AMENDMENT TO THE ENHANCED CARE MANAGEMENT PROVIDER SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

and

County of Tehama DBA Tehama County Community Action Agency

This Amendment to the Enhanced Care Management Provider Services Agreement ("**Amendment**") entered into between Partnership HealthPlan of California, a public entity ("**PARTNERSHIP**"), and County of Tehama DBA Tehama County Community Action Agency (collectively referred to as ("**Provider**" or "**Provider 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 Provider entered into an Enhanced Care Management Provider Services Agreement ("**Agreement**") effective December 1, 2025;

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 Enhanced Care Management ("**ECM**") Quality Incentive Program (QIP) provisions relating to provider incentives are hereby deleted in their entirety and replaced with the following:
    a. ECM Quality Incentive Program ("**ECM QIP**"):
        i. **Eligibility**: At PARTNERSHIP's discretion, Provider will be eligible to participate in the ECM QIP, which is designed to encourage and improve quality care.
        ii. **Good Standing**: In order for Provider to be eligible, Provider must be in good standing continuously from the beginning of the Performance Period to the Latest Payment Date. PARTNERSHIP has the sole authority to determine if a provider is in good standing based on the criteria set forth

below:

1. Provider is open for services for PARTNERSHIP members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider 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. Provider is not pursuing any litigation or arbitration against PARTNERSHIP.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with PARTNERSHIP on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following PARTNERSHIP policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement, or overbilling.
9. Provider 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 Provider's performance under the Agreement will be measured by PARTNERSHIP to determine if Provider 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 Provider to qualify for an Incentive Payment, Provider must meet specific measures as set forth in ECM QIP Exhibit A attached herein and incorporated by reference as well as PARTNERSHIP's ECM QIP Specifications referenced below. Provider understands and agrees that PARTNERSHIP, in its sole discretion, may need to remove a measure from the ECM 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 measure needs to be removed after execution of this Amendment, the measure will be removed from the measure set. Provider 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.

v. **ECM QIP Overview and Specifications:** Detailed terms and specifications are set forth in the PARTNERSHIP's ECM 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 Provider successfully meets the Quality Incentive Standards set forth above, PARTNERSHIP shall pay Provider a maximum of $100 per ECM enrollee per month as outlined in ECM QIP Exhibit A and PARTNERSHIP's ECM QIP Specifications. Applicable QIP payment will be issued to Provider no earlier than the Earliest Payment Date[1] and no later than the Latest Payment Date[2], as set forth in this subsection vi.:

2026 ECM QIP Payment Schedule		
ECM QIP Period	Earliest Payment Date[1]	Latest Payment Date[2]
Q1 (January – March)	July 1, 2026	July 31, 2026
Q2 (April – June)	October 1, 2026	October 31, 2026
Q3 (July – September)	January 1, 2027	January 31, 2027
Q4 (October – December)	April 1, 2027	April 30, 2027

vii. **Termination**: In the event Provider terminates the Agreement at any point during the Performance Period, Provider's participation in the ECM 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 Provider is entered into by and between the undersigned parties.

PROVIDER County of Tehama DBA Tehama County Community Action Agency

Signature:

Printed Name: Teresa Curiel

Title: Chief Deputy Director

Date: 12/30/25

PLAN
Partnership HealthPlan of California

Signature: Signed by: Sonja Bjork 10A81AB5333C440...

Printed Name: Sonja Bjork

Title: Chief Executive Officer

Date: 12/22/2025

ECM QIP Exhibit A

Summary of Measures

The ECM QIP runs on a calendar year with quarterly reporting periods and incentive payment distribution.

Measure	Incentive Pool Allotments	Targets	
		Full Credit	Partial Credit
Gateway Measure			
Timely Reporting	N/A	$100 PMPM placed into incentive pool	$50 PMPM placed into incentive pool
Reporting Measures			
1. Care Plan and Release of Information (ROI) Forms Upload to PointClickCare	25% of Incentive Pool Dollars	≥ 70%	60 - 69%
2. PHQ-9 Depression Screening	25% of Incentive Pool Dollars	≥ 90%	80 - 89%
3. Controlling Blood Pressure (CBP) - Blood Pressure Screening	25% of Incentive Pool Dollars	≥ 80%	70 - 79%
4. Timely Review of Emergency Department and and Hospital Admissions (ED/AD) Notifications	25% of Incentive Pool Dollars	Part 1 25% of earned incentive pool Part 2 ≥ 70%	Part 1 No Partial Credit Part 2 60 - 69%

Measure Descriptions

Gateway Measure. Timely Reporting

The gateway measure determines the number of dollars available for the program's four reporting measures and is mandatory for participation in the program's other measures. ECM providers are required to submit three (3) ECM reporting files monthly.

Timely Reporting Requirements	Earned Incentive Pool
All three (3) required reports submitted on or before due date	100% incentive dollars placed in incentive pool ($100 PMPM)
All three (3) required reports submitted up to one week or five business days past due date	50% incentive dollars placed in incentive pool ($50 PMPM)
Any submission(s) not submitted within the five business days	No incentive dollars placed in incentive pool

1. Care Plan and Release of Information (ROI) Forms Upload to PointClickCare®

ECM providers are required to upload a Care Plan and ROI forms to PointClickCare® within 60 days of the TAR request date or TAR renewal request date.

- Denominator: ECM members enrolled in one or more of the ECM populations of focus
- Numerator: ECM members enrolled in one or more of the ECM populations of focus whose care plans and ROI forms are uploaded in PointClickCare® within 60 days of the current TAR request date

2. PHQ-9 Depression Screening

ECM providers are required to complete depression screening for all ECM enrolled members, 12 years or older, as part of the initial assessment and development of the care plan.

- Denominator: ECM members, 12 years of age or older, enrolled in one or more of the ECM populations of focus
- Numerator: ECM members, 12 years of age or older, enrolled in one or more of the ECM populations of focus, and who are appropriately screened for depression

3. Controlling Blood Pressure (CBP) - Blood Pressure Screening

Blood pressure screening must be completed for all ECM enrolled members, 18 years or older, regardless of prior diagnosis of hypertension. Screening must be completed by ECM provider staff, a clinic visit, or patient use of a Partnership HealthPlan of California approved home blood pressure kit.

- Denominator: ECM members, 18 years of age or older, enrolled in one or more of the ECM populations of focus
- Numerator: ECM members, 18 years of age or older, enrolled in one or more of the ECM populations of focus, who are appropriately screened for blood pressure

4. Timely Review of Emergency Department and Hospital Admissions (ED/AD) Notifications

This measure focuses on reviewing notifications received through PointClickCare® when ECM enrolled members visit the emergency department (ED) or are admitted to the hospital (AD). ECM providers are required to set up ED/AD notification alerts in PointClickCare® (Part 1) and review notifications within 72 hours of receiving in PointClickCare® (Part 2).

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 "PROVIDER" 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 PROVIDER 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. PROVIDER 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. PROVIDER 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. PROVIDER 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. PROVIDER 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 PROVIDER'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. PROVIDER 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. PROVIDER 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. PROVIDER 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 PROVIDER has not performed satisfactorily. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.12.)

13. PROVIDER 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 PROVIDER pursuant to this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.5.A.13.)

14. PROVIDER 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 PROVIDER 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 PROVIDER 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. PROVIDER 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. PROVIDER 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. PROVIDER must notify PARTNERSHIP, and PARTNERSHIP's Subcontractor or Downstream Subcontractor, within ten (10) Working Days of any suspected Fraud, Waste, or Abuse. PROVIDER 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. PROVIDER 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 PROVIDER 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. PROVIDER 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. PROVIDER 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. PROVIDER 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. PROVIDER 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. PROVIDER is precluded from receiving duplicate payments for Covered Services provided to Plan Members. If this occurs, PROVIDER may not retain the duplicate payment. Once the duplicate payment is identified, PROVIDER must reimburse PARTNERSHIP. If PROVIDER fails to refund the duplicate payment, PARTNERSHIP may offset payments made to PROVIDER 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. PROVIDER shall not pay any provider for a Provider-Preventable Condition ("PPC") in accordance with 42 CFR section 438.3(g). PROVIDER 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. PROVIDER 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. PROVIDER 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 PROVIDER 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 PROVIDER and major creditors holding more than 5 percent of the debt of PROVIDER 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, PROVIDER must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type. PROVIDER shall provide verification of enrollment as well as a copy of the executed Medi-Cal Provider Agreement (DHCS Form 6208) between PROVIDER and DHCS, if applicable. In the event PARTNERSHIP assisted PROVIDER with the enrollment process, PROVIDER 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. PROVIDER represents and warrants that PROVIDER 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, PROVIDER represents and warrants that PROVIDER is not excluded from participation in any health care program under section 1128 or 1128A of the Social Security Act nor is PROVIDER 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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