any one or more of the provisions of this Agreement is held invalid or unenforceable, the remaining provisions shall continue in full force and effect.

15.8. Interpretation of Agreement. This Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of which party drafted the Agreement. Section headings are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

15.9. Notices. Any Notice or other communication required or permitted in this Agreement shall be in writing and shall be deemed to have been duly given on the day of service if served personally or by facsimile transmission with confirmation, or three (3) Days after mailing if mailed by registered or certified mail, or two (2) Days after delivery to a nationally recognized overnight courier, to the person and address noted below or to such other person or address as a party may designate in writing from time to time. The addresses for Notice shall be changed in the manner provided for in this §15.9.

If served on CenCal Health, it should be addressed to Director of Provider Services, 4050 Calle Real, Santa Barbara, CA 93110.

If served on County, it shall be addressed to County at the address that appears on the Agreement, the PIF, or to the most recent address on file with CenCal Health.

County shall provide notice of termination of this Agreement to DHCS, by first class certified mail, postage prepaid at the following address:

Chief, COHS, GMC and Other Contracts Section
California Department of Health Care Services
Medi-Cal Managed Care Division
MS # 4408
POB 997413 Sacramento, CA 95899-7413

15.10. Billing and Procedure Codes. Any billing or procedure codes ("Codes") referred to in this Physician Services Provider Agreement or any Exhibits or attachments hereto are for the convenience of the parties only. The parties agree and understand that the Codes may change from time to time and such Code changes shall not require any amendment to this Agreement.

15.11. National Provider Identifiers. The parties agree and understand that all HIPAA covered entities will be required to use their National Provider Identifiers (NPI) in all standard healthcare transactions which includes paper as well as electronic transactions. Claims forms have been modified to accept the NPI.

15.12. Governing Law. This Agreement shall be governed by and construed in accordance with California law and all State and federal laws and regulations applicable to CenCal Health and County. Any provision required by State or federal laws, or by regulatory agencies to be in this Agreement shall bind the parties whether or not provided in this Agreement. Any reference to any law, regulation, rule, program or Plan promulgated by any governmental entity having authority over CenCal Health or the subject matter of this Agreement shall be deemed to refer equally to any amendment, modification, revision or restatement thereof.

16. ENTIRE AGREEMENT

This Agreement in its entirety is comprised of the Agreement, any and/or all of Exhibits A, B and C and their attachments as may be applicable to County, Attachment 1, and the CenCal Health Provider Manual. This Agreement, as described in the preceding sentence, contains the entire agreement of the parties and as of the date of execution below supersedes any prior negotiations, proposals or understandings relating to the subject matter of this Agreement. It is agreed by the parties that this Agreement may not be modified, altered or changed in any manner, except in accordance with §12 hereof.

By signing below, County agrees that its current County Health Care Centers and any new future County Health Care Centers sites agree to participate in the Medi-Cal program administered by CenCal Health, unless the parties agree otherwise, as indicated by receipt of the applicable Exhibits below.

County has received the following Exhibits/Attachments with this Agreement:

__X__ Exhibit A--Protocols for Primary Care Physicians (incl. Attachments A-1, A-2, and A-3)

__X__ Exhibit B--Protocols for Referral (Specialist) Physicians (incl. Attachment B-1)

__X__ Exhibit C--Encounter and Claims Billing Procedures

__X__ Attachment 1--Disclosure Form--Officers and Owners, Stockholders Owning more than 10% Stock, and Major Creditors

[Signatures appear on the following two pages]

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the Effective Date set forth above.

SANTA BARBARA SAN LUIS OBISPO
REGIONAL HEALTH AUTHORITY
dba CENCAL HEALTH

By: _____
Chief Executive Officer

_____
Date of Execution by CenCal Health

APPROVED AS TO FORM:

_____
Caitlin Larsen, Director of Legal Affairs

IN WITNESS WHEREOF**,** the parties have executed this Agreement to be effective on Effective Date set forth above.

COUNTY OF SANTA BARBARA

By: _____
Chair, Board of Supervisors

Date: _____

ATTEST:
CHANDRA L. WALLAR
CLERK OF THE BOARD

By: _____
Deputy

APPROVED AS TO FORM
DENNIS MARSHALL
COUNTY COUNSEL

By: _____
Deputy County Counsel

APPROVED AS TO ACCOUNTING FORM
ROBERT W. GEIS, CPA
AUDITOR-CONTROLLER

By: _____
Auditor-Controller

TAKASHI WADA, MD, MPH
PUBLIC HEALTH DEPARTMENT
DIRECTOR/HEALTH OFFICER

By: _____
Director

APPROVED AS TO FORM
RAY AROMATORIO, ARM, AIC
RISK MANAGEMENT

By: _____
Risk Manager

AGREEMENT - ATTACHMENT 1

DISCLOSURE FORM
PLEASE COMPLETE AND RETURN

Please complete the following information: **(N/A)**

1) Names of the officers and owners *(i.e. if the provider is Dr. John Doe and he is the sole owner of the practice, he should be listed in this section):*

_____ _____

_____ _____

_____ _____

_____ _____

If the following questions 2) and 3) are not applicable to *County*,
please check here [X]

2) Stockholders owning more than 10 percent of the stock issued by County:

_____ _____

_____ _____

_____ _____

3) Major creditors holding more than five percent of the debt of County:

_____ _____

_____ _____

EXHIBIT A

PROTOCOLS FOR PRIMARY CARE PHYSICIANS
COUNTY OF SANTA BARBARA ("County")

The term "PCP" as used in this Exhibit and any and all Attachments including the Provider Manual shall be deemed to also refer to Physicians, Physician groups, clinics, Federally Qualified Health Centers (FQHCs), and/or Primary Care Groups who provide Primary Care Services. CenCal Health acknowledges the differences between these Providers, however for ease of administration of the PCP Incentive Program, all shall be referred to as PCPs, when appropriate, in this Exhibit. "County Health Care Center Physician" shall mean any physician who provides the services of a PCP for County Health Care Centers and meets the qualifications of a PCP as specified in §1 of this Exhibit A.

NOTE: *Additional definitions relevant to PCP participation are set forth in: (i) the Agreement; (ii) the Provider Information Form that is normally sent with the Agreement; and (iii) the Provider Manual at www.cencalhealth.org/for_providers/manuals.*

Medi/Medi Members are excluded from the County's FQHC Capitation reimbursement methodology as reimbursement is included in the County physician specialist and non case-managed Members quarterly installment payment. Medi/Medi Members are not included in the PCP Incentive Program. For purposes of this Exhibit A, including Attachments A-1, A-2 and A-3, references to "Case Managed Member" as regards Capitation payments, the Guaranteed Payment portion of Capitation and the Incentive Plan are not intended to include Medi/Medi Members.

1. COUNTY'S PCP PARTICIPATION

Any physician duly licensed in the State may elect to serve Members as County's PCP if that physician meets the qualifications set by the Board of Directors and the appropriate Committees of CenCal Health as outlined in the Provider Credentialing Policy in the Provider Manual, and has been credentialed or recredentialed by CenCal Health, and:

1.1. Is employed by or contracts with County to provide professional services;

1.2. Will accept a minimum of fifty (50) Members unless exempted from that requirement by CenCal Health.

County has received certification as a California Health and Disability Prevention (CHDP) Program provider and may be assigned SBHI Members under nineteen (19) years of age.

County has completed a PIF, including indicating names of employed or contracted PCP's, the maximum capacity at each site, Peer Pool Designation, age ranges, access and regular office hours and any extended office hours, and/or additional information as requested, updated as necessary.

2. PHYSICIAN/PATIENT RELATIONSHIP

2.1. Member Designation

Each Member who is to be Case Managed shall receive a Contracted Provider List (CPL) and be given the opportunity to choose the PCP through whom the Member will seek all Covered Services. The CPL contains the location of County Health Care Centers. Members are permitted to select a County Health Care Center site but are not permitted to select a specific clinic PCP. County has listed its County Health Care Center locations on the PIF. If County has accepted "auto assignment" to obtain Members who do not select their PCP, it will be so noted on the PIF. Although all County Health Care Centers as indicated on the PIF may be inserted in the CPL, not all clinic sites must be designated as open to accept Members.

2.2. Change of Primary Care Physician by Member

Members may change their PCP or County Health Care Center site in accordance with procedures established by CenCal Health.

2.3. Limitation of Members

CenCal Health will not permit Members to choose any PCP or County Health Care Center site in excess of the stated Physician Patient Load Limitation set forth on the PIF.

2.4. Responsibility of Physician to Exercise Choice

County FQHC Providers, County Health Professionals or the Member's Attending Physician may, on occasion, be faced with an Emergency Medical Condition in which: (i) the Member is unconscious or unable to give reasonable consideration to methods of treatment; and (ii) it appears that the Member is in immediate need of Medically Necessary services and has no reasonable opportunity to obtain such Medically Necessary services from any other source. In any such case, unless said Physicians have prior knowledge of the Member's wishes, e.g. Durable Power of Attorney, "Living Will", Advance Directives, etc., Attending Physician or the Member's PCP may undertake such procedures or courses of treatment which, in his or her professional judgment, are appropriate.

2.5. Unsatisfactory Relationships Between Members and Primary Care Physicians

The physician/patient relationship is a personal relationship and circumstances may arise under which relations between Members and their PCP become unsatisfactory. In such cases, County may request that the Member be reassigned to a PCP with whom a satisfactory physician-patient relationship may be developed. CenCal Health will follow procedures set forth in the Primary Care Provider Request for Member Re-assignment policy set forth in the Provider Manual when reassigning Members under these circumstances. If CenCal Health is unable to make such arrangements, County will continue to provide Covered Service to the Member according to the County's best professional judgment until CenCal Health is able to process the change but not to exceed two (2) months after County's request is received by CenCal Health.

2.6. Member Non-Compliance with Medical Treatment

A Member, for conscientious or other reasons, may refuse or neglect to follow or undergo one or more procedures or courses of recommended treatment. In cases where the Provider is of the opinion that no professionally acceptable alternatives to the recommended procedures or courses of treatment exist ("alternative care"), County shall consult with the Medical Director or a consultant designated for that purpose by the Medical Director. In all cases in which alternative care exists, and which is acceptable to all parties, County shall arrange such services for the Member. In

cases where no alternative care exists that is acceptable to all parties, and provided the alternative care is a covered benefit, the Member may be reassigned to a different PCP in order to receive Covered Services that are Medically Necessary and appropriate.

3. MANAGEMENT OF CARE

3.1. Case Management

With the exception of Emergency Services, Self Referral Services, CenCal Health Referrals and services that do not require RAFs as set forth in this Agreement and the Provider Manual ("RAF Exceptions"), County's PCPs will: (i) determine Medically Necessary and appropriate care; (ii) prescribe Covered Services for Members that at that time are determined to be the least costly Medically Necessary services for the prevention or control of disease, illness, or disability; and (iii) manage the assigned Members care in accordance with sound professional principles and with proper attention to the need for containment of costs.

County agrees to abide by the Case Management Protocols set forth in the Provider Manual.

As County has agreed to submit TARs for TAR covered services, County PCPs shall submit TARs to CenCal Health as set forth in the CenCal Health TAR Required Procedures list available on the CenCal Health website: www.cencalhealth.org/for_providers/procedures_ TAR/tar_required.

Other than the "RAF Exceptions" above or when a provider is specified as on-call for County, when County wishes to make a referral to providers outside of the County's network of care, County staff must submit RAFs to CenCal Health for review and approval.

3.2. Notification of Health Insurance Other Than Medicare

CenCal Health is under a contractual obligation to the State to recover for any Covered Service for which a Member is also covered under any other public or private health insurance. These potential recoveries have already been subtracted from the monthly rate that State pays CenCal Health. If County discovers that a Member has Other Health Coverage, it shall inform CenCal Health of this potential recovery situation. The requirements concerning notification in the current State Manual may apply. See also Other Health Coverage in the Provider Manual.

3.3. Withholding of Care

When a Member changes PCPs, either by the Member's or PCP's choice, and it is subsequently suspected and determined after the Medical Director's review that Medically Necessary services were withheld or delayed by the previous PCP, the Medical Director shall inform the PCP or County, if appropriate, of such findings and allow for further discussion. If the parties conclude that such Medically Necessary services are currently necessary to maintain the health and welfare of the Member, the Medical Director will inform CenCal Health staff of the outcome.

3.4. Recommended Preventive Health Services

In addition to the Medi-Cal Covered Services set forth in §2.3 of the Agreement, CenCal Health recommends that County Health Care Centers perform the services set forth in the

CenCal Health "Recommended Preventive Health Guidelines for Adults" in the Provider Manual. Further information regarding Adult Preventive Health Services is in §4.6 of this Exhibit A.

3.5. Supervision of Non-Physician Medical Providers

If County employs non-physician County Health Professionals, County is responsible for verifying the license and qualifications of such non-physician County Health Professionals under its supervision. Standardized procedures must be developed and maintained by County, and signed by both the supervising Physician and the non-physician County Health Professional. These include, without limitation, the provisions and requirements set forth in Business and Professions Code §2725, and Title 16 CCR §1480 and those set forth in §3.1.6 of the Agreement.

4. PAYMENTS AND INCENTIVES FOR CASE MANAGED MEMBERS

4.1. Guaranteed Payment for Case Managed Members and Acceptance of Guaranteed Payment

CenCal Health shall pay to County a monthly sum called the "Guaranteed Payment". This Guaranteed Payment as indicated in writing by County shall be sixty percent (60%) of the portion of the full Capitation rate allocated to Primary Care Services. The full Capitation rate is specified in §1-C of Attachment A-2, and sixty percent (60%) of that rate will be paid to County by the fifteenth (15th) day of each month, excepting Saturdays, Sundays and holidays. This full Capitation rate allocated to Primary Care Services may be increased, but not decreased, unilaterally by CenCal Health to be applicable to services rendered during a specified period. The Guaranteed Payment will be calculated according to the total number of eligible Case Managed Members (adjusted for eligibility category, Special Case Members, and age and sex if appropriate) assigned to County Health Care Centers for the calendar month. County shall receive notice each month of those Case Managed Members who are entitled to receive Covered Services from or through its County Health Care Centers and for whom County has been paid the Guaranteed Payment. County is expected to authorize Covered Services and cause its County Health Care Centers to render necessary Primary Care Services (as specified in Attachment A-1) to Case Managed Members in exchange for the monthly Guaranteed Payment. County does not receive fee-for-service reimbursement for the capitated services.

4.2. Reporting of Primary Care Services

County agrees to submit Encounters, according to the guidelines set forth in Exhibit C of the Agreement, for all capitated Primary Care Services listed in Attachment A-1 that its County Health Care Centers render to Case Managed Members. Failure to submit Encounters may result in a delay of County's receipt of the monthly Guaranteed Payment. Any service, including said Encounters, not reported on an Explanation of Benefits (EOB) before the final PCP Incentive calculations are completed will not be used in the PCP Incentive calculations. Additional information regarding Encounters is set forth in Exhibit C and in the Provider Manual. See also subsection 4.10, Administrative Data Reporting of this Exhibit A.

Covered Services not listed in Attachment A-1, (when billed under County's FQHC provider numbers) shall be considered Non-Capitated Services, as set forth in subsections 4.1.2 and 4.1.3 of the Agreement. County shall submit an Encounter for said services rendered to Case Managed Members. When Medi/Medi Members who are listed on the County Health Care Centers

case management list receive primary care Covered Services, County shall submit Encounters as indicated above.

4.3. Payment for Non Capitated Services

4.3.1. CenCal Health will process Encounters that County has submitted for authorized Medi-Cal and for CenCal Health only benefits that are not listed in Attachment A-1 and that are rendered to Case Managed Members on the Case Management list. In order to be counted as a valid Encounter, County must meet the criteria set forth in Exhibit C to the Agreement. Encounters that County submits for these Services shall be tracked in order for total dollars paid for each Case Managed Member to be included in each County Health Care Center's Incentive Payment calculation.

4.3.2. County shall submit Encounters to CenCal Health for Covered Services on the CMS 1500 or UB-04 or in an electronic format using industry standards as specified by DHCS and/or HIPAA as agreed by the parties, or via the Internet. CenCal Health will accept Encounters for Case Managed Members from County up to one (1) year from the date of service in order for the services to be included in the Incentive Payment calculation. A reduction in determining the fee-for-service equivalent rate, if there is no valid exception code indicated at the time of submission, is normally made after six (6) months from the end of the month of date-of-service and further reductions are applied after nine (9) months.

4.4. Primary Care Physician Incentive Program

The Primary Care Physician Incentive Program ("PCP Incentive Program") has been established by CenCal Health to reward PCPs and clinics who meet established utilization and quality criteria. Funding for this Program is obtained from CenCal Health's voluntary contribution from its reserve funds and from the withhold contributed by all PCPs from the Guaranteed Payment. The PCP Incentive Program is based on a calendar year ("CY"), and payments will be made within six (6) months of the close of each calendar year. The PCP Incentive Program is not considered "compensation". Therefore while Notice of changes to the PCP Incentive Program will be provided, such changes do not require written acceptance by County. In its sole and absolute discretion, and upon recommendation by staff and CenCal Health Committees and upon approval by the Board of Directors, CenCal Health reserves the right to change or eliminate any or all of the PCP Incentive Program at any time.

To determine the PCP Incentive Program amount payable to County, CenCal Health will prepare an accounting of Covered Services rendered to County's Case Managed Members, and provide monthly reports to County. Utilization of Covered Services will be tracked according to CenCal Health's established Utilization Criteria while quality of Covered Services will be tracked according to CenCal Health's established Quality Criteria. A summary of the PCP Incentive Program is set forth in Attachment A-3, Summary of the PCP Incentive Program. The PCP Incentive Program is set forth in full in the PCP Incentive Protocols in the Provider Manual.

4.5. Special Class Members

4.5.1. Payment For Special Class Members

When a person is identified as a Special Class Member (as previously defined in the Agreement), and while that person remains a Special Class Member, the full Capitation amount for that individual will be placed into an account of CenCal Health from which all Claims for that

Member will be paid. Claims paid for identified Special Class Members will not be used in calculating the Utilization Pool of the PCP Incentive Program.

4.5.2. Special Class Members are subject to Case Management by the CenCal Health UM Unit in consultation with the Attending Physician and, as necessary, with the Medical Director. Providers (but not County) who are authorized to render Covered Services to Special Class Members shall be paid State Medi-Cal allowable rates or at CenCal Health rates in effect at the time of service. County instead will submit Encounters for Special Class Members.

4.6. Preventive Health Services

The following Preventive Health Care Services are not Medi-Cal benefits, but are CenCal Health only benefits, and County does not receive PCP capitation for these services. When said services are rendered to CenCal Health Members, County should submit Encounters to CenCal Health in order for the services to be included in the Incentive Payment calculation.

Procedure Code	**Description**
99385	Initial Preventive Medicine; 18 – 39 years
99386	Initial Preventive Medicine; 40 – 64 years
99387	Initial Preventive Medicine; 65 years & up
99395	Periodic Preventive Medicine; 18 – 39 years
99396	Periodic Preventive Medicine; 40 – 64 years

4.7. Special Case Members

Previously some SBHI Members who were Special Class Members were assigned instead to PCPs and became case managed Class 1 Members. This change addressed regulatory concerns and allowed for more oversight and coordination of all care for SBHI Members that include, but was not limited to those who: (i) received an organ transplant; (ii) were diagnosed with end stage renal disease (“ESRD”) and receiving renal dialysis treatment; and (iii) children designated as California Children’s Services (CCS) eligible.

In order to reimburse County for additional services that may be associated with the assignment of these above Members, CenCal Health: (i) established higher capitation rates for case management of CCS children in SB County; and (ii) placed a limit on the expenses incurred for utilization expense calculation for Special Case Members identified in (i) and (ii) above. The capitation rates for SBHI CCS Members are set forth in Attachment A-2 of this Agreement and the change to utilization measures is set forth in this Exhibit A of the Agreement and more particularly described in the Provider Manual. See Attachment A-3 and the Provider Manual for reference to SLOHI Special Case Members.

4.8. Payment for CHDP Program

For 18 to 21 year old Members who are eligible for a screening exam under CHDP, CHDP Providers must separately bill the State CHDP Program for the Initial or Periodic Preventive Medicine service. Non-CHDP Providers and CHDP Providers whose Claims already have been denied by the State CHDP Program may bill CenCal Health, however these services will be calculated as Non Case Managed Services.

4.9. Reimbursement for Selected Procedures

CenCal Health shall count as Encounters and establish the fee-for-service equivalent rates for the following selected procedures. County shall not be required to submit additional paperwork or invoices in order to process these services as Encounters:

- Code Z7610 miscellaneous drugs and supplies $ 8.12
- Code 96379 unlisted diagnostic or therapeutic injection $15.83

4.10. Administrative Data Reporting

4.10.1. As indicated above in this Exhibit A, County shall report as Encounters the services rendered in County's Health Care Centers that are covered under Capitation. County, using the current Medi-Cal accepted Claim form, or entering Encounters through CenCal Health's web site to report such services must include, at a minimum, the data elements set forth in the current State Manual, and the data elements set forth in Exhibit C to the Agreement.

4.10.2. County must also submit Encounters for Non-Capitated Services and for Covered Services rendered to Medi/Medi Members.

4.10.3. County is required to cooperate with CenCal Health's quality improvement activities, including submission of complete and accurate data and supporting Encounters. County must correct and resubmit data that is unacceptable within six (6) months after the request for additional data on Encounters.

4.10.4. In addition to supplying required data to CenCal Health, County must allow for the inspection and audit of such data at the County Health Care Centers offices upon seven (7) Days advance written notice and within the timeframe specified in the notice.

4.10.5. CenCal Health will monitor County's timely submission of Encounters to CenCal Health in accordance with the relevant provisions of the current State Manual.

4.10.6. CenCal Health will publish reports obtained from the compilation of such required data for quality improvement purposes. Confidentiality of Members' identities shall be maintained in such publications.

4.11. Failure to Provide Data

Failure to provide Encounter Data in accordance with Medi-Cal Claims requirements for timeliness, completeness and accuracy, or to provide additional information required by the Agreement, may result in corrective action as provided for by CenCal Health's Practitioner Corrective Action Policy.

ATTACHMENT A-1

Services Included in Guaranteed Payment/Encounter Procedures For Case Managed Members

CPT-4 Codes (2011)	***Description***
MEDICAL SERVICES - OFFICE	
New Patient	
99201	Office Visit, New, Level 1
99202	Office Visit, New, Level 2
99203	Office Visit, New, Level 3
99204	Office Visit, New, Level 4
99205	Office Visit, New, Level 5
Established Patient	
99211	Office Visit, Established, Level 1
99212	Office Visit, Established, Level 2
99213	Office Visit, Established, Level 3
99214	Office Visit, Established, Level 4
99215	Office Visit, Established, Level 5
MEDICAL SERVICES - HOSPITAL	
Initial Hospital Care	
99221	Hospital Care, Initial, Level 1
99222	Hospital Care, Initial, Level 2
99223	Hospital Care, Initial, Level 3
Subsequent Hospital Care	
99231	Hospital Care, Subsequent, Level 1
99232	Hospital Care, Subsequent, Level 2
99233	Hospital Care, Subsequent, Level 3
99238	Hospital Discharge Management, 30 minutes or less
Critical Care Services	
99291	Critical Care, Evaluation and Management, First 30-74 minutes
99292	Critical Care, Each Additional 30 minutes
SURGICAL PROCEDURES	
10060	Drainage and Incision of Skin Abscess, simple or single
11100	Biopsy of Skin, Subcutaneous Tissue, single lesion
11101	Biopsy Each Separate and Additional Lesion
11740	Evacuation of Sublingual Hematoma
12001	Simple Repair of Superficial Wound to 2.5 Cm - Extremities
12011	Simple Repair of Superficial Wound to 2.5 CM - Face, etc.
16000	Initial Treatment First Degree Burn
16020	Dressing / Debridement -w/o Anesthesia – Small (less than 5% of total body surface area)
69210	Removal Impacted Cerumen - one/both Ears
LABORATORY SERVICES	
81000	Urinalysis by dip stick or tablet reagent, non-automated with microscopy
81002	Urinalysis; non-automated, without microscopy
81005	Urinalysis, qualitative or semi-quantitative
81015	Urinalysis, qualitative or semi-quantitative, microscopic only
82271	Test for blood, other source.

ATTACHMENT A-2

PAYMENT ADDENDUM
SECTION 1-C
***FULL CAPITATION RATES**
CASE MANAGED MEMBERS FOR COUNTY HEALTH CARE CENTERS

JANUARY 1, 2011

(1) Aged: No adjustment for age or sex	$10.39	
	Male	***Female***
(2) Disabled		
Ages:		
Less than 1	$23.61	$23.61
1-4	23.61	23.61
5-14	20.23	16.84
15-19	20.23	16.84
20-44	13.83	27.14
45-64	19.06	28.79
65+	2.55	2.55
(3) Family		
Ages:		
Less than 1	$20.68	$20.46
1-4	12.32	11.75
5-14	6.43	8.52
15-19	6.43	8.52
20-44	10.16	15.62
45-64	16.01	19.84
65+	16.01	19.84
(4) Adult		
Ages:		
Less than 1	$25.60	$25.32
1-4	15.24	14.53
5-14	7.96	10.54
15-19	7.96	10.54
20-44	12.59	19.34
45-64	19.81	24.55
65+	19.81	24.55

***County is paid sixty percent (60%) of this amount monthly (the "Guaranteed Payment"). Attachment A-1 of the Agreement specifies services covered by this payment.**

ATTACHMENT A-2

Section 1-C
January 2011 (continued, Page 2)

	Male	***Female***
(5) BCCTP		
Ages:		
Less than 1	$41.22	$45.62
1-4	41.22	45.62
5-14	29.45	45.62
15-19	29.45	45.62
20-44	27.97	44.18
45-64	33.55	44.18
65+	7.06	7.66
(6) SBHI CCS		
Ages:		
Less than 1	$59.39	$58.73
1-4	35.38	33.74
5-14	18.45	24.45
15-19	18.45	24.45
20-21	29.18	44.86

County is paid sixty percent (60%) of this amount monthly (the "Guaranteed Payment"). Attachment A-1 of the Agreement specifies services covered by this payment.

ATTACHMENT A-3

SUMMARY OF THE PCP INCENTIVE PROGRAM FOR SANTA BARBARA COUNTY ("County")

The Primary Care Physician Incentive Program ("PCP Incentive Program") was established by CenCal Health to reward PCPs (which includes clinics) who meet established utilization and quality criteria and is calculated on a calendar year (CY) time period. This PCP Incentive Program utilizes a model in which the financial incentives for PCP's Case Managed Members are based on the utilization and quality performance relative to peers who share the same provider type, and incorporates criteria more indicative of quality of care.

CenCal Health, in its sole and absolute discretion and only if it is financially feasible, may elect to pay Incentive Payments to some Providers based on specific criteria, which CenCal Health may amend, or delete from time to time. No Provider shall be entitled to any such Incentive Payment. Incentive Payment shall not be deemed to be: (i) compensation for Covered Services under the Agreement; or (ii) a program in which any change requires an amendment to the Agreement.

This Attachment A-3 is a summary of the PCP Incentive Program to provide County with pertinent information about additional funds available when specified utilization and quality measures are met. The PCP Incentive Program is set forth in full in the Provider Manual. All references to Members in this Attachment A-3 are to **Case Managed Members other than Medi/Medi Members, and use of Members and Case Managed Members shall be deemed to be one in the same**.

1. FUNDING OF THE PCP INCENTIVE PROGRAM

The total funds used for the PCP Incentive Program are based in part upon CenCal Health's historical pay out under past trust account methodology. The funds are divided into two pools, one related to utilization and one related to quality. Each pool is based upon a percentage of the monthly guaranteed Capitation rates for Case Managed Members.

The funding for the Quality and Access Pool ("Quality Pool") is only from CenCal Health. The Total Incentive Payments for all PCPs is based on a percentage of the total of the Guaranteed Payments paid to all PCPs during each calendar year.

2. DEFINITIONS

"After Hours PCP Visits" shall mean services that are within the PCP's medical expertise and scope of practice and which are rendered by the PCP during evening and weekend hours. Visits at any time during Saturday or Sunday, or after 5:00 PM that take place Monday through Friday will be counted as After Hours PCP Visits for the After Hours PCP Visits measure. PCPs may not submit Claims for After Hours PCP Visits rendered earlier than 5:00 PM on Monday through Friday.

"Community Clinic" shall mean that organization representing PCPs that is licensed as a community clinic and has executed an Agreement with CenCal Health to provide the services of a PCP, as specified in §§ 2 and 3 of the Agreement.

"Emergency Department Visit" shall mean, for purposes of this Attachment A-3 and the PCP Incentive Program, a visit by a Case Managed Member to any facility or subdivision of a facility that

provides emergency treatment. Facility submits Claims to CenCal Health for treatment room or emergency room accommodations, reported with HCPCS procedure codes Z7500 or Z7502, or with future replacement codes.

"Increased Access" shall mean maintaining an average number of Members per month, or increasing the County Health Care Center's caseload each CY, and meeting the minimum ages for Members as described in "Peer Pool" and in the PCP Incentive Program in the Provider Manual.

"Peer Pool" shall mean the particular pool to which County is assigned by CenCal Health in order to perform benchmark comparisons for most measures within the PCP Incentive Program. The assignment is based on the specialty designation as well as the age ranges that it serves. The Peer Pools are as follows:

Peer Pool F1: CHDP certified family practice/general practice/clinic/Community Clinic physician who accept Members 3 years and older;

Peer Pool M2: Internal medicine and non CHDP certified family practice/general practice/clinic/Community Clinic physicians who accept adult Members age 19 and older;

Peer Pool P4: CHDP certified pediatricians who accept Member children from newborn to, at a minimum, age 12.

"Preventive Health Services" shall mean those Covered Services that are provider-type specific and relate to preventing illnesses from occurring. Preventive Health Services are applicable to the Providers as indicated in this Attachment A-3. The procedure codes that quantify the Preventive Health Services are described in the PCP Incentive Program in the Provider Manual.

"Utilization Expenses" shall mean all expenditures for Case Managed Members, which exclude Encounter Claims and as indicated below but include:

- "Physician and Outpatient Hospital Expenses" (including but not limited to expenditures for ancillary services performed in an outpatient facility, specialist physicians, and outpatient hospital services but excluding visits billed as "After Hours PCP Visits")
- "Hospital Inpatient Expenses" (including but not limited to an acute care or rehabilitative care setting)
- "Pharmacy Expenses" (including but not limited to prescription pharmaceuticals and prescribed over-the-counter pharmaceuticals).
- "Emergency Department Visits" (including one Emergency Department Visit per Member per facility per date of service).

3. ALLOCATION OF POOLS

3.1. Utilization Pool

The Utilization Pool is funded by: (i) the forty percent (40%) of the Capitation that is not paid monthly to County (the County Health Care Centers' withhold); and (ii) contributions by CenCal Health. For each County Health Care Center, the Utilization Pool is allocated into sub-categories by multiplying the total dollar amount in the Pool by the following percentages:

- Physician /Outpatient Expenses 35%
- Hospital Inpatient Expenses 20%
- Pharmacy Expenses 20%
- Emergency Department Visits 25%

3.2. Quality Pool

The Quality Pool is funded solely by CenCal Health. For each County Health Care Center, the Quality Pool is allocated into the "quality-based" sub-categories by multiplying the total dollar amount in the Pool by the following percentages:

- After Hours PCP Visits 30%
- Encounters 25%
- Increased Access 10%
- Preventive Health Services 35%

3.3. Reports

A monthly report ("Schedule 1") is sent to or made available to County which explains the calculation of funding during the CY to date for both the Utilization and Quality Pools and for some measures the report indicates how each County Health Care Center individual values and performance scores compare to others who share a common membership assignment, i.e. a Peer Pool. How each County Health Care Center fared based on CY-to-date Claims data in both the utilization and quality criteria categories results in the "Total Incentive Payment for the Fiscal Year" reflected in the Schedule 1 reports. Additional Schedule reports are available which provide details of each County Health Care Centers' performance.

4. QUALITY MEASURES

4.1. After Hours PCP Visits

The intent of this quality incentive measure is to reward PCPs for offering and actually rendering Covered Services to Members during evening hours (after 5:00 PM) and at any time during the weekend (Saturday and/or Sunday). The goal of CenCal Health is to keep Members out of emergency departments for care that can be appropriately managed by PCPs.

County will submit Encounters using the additional CPT code 99051, or a different designated code as may be required for County's PCPs providing these services. Referral Authorization Forms (RAFs) will be waived for After Hours PCP Visits, thus relieving both the referring PCP and the PCP who is providing the service of initiating or completing this paperwork.

The number of After Hours PCP Visits will be calculated by comparing each PCP to the average number of After Hour PCP Visits for the PCPs in the After Hours Peer Group. The After Hours Peer Group is comprised of all PCPs who submit Claims for After Hours PCP Visits. The average number of After Hours PCP Visits will then be calculated by factoring for case mix. County will not be reimbursed for the visits on a fee-for-service basis but should submit Encounters instead.

In addition to the ability to potentially receive additional monies (due to lower emergency department utilization) in the Emergency Department Visits measure of the PCP Incentive Program, the County will also earn an additional $50 for After Hours PCP Visits by County Case Managed Members or an additional $25 for After Hours PCP Visits by Members not Case Managed by County. In order to determine the reimbursement for After Hours PCP Visits, County will not accept fee-for-service reimbursement for submitted Claims but instead will defer the reimbursement into the PCP Incentive Program. The County will receive EOBs that indicate the following:

After Hours PCP Visits to Case Managed Members	Reimbursement for 99051 = $0.00
After Hours PCP Visits to Case Managed Members not Case Managed by the PCP	Reimbursement for 99051 = $0.00

As previously explained, After Hours PCP Visits shall be submitted as Encounters. CenCal Health will track these Encounters and include results in the monthly reports that County receives from CenCal Health. Any change to this process for any calendar year beyond 2011 must be made by County by December 31 of each year.

4.2. Encounter Data

As one of the PCP Incentive Program measures, comprehensive Encounter data is important to CenCal Health for a variety of reasons including tracking utilization and complying with State, federal, and regulatory requirements and setting Capitation rates. Each County Health Care Center is compared to similar Providers as to the average number of Encounters received in the same timeframe, but the figure is adjusted for the particular case mix and for Special Case Members status to assure a fair comparison. A lower number of Encounters than average may be the result of fewer Member Encounters, or the lack of submission of Encounters. County also submits Encounters for services not covered under Capitation, i.e. After Hours PCP Visits and visits to County Specialists and for Medi/Medi Members; these Encounters are calculated in a different manner and do not affect the Encounter Data measure.

4.3. Increased Access

The CenCal Health quality incentive measure, called “Increased Access” is intended to encourage increased availability of PCPs or County Health Care Centers to Members in order to allow for the most optimal PCP-patient assignment. The measure requires County Health Care Centers: (a) maintain an average of seven hundred (700) Members per month for each full-time PCP throughout the Fiscal Year in specified age ranges; or (b) increase actual caseload a minimum of twenty-five (25) Members in comparison to the previous CY. County will receive 100% of the Increased Access funds in the Quality Pool if either level: (a) is maintained, or if the increase in level (b) is met. The County Health Care Center is compared to fixed values that are not based on the performance of other PCPs and clinics in the Peer Pool.

4.4. Preventive Health Services Measure Criteria

The Preventive Health Services measure criteria is a set of quality criteria designed to be Provider specific, to allow further comparison of Covered Services delivered by Providers that

serve comparable populations, and that are designed to prevent Member illness. This measure is structured as follows:

4.4.1. Family Practice/General Practice/Clinics/Community Clinics who offer initial and periodic Preventive Medicine evaluations as set forth in §4.6 of Exhibit A, Protocols for Primary Care Physicians and submit Encounters for well infants, well child, well adolescent visits and Adult Preventive Health Service evaluations may receive payment for this incentive measure. Such visits shall include: a comprehensive history & examination, counseling/anticipatory guidance/risk factor reduction interventions and ordering of appropriate laboratory/diagnostic procedures, as defined in the most recent American Medical Association Current Procedural Terminology (CPT) manual. Each County Health Care Center is compared to similar Providers in Peer Pool F1 as to the average number of Preventive Medicine evaluations received in the same timeframe, but the figure is adjusted for each County Health Care Center's particular case mix to assure a fair comparison.

4.4.2. Internists who offer Initial and Periodic Preventive Medicine Evaluations and submit Encounters with CPT codes 99381-99387, or 99391-99397 with appropriate diagnostic code(s) may receive payment for this incentive measure. Such visits shall include: a comprehensive history & examination, counseling/anticipatory guidance/risk factor reduction interventions and ordering appropriate laboratory/diagnostic procedures, as defined in the most recent American Medical Association CPT Manual. Each County Health Care Center is compared to similar Providers in Peer Pool M2 as to the average number of Preventive Medicine evaluations received in the same timeframe, but the figure is adjusted for the particular case mix to assure a fair comparison.

4.4.3. Pediatricians who render services during well infant, child and adolescent evaluations and submit Encounters may receive payment for this incentive measure. Services shall meet both the American Academy of Pediatrics and CHDP recommended guidelines. Such visits shall include: a comprehensive history & examination, counseling/anticipatory guidance/risk factor reduction interventions, and ordering of appropriate laboratory/diagnostic procedures, as defined in the most recent American Medical Association Current Procedural Terminology (CPT) Manual. The PCP is compared to similar Providers in Peer Pool P4 as to the average number of Preventive Medicine evaluations received in the same timeframe, but the figure is adjusted for the PCPs particular case mix to assure a fair comparison.

4.4.4. For all applicable Peer Pools CenCal Health will also obtain visit information from the CHDP Program in order to count any qualifying services.

5. UTILIZATION MEASURES

5.1. Physician and Outpatient Hospital Expenses are those services that are not covered under Capitation and include costs incurred for referral to the following (included but not limited to): ancillary services that are performed in an outpatient facility, specialist physicians, and outpatient hospital services. Emergency Department Visits expenses shall also be included in this measure.

5.2. Hospital Inpatient Services are those services that are incurred when the Member is an inpatient at a contracted or non-contracted acute care hospital or a rehabilitation hospital or a rehabilitative care setting.

5.3. Pharmacy Expenses are those expenses that include but are not limited to prescription drugs and over-the-counter drugs which have been prescribed by a prescribing provider.

5.4. Emergency Department Visits are those services that are incurred when the Member is seen in the emergency department. The measure is intended to give PCPs credit for controlling their Members' unnecessary and inappropriate use of emergency departments, and whose members visit the emergency department at below average utilization rates.

The lower the number of Emergency Department Visits for a PCP's Members compared to the average number, the higher the PCP's incentive amount for the measure. To ensure fair comparisons, PCPs will only be compared to those PCPs within their Peer Pools (the three pools are: (i) family practitioners, general practitioners, clinics and Community Clinics); (ii) internists and (iii) pediatricians); adjustments will be made for a PCP's case mix. A PCP's case-mix adjustment is determined by age, sex, Special Case Members grouping, and aid code groupings of assigned Members. Only the number of Emergency Department Visits will be calculated in this measure; the actual costs for such visits are captured in the Physician and Outpatient Hospital measure.

CenCal Health recognizes that there are those Members that no matter what a PCP does will continue to visit emergency departments at excessive rates. However, these Members that are frequent users of the emergency departments are proportionately distributed across both large and small PCP providers, and for this measure PCPs are compared against their Peer Pool. However, CenCal Health reserves the right, when requests meet criteria for Member reassignment as set forth in CenCal Health's Request for Member Reassignment policy, to reassign emergency department abusing Members to a different PCP.

6. PAYMENT THRESHOLDS AND FORMULAS

6.1. Utilization Expenses and Capitation

With the exception of Emergency Department Visits, CenCal Health calculates the PCPs' total Utilization Expenses based on the actual dollars paid for Covered Services for Case Managed Members during the specified time period. Covered Services not included in the said calculation include: (i) all of the capitated services; (ii) any service not reported on an EOB before the final PCP Incentive Program calculations are completed; and (iii) Utilization Expenses (total of Physician and Outpatient Hospital Expenses, Hospital Inpatient Expenses and Pharmacy Expenses) which, when prorated monthly, total more than $15,000 rendered per Member, per County Health Care Center, per CY. An additional $15,000 will be prorated monthly for the number of months that a Member is identified as a Special Case Member. For Special Case Members, Covered Services exceeding $30,000 per Member per PCP per CY year will not be included in the calculation of Total Actual Values and Average Values Adjusted for PCP's Case Mix. The $30,000 maximum for a Special Case Member is subject to monthly pro ration as described above.

6.2. Establishment of Total Actual Values

The total actual utilization expenses and the number of Emergency Department Visits, After Hours PCP Visits, Encounters and Preventive Health Services are the "Actual Values" and are used as a basis to establish the Performance Score for the four Utilization criteria subcategories and the Quality criteria sub-categories Encounters, After Hours PCP Visits, and Preventive Health Services.

6.3. Establishment of Average Values Adjusted for PCP's Case Mix

For all PCPs in the PCP's Peer Pool, the Total Actual Values per Member per month are calculated for each aid category or aid sub-category and by the Member's age category and gender (when applicable). This calculation produces a set of numbers that are the average per Member per month grouped by aid category and by the Member's age category and gender (when appropriate) for all PCPs within that Peer Pool. Next, the individual PCP's number of actual Member months is calculated for these same categories and then multiplied by the corresponding, just calculated, average per Member per month values. Lastly, these separate values for each category are all totaled together to produce a single "Average Value Adjusted for PCP's Case Mix". The above steps are completed for: (i) Physician/Outpatient Expenses; (ii) Hospital Inpatient Expenses; (iii) Pharmacy Expenses; (iv) Emergency Department Visits; and (v) Encounters.

The After Hours PCP Visits are calculated in the same manner except that there are no PCP Peer Pools. PCP Peer Pools are not used in the calculation because there are fewer numbers of After Hours PCP Visits resulting in all of the PCPs being grouped together (in the After Hours Peer Group), regardless of type.

The grouping of all individual values above make up the Average Values Adjusted for PCP's Case Mix.

6.4. Calculation of Performance Scores

The performance scores are calculated by dividing the Total Actual Values by the Average Values Adjusted for PCP's Case Mix to determine the resulting percentage score. For example, if Dr. John Doe's actual Physician/Outpatient Hospital Expenses total $32,946.41 (Total Actual Values) and the Average Values Adjusted for PCP's Case Mix total $24,432.26 for the same time period, then Dr. Doe's performance score for this criteria would be 134.85%. Performance scores for Hospital Inpatient, Pharmacy, Encounters, Emergency Department Visits, After Hours PCP Visits, and Preventive Health Services criteria will be calculated using the same methodology.

6.5. Variables Used In Calculating Earned Percent Of Pool

	% Of Pool Earned		County Health Center's Performance	
	Min %	Max %	Start Pay	Max Pay
Utilization Pool Criteria Expenses:				
Physician/Outpatient	20%	120%	110%	75%
Inpatient Hospital	20%	120%	110%	50%
Pharmacy	20%	120%	110%	75%
Emergency Dept Visits	20%	120%	110%	75%
Quality Pool Criteria:				
Encounters	20%	100%	90%	125%
After Hours PCP Visits	20%	100%	50%	110%
Preventive Health Svs	20%	100%	90%	125%

6.6. Incentive Payments

The Incentive Payment for each Utilization Pool and Quality Pool sub-category is determined by multiplying sub-category Pool amount by corresponding earned percent of Pool values.

7. INCENTIVE PAYMENTS

The total incentive payment for each County Health Care Center for the CY is equal to the sum of the Utilization Pool and Quality Pool sub-category Incentive Payments. If County qualifies for a total incentive payment, such payment shall be made in two installments within six (6) months of the close of that CY. The initial pay out of 25% of the estimated total Incentive Payment will be made to County in December of the current CY, with the remaining Incentive Payment to be paid in June of the next CY.

8. CHANGES IN PRACTICE OWNERSHIP AND GROUP MEMBERSHIP

Incentive Payments represent additional payment for performance during each CY. When a PCP commences or terminates membership in a clinic, this change will affect distribution of potential PCP Incentive Program payments. County should send written Notice of the date of the transfer and any relevant terms related to accounts receivable, as soon as possible.

EXHIBIT B

PROTOCOLS FOR REFERRAL PHYSICIANS

INTRODUCTION

This Exhibit B shall address protocols for specialist (Referral) Physicians. For purposes of this Exhibit B: (i) "Members" shall mean those SBHI Members who are assigned to County; and (ii) "Referral Physician" shall mean those who provide specialist services inside or outside of the County Health Care Center or inside or outside of County's specialty clinics, (i.e. a contracted orthopedic surgeon in solo practice).

For purposes of this Exhibit B, OB/GYN Physicians shall also be included as either a Referral Physician or as a County Physician Specialist. Additional protocols specific to OB/GYN Physicians are set forth in Exhibit B-1.

1. ADDITIONAL DEFINITIONS

"Specialist Physicians" shall include both County Physician Specialist and Referral Physician for the purposes of this Exhibit B. The terms "County Physician Specialist" and "Referral Physician" are defined in the Agreement of which this Exhibit B is a part.

2. SERVICES

Specialist Physicians agree to be responsible for provision and coordination of appropriate care for Members over indefinite time periods, including, as necessary, admission to institutional care and referral to other specialists and the coordination of such care through diverse resources.

2.1. Covered Services that all Referral Physicians may render include but are not limited to:

2.1.1. Consultation, specialty services, and referrals for a second professional opinion as deemed Medically Necessary for: (i) prevention of anticipated illness; (ii) appropriate treatment due to exposure to illness; (iii) detection, treatment, or diagnosis of illness or injury or the effects of illness or injury; or (iv) care of mother and unborn or newborn child during and following pregnancy.

2.1.2. Admission to Hospital, nursing facility, intermediate care facility, or other institutional care setting.

2.1.3. Referral to x-ray, radiotherapy, audiology, electro-biometry, nuclear study, physical therapy, occupational therapy, speech therapy, dialysis, and/or other therapeutic and diagnostic measures prescribed by the County Health Care Center or Attending Physician which are held to be necessary and appropriate to the process of prevention, diagnosis, the management or treatment of diagnosed health impairment, or rehabilitation of the Member.

2.1.4. Approval of necessary durable medical equipment rental, medical supplies and medical transportation.

2.1.5. Services provided by Physicians that are billed under County's Physician Medical Group (PMG) provider number.

3. PROPER AUTHORIZATION OF SERVICES AND BILLING PROCEDURES

3.1. CenCal Health will be responsible for payment of all authorized Clean Claims according to the payment approach agreed to in the Referral Physician's Provider Agreement with CenCal Health. Evidence of authorization will be an approved Referral Authorization Form (RAF), or other form as indicated below, unless the PCP is a County PCP and the physician to whom the referral is being made is a County Physician Specialist who works in any of County's Health Care Centers, in which case no RAF is required.

3.2. Authorization For Services Outside of County Health Care Centers

When it is appropriate to have the consultation and/or medical advice, diagnosis, treatment, or other services of a Referral Physician, the County's Physicians will discuss the need for such referral with the Member and provide the name of the Referral Physician to whom the referral is made. County: (i) may arrange for the Member to be seen or allow the Member to make his/her own appointment; and (ii) will initiate the referral by preparing a RAF that will be submitted to CenCal Health. The Referral Physician must verify that the Member is eligible for the Covered Service and provide services as requested. An exception to this process occurs if there is no RAF and the Referral Physician considers the service to be an Emergency Service, or acting reasonably, the Referral Physician renders services as he or she feels the immediate concern for the Member's welfare precludes contacting the County Health Care Center. Should County then deny authorization for services for medical necessity reasons, the Referral Physician may contact CenCal Health as specified in the CenCal Health Referral, Authorization, and Utilization Review Process Policy. A copy of said Policy is summarized in the Provider Manual.

In subsequent billing for any Covered Services rendered to the Member, the approved RAF will constitute certification of authorization.

With the exception of Emergency Services, Self Referral Services, CenCal Health Referrals and services that do not require RAFs, County Referral Physicians who wish to make a subsequent referral to providers outside of the County Health Care Centers must contact the County Member's PCP and request they submit a RAF to CenCal Health for review and approval.

If Referral Physician is prescribing pharmaceuticals, he or she must follow the authorization protocols required of the prescribing Physician and complete the MRF when required as set forth in the Agreement.

3.3. Eligibility

The Referral Physician must ascertain that the patient presenting in his/her office is a Member and is eligible for Covered Services under CenCal Health. Eligibility certification can be accomplished by: (i) verifying that the Covered Service is to be rendered during the same month as the date indicated on the RAF; or (ii) checking eligibility via the CenCal Health web site at www.cencalhealth.org.; or (iii) contacting CenCal Health.

In the event the patient is not eligible under CenCal Health, payment for any services provided to the patient will not be the responsibility of CenCal Health.

3.4. Delegation of Treatment Responsibility

Certain Member conditions may demand ongoing treatment by a Referral Physician. In that event, County may submit a referral to CenCal Health for such treatment on the initial RAF or by initiating an additional RAF. Approved RAF(s) will be submitted to County's utilization review department staff. RAFs may be submitted electronically by the PCP via the CenCal Health web site. If the Referral Physician is a County Referral Physician, no RAF is required.

3.5. Hospital Admissions

If County's Member is under the care of the Referral Physician and requires admission to a Hospital, County must be notified regarding acute care hospital admissions, and authorize said admissions, except in cases of an Emergency Medical Condition. For emergency admissions, County is to be notified by the Hospital within 24 hours of such admission. Further information on authorization of hospital admissions may be found in the Provider Manual. Non-emergency admissions to out of Service Area hospitals require CenCal Health approval.

3.6. Medi/Medi Claims

For Medicare members who are also Medi-Cal Members, CenCal Health does NOT require a RAF, unless the service rendered is only a Medi-Cal benefit, in which case a RAF would be required. Further information on payment of Medi/Medi claims may be found in the Provider Manual.

3.7. Submission of Authorization Forms

Referral Physician shall submit TARs to CenCal Health for TAR required Covered Services as set forth in the CenCal Health TAR Required Procedures list which may be amended from time to time. The list is available on the website at www.cencalhealth.org/For Providers/ Procedures Requiring TAR.

If a RAF is also required in addition to the TAR, both forms should be submitted prior to submission of the Claim form. The Claim should include the number(s) imprinted on the TAR or RAF to permit CenCal Health to cross-reference authorization and payment. Lack of required authorization will render the Claim as "not a Clean Claim" and will delay payment. Further information on authorization and Claims submission is in the Provider Manual.

4. THE ROLE OF SPECIALIST PHYSICIANS

4.1. Upon receipt of proper authorization and verification of Member eligibility, the Specialist Physicians will serve as a consultant to the PCP or County Health Care Center. If there is information from the medical record or any other information forms requested by CenCal Health that may be helpful to the Specialist Physicians, this information should be forwarded to the Specialist Physicians.

4.2. Additional Consultation

If after the initial authorized consultation, further treatment, observation, or study is Medically Necessary, such recommendation shall be made to the Member's PCP or County. If Specialist Physicians are requested to continue with treatment or observation beyond the timeframe or beyond the level of care indicated in the currently issued RAF, the PCP must submit another RAF to CenCal Health to authorize additional treatment or observation; County is not required to submit

RAFs to Specialist Physicians within the County network of care. Throughout the consultation, Specialist Physicians are expected to keep the PCP or County advised of the course, likely duration and prognosis for the condition.

5. SUPPORTIVE DIAGNOSTIC STUDIES

If no restrictions are indicated on the RAF, and radiographic, laboratory, or other diagnostic studies are required in order to evaluate the Member's condition, or to make a diagnosis, Specialist Physicians are automatically authorized to perform or to arrange for such studies which do not necessarily duplicate information which has been made available to said Specialist Physicians. If the services are provided within his or her office, Specialist Physicians (or County, on behalf of its County Physician Specialists) should bill these services when billing for Covered Services. If a Member is to be referred to a non-contracted provider for required services, the PCP or County should be contacted.

6. HEALTH PROFESSIONALS

County may employ County Health Professionals to assist in providing needed services to assigned or referred Members. County shall be responsible to ensure that all such Health Professionals under its supervision will provide cooperative and effective medical care relationships, consistent with State Medi-Cal regulations applicable to such Health Professionals.

7. WRITTEN REPORT ON CONSULTATION

Referral Physicians will provide a report of findings to the PCP and/or to County when Covered Services are provided outside of the County Health Care Centers. The report shall be submitted immediately following authorized services and at subsequent periodic intervals during the care of the Member, consistent with the need of County to maintain an adequate medical record with respect to that Member. County Physician Specialists shall follow County's policies and procedures in supplying reports to the County Health Care Center PCPs.

8. REIMBURSEMENT FOR COUNTY PHYSICIAN SPECIALISTS AND HEALTH PROFESSIONALS' SERVICES PROVIDED OUTSIDE OF COUNTY'S NETWORK OF CARE

Covered Services rendered by County Physician Specialists and Health Professionals outside of the County's network of care shall be paid by CenCal Health on a fee-for-service basis when a Clean Claim is submitted for said Covered Service. County shall submit the Claim using the Physician Medical Group (PMG) Provider Number when billing for services provided outside of County's network of care. Reimbursement shall be at the State Medi-Cal rate or at CenCal Health's rate in effect at the time of service.

EXHIBIT B-1

PROTOCOLS FOR OB/GYN PHYSICIANS

The following Protocols shall be applicable for OB/GYN Physicians in addition to those indicated in Exhibit B, Protocols for Referral Physicians.

1. SERVICES

1.1. Covered Services that OB/GYN Physicians may additionally render include, but are not limited to:

1.1.1. County's OB/GYN Physicians shall provide services to pregnant Members in accordance with the most recent Standards of American College of Obstetrics and Gynecologists (ACOG) standards or currently approved guidelines as the minimal basis for services provided to pregnant women. CenCal Health may provide to OB/GYN Physicians standardized risk assessment tools that have been approved by DHCS to obtain required information.

1.1.2. County's OB/GYN Physicians are required to offer all pregnant Members at the initiation of pregnancy-related services a medical/obstetrical risk assessment, nutritional assessment, psycho-social assessment and health education assessment. Additionally, at each trimester and at the postpartum visit, OB/GYN Physicians are encouraged to evaluate the Member's risk status. County's OB/GYN Physicians should; (i) prioritize any identified risks to ameliorate or remedy the condition or problem;(ii) document in the medical record all services provided; and (iii) indicate if the Member refuses to cooperate in meeting any of the above stated activities.

1.1.3. County's OB/GYN Physicians may render GYN surgeries to Members Case Managed by County or to Non Case Managed Members in any or all hospitals in SB County.

1.1.4. County must also develop policies and procedures for: (i) appropriate referrals of Members with high risk pregnancies to specialists; (ii) genetic screening and referral; and (iii) admission to an appropriate hospital for delivery.

1.1.5. County must, when applicable to the services rendered, submit the Sterilization Form required for use by State Medi-Cal as set forth in the State Manual and the Provider Manual.

1.2. OB/GYN Physician Visits

The first prenatal visit for a pregnant Member shall be available within two weeks upon request of the Member.

If Member is seeking Sensitive Services, OB/GYN Physician shall ensure both confidentiality and ready access to the Member, including minor Members.

1.3. Hospital Services for Members Requiring OB/GYN Services

Inpatient delivery services are reimbursable without prior authorization up to a maximum of two consecutive days, regardless of the type of delivery, beginning the day the mother is admitted to the hospital, if delivery occurs within that two day period. Referral Physician shall comply with *Welfare and Institutions Code §* 14132.42.

2. BILLING FOR OB SERVICES

County should generally follow the guidelines for billing as a FQHC provider on a per visit basis with no limitation on prenatal visits and as indicated in the State Manual for OB Services. Office visits shall normally be considered a capitated service.

When a County OB/GYN Physician renders delivery services in a Hospital, County shall submit a Claim to CenCal Health, including the ICD-9 CM codes denoting birth status referenced in the Provider Manual, and CenCal Health will reimburse County under its PMG provider number.

County shall submit an Encounter for the post-partum visit using HCPCS Code Z1038, or other appropriate CPT Codes, and said service shall be considered a Non-Case Managed Service. Submission of the properly completed Encounter shall constitute reporting of the post-partum visit and no additional reporting form will be required from the OB/GYN Physician.

When a County OB/GYN Physician renders GYN surgeries in any SB County hospital, County will reimburse said Physician for services and subsequently submit a Claim to CenCal Health using the County's PMG number. CenCal Health will reimburse County on a fee-for-service basis for the GYN surgeries at the State Medi-Cal rate or at the CenCal Health rate in effect at the time of service.

3. ADDITIONAL REFERENCES

County should consult the CenCal Health Provider Manual or the Medical Services - Obstetrics State Manual for additional information. Sections in the latter pertinent to OB/GYN services include, but are not limited to:

- CPSP
- Family Planning
- Genetic Disease Screening
- HCPCS, Level III List
- Hysterectomy
- Minor Consent Program
- Non Physician Medical Practitioners
- Pathology: Cytopathology

EXHIBIT C

ENCOUNTER AND CLAIMS BILLING PROCEDURES

1. ENCOUNTER BILLING PROCEDURES

1.1. Submission of Encounters

As indicated in the Agreement and in Exhibits A and/or B to the Agreement, County shall submit Encounters for Covered Services provided to Case Managed Members and for Members receiving Non-Capitated Covered Services, including Covered Services rendered to Medi/Medi Members. The parties agree that the Encounters shall be processed and counted according to the following criteria.

For all Covered Services meeting the above description, County shall submit to CenCal Health an Encounter using the all-inclusive per visit codes:

01	Medi-Cal per visit code	**OR**
02	Medi/Medi Crossover claims code	**OR**
04	Optometry	**OR**
19	Healthy Families	

In addition, County must submit any and all of the CPT or HCPCS code that defines the actual Covered Services rendered to the Member ("ancillary lines") that were rendered on the date of service of the visit. These lines should be submitted with County's usual and customary charges. If the Encounter does not include a quantity on each claim line, the parties agree that in order to process the Encounter, CenCal Health will set the default to be equal to a quantity of one (1).

1.2. Limited Edits

CenCal Health will process the Encounter, and the Explanation of Benefits (EOB) shall contain the result of the processing using an explain code 1-F (paid Encounter) that indicates that this was an acceptable Encounter if the submission passes the following limited edits established for codes 01, 02 or 04:

1. The provider number was a valid County FHC provider number assigned to County or a designated National Provider Identifier (NPI);
2. The date of service was included;
3. The Member was eligible on the date of service;
4. The provider number of the person rendering the service (rendering provider number) was included on each claim line. The rendering provider number may be either the rendering provider's Medi-Cal number issued by the State, the provider's license number, or the NPI per applicable billing requirements; and
5. If the Member is not Case Managed by County but was being referred to County by a non-County Provider (other than one of the other County sites) for either PCP or specialty services, the referring Provider must contact the Member's PCP and request

the PCP initiate a Referral Authorization Form (RAF). The approved RAF number must be included on the Claim form, unless the Claim is for After Hours PCP Visits.

1.3. Full Edits

Ancillary lines of the Encounters submitted by County will be subject to full edits and at least one (1) of the Covered Services, identified by the CPT or HCPCS codes, rendered to the Member on the date of service of the visit must receive an explain code that indicates that this was an acceptable Encounter.

1.4. Encounter EOB Examples

As an example of an Encounter submitted for FHCXXXXX or NPI 1234567890 for a rendering provider who is a PCP providing a capitated service, the EOB would indicate:

HCPCS/CPT Code	Explain Code	FFS Equivalent	Paid Amount
01	PY-1F	$0	$0
99213	PY-02, 11	$35	$0
X1023	DY-87	$0	$0

As an example of a Claim submitted for FHCXXXXX or NPI 1234567890 for a rendering provider who is a PCP providing a non capitated service, the EOB would indicate:

HCPCS/CPT Code	Explain Code	Allowable	Paid Amount
01	Y-1F	$0	$0
99213	PY-02	$35	$0
X1023	DY-87	$50	$0

2. REPORTING

2.1. Monthly Reports to County

CenCal Health agrees to provide reports to the County on a monthly basis for County's usage for its Department of Health Services annual claims reconciliation process. These reports shall include all Encounters and Claims submitted by County to CenCal Health that contain the following all-inclusive per visit codes (as shown above):

01	Medi-Cal per visit code	**OR**
02	Medi/Medi Crossover claims code	**OR**
04	Optometry	**OR**
19	Healthy Families	

Encounters and Claims to be included in the monthly reports, when coded by County as indicated above, may include FQHC services provided to Members by County that are recognized FQHC Medicaid services although the services are not CenCal Health Covered Services. Such claims may include:

- Other Health Care claims, including Medicare Advantage claims, where CenCal Health is the secondary payor;

- Any claims for new services added to the FQHC Scope of Services as approved by the federal government, but not yet added as Medi-Cal Covered Services;

Such claims may show on the reports as paid at zero to the extent they include Services not covered by CenCal Health and are Clean Claims.

If either County or CenCal Health creates a billing error that impacts the calculation of the Encounters on the report, the County will not be required to invoke the formal grievance process outlined in Section 5.2 of the Agreement, and the County may correct the error either by using CenCal Health's standard claims correction procedures or, where an expedited resolution of the problem is necessary, by contacting CenCal Health directly for individualized assistance with an expedited correction, as addressed below.

Each monthly report shall include encounter totals for the reporting month, as well as the comparable months for each of the two previous years. Summary Data Report.

CenCal Health shall provide County with an annual (Calendar Year) summary data report of all CenCal members auto-assigned to County and the aggregate number of Members assigned to other community medical providers within thirty (30) days of the close of the Calendar Year.

2.3. Additional Reporting

CenCal Health shall provide County with additional reporting for data analysis upon request and mutual agreement of both parties.

3. CLAIMS ADJUDICATION

County may question claims denials made by CenCal Health without engaging the formal provider grievance policy.

CenCal Health's standard processes for handling claims corrections, requests for adjustments, grievances and/or appeals are described in the Agreement and in the Provider Manual. In addition, each of the CenCal Health Provider Services Department and the CenCal Health Claims Department has identified to the County a specific individual who will assist the County with resolving corrections, grievances, errors or other problems that result in what may be inappropriate denials or untimely adjudication or resolution.

County has the ability, in unusual circumstances, to request an expedited claims adjudication process. In those rare instances, special attention will be paid by CenCal Health to ensure that any inappropriate claims denials are attended to and corrected promptly, no more than thirty (30) days. In addition, special attention will be paid by CenCal Health to ensure that all known inappropriate claims denials and/or pended or suspended claims for a particular fiscal year are corrected no later than November 1st of the subsequent fiscal year and reflected in the November encounter reporting to County.