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

This Amendment Ten further amends the Medi-Cal Physician Services Provider Agreement, Federally Qualified Health Center, as amended, ("Agreement") between the **Santa Barbara San Luis Obispo Regional Health Authority, dba CenCal Health**, (hereinafter, "CenCal Health"), and **County of Santa Barbara,** an organization approved by the State Department of Health Care Services as a Federally Qualified Health Center (hereinafter, "County").

RECITALS:

A. County and CenCal Health are parties to the Agreement and nine amendments, effective January 1, 2012 through December 31, 2024, pursuant to which County is to deliver certain medical services to CenCal Health Members.

B. County and CenCal Health have continued performance under the Agreement and nine amendments and now wish to extend the term of the Agreement to the period from January 1, 2025 through December 31, 2030.

C. CenCal Health intends to operate a Dual Special Needs Plan ("D-SNP") line of business commencing January 1, 2026, and County agrees to participate in said D-SNP network.

D. The parties shall hereby amend the Agreement to include terms for County's participation in the CenCal Health D-SNP network.

E. County and CenCal Health wish to amend the Agreement to add Addendum: Medicare Advantage Contract Requirements.

F. County and CenCal Health wish to amend the Agreement to add Exhibit D: FQHC Medicare Program Reimbursement Terms.

NOW, THEREFORE, the parties agree as follows:

1. The above Recitals are true and correct.

2. This Amendment Ten shall be effective on January 1, 2025 for all Covered Services rendered on and after January 1, 2025.

3. Upon full execution by both parties, D-SNP Covered Services shall be rendered on and after January 1, 2026.

4. The Agreement shall be amended to add Addendum: Medicare Advantage Contract Requirements, incorporated by reference herein.

5. The Agreement shall be amended to add Exhibit D: FQHC Medicare Program Reimbursement Terms, incorporated by reference herein.

6. The effective term of the Agreement as described in **Section 9.1** of the Agreement is hereby extended through December 31, 2030.

7. Except as amended by this Amendment Ten, all other provisions of the Agreement shall remain in full force and effect.

8. This Amendment Ten may be executed in several counterparts, all of which taken together shall constitute a single agreement between the parties.

[This area intentionally left blank.]

Amendment Ten to Medi-Cal Physician Services Provider Agreement, Federally Qualified Health Center between the **County of Santa Barbara** and **CenCal Health.**

IN WITNESS WHEREOF, the parties have executed this Tenth Amendment to be effective on the dates set forth herein.

COUNTY OF SANTA BARBARA

ATTEST:

Mona Miyasato
County Executive Officer
Clerk of the Board

By: _____
Deputy Clerk

COUNTY OF SANTA BARBARA:

Steven Lavagnino

By: _____
Chair, Board of Supervisors

Date: _____

RECOMMENDED FOR APPROVAL:

Mouhanad Hammami, Director
Public Health Department

By: DocuSigned by: Mouhanad Hammami 4F9DA021F228448...
Department Head

APPROVED AS TO ACCOUNTING FORM:

Betsy M. Schaffer, CPA
Auditor Controller

By: DocuSigned by: C. Edi... A99ED3BD71D04FB...
Deputy

APPROVED AS TO FORM:

Rachel Van Mullem
County Counsel

By: Signed by: Lindy Giacopuzzi Roth B881EBAD8CD446F...
Deputy County Counsel

APPROVED AS TO FORM:

Gregory Milligan, ARM
Risk Management

By: DocuSigned by: Gregory Milligan 05F555F00269466...
Risk Management

Amendment Ten to Medi-Cal Physician Services Provider Agreement, Federally Qualified Health Center between the **County of Santa Barbara** and **CenCal Health.**

IN WITNESS WHEREOF, the parties have executed this Tenth Amendment to be effective on the dates set forth herein.

SANTA BARBARA SAN LUIS OBISPO REGIONAL HEALTH AUTHORITYdba CENCAL HEALTH

By: Signed by: Marina Owen AEA8F3E4CDD04CF...

Name: Marina Owen

Title: Chief Executive Officer

Date: 11/25/2024

ADDENDUM:

MEDICARE ADVANTAGE CONTRACT REQUIREMENTS

This added Addendum to the network provider agreement with CenCal Health ("Agreement") is entered into by and between Provider and the Santa Barbara San Luis Obispo Regional Health Authority, dba CenCal Health, a body corporate and politic, (hereinafter referred to as "CenCal Health" and/or "MA Organization").

This Addendum applies to all first tier or downstream entities that provide administrative services or health care services to a Medicare eligible individual (per 42 CFR section 423.501 and Chapter 21, Medicare Managed Care Manual Section 20 (Definitions). In the event of a conflict between the terms and conditions below and the terms of the Agreement, the terms below shall control.

RECITALS

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between CenCal Health and Provider not inconsistent herein shall remain in full force and effect. This amendment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

DEFINITIONS

Administrative Services: Services covered by this contract that CenCal Health is permitted to delegate to fulfill terms and conditions of its contract with CMS (delineated in 42 CFR section 422.504) and for meeting Medicare program requirements.
Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and Administrative Services.
Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide Administrative Services or health care services for a Medicare eligible individual under the MA program.

Medicare: means the federally-administered program, begun in 1965, which covers basic

medical, hospital and prescription drug services for eligible individuals.

Medicaid: the cooperative federal-state program administered by states, begun in 1965, which covers basic medical care for low-income individuals based on eligibility requirements set forth under federal law at 42 USC section 1396a.

Medi-Cal: California's version of the Medicaid program

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

TERMS AND CONDITIONS

Provider agrees to participate in CenCal Health's MA program.

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with [Entity Name], (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§422.504(i)(2)(ii) and (iii)]

3. Provider will comply with the confidentiality and enrollee record accuracy requirements, including:
(1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

4. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. For all enrollees eligible for both Medicare and Medi-Cal, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will:
(1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

7. Contracts or other written agreements between the MA organization and providers or between providers and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between CenCal Health and the provider and the first tier entity providers must adhere to the timely payment requirements when paying their contracted downstream entity providers [42 C.F.R. §§ 422.520(b)(1) and (2)]

8. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

9. No activity or responsibility of the MA organization under its contract with CMS is delegated to any first tier, downstream, or related entity.

10. The parties agree and acknowledge the provisions of Exhibit D(F), Provision 1.A–G, Federal Equal Opportunity Requirements, of the Medi-Cal Contract are hereby incorporated into this Agreement by this reference. [Medi-Cal Contract, Exhibit D(F), Provision 1.G.]

EXHIBIT D

FQHC MEDICARE PROGRAM REIMBURSEMENT TERMS

1. DEFINITIONS

Those terms as outlined and defined in Exhibit D: Medicare Advantage Contract Requirements" attached to the Agreement are hereby incorporated by reference.

"Dual Special Needs Plan" or "D-SNP Plan" means the Medicare Advantage health insurance plan and line of business operated by CenCal Health for Members eligible for both Medicare and Medi-Cal coverage.

"D-SNP Plan Member(s)" means those CenCal Health Members duly enrolled in the CenCal Health D- SNP Plan.

"D-SNP Covered Services" means those benefits covered by CenCal Health for its D-SNP Plan and enrolled D-SNP Plan Members.

2. GENERAL TERMS AND PROVIDER OBLIGATIONS

This Exhibit D shall apply to all D-SNP Covered Services provided by Provider to CenCal Health's Members enrolled in the CenCal Health Dual Special Needs Plan ("D-SNP Plan").

Provider hereby warrants it is duly licensed and certified to render D-SNP Covered Services within the scope of its credentialing with CenCal Health and applicable certification and/or licensure to D-SNP Plan Members in accordance with CenCal Health policies. Provider acknowledges additional information regarding Member access and requirements for authorization are outlined in the Provider Manual and on the CenCal Health website at www.cencalhealth.org.

3. REIMBURSEMENT

CenCal Health will reimburse Provider for D-SNP Covered Services when all requirements for payment as outlined in the Agreement and in this Exhibit D have been met.

Reimbursement for D-SNP Covered Services shall be at the lesser of Provider's billed charges or 100% of the Medicare fee schedule allowable rate in effect at the time of service and geographically-adjusted to the locality where services were rendered. The Medicare fee schedule allowable rate is derived from all applicable factors including but not limited to fee schedules, methodologies, rules and other guidance provided by CMS or its local contractors as-applicable for such services. For the avoidance of doubt, CenCal Health shall not reimburse Provider based on the CMS prospective payment system ("PPS") for FQHC providers; however, nothing shall preclude Provider from seeking supplemental payments under the PPS from the applicable Medicare Administrative Contractor (MAC) in accordance with CMS policies.

CenCal Health shall reimburse Provider in accordance with all Medicare managed care policies and other Applicable Requirements for FQHC providers, including that services shall be reimbursed at the same rate as services provided by an entity providing similar services that was not a FQHC. The reimbursement rate shall be less any adjustments implemented by CMS (including but not limited to sequestration reductions initially provided for in the Budget Control Act of 2011 as such amounts may be amended or changed from time to time, deductibles, coinsurance) unless specifically exempted by CenCal Health policies and procedures. Additional guidance or terms beyond that established by CMS for the Medicare program may be found in

the CenCal Health Provider Manual.

Rate information for specified reimbursement codes are available by request through the CenCal Health website at www.cencalhealth.org or by contacting a CenCal Health representative.

For services for which no Medicare rate exists, reimbursement shall be at the lesser of billed charges or the contracted Medi-Cal rate per this Agreement. If an "unlisted procedure", by definition, code is billed, or no Medicare or Medi-Cal Fee Schedule rate exists, CenCal Health performs a manual review/pricing by taking into account the service provided and correlating the unlisted procedure to an established procedure(s), which has/have a Medicare or Medi-Cal rate. CenCal Health adjudication staff uses this information and manually prices the unlisted procedure. Provider shall not bill the Member for payments due from Medi-Cal.