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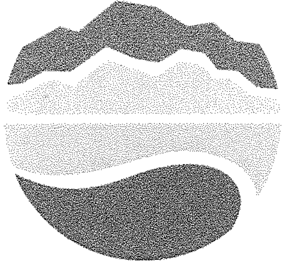

CenCal HEALTH®
Local. Quality. Healthcare.

PROVIDER SERVICES AGREEMENT
ENHANCED CARE MANAGEMENT

FOR

COUNTY OF SANTA BARBARA
PUBLIC HEALTH DEPARTMENT

PROVIDER SERVICES AGREEMENT
ENHANCED CARE MANAGEMENT

GENERAL TABLE OF CONTENTS

SECTION #	TITLE OF SECTION
1	Definitions
2	Service Obligations
3	Obligations of Provider
4	Payment and Billing
5	Administrative Procedures
6	CenCal Health Obligations
7	Insurance and Indemnification
8	Records and Confidentiality
9	Agreement Term and Termination
10	Responsibility Upon Termination
11	HIPAA Compliance
12	Amendment
13	Authority
14	Miscellaneous
15	Entire Agreement
----	Execution Page

Provider has received any or all Exhibits/Attachments as indicated below.

Exhibit A – Enhanced Care Management

Exhibit B – N/A

Exhibit C – N/A

Exhibit D – ICD-10-CM Social Determinants of Health Codes

Exhibit E – N/A

PROVIDER SERVICES AGREEMENT
ENHANCED CARE MANAGEMENT (ECM)

THIS PROVIDER SERVICES AGREEMENT – ENHANCED CARE MANAGEMENT ("Agreement"), is effective as of the date of final execution signature by both parties (the "Effective Date"), executed by and between **County of Santa Barbara Public Health Department** (hereafter "Provider," as defined below"), and **Santa Barbara San Luis Obispo Regional Health Authority**, a body corporate and politic, dba CenCal Health ("CenCal Health") (Provider and CenCal Health jointly are the "parties").

RECITALS

A. On July 1, 2022, certain Medi-Cal Managed Care Plans are required to provide new Medi-Cal managed care benefits to eligible high-need Members called Enhanced Care Management and are permitted to offer certain Community Supports. These new benefits and services are provided under California Advancing and Innovating Medi-Cal ("CalAIM"), a multi-year and multi-faceted Medicaid waiver initiative from the California Department of Health Care Services ("DHCS").

B. CalAIM is designed to implement broad delivery system and payment reform across Medi-Cal, CalAIM is DHCS' primary vehicle for addressing the social determinants of health and health care inequities through Medi-Cal. Enhanced Care Management (defined below) is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. Community Supports (defined below) are, pursuant to 42 CFR, Section 438.3(e)(2), services or settings that are offered in place of services or settings covered under the Medi-Cal Managed Care Program and are medically appropriate, cost-effective alternatives to services or settings under Medi-Cal. Community Supports are optional for both CenCal Health and the Member and must be approved by DHCS. DHCS requires managed care plans to offer Enhanced Care Management services as a Medi-Cal benefit.

C. CenCal Health offers or directly administers one or more health benefit products or plans and wishes to arrange for the provision of Enhanced Care Management and/or Community Supports to Members of such products or plans, as specified in this Agreement.

D. CenCal Health desires to engage Provider to deliver or arrange for the delivery of Enhanced Care Management, as specified in this Agreement.

E. Under this Agreement, Provider will not deliver or arrange for the delivery of Community Supports.

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.

"Applicable Requirements" shall mean to the extent applicable to this Agreement and duties, rights and privileges hereunder: (i) the Provider Manual and any other policies and procedures of CenCal Health; (ii) federal, State and local laws and regulations, including, but not limited to the California Code of Regulations ("CCR"), and laws governing the use of federal funds, such as the fraud and abuse prevention and detection laws; (iii) the Centers for Medicare and Medicaid Services (CMS) Standard Terms and Conditions of the CalAIM Section1115(a) Demonstration and CalAIM Section 1915(b) Waiver; and (iv) the State Contract (including any ECM or CS amendment thereto), DHCS-MCP ECM and ILOS Contract (defined below), DHCS All Plan Letters ("APLs"), DHCS Standard Provider Terms and Conditions for ECM and or CS (defined below), and the ECM and CS Policy Guides and associated DHCS guidance, as maybe updated from time to time.

"Care Management Plan" is a care plan that is comprehensive and person-centered, and builds off of a Participant's strengths and existing natural supports to support Participants in monitoring and managing their health, as well as actively engaging in their health care as evidenced by identifying and accessing any resources that may be needed to manage their conditions. At a minimum, a Care Management Plan shall cover four (4) domains: (i) physical health; (ii) behavioral health; (iii) social determinants of health (housing insecurity, food insecurity, safety in the home, etc.); and (iv) coordination with current services being provided to the Participant.

"Claim" or "Claims" shall mean a statement or statements of services submitted to CenCal Health by Provider following the provision of Covered Services (defined below), as applicable to this Agreement (see Recital E) to a Member that shall include diagnoses and an itemization of services provided to Member. A Claim may be paper or electronic.

"Clean Claim" shall mean a billing form that has been properly completed in accordance with this Agreement.

"Community Supports" or "CS" are, pursuant to 42 CFR, Section 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. DHCS previously referred to Community Supports as "In Lieu of Services" or "ILOS," and any references in DHCS policy guidance or this Agreement to In Lieu of Services or ILOS shall mean Community Supports as referenced in this Agreement.

"Community Supports Provider" or "CS Provider" is a contracted provider of DHCS-approved CS. A CS Provider is an entity with experience and/or training providing one or more of the Community

Supports approved by DHCS. CS Provider includes the medical professionals, subcontractors, staff, and other persons who provide CS to Members by and/or through CS Provider as referenced in this Agreement.

"Confidential Information" shall have the meaning set forth in subdivision (d) Section 3426.1 of the California Civil Code. For purposes of this Agreement, Confidential Information includes Protected Health Information as defined in this Agreement, and specific facts or documents identified as "confidential" by law, regulations, or contract language. For the avoidance of doubt, Confidential Information does **not** include this Agreement or the rate or compensation outlined in this Agreement.

"Covered Services" shall mean as applicable to this Agreement (see Recital E) the ECM Services as outlined in Exhibit A that are benefits (including initial outreach to determine eligibility and ongoing Enhanced Care Management for eligible Participants) and/or applicable CS that are substitutes for services covered under the Medi-Cal State Plan that Members are entitled to receive under this Agreement and/or are provided by and through ECM Providers or CS Providers contracted through CenCal Health. For CS, Covered Services shall be determined to be Medically Appropriate or Medically Necessary.

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

"DHCS" shall mean the State of California Department of Health Care Services.

"DHCS-MCP ECM and ILOS Contract" is the DHCS-Managed Care Plan (MCP) ECM and In Lieu of Services (ILOS) template for the contract between DHCS and CenCal Health that establishes the terms for the ECM and CS services.

"Enhanced Care Management" or "ECM" is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch and person-centered. ECM is a Medi-Cal benefit.

"Enhanced Care Management Provider" or "ECM Provider" is a provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus (defined in Exhibit A) for ECM. ECM Providers may include, but are not limited to the following entities: (1) Counties; (2) County behavioral health providers; (3) primary care providers or specialist or physician groups; (4) Federally Qualified Health Centers; (5) Community Health Centers; (6) Community Based Organizations; (7) hospitals or hospital-based physician groups or clinics (including public hospitals and district and/ormunicipal public hospitals); (8) Rural Health Clinics and/or Indian Health Service Programs; (9) localhealth departments; (10) behavioral health entities; (11) community mental health centers; (12) Substance Use Disorder ("SUD") treatment providers; (13) organizations serving individuals Experiencing Homelessness; (14) organizations serving justice-involved individuals; (15) California Children's Services ("CCS") providers; and (16) other qualified providers or entities that are not listed above, as approved by DHCS.

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"Enhanced Care Management Care Team" or "ECM Care Team" is a multi-disciplinary, community-based team serving ECM Participants that provides intensive care coordination and linkages to necessary services including social services and benefits, health care services, available Community Supports and other community-based resources.

"Lead Care Manager" is a Participant's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with CenCal Health, as described in the DHCS-CenCal Health ECM and ILOS Contract, Section 4: ECM CS Provider Capacity). The Lead Care Manager operates as part of the Participant's multi-disciplinary ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Participant has other care managers, the Lead Care Manager shall be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Participant and non-duplication of services.

"Medically Appropriate" shall mean that provision of the Community Support recommended by a Provider or CenCal Health, using their professional judgment, is likely to reduce or prevent the need for acute care or other Medicaid services, including but not limited to inpatient hospitalizations, skilled nursing facility stays, or emergency department visits. Therefore, the Community Support is Medically Appropriate for that Member. The decision that any given service is Medically Appropriate shall be documented by appropriate clinical support. All Community Supports are required to be Medically Appropriate.

"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; (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." Eligibility for certain CS is based on the service being Medically Necessary.

"Member" shall mean a general term used in this Agreement, unless otherwise specified, to collectively describe any SBHI Member(s) and/or SLOHI Member(s) (defined below).

"Notice" shall mean a communication by CenCal Health to Provider informing Provider of the terms of a Plan, modification to the Plan, and any other information relevant to the provision of Covered Services pursuant to this Agreement made in accordance with the provisions of Section 14.8.

"Participant" is a Member who is for eligible for, has consented to receive, and has been authorized by CenCal Health to receive Covered Services from a Provider.

"Protected Health Information" shall mean Member information subject to requirements of the federal Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and regulations promulgated thereunder (collectively, "HIPAA"). PHI includes information in any format, including paper, oral, and electronic.

"Provider" shall mean an ECM Provider. Such Provider shall provide Covered Services described in the Exhibits attached hereto. ECM Provider is further definedin the definitions above.

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"Provider Manual" shall mean the CenCal Health manual which sets forth operational documents including but not limited to Medi-Cal services, statutes, regulations, telephone access and special requirements, 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, titled "CenCal Health Provider Manual" prepared by the CenCal Health Provider's services staff, may contain provisions of the State Manual as specifically modified by CenCal Health, so long as such modifications are allowed by the State and law.The applicable information set forth in the Provider Manual is part of this Agreement and may, in thesole discretion of CenCal Health, be amended from time to time and is incorporated by reference intothe Agreement as if set out herein in full. CenCal Health will give County advance notice as soon as possible and time to adjust to material changes to the Provider Manual. 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. The Provider Manual is available on the CenCal Health web site at www.cencalhealth.org.

"Quality Program" or "QP" shall mean the CenCal Health organizational structure and clinical and non-clinical processes vital to implementation of continuous quality improvement in health care. The evolving QP is adopted by the CenCal Health Board of Directors and approved by appropriate State agencies pursuant to contractual and regulatory requirements. The current QP is available on the CenCal Health web site: www.cencalhealth.org or upon request to the Health Services Department of CenCal Health.

"San Luis Obispo Health Initiative" or "SLOHI" shall mean CenCal Health's name for its Medi-Cal line of business in San Luis Obispo County.

"Santa Barbara Health Initiative" or "SBHI" shall mean CenCal Health's name for its Medi-Cal line of business in Santa Barbara County.

"SB County" shall mean the geographical area that encompasses Santa Barbara 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.

"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.

"State" shall mean the State of California.

"State Contract" shall mean CenCal Health's contract with DHCS in which CenCal Health agrees to provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of the contract.

"State Manual" shall mean the DHCS issued series of Provider manuals based on Provider types containing general Medi-Cal information and specific Provider community information, and serve as the primary billing reference for the Medi-Cal program.

"Subcontract" shall mean a written agreement entered into by a Provider with: (i) an entity that 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 a Provider specifically related to fulfilling the Provider's obligations to CenCal Health under the terms of this Agreement.

"Subcontractor" shall mean a person or any organization that has entered into a Subcontract with a Provider. Subcontractors shall meet specified requirements as set forth in this Agreement.

"Utilization Management" or "UM" shall mean the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable Covered Services, sometimes called "Utilization Review."

"Utilization Review" or "UR" shall mean applying the decision-making component of UM principles and practices in which CenCal Health reviews and determines medical appropriateness of CS by performing prospective, concurrent, or retrospective (post-service) reviews.

2. SERVICE OBLIGATIONS

2.1 Provision of Covered Services. Provider shall provide and cause its Subcontractors to provide Covered Services to Members as further described in the exhibits hereto, including the authorization requirements therein, and in accordance with this Agreement and the Applicable Requirements.

2.2 Amendment to Comply with Changes in Law. Without amending this Agreement, CenCal Health may incorporate any change mandated by federal or State law or regulation or required by DHCS through APLs, contracts, or related guidance into the Agreement effective the date such change goes into effect. CenCal Health shall give Provider thirty (30) Days prior notice of any such change. CenCal Health shall determinethe effective date of the change.

2.3 No Balance Billing. In no event, including but not limited to, non-payment by or insolvency, of CenCal Health, or breach of this Agreement by Provider or CenCal Health, shall Provider or its Subcontractors, submit a claim or demand, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member, or persons acting on the behalf of a Member for Covered Services provided pursuant to this Agreement. Provider further agrees that:

2.3.1 This subsection 2.3 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;

2.3.2 This subsection 2.3 shall supersede any oral or written contrary agreement now existing or hereafter entered into between Provider or Subcontractors;

2.3.3 Language to ensure the foregoing shall be included in all of Provider's Subcontracts; and

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2.3.4 No change or amendment to this subsection 2.3 to similar section(s) in Subcontracts between Provider and its Subcontractors shall be made without the prior written approval of CenCal Health.

2.4 Subcontracts. If Provider subcontracts with other entities to administer its functions, Provider shall ensure agreements with each entity bind each entity to the applicable terms and conditions set forth in this Agreement, including the Applicable Requirements. If Provider arranges for the provision of some Covered Services from Subcontractors, Provider shall enter into written Subcontracts, specifying that such Subcontractors shall: (i) seek payment only from Provider, and not from CenCal Health, State or the Member as set forth in Section 2.3; (ii) maintain and disclose records and otherinformation as set forth in Section 8; (iii) abide by the Non-Discrimination and ConfidentialInformation provisions set forth in Sections 5.5 and 8.4, respectively; (iv) maintain insurance as set forth in Section 7.1; (v) comply with Medi-Cal enrollment and/credentialing requirements, if required, as set forth in Section 3.1; (vi) comply with thegrievance resolution provisions as set forth in Section 5.4 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, Provider shall make such Subcontracts available to CenCal Health and government officials for review and approval.

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

3. OBLIGATIONS OF PROVIDER

3.1 Medicaid Enrollment/Standards for Providers.

3.1.1 If a State-level enrollment pathway exists, Provider shall enroll as a Medi-Cal Provider, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004, and the terms of the Agreement.

3.1.2 If APL 19-004 does not apply to Provider, including any individuals or organizations employed by or subcontracted with Provider to deliver services on its behalf, such Provider must comply with the CenCal Health's policies for vetting the Provider to ensure it can meet the capabilities and standards required to be a Provider.

3.1.3 CenCal Health has established a credentialing policy that establishes standards for vetting Providers, which may be amended from time to time. The standards may include, but are not limited to, review and/or verification of the following:

3.1.3.1 Current reference(s) that can speak to potential contracted services;

3.1.3.2 Business license (if applicable). If not, verify other alternatives (e.g., IRS

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Form 990, non-profit status, other documentation demonstrating they are an established business entity);

3.1.3.3 Proof of insurance coverage and status;

3.1.3.4 Individual or entity for criminal activity;

3.1.3.5 History of liability claims in the past seven (7) years; and

3.1.3.6 Any other additional documentation as is requested by CenCal Health in making its determination.

3.1.4 Provider agrees to cooperate in credentialing and recredentialing in accordance with CenCal Health policies as set forth in the Provider Manual, if applicable. Additionally, Provider 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 meet credentialing standards as specified inCenCal Health, if applicable. Provider 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.

3.1.5 Covered Services that are provided by or arranged for or by Provider shall be delivered by personnel qualified by licensure, training, or experience to discharge their responsibilities and/or 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.

3.2 Provider Staffing. At all times, Provider shall maintain staffing that allows for timely, high-quality service delivery of Covered Services for each Participant consistent with this Agreement, the DHCS-MCP ECM and ILOS Contract, and any other related DHCS guidance.

3.3 Notification of Changes. If Provider decides to cease providing or suspend any Covered Services, then Provider shall notify CenCal Health in writing at least forty-five (45) Days prior to any such cessation, suspension, or reduction. Provider will notify CenCal Health immediately of any changes in operation, emergency conditions or factors such as limited capacity that may significantly affect Covered Services provided to any Member or that may impair Provider's ability to perform its obligations under this Agreement. Provider shall notify CenCal Health promptly of any material change in ownership, control, legal status, name, location, tax identification number, Medicare or Medi-Cal number or Provider's National Provider Identifier ("NPI"). Any material change of ownership or control is subject to the requirements of Section 9.6. For purposes of this Agreement, a material change in ownership or control shall mean a sale or transfer during any five (5) consecutive years of twenty-five percent (25%) or more of the assets, stock, partnership, or members of the Provider. See also Section 9.6 of this Agreement.

3.4 Provider Responsibilities.

3.4.1 Provider agrees to cooperate with CenCal Health quality improvement activities and to provide access to medical, fir 11 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 and applicable: utilization review, grievance process, credentialing and recredentialing, 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. If Provider is delegated any quality improvement functions as defined in the State Contract, the provisions required in the State Contract regarding: (i) quality improvement responsibilities and specific delegated functions; (ii) oversight, monitoring, and evaluation processes; (iii) reporting requirements and approval processes; and (iv) actions/remedies if CenCal Health's obligations are not met, are specifically stated in CenCal Health's delegation agreements and are hereby incorporated by reference into this Agreement.

3.4.2 Provider agrees to comply with all final recommendations and determinations rendered by CenCal Health quality or provider oversight committees appropriate to the issue in question.

3.4.3 If providing Covered Services to SBHI and SLOHI Members, Providers and/or their staff are responsible for reviewing and becoming familiar with the Applicable Requirements,as respectively amended from time to time by the State and CenCal Health.

3.5 Cultural and Linguistic Services. CenCal Health and Provider 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 oral interpreter services at all key points of contact for monolingual, non-English speaking or Limited English Proficient ("LEP") members in a manner appropriate for the situation in which language assistance is needed; (ii) access to interpreter services, which may include face-to face encounters with Provider or Provider's staff, telephone language services, or the use of urgent care telephone lines, for all limited English proficient Members seeking health services from a Provider; (iii) referrals to culturally and linguistically appropriate community services programs; (iv) use of translated signage and written translated materials appropriate for Provider's Members. A Provider who indicates bilingual language capabilities shall ensure those providing interpreter services are bilingually proficient at medical and non-medical pointof contact; (v) provide cultural competency, sensitivity and diversity training for staff, Providers and its Subcontractors serving CenCal Health Members; and (vi) comply with language assistance standards with respect to services provided for covered benefits underthe Knox-Keene Act pursuant to Health and Safety Code section 1367.04.

CenCal Health may provide training for Provider and Provider's 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 Provider from time to time, and provide tools to assist Provider in cultural or linguistic

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competency.

3.6 Quality and Oversight.

3.6.1 Provider acknowledges CenCal Health shall conduct oversight of its delivery of Covered Services to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both CenCal Health and the Provider have, including, but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

3.6.2 Provider shall respond to all CenCal Health requests for information and documentation to permit ongoing monitoring of Covered Services and submit reports in accordance with the exhibits hereto.

3.7 Compliance. Provider shall provide ongoing oversight of the structures, processes, and outcomes of its operations.

3.7.1 Provider shall continually assess its ability to perform required activities through initial reviews, on-going monitoring, analysis of data and utilization of benchmarks and maintain documentation of oversight activities.

3.7.2 Provider shall comply and deliver Covered Services and the deliverables in accordance with this Agreement and all Applicable Requirements.

3.8 Utilization Management. Unless otherwise set forth in a written delegation acknowledgement that is mutually satisfactory to the parties, Provider hereby acknowledges that CenCal Health: (i) conducts UM programs to manage CenCal Health's coverage of services provided to Members; and (ii) offers no financial incentive to contracted Providers or any of CenCal Health's staff, including but not limited to, staff involved in UM coverage decisions. The absence of financial incentives to withhold medically necessary services is affirmatively stated in the prevailing version of CenCal Health's Provider Manual. Provider shall participate in, cooperate with, and comply with the provisions of CenCal Health UM programs and its policies and procedures, including prospective, concurrent, and retrospective review by CenCal Health, Quality Program, committees, and staff. Upon reasonable notification, Provider shall allow CenCal Health UM personnel, or their designees, or any CenCal Health authorized entity that oversees UM functions, physical and remote access to review, observe, and monitor Member care and Provider's performance of Provider's obligations under this Agreement. Additional information on UM is set forth in the Provider Manual and on the CenCal Health website.

3.9 Compliance With Monitoring Requirements. Provider shall comply with all monitoring provisions of the State Contract and any monitoring requests by DHCS, including but not limited to those addressed further in Section 8 below.

4. PAYMENT AND BILLING

4.1 Payment of Compensation for Covered Services. CenCal Health shall pay contracted Providers for the provision of Covered Services in accordance with the Compensation

Schedule in the exhibits hereto when all Applicable Requirements have been met.

4.2 Payment in Full. Provider must have a system in place to accept payment from CenCal Health for Covered Services rendered. Provider shall accept payments as provided herein as payment in full for providing or arranging Covered Services under this Agreement.

4.3 Funding. CenCal Health's obligation to pay Provider is subject to CenCal Health's corresponding receipt of funding from DHCS, CMS, or any other governmental agency providing revenue to CenCal Health, as applicable. In the event funding to CenCal Health is terminated or delayed, CenCal Health's payment to Provider shall be terminated or delayed, and CenCal Health's obligation shall only resume within fifteen (15) Days following CenCal Health's receipt of its capitation payment from DHCS for Participants who received Covered Services from Provider if said Participants are listed on the most current enrollment information as transmitted by DHCS.

4.4 Uncashed Checks. When checks issued to Providers remain uncashed beyond three (3) years of issuance, CenCal Health will send legally required notice to the Provider and, if unclaimed, CenCal Health will void the check and forward the funds to the State Controller's Office, all in accordance with California escheatment laws and regulations (Code. Civ. Proc., §§ 1500-1582, and 22 Cal. Code Regs, §§ 1150-1180).

4.5 Claims. CenCal Health shall pay ninety (90) percent (90%) of all Clean Claims from Provider within thirty (30) Days of the date of receipt and ninety-nine (99) percent (99%) of all Clean Claims within ninety (90) Days of receipt. The date of receipt shall be the date CenCal Health receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4.5.1 Provider shall submit Claims within one hundred and eighty (180) Days from the date of service in order to receive payment.

4.5.2 Should Provider submit requests for adjustments and/or disputes regarding Claim payments or denials for SBHI or SLOHI Members, such requests should be as soon as feasible but no later than one hundred and eighty (180) Days after the date of the payment or denial of such Claim, except no such time limit shall apply to CenCal Health in instances of suspected fraud, waste, or abuse. If the dispute has not been filed within this time period, there shall be no right to dispute such Claim. Further information about Claims appeals is set forth on CenCal Health's website and in its Provider Manual.

4.6 Repayment. CenCal Health hereby agrees that Claims submitted for services rendered by Provider 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 this Agreement. If an audit conducted by CenCal Health concludes that Provider owes monies to CenCal Health, CenCal Health reserves the right to require repayment or to deduct monies that may be due to Provider from subsequent payable Claims. CenCal Health alsoreserves the right to take such action if: (i) Provider fails to meet its Medi-Cal enrollmentand/or credentialing requirements, as applicable; (ii) Provider fails to report services rendered in the manner specified herein; (iii) overpayment occurs; (iv) fraudulent billing by Provider has been discovered and

substantiated; and (v) other such circumstances as determined by CenCal Health.

Should CenCal Health seek repayment or elect to deduct money from subsequent Claims, it is required to do so in accordance with CenCal Health's established policies and procedures, and shall notify Provider in writing as soon as feasible. If Provider wishes to dispute such action, it shall do so in accordance with the processes in CenCal Health grievance system policies and procedures set forth in the Provider Manual.

4.7 Billing Requirements. Providers shall record, generate, and send a claim or invoice to CenCal Health for Covered Services rendered.

4.7.1 If Provider submits claims, Provider shall submit claims to CenCal Health using specifications based on national standards and code sets to be defined by DHCS, as amended from time to time. All claims must be submitted with required documentation to be considered a "Clean Claim."

4.7.2 For Providers who are unable to submit claims using national standards through CenCal Health's normal avenues of accepting payment submissions, CenCal Health will create, accept, and process for payment using a customized file with data elements as defined by DHCS encounter data reporting standards (which will allow CenCal Health to convert Covered Services invoice information into DHCS-standard specifications and code sets for submission to DHCS). CenCal Health will provide training on this supplemental data file submission method (invoice) as well as monitor it internally to maximize data quality for timely and accurate Provider payments to Providers.

4.7.3 Provider shall not receive payment from CenCal Health for the provision of any Covered Service not authorized by CenCal Health.

4.7.4 Provider reporting of applicable diagnoses is required on all claim submissions to CenCal Health. For Participants with Social Determinants of Health ("SDOH"), Provider must report the applicable diagnoses recognized by the Centers for Disease Control and Prevention ("CDC") that identify SDOH. See Exhibit D for the prevailing list of CDC-recognized ICD-10-CM SDOH codes.

4.8 Billing Member. Provider may bill the Member in the following circumstances:

4.8.1 Copayments payable, if any.

4.8.2 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 Provider shall seek compensation solely from such Member (or such Member'srepresentative) for such services, or if the Member is not legally responsible for suchservices, Provider shall seek compensation from the legally responsible person or entity.

4.9 Other Health Coverage. At this time, ECM is solely a Medi-Cal managed care benefit, which is not covered by Medicaid Fee-For-Service ("FFS"), Medicare, or other health care

insurers. If, at some time in the future, ECM becomes a benefit covered by such health care insurers, CenCal Health's Other Health Coverage ("OHC") rules, as provided in this Agreement and the Applicable Requirements shall apply.

4.10 Payer of Last Resort. Reimbursement for ECM Services is contingent upon ECM Provider billing to CenCal Health only as the payer of last resort. ECM Provider must take all necessary and reasonable measures within ECM Provider's ability to identify, locate, and bill any and all OHC, including Medicare, prior to billing CenCal Health.

4.11 Recovery. 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. If ECM Provider discovers that a Member has OHC, ECM Provider shall inform CenCal Health of this potential recovery situation. Further information is available in the Provider Manual.

4.12 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, Provider agrees to notify CenCal Health that a potential tort, casualty insurance, Workers' Compensation award, or uninsured motorist's coverage may cover any Covered Services provided by Provider whenever Provider discovers such potential awards.

4.13 No Reimbursement from State or Members. Provider shall hold harmless the Members and the State, in the event that CenCal Health cannot or will not pay for Covered Services performed by Provider pursuant to this Agreement.

4.14 Payment Option. Should the State, through an Operating Instruction Letter ("OIL") or otherwise, require CenCal Health to implement benefit changes that would result in reimbursement to Provider at a rate different than the rate indicated in any and all Exhibits and/or attachments, CenCal Health will make said adjustments. In the event CenCal Health does 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 Provider will be provided.

4.15 Non-Duplication and Non-Supplantation of Services.

4.15.1 Participants may not receive duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding. When a Participant is enrolled in ECM and/or CS, Covered Services should be managed in coordination with other ECM and CS Providers. Covered Services provided to Participants under this Agreement that duplicate services from other sources and/or supplant Medi-Cal services are not in accordancewith Applicable Requirements.

4.15.2 Provider shall execute the Attestation set forth in the applicable exhibits hereto or as otherwise required by CenCal Health. The Attestation shall be executed by the Chief

Executive Officer of Provider, or such other authorized representative of Provider as agreed to in writing by CenCal Health. Provider acknowledges and agrees that should Provider receive payments as provided in this Agreement that duplicate and/or supplant Medi-Cal services or are not in accordance with DHCS requirements as determined by CenCal Health, CenCal Health shall demand repayment of any such payments, and Provider shall repay such demanded amounts within thirty (30) Days of such demand. Further, CenCal Health may deem any such payments to be an overpayment to Provider as described in the Agreement and may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. The terms of this section shall survive expiration or termination of the Agreement.

4.16 Confidentiality. To the extent not prohibited by applicable laws and regulations, including but not limited to, the California Public Records Act and the California Brown Act, the Parties agree to protect Confidential Information disclosed to it and not to use such Confidential Information other than as necessary and appropriate in connection with performance of this Agreement.

4.16.1 This provision does not apply to Confidential Information that is (a) in the public domain through no fault of the receiving party; (b) was independently developed as shown by documentation; (c) is disclosed to others without similar restrictions; (d) was already known by the receiving party -- was known by or rightfully in the possession of receiving party or its representatives prior to being disclosed by or on behalf of disclosing party; (e) is subject to disclosure under court order or other lawful process; or, (f) at the time of disclosure is, or thereafter becomes, lawfully available from a third party source not subject to a duty of confidentiality to disclosing party.

4.16.2 The parties agree, acknowledge, and understand that all information that is not Confidential Information as defined are subject to open records laws and regulations such as the California Brown Act and the Public Records Act, and therefore may be released, disclosed, and posted online, to and for the public without prior notice to the other party.

4.17 Deficit Reduction Act (DRA) of 2005. Pursuant to the DRA § 6032, which created the section of the Social Security Act § 1902(a)(68), Provider 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. 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, Provider, 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. Provider will comply with the State Manual, Provider Manual, and the policies and procedures

established by CenCal Health, and will be deemed to have accepted same. As of the Effective Date, the policies, rules, and procedures applicable to Provider are set forth in the Provider Manual and other Exhibits, attached hereto and incorporated herein by this reference. Provider is hereby deemed to have Notice 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.

5.2 Amendments to Provider Manuals, Rules, Policies, and Procedures. Non-material adverse changes to the language in the Provider Manuals or policies, rules, and procedures applicable to Provider shall be deemed approved upon Notice of same unless Provider advises CenCal Health otherwise in writing within forty-five (45) business days of the date of such Notice. Changes to the SBHI and SLOHI language in the above referenced documents and directions for acceptance of said changes will be indicated in a cover letter accompanying such proposed changes.

5.3 Data Sharing.

5.3.1 When federal law requires authorization for data sharing, Provider shall obtain and/or document such authorization from each assigned Participant, including sharing of Protected Health Information ("PHI"), and shall confirm it has obtained such authorization to the CenCal Health.

5.3.2 Participant authorization for data sharing related to Covered Services is not required for the Provider to initiate delivery of Covered Service unless such authorization is required by federal law.

5.3.3 As part of the referral process, CenCal Health will ensure Provider has access to:

5.3.3.1 Demographic and administrative information confirming the referred Member's eligibility for the requested service;

5.3.3.2 Appropriate administrative, clinical, and social service information the Provider might need in order to effectively provide the requested service; and

5.3.3.3 Billing information necessary to support the Provider's ability to submit invoices to CenCal Health.

5.3.4 Provider shall provide any and all data to CenCal Health that is required for CenCal Health to administer Covered Services, including data required for reporting to DHCS related to ECM and/or CS, as applicable.

5.4 Grievance System. Provider and its Subcontractors shall comply with the CenCal Health grievance system policy and procedures, and CenCal Health shall provide Provider a reasonable system for the resolution of disputes between Provider and CenCal Health. Additionally, Provider shall cooperate with CenCal Health in identifying, processing, and resolving all Member concerns and complaints pursuant to CenCal Health Member grievance procedures. CenCal Health's grievance system policies are set out in full in the Provider Manual. With respect to services provided for covered benefits under the Knox-

Keene Act pursuant to Health & Safety Code section 1367(h)(1), Provider is entitled to a fast, fair, and cost-effective dispute resolution mechanism wherein Provider may submit disputes to CenCal Health and CenCal Health shall inform Provider of its procedures for processing and resolving disputes, including the location and telephone number where information may be submitted.

5.5 Non-Discrimination. During the performance of this Agreement, neither Provider 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), medical condition (including cancer), mental disability, marital status, age (over 40) or the use of family and medical care leave and pregnancy disability leave. Provider and its Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and its 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 § 11000 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4.1 of 2 CCR are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Provider shall include the non-discrimination and compliance provisions of this clause in all Subcontracts to performwork under this Agreement.

5.5.1 Neither Provider nor its 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 Part84 (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.

5.5.2 Provider shall take steps to ensure that all Members are provided 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 is not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

5.5.3 Provider shall act upon all complaints alleging discrimination against Members in accordance with the CenCal Health Member grievance system and shall forward copies of all such grievances to CenCal Health within five (5) Days of receipt of same.

6. CENCAL HEALTH OBLIGATIONS

6.1 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 Provider renders health care services or provides health care supplies to Members. Nothing herein shall be construed to require Provider to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Members.

6.2 Data Reporting Oversight. Providers shall submit data to CenCal Health showing evidence of rendering Covered Services. Clean Claims should include the data elements required by CenCal Health as set forth in Section 4.7. In order to comply with the CenCal Health QP, Providers must correct and resubmit data that is unacceptable within six (6) months after the date of denial of payment and within six (6) months after request for additional data on encounters.

In addition to supplying CenCal Health with required data within one (1) year from the date of service, Providers must allow CenCal Health to inspect and audit such data at the Provider's office after seven (7) Days advance written notice. Additionally, Providers acknowledge that CenCal Health has the right to monitor Provider's timely submission of Claims in accordance with the relevant provisions of the Medi-Cal program or as set forth in the Provider Manual. Provider 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.

6.3 Utilization Data. CenCal Health shall share with Provider any utilization data that DHCS has provided to CenCal Health, and Provider agrees to use said data for purposes of care coordination for CenCal Health Members.

6.4 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 Provider shall carry at Provider'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 Provider, its employees, CenCal Health Members, third parties, and CenCal Health. If applicable, each of Provider's drivers shall be insured with automobile liability insurance. Provider shall also carry appropriate Workers' Compensation Insurance. Insurance may be provided in a form of blanket policy. Allinsurance shall be at limits reasonably required by CenCal Health.

7.1.2 CenCal Health acknowledges and accepts Provider is self-insured for General, Professional and Auto liability losses up to $750,000 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. In lieu of and notwithstanding the pro rata risk allocation which might otherwise be imposed between the parties pursuant to California Government Code Section 895.6, the parties agree that all losses or liabilities incurred by a party shall not be shared pro rata but instead the parties agree that pursuant to California Government Code Section 895.4, each party hereto shall fully indemnify and hold the other party, its officers, board members, employees and agents, harmless from any claim, expense or cost, damage or liability imposed for injury (as defined by California Government Code Section 810.8) occurring by reason of the negligent acts or omissions or willful misconduct of the indemnifying party, its officers, board members, employees or agents, under or in connection with or arising out of any work, authority or jurisdiction delegated to such party under this Agreement. No party, nor any officer, board member, employee or agent thereof shall be responsible for any damage or liability occurring by reason of the negligent acts or omissions or willful misconduct of other party hereto, its officers, board members, employees or agents, under or in connection with or arising out of any work, authority or jurisdiction delegated to such other parties under this Agreement.

8. RECORDS AND CONFIDENTIALITY

8.1 Maintenance and Scope of Records. Provider, its employees and any Subcontractors, pertaining to the goods and services furnished under the terms of this Agreement, shall maintain equipment, computer and other electronic systems, contracts, 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 Covered 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 Provider ("Records"). Records also include those that are customarily maintained by Provider for purposes of verifying Claims information and reviewing appropriate utilization requirements, including privacy and confidentiality requirements, shall be maintained in a form in accordance with the general standards applicable to such 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 review and external audit process; and (iii) which facilitates an adequate system for care management. Provider shall be fully bound by the requirements in 42 CFR section 2.1 and following, relating to the maintenance and disclosure of Member records received or acquired by federally assisted alcohol or drug programs. Upon request, at any time during the period of this Agreement, Provider and its Subcontractors shall furnish any such

Record, equipment, computer and electronic systems, contracts, books, or copy thereof, to CenCal Health, DHCS, CMS, Department of Health and Human Services ("DHHS") Inspector General, the Comptroller General, Department of Justice ("DOJ"), and Department of Managed Health Care or their designees for the purpose of an audit, inspection, evaluation, examination, or copying, including, but not limited to, the provisions regard Access Requirements and State's Right to Monitor as set forth in the State Contract.

8.2 Records Retention. In order to comply with CenCal Health's obligations under the State Contract, Provider and its Subcontractors shall retain, preserve and make available for the purpose of an audit, inspection, evaluation, examination or copying, upon request, all Records relating to the performance of its obligations under the Agreement, including:

8.2.1 Claim forms for a term of at least ten (10) years from the final date of the contract periodor from the date of completion of any audit, whichever is later; and

8.2.2 Encounter data shall be retained for a period of ten (10) years.

8.2.3 Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years as indicated above, following termination of litigation.

Upon request by DHCS, Provider shall timely gather, preserve, and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Provider's possession, relating to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, it shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CenCal Health or DHCS of any subpoenas, document production requests, or requests for records, received by Provider related to this Agreement. Such provisions also apply to Provider's Subcontractors.

Inspection Rights. Provider 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 government officials, including DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ and Department of Managed Health Care, 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, facilities, and premises maintained by Provider and any and all Subcontractors of Provider pertaining to these services at all reasonable times at the Provider's normal place of business, or at such other mutually-agreeable location in California. If DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector

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General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal Program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Contract, and direct CenCal Health to terminate the Agreement due to fraud.

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

8.3 Confidentiality of Information. Notwithstanding any other provision of this Agreement, names of persons receiving public social services are Confidential Information and are to be protected from unauthorized disclosure in accordance with Title 42, CFR § 431.300 et seq., Welfare and Institutions Code § 14100.2, and regulations adopted thereunder. Additionally, CenCal Health, Provider and its 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. Either party may release medical records in accordance with applicable law pertaining to release of this type of Information.

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

Member Request for Medical Records. Provider and Provider's Subcontractors shall furnish a copy of a Member's medical record 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.

8.4 Use of Name. Provider 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 Provider 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 Provider's name, address(es), telephone number(s), office hours, language capabilities, handicap access, specialty, affiliations, and Subcontractors or other affiliates to Providers and Members.

8.5 Participation in Communications Activities. Provider shall support, engage, and cooperate in CenCal Health communications efforts, both internally and externally, which may include (but are not limited to) coordinating on press releases, publicity, and media production. Provider shall also coordinate with CenCal Health efforts aimed at the public, media, and elected officials, including, but not limited to, sharing program outcomes documenting Participant stories, subject to advance written consent by Participant to share any protected health information ("PHI") [see paragraph 5.3.1 above] (and obtaining and maintaining informing consent forms for any video, written, photographic or verbal documentation that identifies the Participant).

9. AGREEMENT TERM AND TERMINATION

9.1 Term. This term of this Agreement shall be from the Effective Date for a period of three (3) years notwithstanding the date of execution, pending any approvals required by DHCS, and unless terminated or amended as hereinafter provided.

9.2 Without Cause Termination. Either party may terminate this Agreement at any time for any reason or for no reason with at least (60) Days prior written Notice to the other party.

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 Provider shall immediately notify CenCal Health and CenCal Health may immediately suspend this Agreement in the event there is a material adverse change in Provider's insurance coverage, or Provider's license(s), Medicare or Medi-Cal certification, accreditation (if applicable) or the credentialing status with CenCal Health is suspended or limited. If Provider does not provide adequate insurance coverage within thirty (30) Days of the material adverse change, or if Provider's license(s), certification, accreditation (if applicable) or the credentialing is not fully reinstated within thirty (30) Days of such suspension or limitation, CenCal Health may terminate this Agreement immediately. Provider shall immediately notify CenCal Health and this Agreement will terminate without further action of the parties if Provider's insurance coverage is canceled, not renewed or expires, or if Provider fails to obtain insurance coverage as required by this Agreement, or if Provider's license(s), Medicare or Medi-Cal certification (if applicable), accreditation (if

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applicable) or credentialing status with CenCal Health is revoked, not renewed or expires, if Provider's licensure or certification is not obtained as required by this Agreement, or if Provider 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 addition, this Agreement will automatically terminate in the event of termination of the State Contract.

9.4.3 Provider shall notify CenCal Health and CenCal Health may terminate this Agreement immediately upon written Notice to Provider if Provider files a petition in or for bankruptcy, reorganization, or an arrangement with creditors, makes a general assignment for the benefit of creditors, is adjudged bankrupt, is unable to pay debts as they become due, has a trustee, receiver, or other custodian appointed on its behalf, or has a case or proceeding commenced against it under any bankruptcy or insolvency law.

9.4.4 Provider shall notify CenCal Health and CenCal Health may terminate this Agreement immediately upon written Notice to Provider if Provider provides services to Members through a Subcontractor and: (i) such Subcontractor's license issuspended, revoked, expired or not renewed (if Subcontractor is licensed); (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 information provided to CenCal Health to vet or credential the Provider with respect to such Subcontractor was materially false; or (vi) such Subcontractor no longer satisfies such standards of CenCal Health.

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

9.4.6 If Provider is an individual health care Provider and: (i) Provider's office closes and/or his/her practice or business ceases, or (ii) in the event of death, this Agreement shall terminate immediately.

9.5 <u>Provider Closure</u>. In the event Provider ceases to be a Provider, this Agreement, with the exception of Section 10.2, shall be of no further effect, except insofar as moneys owed,

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either party shall remain a liability for the applicable party.

9.6 Successors and Assigns; Assignment. Subject to the restrictions set forth herein, this Agreement shall be binding upon and shall inure to the benefit of the parties and their respective legal representatives and permitted successors and assigns. Neither party shall assign nor permit to be assigned either this Agreement or any of its rights or delegate any duties hereunder without the other party's prior written consent, which consent shall not be unreasonably withheld or delayed. Any such permitted assignment or delegation shall require the review and written approval of any applicable governmental or regulatory agency(ies), including but not limited to DHCS. Provider also agrees that any Subcontract shall be in writing and shall comply with requirements for Subcontracts as set forth in this Agreement, the State Contract, and applicable laws and regulations. Any attempted assignment in violation of the provisions of this Section 9.6 shall be void at inception. If the party from whom consent is sought for any such assignment does not consent to such assignment, or a transferee does not accept such assignment, the non-assigning party may terminate this Agreement without cause upon sixty (60) Days prior written notice. Any sale, transfer, or other conveyance of twenty-five percent (25%) or more of Provider's business or assets shall be deemed an assignment for the purposes of this Section 9.6. In addition, Provider acknowledges, agrees, and understands that CenCal Health shall revoke its delegation of activities or obligations, or specify other remedies in instances where DHCS or CenCal Health determines that Provider has not performed satisfactorily.

10. RESPONSIBILITY UPON TERMINATION

10.1 Continuation of Covered Services. In the event of termination of the State Contract or this Agreement, or any Subcontract under this Agreement, Provider shall assist CenCal Health in the transfer of care as required by applicable laws and regulations under the State Contract.

10.2 Provisions Surviving Termination. Provisions of this Agreement including, but not limited to, Section 3.8 (Utilization Management), Section 5.4 (Grievance System), Section 7 (Insurance and Indemnification), Section 8 (Records and Confidentiality), and Section 10.1 (Continuation of Covered Services) 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. Provider further agrees that Section 2.3 shall: (i) survive the termination of this Agreement regardless of the cause giving rise to termination; (ii) be construed to be for benefit of Members; and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into by the parties. Any modification to this Section 10.2 shall become effective only after proper State and federal regulatory authorities have received written notification of the proposed change.

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

11. HIPAA COMPLIANCE

11.1 Provider 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 26 he 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.

Provider shall comply with HIPAA requirements as currently established in the Provider Manual. Provider 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 standard formats.

If Provider and CenCal Health are covered entities, they may disclose PHI to conduct 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. Disclosures of information subject to special protections under State or federal law will be disclosed only as permitted by such laws.

12. AMENDMENT

CenCal Health and Provider may amend this Agreement by executing a written amendment signed by both parties. Notwithstanding the foregoing, amendments required due to legislative, regulatory, or other legal authority do not require prior approval of either party and shall be deemed effective immediately upon receipt of Notice. Notwithstanding anything to the contrary herein, any contract amendments shall be subject to any approval required by DHCS.

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); and (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. MISCELLANEOUS

14.1 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.

14.2 Future Requirements. CenCal Health shall inform Provider of any prospective requirements added by DHCS to the State Contract before the requirement would be

effective, to the extent possible, and Provider shall comply with the new requirements within thirty (30) Days of the effective date, unless otherwise instructed by DHCS.

14.3 Approval by DHCS. This Agreement and any amendments hereto shall be effective upon approval of DHCS. Both parties shall notify DHCS of any amendments to or termination of this Agreement.

14.4 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.

14.5 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 herein contained.

14.6 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.

14.7 Interpretation of Agreement. Section headings are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

14.8 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. Addresses for Notice shall be changed in the manner provided for in this Section 14.8.

Notices to CenCal Health should be addressed to:
Director of Provider Services
4050 Calle Real
Santa Barbara, CA 93110.

Notices to Provider shall be addressed to Provider at the address that appears on the Agreement, or to the most recent address on file with CenCal Health.

Provider shall provide notice of termination or amendment of this Agreement to DHCS, by United States Postal Service first class registered mail, postage prepaid at the following address:

Chief, COHS, GMC and Other Contracts Section

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California Department of Health Care Services
Medi-Cal Managed Care Division
MS # 4408, POB 997413
Sacramento, CA 95899-7413

14.9 Billing and Procedure Codes. Any billing or procedure codes ("Codes") referred to in this Agreement, any Exhibits, or attachments hereto, or in the Provider Manual are for the convenience of the parties only. The parties agree and understand that the Codes may change from time to time and shall not be considered material changes, and shall not require any amendment to this Agreement.

14.10 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.

14.11 Governing Law and Venue. This Agreement shall be governed by and construed in accordance with the laws of California. 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. All actions and proceedings arising in connection with this Agreement shall be tried and litigated in a court of competent jurisdiction located in Santa Barbara, California, or if required by law, the federal courts of the Central District of California. The parties agree to comply with the provisions of the California Government Claims Act (Government Code Section 900, *et seq.*) for any disputes arising under this Agreement.

14.12 Health Care Providers' Bill of Rights. The parties agree and understand that, with respect to services provided for covered benefits under the Knox-Keene Act, Provider shall be entitled to all protections afforded under the Health Care Providers' Bills of Rights, as defined in Health & Safety Code Section 1375.7.

14.13 Public Entity Status. It is understood and acknowledged by Provider that CenCal Health is a public entity and subject to all applicable open meeting and record laws, including but not limited to the California Public Records Act and the Ralph M. Brown Act.

14.14 DEBARMENT AND SUSPENSION: The parties agree and certify its employees and principals are not debarred, suspended, or otherwise excluded from or ineligible for, participation in federal, state, or county government contracts or billing for eligible Medicare or Medicaid (Medi-Cal in California) services; and, certify that it shall not contract with a subcontractor that is so debarred or suspended.

14.15 Remedies Not Exclusive. No remedy herein conferred upon or reserved to either party is intended to be exclusive of any other remedy or remedies, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy given hereunder or now or hereafter existing at law or in equity or otherwise.

14.16 Execution of Counterparts. This Agreement may be executed in any number of counterparts and each of such counterparts shall for all purposes be deemed to be an original; and all such counterparts, or as many of them as the parties shall preserve undestroyed, shall together constitute one and the same instrument.

14.17 Precedence. In the event of conflict between the provisions contained in the numbered sections of this Agreement and the provisions contained in the Exhibits, the provisions of the Exhibits shall prevail.

15. ENTIRE AGREEMENT

This Agreement in its entirety is comprised of the Agreement, any and/or all of Exhibits and their attachments as may be applicable to Provider, and the Provider Manuals. If the parties negotiate any amendments such amendments shall be set forth in writing and may include additional exhibits to this Agreement and made a part hereof. This Agreement, as described in the preceding sentences, 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 partiesthat this Agreement may **not** be modified, altered, or changed in any manner, except: (i) in accordancewith Section 12 hereof; or (ii) in accordance with the provision of Section 5.2, by written instrument duly executed by both parties (unless excepted as permitted pursuant to the Act or as required pursuantto HIPAA).

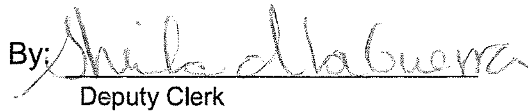
[This area intentionally left blank. Signature page to follow.]

Provider Services Agreement for Enhanced Care Management between the **COUNTY OF SANTA BARBARA** and **CenCal Health.**

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the final date signed.

ATTEST:

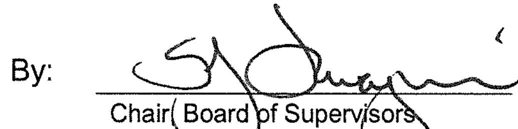
Mona Miyasato
County Executive Officer
Clerk of the Board



By: ______________________
Deputy Clerk

COUNTY OF SANTA BARBARA:

Steve Lavagnino

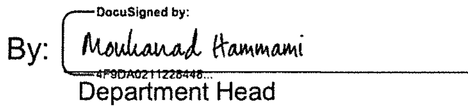


By: ______________________
Chair, Board of Supervisors

Date: 3-5-24

RECOMMENDED FOR APPROVAL:

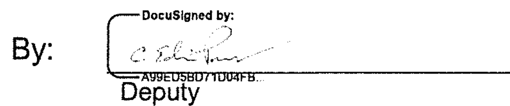
Mouhanad Hammami
Public Health Director



By: ______________________
Department Head

APPROVED AS TO ACCOUNTING FORM:

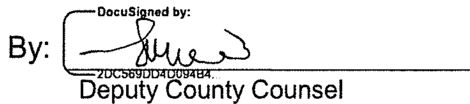
Betsy M. Schaffer, CPA
Auditor-Controller



By: ______________________
Deputy

APPROVED AS TO FORM:

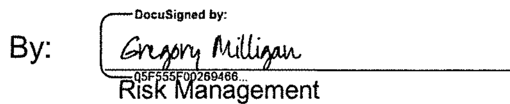
Rachel Van Mullem
County Counsel



By: ______________________
Deputy County Counsel

APPROVED AS TO FORM:

Gregory Milligan, ARM
Risk Management



By: ______________________
Risk Management

COUNTY OF SANTA BARBARA	**CENCAL HEALTH**
DocuSigned by: Mouhanad Hammami 4F9DA0211228448...	DocuSigned by: Marina Owen AEABF3E4CDD03CF...
Signature	CenCal Health Officer
Mouhanad Hammami	Marina Owen
Print Name of Person Signing	Print Name of Person Signing
Director	Chief Executive Officer
Title of Person Signing	Title of Person Signing
	2/22/2024
Date of Execution by Provider or Group	Date of Execution by CenCal Health
Medi-Cal Provider Number/NPI Number	
Tax Identification Number	

EXHIBIT A
ENHANCED CARE MANAGEMENT SERVICES

1. DEFINITIONS

1.1. "Enhanced Care Management ("ECM")" is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.2. "Experiencing Homelessness," as defined by DHCS for the purpose of ECM eligibility determination, is an individual or family who meet any of the following criteria:

1.2.1. An individual or family who lacks adequate nighttime residence;
1.2.2. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation;
1.2.3. An individual or family living in a shelter;
1.2.4. An individual exiting an institution to homelessness (If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization);
1.2.5. An individual or family who will imminently lose housing in next 30 days;
1.2.6. Unaccompanied youth and homeless families and children and youth defined as homeless under other Federal statutes; or
1.2.7. Individuals fleeing domestic violence.

1.3. "Member Information File" is a file produced by CenCal Health and shared with ECM Provider in accordance with DHCS guidance inclusive of demographic, utilization, and other information about Members assigned to ECM Provider to receive Covered Services.

1.4. "Member Information File Return Transmission" is a file produced by the ECM Provider and shared with CenCal Health in accordance with DHCS guidance inclusive of new and updated Member engagement information.

1.5. "Outreach Attempt" is an attempt to correspond with a Member potentially eligible for ECM Services. ECM Provider shall conduct outreach primarily through in-person interaction, or other modalities as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences.

1.6. "Populations of Focus" are categories of adult and children/youth Members who are eligible to receive ECM Services and are defined by DHCS as follows:

1.6.1. Adult Populations of Focus

1.6.1.1. Experiencing Homelessness
1.6.1.2. Members with High Utilization Patterns
1.6.1.3. Serious Mental Illness ("SMI") or SUD
1.6.1.4. Transitioning from Incarceration
1.6.1.5. Individuals At Risk for Institutionalization who are Eligible for Long-Term Care Services
1.6.1.6. Nursing Facility Residents Transitioning to the Community

1.6.2. Children and Youth Population of Focus

1.6.2.1. Children/Youth (up to Age 21) Experiencing Homelessness
1.6.2.2. Members with High Utilization Patterns
1.6.2.3. Serious Emotional Disturbance ("SED") or Identified to be At Clinical High Risk ("CHR") for Psychosis or Experiencing a First Episode of Psychosis
1.6.2.4. Enrolled in CCS/CCS Whole Child Model with Additional Needs Beyond the CCS Qualifying Condition
1.6.2.5. Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26)
1.6.2.6. Transitioning from Incarceration

Populations of Focus are further defined in the DHCS Enhanced Care Management Policy Guide (September 2021), as it may be updated from time to time, which is hereby incorporated herein by reference.

2. GENERAL

2.1. ECM Provider Experience and Qualifications. All ECM Providers, regardless of enrollment as a Medi-Cal Provider, shall have the following experience and qualifications:

2.1.1. ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve;
2.1.2. ECM Provider shall have experience and expertise with the services it will provide;
2.1.3. ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Participants to critical appointments when necessary; and
2.1.4. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

2.2. Provider Requirements

2.2.1. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the "DHCS-MCP ECM and In Lieu of Services Contract" and associated guidance.

2.2.2. ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports ("CS") Providers, to coordinate care as appropriate to each Participant.

2.2.3. ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Participant care plan that can be shared with other providers and organizations involved in each Participant's care.

2.3. Training. ECM Providers shall participate in all mandatory, ECM Provider-focused training and technical assistance provided by CenCal Health, including in-person sessions, webinars, and/or calls as necessary. ECM Provider shall provide on-going training to ECM staff to ensure services are appropriate and to promote continuous quality improvement.

3. MEMBER ELIGIBILITY

3.1. Populations of Focus. ECM Provider shall serve assigned members at its predetermined capacity from the following Adult Populations of Focus under this Agreement: (a) Individuals and Families Experiencing Homelessness; (b) Adults with Patterns of High Utilization; (c) any other Populations of Focus as defined and allowed by DHCS that may be mutually-agreed between the parties.

3.2. ECM Eligibility Criteria. Member participation in ECM requires the Member to meet the following criteria defined and required by DHCS:

3.2.1. Adult Populations of Focus

3.2.1.1. Individuals and Families Experiencing Homelessness

3.2.1.1.1. Individuals who are Experiencing Homelessness; and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

3.2.1.2. Adult with Patterns of High Utilization:

3.2.1.2.1. Adults eighteen (18) years and older who have had five (5) or more emergency room visits in a six (6) month period that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a six (6) month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

Definitions and detailed eligibility criteria for the Children and Youth Populations of Focus are further defined in the DHCS Policy Guide, as it may be updated from time

to time, which is hereby incorporated herein by reference. In the case of a conflict between the ECM eligibility criteria defined by this Exhibit A and the ECM eligibility criteria defined by the DHCS ECM Policy Guide, the DHCS ECM Policy Guide shall control.

4. INITIATING ECM SERVICES

4.1. Identifying Members for ECM.

4.1.1. ECM Provider shall identify Members who would benefit from ECM and send a request to CenCal Health, to determine if the Member is eligible for ECM, consistent with the CenCal Health's process for such request.

4.1.2. CenCal Health shall use available data to identify Members who are eligible for ECM Services.

4.1.3. CenCal Health shall authorize ECM Services in accordance with any CenCal Health's pre-service review policy.

4.1.4. Upon notification of Member assignment, ECM Provider shall submit an ECM authorization request that will be auto approved for six (6) weeks to begin Participant outreach and completion of the Comprehensive Assessment. If no authorization is submitted after the six (6) weeks, the ECM Provider shall submit a new authorization request with the following documentation:

4.1.4.1. TAR checklist

4.1.4.2. Comprehensive assessment

4.1.4.3. Care Plan

4.1.4.4. Documentation demonstrating care management activities including outreach efforts, which delineate the activities of in person vs telephonic.

4.1.4.5. Other relevant clinical information related to ECM Services the Participant is receiving, the frequency and name of Lead Care Manager.

4.1.5. ECM authorizations that are approved will be authorized in six (6) month increments. During authorization submissions, Participants shall be re-assessed for ECM eligibility.

4.2. Member Assignment to an ECM Provider.

4.2.1. CenCal Health shall communicate new Member assignments to ECM Provider as soon as possible, but in any event no later than ten (10) business days after ECM authorization.

4.2.2. ECM Provider shall immediately accept all Members assigned by CenCal Health for ECM, with the exception that an ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.

4.2.3. ECM Provider shall immediately alert CenCal Health if it does not have the capacity to accept a Member assignment.

4.3. Designation of Lead Care Manager.

4.3.1. Upon initiation of ECM, ECM Provider shall ensure each Participant assigned has a Lead Care Manager who interacts directly with the Participant and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, Long Term Se[illegible] [illegible] Supports ("LTSS"), Specialty Mental Health

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Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health ("SDOH") needs, regardless of setting.

4.3.2. ECM Provider shall advise the Participant on the process for changing ECM Providers, which is permitted at any time.

4.3.2.1. ECM Provider shall advise the Participant on the process for switching ECM Providers, if requested;

4.3.2.2. ECM Provider shall notify CenCal Health, as required by CenCal Health, if the Participant wishes to change ECM Providers; and

4.3.2.3. CenCal Health must implement any requested ECM Provider change within thirty (30) days.

4.3.3. ECM Provider shall ensure each Participant receiving ECM has a Lead Care Manager who best meets the Participants' needs and preferences.

4.3.4. The Lead Care Manager shall be a member of the Participant's ECM Care Team and shall have primary responsibility for coordinating all aspects of ECM for the Participant.

4.3.5. The Lead Care Manager shall serve as the main point of contact for the Participant and interact directly with the Participant and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate. To the extent a Participant has other care managers, the Lead Care Manager shall be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Participant and non-duplication of services.

4.4. <u>ECM Provider Outreach and Member Engagement</u>.

4.4.1. ECM Provider shall send a request to CenCal Health for Members it identifies as eligible to determine if the Member is eligible for ECM, consistent with the CenCal Health's process for such a request.

4.4.2. ECM Provider shall be responsible for completing outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CenCal Health's policies and procedures.

4.4.3. ECM Provider shall ensure outreach to assigned Members prioritizes Members with the highest risk and/or need for outreach efforts, as identified by CenCal Health and/or ECM Provider.

4.4.4. ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, in compliance with all applicable federal and state privacy and security regulations, to supplement to in-person services to build and maintain rapport between a Lead Care Manager and Participant where appropriate and with the Member's consent.

4.4.4.1. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (a) mail; (b) email; (c) texts; (d) telephone calls; and (e) telehealth.

4.4.5. ECM Provider shall complete and document Outreach Attempts as required by CenCal Health. For each unsuccessful Outreach Attempt, ECM Provider shall document Member name, M r identification number, Member date of birth,

the date of each Outreach Attempt, and modality used.

4.4.6. For homeless and/or other hard-to-reach and/or difficult to engage populations, including but not limited to Members with literacy or language barriers, those suffering from addiction or severe mental illness, and those living in remote locations, ECM Provider shall make best efforts to complete at least four (4) Outreach Attempts, if needed to contact Member and shall utilize additional means to successfully contact and engage Members.

4.4.7. ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and the Agreement.

4.5. Initiating Delivery of ECM.

4.5.1. CenCal Health shall ensure that authorization or a decision not to authorize ECM occurs as soon as possible (*i.e.*, within five (5) working days for routine authorizations and within 72 hours for expedited requests).

4.5.1.1. CenCal Health shall not require ECM Provider or its own staff to obtain Member consent to participate (in writing or otherwise) as a condition of initiating delivery of ECM, unless required by federal law.

4.5.2. ECM Provider shall obtain, document, and manage Participant authorization for the sharing of Personally Identifiable Information between CenCal Health, ECM Provider, Community Supports providers, and other providers involved in the provision of Participant care to the extent required by federal law.

4.5.3. When federal law requires authorization for data sharing, ECM Provider shall communicate to CenCal Health that it has obtained Participant authorization for such data sharing and provide Participant-level record of written authorization.

4.5.4. ECM Provider shall notify CenCal Health to discontinue ECM Services under the following circumstances:

4.5.4.1. The Participant has met their care plan goals for ECM;

4.5.4.2. The Participant is ready to transition to a lower level of care;

4.5.4.3. The Participant no longer wishes to receive ECM Services or is unresponsive or unwilling to engage; and/or

4.5.4.4. ECM Provider has not had any contact with the Participant despite the minimum number of Outreach Attempts required of ECM Provider by this Agreement.

4.5.5. When ECM is discontinued, or will be discontinued for the Participant, CenCal Health is responsible for sending a Notice of Action ("NOA") notifying the Participant of the discontinuation of the ECM benefit and ensuring the Participant is informed of their right to appeal and the appeals process as instructed in the NOA. ECM Provider shall make efforts to notify the Participant telephonically, in person or in writing of the reason why the ECM services will be discontinued. ECM Provider shall communicate to the Participant other benefits or programs that may be available to the Member, as applicable (*e.g.*, Complex Care Management, Basic Care Management, etc.).

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5. ECM REQUIREMENTS AND CORE SERVICES COMPONENTS

5.1. Enhanced Care Management Services. ECM Provider shall provide the following ECM Services:

5.1.1. ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

5.1.2. ECM Provider shall:

5.1.2.1. Ensure each Participant receiving ECM Services has a Lead Care Manager;

5.1.2.2. Coordinate across all sources of care management in the event that a Participant is receiving care management from multiple sources;

5.1.2.3. Alert CenCal Health to ensure non-duplication of services in the event that a Participant is receiving care management or duplication of services from multiple sources; and

5.1.2.4. Follow CenCal Health instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

5.1.3. ECM Providers and Lead Care Managers shall meet Participants where they are in terms of the physical location that is most convenient and desirable for the Participant to engage in services and from a medical management and plan of care perspective.

5.1.4. ECM Provider shall collaborate with area hospitals, primary care providers (when not serving as the ECM Provider), behavioral health providers, specialists, dental providers, providers of services for LTSS and other associated entities, such as CS providers, as appropriate, to coordinate Participant care.

5.1.5. ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with CenCal Health's Policies and Procedures, as follows:

5.1.5.1. Outreach and Engagement of CenCal Health Members into ECM:

5.1.5.1.1. ECM Provider shall attempt to locate, contact, and engage Members who have been identified as good candidates to receive ECM Services, promptly after assignment from CenCal Health;

5.1.5.1.2. ECM Provider shall use multiple strategies for engagement, as appropriate and to the extent possible, including direct communications with the Member, such as in-person meetings where the Member lives, seeks care or is accessible; mail, email, texts, telephone, and telehealth; community and street-level outreach; or follow-up if the Member presents to another partner in the ECM network.;

5.1.5.1.3. ECM Provider shall use an active and progressive approach to outreach and engagement until the Member is engaged;

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5.1.5.1.4. ECM Provider shall document outreach and Outreach Attempts and modalities;

5.1.5.1.5. ECM P 39 er shall utilize educational materials and scripts developed for outreach to and engagement of Members, as appropriate;

5.1.5.1.6. ECM Provider shall share information with CenCal Health to ensure that the CenCal Health can assess Members for other programs if they cannot be reached or decline ECM; and

5.1.5.1.7. ECM Provider shall ensure that culturally and linguistically appropriate communications andinformation is used to engage Members and shall provide ECM Services in the Member's primary language.

5.1.5.2. On the successful engagement of a Member, ECM Provider shall complete a Comprehensive Assessment, which shall involve a review of clinical and non-clinical needs to assess the Member's health status.

5.1.5.3. Upon completion of a Comprehensive Assessment, ECM Provider shall develop a Care Management Plan, which shall include, but is not limited to:

5.1.5.3.1. Engaging with each Participant authorized to receive ECM primarily through in-person contact; and when in-person communication is unavailable or does not meet the needs of the Participant, the ECM Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Participant choice;

5.1.5.3.2. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Participant health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan; and

5.1.5.3.3. Developing a comprehensive, individualized, person-centered Care Management Plan by working with the Participant and/or their family member(s), guardian, Authorized Representative ("AR"), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences and make recommendations for service needs;

5.1.5.3.4. Incorporating into the Participant's Care Management Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

5.1.5.3.5. Ensuring the Care Management Plan is reassessed at a frequency appropriate for the Participant's individual progress or changes in needs and/or as identified in the Care Management Plan; and

5.1.5.3.6. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

5.1.5.4. ECM Provider shall provide Enhanced Coordination of Care to include all services necessary to implement the Care Management Plan, which shall include, but is not limited to:

5.1.5.4.1. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Participant's multi-disciplinary care team, and implementing activities identified in the Participant's Care Management Plan;

5.1.5.4.2. Maintaining regular contact with all providers, that are identified as being a part of the Participant's multi-disciplinary care team, who's input is necessary for successful implementation of Participant goals and needs, including case conferences, as necessary, to ensure the Participant's care is continuous and organized;

5.1.5.4.3. Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;

5.1.5.4.4. Providing support to engage the Participant in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Participant engagement in treatment;

5.1.5.4.5. Communicating the Participant's needs and preferences timely to the Participant's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and

5.1.5.4.6. Ensuring regular contact with the Participant and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the Care Management Plan.

5.1.5.5. ECM Provider shall provide health promotion services, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:

5.1.5.5.1. Working with Participants to identify and build on successes and potential family and/or support networks;

5.1.5.5.2. Providing services to encourage and support Participants to make lifestyle choices based on healthy behavior, with the goal of supporting Participants' ability to successfully monitor and manage their health;

5.1.5.5.3. Supporting Participants in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions;

5.1.5.5.4. Linking Participants to resources for smoking cessation, management of Participant chronic conditions, self-help recovery resources and other services based on Participant needs and preferences; and

5.1.5.5.5. Using evidence-based practices, such as motivational interviewing to engage and help the Participant participate in and manage their care.

5.1.5.6. ECM Provider shall provide Comprehensive Transitional Care to support Participants and their support networks during discharge from hospital and institutional settings, which shall include, but is not limited to:

5.1.5.6.1. Developing strategies to reduce avoidable Participant admissions and readmissions across all Participants receiving ECM;

5.1.5.6.2. For Participants who are experiencing, or who are likely to experience a care transition:

5.1.5.6.2.1. Developing and regularly updating a transition of care plan for the Participant;

5.1.5.6.2.2. Evaluating a Participant's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

5.1.5.6.2.3. Tracking each Participant's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team Members;

5.1.5.6.2.4. Coordinating medication review/ reconciliation; and

5.1.5.6.2.5. Providing adherence support and referral to appropriate services.

5.1.5.7. ECM Provider shall provide Participant and Family Supports, which shall include, but are not limited to:

5.1.5.7.1. Documenting a Participant's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the ECM Providers, the Participant and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and CenCal Health, as applicable;

5.1.5.7.2. Conducting activities to ensure the Participant and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Participant's condition(s) with the overall goal of improving the Participant's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State, and local privacy and confidentiality laws;

5.1.5.7.3. Ensuring the Participant's ECM Provider serves as the primary point of contact for the Participant and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);

5.1.5.7.4. Identifying supports needed for the Participant and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Participant's condition and assist them in accessing needed support services;

5.1.5.7.5. Providing for appropriate education of the Participant and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Participant; and

5.1.5.7.6. Ensuring that the Participant has a copy of their Care Management Plan and information about how to request updates.

5.1.5.8. ECM Provider shall provide Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:

5.1.5.8.1. Determining appropriate services to meet the needs of Participants, including services that address SDOH needs, including housing, and services offered by CenCal Health as Community Supports; and

5.1.5.8.2. Coordinating and referring Participants to available community resources and following up with Participants to ensure services were rendered (*i.e.*, "closed loop referrals").

6. DATA SHARING TO SUPPORT ECM

6.1. Data Sharing to Support ECM.

6.1.1. CenCal Health shall provide to ECM Provider the following data at the time of assignment and periodically thereafter, in accordance with DHCS guidance for data sharing where applicable:

6.1.1.1. Member Assignment Files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

6.1.1.2. Encounter and/or claims data;

6.1.1.3. Physical, behavioral, administrative, and SDOH data for all assigned Members; and

6.1.1.4. Reports of performance on quality measures and/or metrics, as requested.

6.1.2. ECM Provider shall obtain, document, and manage Participant authorization for the sharing of Personally Identifiable Information between CenCal Health, ECM Provider, CS providers, and other providers involved in the provision of Participant care to the extent required by federal law.

6.1.3. ECM Provider shall follow the timeline and communication processes established by CenCal Health for the transmission of the Member Information File Return Transmission, including acknowledgement of receipt of Member Information File, communicating, or updating Member Information File information as required by DHCS guidance, and reconciling identified errors or other inaccurate or outdated information.

6.1.4. ECM Provider's Care management documentation systems may include Certified Electronic Health Record Technology as defined at 42 C.F.R. § 495.4, or other documentation tools which meet Health Insurance Portability and Accountability Act ("HIPAA") security standards that can effectivelydocument Participant goals and goal attainment status; develop and assign careteam tasks; define and support Participant care coordination and care management needs; gather information from other sources to identify Participant needs and support care team coordination and communication and support notifications regarding Participant health status and transitions in care (e.g., discharges from a hospital, long term care facility, housing status).

6.1.5. CenCal Health and ECM Provider shall collaborate to facilitate the implementation of health information exchange to share relevant Participant information with other entities providing services to the Participant as needed for effective care coordination and reporting, subject to state and federal laws regarding confidentiality of health information.

7. QUALITY AND OVERSIGHT

7.1. Reporting.

7.1.1. Outreach Reporting. ECM Provider shall submit, no less than quarterly, reports on outreach activities, including but not limited to, data regarding:

7.1.1.1. Number of identified individuals targeted for ECM;

7.1.1.2. Number of individuals targeted for ECM with at least one Outreach Attempt;

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7.1.1.3. Number of total Outreach Attempts (by attempt method);

7.1.1.4. Number of succ[illegible]l Outreach Attempts (a successful attempt is defined as an act[illegible]teraction with the individual); and

7.1.1.5. Total time spent (in hours) performing outreach efforts related to potential ECM enrollees.

7.1.2. Encounter Reporting. ECM Provider shall submit encounter data pursuant to standards defined by CenCal Health policies, or as set forth in this Agreement or in the Provider Manual. ECM Provider shall furnish CenCal Health, no less than monthly, complete, accurate, reasonable, and timely encounter data in a manner which enables CenCal Health to meet its administrative functions and encounter data reporting requirements to DHCS. ECM Provider shall also cooperate with CenCal Health's mechanisms, including edits and reporting systems, to ensure encounter data is complete and accurate prior to submission to DHCS. If CenCal Health determines that ECM Provider is reporting less than all encounters in the required format and timelines, CenCal Health will work with ECM Provider to meet this requirement.

7.1.3. Supplemental Reporting. ECM Provider shall provide supplemental reports on ECM Provider's outreach efforts; frequent updates on member support being provided and/or needed, as well as member input and engagement in ECM Services; and documentation of services and timeliness of follow up.

7.1.4. Other Reporting. ECM Provider shall also supply CenCal Health, upon request, with other periodic reports and information pertaining to:

7.1.4.1. ECM provided to Members by ECM Provider or ECM Provider's Subcontractors;

7.1.4.2. ECM Provider's financial resources, on such forms and within such times as requested by CenCal Health, to enable CenCal Health to meet federal and State legal and contractual reporting requirements;

7.1.4.3. Complete, accurate, reasonable, and timely ECM Provider data in order for CenCal Health to meet its ECM Provider data reporting requirements to DHCS; and

7.1.4.4. Any other reports, which may be required by CenCal Health upon request and in a format agreeable to the parties.

7.2. <u>Monitoring</u>.

7.2.1. CenCal Health will review ECM Provider reports to ensure that ECM is provided in an equitable and non-discriminatory manner. Where CenCal Health identifies a concern regarding inequity or discrimination in approval of ECM, CenCal Health shall conduct a review and make a determination about appropriate next steps. Based on the determination, CenCal Health will develop a corrective action plan to address the findings of inequity and/or discrimination, as appropriate.

8. COMPENSATION

8.1. <u>Payment for ECM</u>.

8.1.1. CenCal Health shall pay contracted ECM Providers for the provision of ECM in accordance with Exhibit A-1 ECM Services Compensation Schedule.

8.1.2. ECM Provider is eligible to receive payment when ECM is initiated for any given CenCal Health Member.

EXHIBIT A-1
ENHANCED CARE MANAGEMENT SERVICES
COMPENSATION SCHEDULE

Notwithstanding rates established for any Covered Services other than ECM Services as set forth in this Agreement, CenCal Health shall pay ECM Provider for ECM Services in accordance with the terms and conditions of this Agreement and the reimbursement terms set forth in this Exhibit and any applicable exhibits referenced hereto and incorporated herein.

1. **COMPENSATION TERMS.**

1.1 Payment Terms.

1.1.1 Claims Submission. ECM Provider shall submit Claims (or invoices, as applicable) for ECM Services provided to Members in accordance with this Agreement.

1.1.2 Claims Reimbursement. For all Clean Claims (and invoices, as applicable) for Covered Services provided to Members and submitted in accordance with Section 1.1.1 above, CenCal Health shall reimburse ECM Provider in accordance with the rates and subject to the limitations set forth in Section 1.2 and as further described in Tables 1 and 2 of this Exhibit A-1 of the Agreement, below.

1.2 Limitations.

1.2.1 ECM Services: Initial Outreach and Engagement, and Comprehensive Assessment

1.2.1.1 Initial Outreach and Engagement, and Comprehensive Assessment ECM Services are described in Exhibit A, Sections 5.1.5.1 and 5.1.5.2 of this Agreement. Payment for these Services are referred to as the ECM "Outreach Case Rate." Their associated codes and modifiers can be found in Table 1, below.

1.2.1.2 The ECM Outreach Case Rate is the total amount to be reimbursed per Member for the authorized six (6) week period for Initial Outreach and Engagement, and Comprehensive Assessment ECM Services.

1.2.1.2.1 ECM Provider will be reimbursed for these outreach Services that seek to or successfully result in the engagement of a Member as evidenced by completion of a Comprehensive Assessment. Should the ECM Provider be unable to engage the Member or be unable to complete a Comprehensive Assessment, the ECM Outreach Case Rate will be paid for completion of its Outreach Attempts. ECM Provider will make best effort to complete three (3) Outreach Attempts, or four [illegible]treach Attempts for homeless and/or other

hard-to-reach and/or difficult to engage populations (see Exhibit A, Section 4.4.6) during the authorized six (6) week period.

1.2.2 ECM Services: Care Management Plan and related services

1.2.2.1 Care Management Plan and related ECM Services are described in Exhibit C, Sections 5.1.5.3-5.1.5.8, of this Agreement. Payment for these Services are referred to as the ECM "Case Rate." Their associated codes and modifiers can be found in Table 2, below.

1.2.2.2 The ECM PMPM Rate is the total amount to be reimbursed per Participant, per month for the authorized six (6) month period for Care Management Plan and Related ECM Services.

1.2.2.2.1 If ECM Provider submits one (or more) ECM code and modifier in a single month within the authorized six (6) month period, ECM Provider will be reimbursed for any and all Services for that month at the ECM PMPM Rate. Submitting additional codes does not increase reimbursement beyond the ECM PMPM Rate.

1.2.2.2.2 If ECM Provider submits no ECM code and modifier, as applicable, in a month within the authorized six (6) month period, ECM Provider will NOT receive reimbursement for that month.

1.2.3 Reimbursement for ECM Services shall be subject to the further limitations set forth in this Agreement and shall be in accordance with the applicable payment provisions of this Agreement.

Table 1: Payment Rates for ECM Services – Initial Outreach and Engagement (Case Rate)

Code	Description	Modifier	Case Rate
G9008	ECM In-Person Outreach: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U8	$250.00
G9008	ECM Phone/Telehealth Outreach: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U8, GQ	
G9012	ECM In-Person Outreach: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8	
G9012	ECM Phone/Telehealth Outreach: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	

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Table 2: Payment Rates for ECM Services – Care Management Plan and related services (Case Rate)

Code	Description	Modifier	Case Rate
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	$500.00
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	

1.3 Funding Terms.

1.3.1 ECM Reimbursement Distinct from Prospective Payment System. If ECM Provider is a FQHC, RHC, or IHS-MOA 638 Clinic, compensation for ECM Services by CenCal Health is outside of and will not affect the DHCS PPS rates payable to the FQHC, RHC, or IHS-MOA 638 Clinic according to DHCS guidance, which may be updated from time to time, and is incorporated here by reference. In the event DHCS reverses its position on such carve out of ECM payment from PPS reimbursement, ECM Provider may terminate this Exhibit A upon 60 days' prior written notice to CenCal Health. Upon termination, ECM Provider shall assist CenCal Health in the transfer of ECM Services to another ECM provider in accordance with continuity of care requirements set forth in this Agreement. In all events, Provider shall continue to fulfill any obligations for care coordination for Members as described in the Agreement.

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EXHIBIT A-2
ENHANCED CARE MANAGEMENT SERVICES
PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for ECM Services. The HCPCS codes and modifiers applicable for ECM Services provided in the table below are sourced from and further defined in the DHCS ECM and ILOS Coding Options guide (March 2022), as it may be updated from time to time, which is hereby incorporated by reference.

The HCPCS code and modifier combined define the service as an ECM Service. As an example, HCPCS code G9008 by itself does not define the service as an ECM Service. HCPCS code G9008 must be reported with modifier U1 for the care coordination service to be defined and categorized as an ECM Service. If an ECM Service is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.[1]

HCPCS Code	HCPCS Description	Modifier	Modifier Description
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	Used by Managed Care with HCPCS Code G9008 to indicate ECM Services.
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used by Managed Care with HCPCS Code G9008 to indicate ECM Services.
G9008	ECM Outreach In-Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9008 to indicate a single in-person ECM Outreach Attempt for an individual member, for the purpose of initiation into ECM.

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HCPCS Code	HCPCS Description	Modifier	Modifier Description
G9008	ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used by Managed Care with HCPCS code G9008 to indicate a single telephonic/electronic ECM Outreach Attempt for an individual member, for the purpose of initiation into ECM. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	Used by Managed Care with HCPCS Code G9012 to indicate ECM Services.
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	Used by Managed Care with HCPCS Code G9012 to indicate ECM Services.
G9012	ECM Outreach In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9012 to indicate a single in-person ECM Outreach Attempt for an individual member, for the purpose of initiation into ECM.

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HCPCS Code	HCPCS Description	Modifier	Modifier Description
G9012	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used by Managed Care with HCPCS code G9012 to indicate a single telephonic/electronic ECM Outreach Attempt for an individual member, for the purpose of initiation into ECM. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.

[1] For more information refer to the DHCS Medi-Cal Provider Manuals.

EXHIBIT A-3
ATTESTATION OF NON-SUPPLANTATION OF MEDI-CAL SERVICES

Attestation of Non-Supplantation of Medi-Cal Services

Provider hereby attests that Enhanced Care Management Services provided to Members under this Agreement do not supplant services received by a Medi-Cal beneficiary from other State, local, or federally funded programs and are in accordance with the CalAIM Standard Terms and Conditions and federal and DHCS requirements.

Date: 2/22/2024

DocuSigned by:
Marina Owen
AEA8F3E4CDD04CF...

Signature of Authorized Representative of ECM Provider

Marina Owen

Printed Name

Chief Executive Officer

Title

EXHIBIT D
ICD-10-CM SOCIAL DETERMINANTS OF HEALTH CODES

ICD-10-CM Codes Z55-Z65 – Persons with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances. The ICD-10-CM SDOH codes provided in the table below are sourced from and further defined by the CDC, as it may be updated from time to time, which is hereby incorporated by reference.

Category	Code	Description
Problems related to education and literacy	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in school
	Z55.4	Educational maladjustment and discord with teachers and classmates
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Problems related to employment and unemployment	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful work schedule
	Z56.4	Discord with boss and workmates
	Z56.5	Uncongenial work environment
	Z56.6	Other physical and mental strain related to work
	Z56.81	Sexual harassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Occupational exposure to risk factors	Z57.0	Occupational exposure to noise
	Z57.1	Occupational exposure to radiation
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
	Z57.6	Occupational exposure to extreme temperature
	Z57.7	Occupational exposure to vibration
	Z57.8	Occupational exposure to other risk factors
	Z57.9	Occupational exposure to unspecified risk factor
Problems related to housing and economic circumstances	Z59.0	Homelessness
	Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
	Z59.2	Discord with neighbors, lodgers, and landlords

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Category	Code	Description
	Z59.3	Problems related to living in residential institution
	Z59.4	Lack of adequate food and safe drinking water
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems related to social environment	Z60.0	Problems of adjustment to life transitions (life phase, retirement)
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty (migration, social transplantation)
	Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
	Z60.5	Target of (perceived) adverse discrimination and persecution
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
Problems related to upbringing	Z62.0	Inadequate parental supervision and control
	Z62.1	Parental overprotection
	Z62.21	Child in welfare custody (non-parental family member, foster care)
	Z62.22	Institutional upbringing (orphanage or group home)
	Z62.29	Other upbringing away from parents
	Z62.3	Hostility towards and scapegoating of child
	Z62.6	Inappropriate (excessive) parental pressure
	Z62.810	Personal history of physical and sexual abuse in childhood
	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.813	Personal history of forced labor or sexual exploitation in childhood
	Z62.819	Personal history of unspecified abuse in childhood
	Z62.820	Parent-biological child conflict
	Z62.821	Parent-adopted child conflict
	Z62.822	Parent-foster child conflict
	Z62.890	Parent-child estrangement NEC
	Z62.891	Sibling rivalry
	Z62.898	Other specified problems related to upbringing
	Z62.9	Problem related to upbringing, unspecified
Other problems related to primary support group, including family circumstances	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military deployment
	Z63.32	Other absence of family member
	Z63.4	Disappearance/death of family member (assumed death, bereavement)

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Category	Code	Description
	Z63.5	Disruption of family by separation and divorce (marital estrangement)
	Z63.6	Dependent relative needing care at home
	Z63.71	Stress on family due to return of family from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.79	Other stressful events affecting family/household (ill/disturbed member)
	Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
	Z63.9	Problem related to primary support group, unspecified
Problems related to psychosocial circumstances	Z64.0	Problems related to unwanted pregnancy
	Z64.1	Problems related to multiparity
	Z64.4	Discord with counselors
Problems related to other psychosocial circumstances	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war, and other hostilities
	Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
	Z65.9	Problem related to unspecified psychosocial circumstances