AMENDMENT TO THE PROFESSIONAL SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

and

Tehama County Health Services Agency

This Amendment to the Professional Services Agreement ("**Amendment**") entered into between Partnership HealthPlan of California, a public entity ("**PARTNERSHIP**"), and Tehama County Health Services Agency (collectively referred to as "**Physician**" or "**Physician Group**"), shall be effective January 1, 2026. In the event of a conflict between this Amendment and any other provision of the Agreement, this Amendment will control. Any capitalized term utilized in this Amendment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this Amendment. If a capitalized term used in this Amendment is not defined in the Agreement or this Amendment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

WHEREAS, PARTNERSHIP and Physician or Physician Group entered into a Primary Care Professional Services Agreement ("**Agreement**") effective January 01, 2024;

WHEREAS, the parties desire to amend the Agreement regarding PARTNERSHIP's quality incentive program in compliance with the CMS Final Rule (CMS-2439-F); and

WHEREAS, the parties agree to the terms set forth herein relating to the quality incentive program and execute this Amendment prior to the applicable Performance Period as defined below.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree to be legally bound as follows:

1. PARTNERSHIP's Primary Care Provider Quality Incentive Program (QIP) provisions relating to provider incentives are hereby deleted in their entirety and replaced with the following:

    a. Primary Care Provider Quality Incentive Program ("**PCP QIP**"):

        i. **Eligibility**: At PARTNERSHIP's discretion, Physician's or Physician Group's Primary Care Sites will be eligible to participate in the PCP QIP, which is designed to encourage and improve quality care. New sites joining PARTNERSHIP as part of the Physician Group Parent Organization credentialed by October 1st of the Performance Period will be eligible for participation in the PCP QIP.

        ii. **Good Standing**: In order for Physician or Physician Group to be eligible, Physician or Physician Group must be in good standing continuously from

the beginning of the Performance Period to the Payment Date. PARTNERSHIP has the sole authority to determine if a provider is in good standing based on the criteria set forth below:

1. Physician or Physician Group is open for services for PARTNERSHIP members.
2. Physician or Physician Group is financially solvent (not in bankruptcy proceedings).
3. Physician or Physician Group is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, PARTNERSHIP will consider a request to change the provider status to good standing.
4. Physician or Physician Group is not pursuing any litigation or arbitration against PARTNERSHIP.
5. Physician or Physician Group has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Physician or Physician Group has demonstrated the intent to work with PARTNERSHIP on addressing community and member issues.
7. Physician or Physician Group is adhering to the terms of their contract (including following PARTNERSHIP policies, quality, encounter data completeness, and billing timeliness requirements).
8. Physician or Physician Group is not under investigation for fraud, embezzlement, or overbilling.
9. Physician or Physician Group is not conducting other activities adverse to the business interests of PARTNERSHIP.

iii. **Performance Period**: The Performance Period is defined as the period of time in which Physician's or Physician Group's performance under the Agreement will be measured by PARTNERSHIP to determine if Physician or Physician Group is eligible for an incentive payment. Provider's Performance Period is January 1, 2026 through December 31, 2026, which is tied to PARTNERSHIP's Medical Loss Ratio Reporting Period of calendar year 2026.

iv. **Quality Incentive Standards**: In order for Physician or Physician Group to qualify for an Incentive Payment, Physician or Physician Group must meet specific measures as set forth in PCP QIP Exhibit A attached herein and incorporated by reference as well as PARTNERSHIP's PCP QIP Specifications referenced below. Physician or Physician Group understands and agrees that PARTNERSHIP, in its sole discretion, may need to remove a measure from the PCP QIP during the Performance

Period. For example, PARTNERSHIP may not be able to generate data to calculate a valid rate. In the event that a specific unit of service measure needs to be removed after execution of this Amendment, the measure will be removed from the unit of service measure set. Physician or Physician Group will receive notice of such changes within 30 days of PARTNERSHIP's decision to remove the measure, and no later than 30 days before the end of the calendar year. Physician Group Parent Organizations with over 500 assigned members as of December 1st of the year prior earning the fewest QIP points will be required to participate in additional performance improvement activities as determined in collaboration with a Performance Improvement Advisor on an individualized improvement plan.

v. **PCP QIP Overview and Specifications:** Detailed terms and specifications are set forth in the PARTNERSHIP's PCP QIP Specifications which is available on PARTNERSHIP's website https://partnershiphp.org/Providers/Quality/Pages/default.aspx and is incorporated herein by reference.

vi. **Incentive Payment**: In the event Physician or Physician Group successfully meets the Quality Incentive Standards set forth above, PARTNERSHIP shall pay Physician or Physician Group for the Core Measurement Set and the Units of Service Measures up to the maximum amounts as outlined in PCP QIP Exhibit A and PARTNERSHIP's PCP QIP Specifications and as set forth in this subsection vi.:

2026 PCP QIP Maximum Payments		
PCP QIP Measurement	**Maximum Payment**	**Pay To**
Core Measurements Set	$23.25 PMPM	Site Level
Unit of Service Measures		
Advance Care Planning	$10,000	Site Level
PCMH Accreditation	$1,000	Site Level
Peer-led & Pediatric Group Visits	$15,000	Parent Level
Health Information Exchange	$3,000	Parent Level
Health Equity	$2,000	Parent Level
Tobacco Screening	$5.00 per eligible member screening	Site Level
Electronic Clinical Data System	$5,000	Parent Level
Clinician Education on Improving Medication Management	$2,500	Parent Level

Core Measurements Set's Equity Adjusted Payment Methodology is detailed as follows:

1. A base rate of $4 PMPM minimum

2. For PCPs with at least 100 assigned members, a site-adjusted supplemental rate based on the following six (6) factors (adjustments may range between a minimum and maximum dollar range):

- **Factors 1a & 1b** (20% each)
  An adjustment for the severity of the patient mix of the site, based on an estimate of the additional workload of caring for that patient population.
- **Factor 2** (20%)
  An adjustment for the unfavorable socio-demographic mix of patient population.
- **Factors 3a & 3b** (10% each)
  An adjustment for the difficulty in hiring primary care clinicians at the site.
- **Factor 4** (20%)
  An adjustment for low practice resources.

Supplementary adjustments (not available to all PCPs)

- **Factor 5**
  An adjustment for major disruptions in service related to natural disasters.
- **Factor 6**
  An adjustment to support pediatric access for sites meeting certain criteria.

Applicable QIP payment will be issued to Physician or Physician Group Parent and/or Site Levels no earlier than April 1, 2027 and no later than May 31, 2027.

vii. **Termination**: In the event Physician or Physician Group terminates the Agreement at any point during the Performance Period, Physician's or Physician Group's participation in the PCP Quality Incentive Program is forfeited.

2. Attachment X, Network Provider Medi-Cal Requirements, is deleted in its entirety and replaced with the new Attachment X, Network Provider Medi-Cal Requirements, as set forth in this Amendment.

[SIGNATURE ON NEXT PAGE]

IN WITNESS WHEREOF, the Amendment between PARTNERSHIP and Physician or Physician Group is entered into by and between the undersigned parties.

PHYSICIAN OR PHYSICIAN GROUP
Tehama County Health Services Agency

Signature: Jayme S Bottke

Printed Name: JAYME S. BOTTKE

Title: EXECUTIVE DIRECTOR

Date: 12-11-25

PLAN
Partnership HealthPlan of California

Signed by:
Signature: Sonja Bjork
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Printed Name: Sonja Bjork

Title: Chief Executive Officer

Date: 11/21/2025

PCP QIP Exhibit A

Summary of Measures

The PCP QIP is a Calendar Year program: January 1 – December 31

Core Measurement Set – Family Medicine

Measure Name	Full Point Target 90th Percentile (unless otherwise indicated)	Partial Point Target 75th Percentile (unless otherwise indicated)	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening (40-74yo)	**50th Percentile (55.87%)**	**New measure. Does not qualify for partial points during the first active measurement year**	5	N/A
Cervical Cancer Screening	(68.16%)	(64.06%)	5	3
Child and Adolescent Well Care Visits	(67.63%)	(64.47%)	9	6
Childhood Immunization Status: Combo 10	(39.89%)	(33.41%)	5	3
Chlamydia Screening in Women (16-24yo)	**50th Percentile (56.30%)**	**New measure. Does not qualify for partial points during the first active measurement year**	3	N/A
Colorectal Cancer Screening	(53.31%)	(48.22%)	5	3
Comprehensive Diabetes Care: HbA1c Control	(76.40%)	(73.48%)	5	3
Comprehensive Diabetes Care - Retinal Eye Exams	(68.61%)	(62.53%)	5	3
Controlling High Blood Pressure	(75.43%)	(71.34%)	5	3
Kidney Health Evaluation for Patients With Diabetes (KED)	**50th Percentile (41.74%)**	**New measure. Does not qualify for partial points during the first active measurement year**	3	N/A
Lead Screening in Children	(82.86%)	(76.34%)	5	3
Immunizations for Adolescents – Combo 2	(52.31%)	(43.55%)	5	3
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
Well-Child Visits in the First 15 Months of Life	(71.71%)	(67.49%)	11	8

NON-CLINICAL DOMAIN: HOSPITAL UTILIZATION				
Ambulatory Care Sensitive Admissions	9.17 (60th Percentile)	11.91 (70th Percentile)	5	3
Follow-Up within 7 Days after Hospital Discharge	Score >=33%	Score 28-32%	5	3
NON-CLINICAL DOMAIN: PRIMARY CARE UTILIZATION				
Avoidable ED Visits	13.14 (60th Percentile)	16.28 (70th Percentile)	5	3
PCP Office Visits	>2.1 visits per member per year on average	Between 1.8-2.1 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	50th Percentile (Access 49.14%) 50th Percentile (Communication 75.83%)	25th Percentile (Access 40%) 25th Percentile (Communication 65.84%)	9	6
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				
Topical Fluoride in Children ***Monitoring Measure***	**Monitoring at the 50th Percentile (21.60%)**	**N/A- Monitoring measure. Does not qualify for partial points during first measurement year of implementation**	0	0
Well-Child Visits in the First 15-30 Months of Life ***Monitoring Measure***	**Monitoring at the 50th Percentile (72.32%)**	**N/A- Monitoring measure. Does not qualify for partial points during first measurement year of implementation**	0	0
		TOTAL FULL POINTS	**100**	

2026 Core Measurement Set – Internal Medicine

Measure Name	Full Point Target 90th Percentile (unless otherwise indicated)	Partial Point Target 75th Percentile (unless otherwise indicated)	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening (40-74yo)	**50th Percentile (55.87%)**	**New measure. Does not qualify for partial points during the first active measurement year**	7	N/A
Cervical Cancer Screening	(68.16%)	(64.06%)	10	7
Colorectal Cancer Screening	(53.31%)	(48.22%)	12	8
Chlamydia Screening in Women (21-24yo)	**50th Percentile (56.30%)**	**New measure. Does not qualify for partial points during the first active measurement year**	6	N/A
Comprehensive Diabetes Care: HbA1c Control	(76.40%)	(73.48)	10	7
Comprehensive Diabetes Care - Retinal Eye Exams	(68.61%)	(62.53%)	10	7
Controlling High Blood Pressure	(75.43%)	(71.34%)	10	7
Kidney Health Evaluation for Patients With Diabetes (KED)	**50th Percentile (41.74%)**	**New measure. Does not qualify for partial points during the first active measurement year**	6	N/A
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
NON-CLINICAL DOMAIN: HOSPITAL UTILIZATION				
Ambulatory Care Sensitive Admissions	9.17 (60th Percentile)	11.91 (70th Percentile)	5	3
Follow-Up within 7 Days after Hospital Discharge	Score >=33%	Score 28-32%	5	3
NON-CLINICAL DOMAIN: PRIMARY CARE UTILIZATION				
Avoidable ED Visits	13.14 (60th Percentile)	16.28 (70th Percentile)	5	3
PCP Office Visits	>2.1 visits per member per year on average	Between 1.8-2.1 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	50th Percentile (Access 49.14%) 50th Percentile (Communication 75.83%)	25th Percentile (Access 40.00%) 25th Percentile (Communication 65.84%)	9	6
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				
N/A	**N/A**	**N/A**	0	0
		TOTAL FULL POINTS	**100**	

2026 Core Measurement Set – Pediatrics

Measure Name	Full Point Target 90th Percentile (unless otherwise indicated)	Partial Point Target 75th Percentile (unless otherwise indicated)	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Child and Adolescent Well Care Visits	(67.63%)	(64.47%)	11	8
Childhood Immunization Status: Combo 10	(39.89%)	(33.41%)	11	8
Chlamydia Screening (16-20yo)	(70.67%)	(65.47%)	9	6
Lead Screening in Children	(82.86%)	(76.34%)	9	6
Immunizations for Adolescents – Combo 2	(52.31%)	(43.55%)	11	8
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
Well-Child Visits in the First 15 Months of Life	(71.71%)	(67.49%)	11	8
Well-Child Visits in the First 15-30 Months of Life	(82.12%)	(77.50%)	9	6
NON-CLINICAL DOMAIN: PRIMARY CARE UTILIZATION				
Avoidable ED Visits	13.14 (60th Percentile)	16.28 (70th Percentile)	10	7
PCP Office Visits	<2.1 visits per member per year on average	Between 1.8-2.1 visits per member per year average	10	7
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	50th Percentile (Access 49.14%) 50th Percentile (Communication 75.83%)	25th Percentile (Access 40.00%) 25th Percentile (Communication 65.84%)	9	6
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				
Topical Fluoride in Children *Monitoring Measure*	**Monitoring at the 50th Percentile (21.60%)**	**N/A- Monitoring measure. Does not qualify for partial points during first measurement year of implementation**	0	0
		TOTAL FULL POINTS	**100**	

Core Measure Set Summaries – All Practice Types

MEASURE NAME	MEASURE DESCRIPTION
Breast Cancer Screening (40-74yo)	The percentage of continuously enrolled assigned members 40 - 74 years of age were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
Cervical Cancer Screening	The percentage of continuously enrolled assigned members 21 – 64 years of age who were recommended for routine cervical cancer screening
Child and Adolescent Well Care Visits	The percentage of members continuously enrolled assigned members 3 - 17 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year
Childhood Immunization Status: Combo 10	The percentage of assigned children continuously enrolled, 2 years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) haemophilus influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday
Chlamydia Screening in Women (16-24yo)	The percentage of continuously enrolled assigned members who are assigned as female at birth 16 - 24 years of age who had at least one (1) test for chlamydia during the measurement year.
Colorectal Cancer Screening	The percentage of continuously enrolled assigned members 45 – 75 years of age who had appropriate screening for colorectal cancer.
Comprehensive Diabetes Care: HbA1c Control	The percentage of continuously enrolled assigned members 18 - 75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold of ≤9.0% during the measurement year.
Comprehensive Diabetes Care - Retinal Eye Exams	The percentage of continuously enrolled assigned members 18 - 75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy.
Controlling High Blood Pressure	The percentage of continuously enrolled assigned members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140-90 mm Hg) during the measurement year.

Kidney Health Evaluation for Patients With Diabetes (KED)	The percentage of continuously enrolled assigned members 18 – 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation which includes an estimated glomerular filtration rate (eGFR) and a urine albumincreatinineratio (uACR), during the measurement year.
Lead Screening in Children	The percentage of continuously enrolled children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday
Immunizations for Adolescents – Combo 2	The percentage of continuously enrolled assigned adolescents 13 years of age who had one (1) dose of meningococcal conjugate vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and two (2) doses of the human papillomavirus (HPV) vaccine by their 13th birthday.
Reducing Healthcare Disparity *Optional Measure*	Optional clinical measure. This new clinical measure will incentivize participating sites with set dollar amounts if they improve performance in a specific priority group within an identified measure of focus (Child and Adolescent Well Care Visits being the primary focus, followed by Breast Cancer Screening, Controlling High Blood Pressure & Colorectal Cancer Screening). Parent Organizations that have sufficient Partnership Healthplan assigned member volume can earn up to a maximum of 7% of a designated PCP site's total baseline PCP QIP payment for meeting performance thresholds in certain race/ethnicity groups.
Topical Fluoride in Children	**Monitoring Measure for MY2026**. The percentage of members 1 - 4 years of age who received at least two (2) fluoride varnish applications during the measurement year.
Well-Child Visits in the First 15 Months of Life	The percentage of continuously enrolled assigned members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life.
Well-Child Visits in the First 15-30 Months of Life	**Monitoring Measure for MY2026 for Family Medicine practices only.** The percentage of continuously enrolled assigned members who turned 30 months old during the measurement year and had two (2) or more well-child visits between the age of 15 months plus (1) day and 30 months.
Ambulatory Care Sensitive Admissions	Admission rate of assigned members with any of the principal diagnoses from Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) listed in the numerator, during the measurement year.
Follow-Up within 7 Days after Hospital Discharge	The percentage of discharges for members 18 - 64 years of age who received a clinical follow-up with a primary care provider, a hospital-based provider or specialist provider within 7 days of discharge.

Avoidable ED Visits	The rate of assigned members with "avoidable ED visits" with a primary diagnosis that matches the diagnosis codes selected by Partnership.
PCP Office Visits	The average rate of Primary Care Provider visits per member per year by Partnership eligible members with participating QIP providers.
Patient Experience (CG-CAHPS) (Survey)	This measure aims to improve patient experience. There are two (2) ways in which to earn points: • Partnership contracts with a vendor to conduct the Clinician-Group Consumer Assessment of Healthcare Providers and System (CG-CAHPS) survey once during the measurement year **OR** • PCP conducts a survey to understand the patient's experience and reports results and findings using the submission template

Unit of Service Measure Summaries – All Practice Types

Measure	Incentive
Advance Care Planning	This measure encourages the PCP to provide annual awareness to Partnership members 18 years or older regarding how Advance Care Planning (ACP) can help alleviate unnecessary suffering, improve quality of life and provide better understanding of the decision-making challenges facing the individual and his or her caregivers. ACP discussions must take place between January 1 and December 31 of the measurement year to be eligible for this measure. Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000 per site. **OR** • $100 per Advance Directive/POLST, Maximum payment $10,000 per site
PCMH Certification	This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. PCP sites must receive accreditation, maintain accreditation, or re-certify within the measurement year from NCQA, or equivalent from AAAHC or JCAHO. The incentive is $1,000 yearly per site, for achieving or maintaining PCMH accreditation.

Peer-led & Pediatric Group Visits	The parent organization is eligible to earn $1,000 per group, maximum 15 groups, to the parent organization. The peer-led self-management or pediatric well-care visit group must meet at least four (4) times and have at least 16 Partnership total member visits per group, during the measurement year.
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. This incentive is available at the parent organization level.
Health Equity	$2000 per parent organization for submission of Health Equity (HE) implementation initiative or an annual updated Health Equity report. Submission shall demonstrate HE characteristics PCPs can successfully integrate as a core strategy. Should include how best practices apply to internal domains such as: Access, Referral Processes, Avoidable ED Visits, Community Partnerships, and Staff Education. 1.Make HE a leader-driven priority. 2.Identify specific health disparities, then act to close the gaps. 3.Confront institutional racism. 4.Develop processes that support equity (health systems/dedicated resources, oversight). 5.Partner with community organizations.
Tobacco Screening	Incentive to improve early detection of and intervention toward tobacco use. $5.00 per tobacco use screening or counseling during the measurement year, of members 11- 21 years of age after 3% threshold of assigned members screened.
Electronic Clinical Data System (ECDS)	**Partnership is planning for 2027 to mandate the use of Datalink or administrative codes for all measures in the core measure set, eliminating the option for manual uploads**. Incentive is a maximum of one-time $5,000 per parent organization. Allowance of data exchange from Provider Electronic Health Records to Datalink to capture clinical screenings, follow-up care and outcomes. Participation to include data collection of specific clinical components for all Partnership members within your organization. 1. $2,000 per Parent Organization who signs an agreement with DataLink to allow the extraction of HEDIS data by September 30, 2026. Agreements signed after September 30, 2026 will be eligible for half payment ($1,000) through December 31, 2026 2. An additional $3,000 per Parent Organization when DataLink receives HEDIS data abstraction successfully from EMR by October 31, 2026 and the Parent Organization responds timely to request for verification.

Clinician education on improving medication management	This measure incentivizes the Parent Organizations for hosting a two-part academic detailing meeting with Partnership's Pharmacy Team/Medical Director. Pharmacy academic detailing meetings will focus on discussing improving medication management through pharmacy claims analysis. There is a two-part meeting requirement for the incentive: First meeting to review the data ($1500) and must be completed by July 1, 2026. The second meeting to follow-up for feedback ($1000) and must be completed by December 15, 2026. If a pharmacy academic meeting is scheduled with only one medical director at the first initial meeting, only $500 will be given.

ATTACHMENT X
NETWORK PROVIDER
MEDI-CAL REQUIREMENTS

This Attachment X sets forth the applicable requirements that are mandated by the DHCS Medi-Cal Contract with Partnership HealthPlan (the "Medi-Cal Contract"), State and Federal laws and regulations, and applicable DHCS All Plan Letters ("APLs"). This Attachment X is included in this Agreement to reflect compliance with laws and DHCS's requirements for "PHYSICIAN OR PHYSICIAN GROUP" as a contracted Network Provider. Any citations in this Attachment are to the applicable sections of the Medi-Cal Contract or applicable law. This Attachment will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this Attachment and any other provision of the Agreement, this Attachment will control with respect to terms relevant to the provision of Medi-Cal services. Any capitalized term utilized in this Attachment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this Attachment. If a capitalized term used in this Attachment is not defined in the Agreement or this Attachment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

1. The parties acknowledge and agree that this Agreement specifies the Covered Services to be ordered, referred, or rendered under the Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.1.)

2. The parties acknowledge and agree that the term of the Agreement, including the beginning and end dates as well as methods of extension, renegotiation, phaseout, and termination, are included in this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.2.)

3. The parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by PHYSICIAN OR PHYSICIAN GROUP from PARTNERSHIP. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.3.)

4. This Agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Medi-Cal Contract, including, but not limited to, the Knox-Keene Health Care Service Plan Act of 1975, codified in Health & Safety Code Section 1340 et seq. (unless expressly excluded under the Medi-Cal Contract); 28 CCR Section 1300.43 et seq.; Welfare and Institutions Code ("W&I") Code Sections 14000 et seq. and 14200 et seq.; 22 CCR Section 53800 et seq.; and 22 CCR Section 53900 et seq. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.4.)

5. PHYSICIAN OR PHYSICIAN GROUP shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Agreement, including, but not limited to, all applicable Federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.5.)

6. PHYSICIAN OR PHYSICIAN GROUP shall submit to PARTNERSHIP, either directly or through a designated Subcontractor of PARTNERSHIP as applicable, complete, accurate, reasonable, and timely Encounter Data, Provider Data, Program Data, Template Data, and any other reports or data as requested by PARTNERSHIP, in order for PARTNERSHIP to meet its reporting requirements to DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.6.)

7. PHYSICIAN OR PHYSICIAN GROUP will maintain and make available to DHCS, upon request, copies of all contracts it enters into relating to ordering, referring, or rendering Covered Services under this Agreement, and will ensure that all such contracts are in writing. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.7.)

8. PHYSICIAN OR PHYSICIAN GROUP agrees to make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Agreement, available for the purpose of an audit, inspection, evaluation, examination, or copying, as set forth in Medi-Cal Contract, Exhibit E, Provision 1.1.22 (*Inspection and Audit of Records and Facilities)* as follows:

   (a) In accordance with inspections and audits, as directed by DHCS, the Centers for Medicare & Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("DHHS") Inspector General, the Comptroller General, Department of Justice ("DOJ"), Department of Managed Health Care ("DMHC"), DHCS's External Quality Review Organization contractor, or their designees; and

   (b) At all reasonable times at PHYSICIAN's OR PHYSICIAN GROUP's place of business or at such other mutually agreeable location in California.

   (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.8.)

9. PHYSICIAN OR PHYSICIAN GROUP will maintain all of its books and records, including all Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.9.)

10. PHYSICIAN OR PHYSICIAN GROUP shall timely gather, preserve and provide to DHCS, CMS, Office of the Attorney General's Division of Medi-Cal Fraud and Elder Abuse ("DMFEA"), and any authorized State or Federal regulatory agencies, any records in PROVIDER's possession, in accordance with the Medi-Cal Contract, Exhibit E, Provision 1.1.27 (*Litigation Support*). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.10.)

11. PHYSICIAN OR PHYSICIAN GROUP must assist PARTNERSHIP, or if applicable a PARTNERSHIP Subcontractor or Downstream Subcontractor, in the transfer of the Member's care in accordance with Exhibit E, Section 1.1.17 (*Phaseout Requirements*) of the Medi-Cal Contract, in the event of Medi-Cal Contract termination or in the event of termination of this Agreement for any reason. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.11.)

12. The parties agree this Agreement may be terminated, or subject to other remedies, actions, fines and/or penalties, if DHCS or PARTNERSHIP determine that PHYSICIAN OR PHYSICIAN GROUP has not performed satisfactorily. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.12.)

13. PHYSICIAN OR PHYSICIAN GROUP will hold harmless both the State and Members in the event PARTNERSHIP or, if applicable, a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by PHYSICIAN OR PHYSICIAN GROUP pursuant to this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.13.)

14. PHYSICIAN OR PHYSICIAN GROUP shall not bill a Member for Medi-Cal Covered Services. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.14.)

15. PARTNERSHIP will inform PHYSICIAN OR PHYSICIAN GROUP of prospective requirements added by Federal or State law or DHCS related to the Medi-Cal Contract that impact obligations and functions undertaken pursuant to the Agreement before the requirement is effective, and PHYSICIAN OR PHYSICIAN GROUP agrees to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.15.)

16. PHYSICIAN OR PHYSICIAN GROUP must ensure to provide cultural competency, Health Equity, sensitivity, and diversity training to its workforce, including employees and staff at key points of contact with Members, on an annual basis, in accordance with the Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.11.C (*Diversity, Equity and Inclusion Training*). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.16.)

17. PHYSICIAN OR PHYSICIAN GROUP must provide interpreter services for Members and comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.17.)

18. PHYSICIAN OR PHYSICIAN GROUP must notify PARTNERSHIP, and PARTNERSHIP's Subcontractor or Downstream Subcontractor, within ten (10) Working Days of any suspected Fraud, Waste, or Abuse. PHYSICIAN OR PHYSICIAN GROUP shall allow PARTNERSHIP to share such information with DHCS in accordance with Exhibit A, Attachment III, Provision 1.3.2.D (*Contractor's Reporting Obligations*) and Provision 1.3.2.D.6 (*Confidentiality*) of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.18.)

19. PHYSICIAN OR PHYSICIAN GROUP must report to PARTNERSHIP when it has received an overpayment; return the overpayment to PARTNERSHIP within 60 calendar days of the date the overpayment was identified; and notify PARTNERSHIP in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Provision 1.3.6 (*Treatment of Overpayment Recoveries)* of the Medi-Cal Contract, and 42 CFR Section 438.608(d)(2). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.19.)

20. The parties confirm PROVIDER's right to all protections afforded to PHYSICIAN OR PHYSICIAN GROUP under the Health Care Providers' Bill of Rights, as set forth in Health & Safety Code Section 1375.7, including, but not limited to, PROVIDER's right to access PARTNERSHIP's dispute resolution mechanism and submit a grievance pursuant to Health & Safety Code Section 1367(h)(1). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.20.)

21. PHYSICIAN OR PHYSICIAN GROUP must execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to Health & Safety Code Section 130290. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.21.)

22. This Agreement and any amendment thereto will become effective only upon approval by DHCS in writing. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.2.A.2.)

23. PHYSICIAN OR PHYSICIAN GROUP agrees to receive training from PARTNERSHIP and receive notice from PARTNERSHIP of any changes to PARTNERSHIP's Grievance and Appeals policies and procedures. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 4.6.I.)
24. PHYSICIAN OR PHYSICIAN GROUP agrees to participate in all timely access surveys and network adequacy activities conducted by PARTNERSHIP or DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.5.A.6.)

25. PROVIDER, and PROVIDER's employees, officers and directors, shall comply with the conflict of interest requirements set forth in Exhibit H of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit H, Provision 1.1.1.)

26. PHYSICIAN OR PHYSICIAN GROUP shall notify PARTNERSHIP and DHCS within ten (10) calendar days of discovery that any third party may be liable for reimbursement to PARTNERSHIP and/or DHCS for Covered Services provided to a Member, such as for treatment of work-related injuries or injuries resulting from tortious conduct of third-parties. PHYSICIAN OR PHYSICIAN GROUP is precluded from receiving duplicate payments for Covered Services provided to Plan Members. If this occurs, PHYSICIAN OR PHYSICIAN GROUP may not retain the duplicate payment. Once the duplicate payment is identified, PHYSICIAN OR PHYSICIAN GROUP must reimburse PARTNERSHIP. If PHYSICIAN OR PHYSICIAN GROUP fails to refund the duplicate payment, PARTNERSHIP may offset payments made to PHYSICIAN OR PHYSICIAN GROUP to recoup the funds. Notice shall be provided to DHCS in accordance with Exhibit E, Provision 1.1.26.C of the Medi-Cal Contract. (DHCS APL 21-007; Welfare & Institutions Code Sections 14124.70 – 14124.791.)

27. PHYSICIAN OR PHYSICIAN GROUP shall not pay any provider for a Provider-Preventable Condition ("PPC") in accordance with 42 CFR section 438.3(g). PHYSICIAN OR PHYSICIAN GROUP agrees to report to PARTNERSHIP all PPCs in the form and frequency required by DHCS APL 17-009. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.17; 42 CFR 438.3(g).)

28. PHYSICIAN OR PHYSICIAN GROUP will immediately report to PARTNERSHIP the discovery of a security incident, breach or unauthorized access of Medi-Cal Member protected health information (as defined in 45 CFR 160.103) or personal information (as defined in California Civil Code Section 1798.3(a)). (Medi-Cal Contract, Exhibit G.)

29. PHYSICIAN OR PHYSICIAN GROUP agrees to provide PARTNERSHIP with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under this Agreement. This Agreement and all information received from PHYSICIAN OR PHYSICIAN GROUP in accordance with this Agreement shall become public record on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of PROVIDER, stockholders owning more than 5 percent of the stock issued by PHYSICIAN OR PHYSICIAN GROUP and major creditors holding more than 5 percent of the debt of PHYSICIAN OR PHYSICIAN GROUP will be attached to the Agreement at the time the Agreement is presented to DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.11.)

30. To the extent a pathway to enrollment exists, PHYSICIAN OR PHYSICIAN GROUP must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type. PHYSICIAN OR PHYSICIAN GROUP shall provide verification of enrollment as well as a copy of the executed Medi-Cal Provider Agreement (DHCS Form 6208) between PHYSICIAN OR PHYSICIAN GROUP and DHCS, if applicable. In the event PARTNERSHIP assisted PHYSICIAN OR PHYSICIAN GROUP with the enrollment process, PHYSICIAN OR PHYSICIAN GROUP consents to allow DHCS and PARTNERSHIP to share information relating to PROVIDER's application and eligibility, including, but not limited to, issues related to program integrity. PROVIDER's enrollment documentation must be made available to DHCS, CMS or other authorized Governmental Agencies upon request. (DHCS APL 22-013; 42 CFR 438.602(b).)

31. PHYSICIAN OR PHYSICIAN GROUP represents and warrants that PHYSICIAN OR PHYSICIAN GROUP and its affiliates are not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in

nonprocurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549. Further, PHYSICIAN OR PHYSICIAN GROUP represents and warrants that PHYSICIAN OR PHYSICIAN GROUP is not excluded from participation in any health care program under section 1128 or 1128A of the Social Security Act nor is PHYSICIAN OR PHYSICIAN GROUP excluded, suspended, or ineligible to participate, either directly or indirectly, in the Medicare or Medi-Cal programs. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 1.3.4.B; 42 CFR 438.610.)

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