

**1<sup>st</sup> AMENDMENT  
to the  
PROVIDER PARTICIPATION AGREEMENT  
between**

**HEALTH NET of CALIFORNIA, INC.  
and  
TULARE COUNTY HEALTH & HUMAN SERVICE AGENCY**

The Provider Participation Agreement, ("Agreement"), dated July 1, 2022, as subsequently amended, between Health Net of California, Inc. on behalf of itself and the subsidiaries and affiliates of Health Net, LLC (formerly known as Health Net, Inc.) (collectively, "Health Net") and Tulare County Health & Human Service Agency ("Provider"), is hereby amended effective November 1, 2024 as follows:

**RECITALS**

- A. **Whereas**, on January 1, 2024, DHCS has made updates to Enhanced Care Management (ECM) billing codes.
- B. **Whereas**, ECM Providers are expected to implement and adhere to the updates as published by DHCS.

**NOW, THEREFORE**, in consideration of the above recitals and the covenants contained herein, Provider and Health Net hereby agree to amend the Agreement as follows:

Health Net and Provider hereby agree to amend the Agreement as follows:

1. Exhibit A-1, **Enhanced Care Management**, shall be deleted in its entirety and replaced with a new Exhibit A-1, **Enhanced Care Management**, which is attached and incorporated herein by reference.

This Amendment shall be deemed to be part of the Agreement and, except as modified herein, the Agreement is hereby reaffirmed and declared in full force and effect.

**IN WITNESS WHEREOF**, the parties hereto have executed this Amendment by their offices duly authorized to be effective on the date and year first written above.

**Tulare County Health  
& Human Service Agency**

  
Signature

Larry Micari  
Print Name

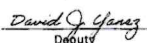
Chair, Board of Supervisors  
Title


9/10/2024  
Date

94-6000545  
Federal Tax Identification Number

1770529752  
NPI #

Tulare County Health & Human Service Agency  
Enhanced Care Management Amendment  
Effective 11/1/2024

Approve As To Form:  
County Counsel  
By:   
Deputy  
Date: 8/27/2024  
Matter No: 20241022

ATTEST: JASON T. BRITT  
County Administrative Officer/Clerk of the Board  
Of Supervisors of the County of Tulare  
By:   
Deputy Clerk



**Health Net Of California, Inc.**

Erik Korolev  
Digitally signed by: Erik Korolev  
DN: CN = Erik Korolev email =  
ekorolev@centene.com C = US  
Date: 2024.09.23 14:19:43 -07'00'  
Signature

Erik Korolev  
Print Name

Regional Health Plan Officer  
Title

Date

TULARE COUNTY AGREEMENT NO. 30804-A

## EXHIBIT A-1

### ENHANCED CARE MANAGEMENT

In consideration, Provider agrees to accept reimbursement as set forth in this Exhibit. For the purposes of this Exhibit only, Provider shall be referred to as ECM Provider.

#### I. DEFINITIONS

- 1.1 **Assigned Member.** An eligible Health Net Medi-Cal Beneficiaries who meets one or more of the ECM Populations of Focus for the ECM benefit and are assigned to an ECM Provider for assessment.
- 1.2 **Community Supports (CS).** Community Supports (CS) services are medically appropriate and cost-effective alternatives to services covered under the Medi-Cal State Plan. CS services include, but are not limited to, housing transition navigation services, housing deposits, respite services, nursing facility transition, personal care and homemaker services, medically tailored meals, and asthma remediation.
- 1.3 **CS Provider.** A contracted provider of DHCS-authorized CS services. CS Providers are community-based entities with experience and expertise providing one (1) or more of the CS services authorized by DHCS to individuals with complex physical, behavioral, developmental and social needs.
- 1.4 **ECM Provider.** 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 for ECM.
- 1.5 **Engagement List.** A list of Assigned Members to each ECM Provider for assessment.
- 1.6 **Enhanced Care Management (ECM).** 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.
- 1.7 **Enrolled Member.** An Assigned Member who has accepted ECM services and is authorized by Health Net to receive ECM services from an ECM Provider.
- 1.8 **Lead Care Manager.** An Enrolled Member's designated care manager for ECM, who works for the ECM Provider (except in circumstances under which the Lead Care Manager could be on staff with Health Net, as described in the DHCS-MCPECM and CS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Enrolled Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any CS services. To the extent an Enrolled Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Enrolled Member and non-duplication of services.
- 1.9 **Population of Focus.** The following populations have been defined by DHCS to be a Population of Focus: Adult Individuals and families experiencing homelessness; high utilizers; adults with Serious Mental Illness (SMI); Substance Use Disorder (SUD); incarcerated persons and persons transitioning to the community; persons at risk for institutionalization; persons eligible for Long Term Care (LTC); nursing facility residents transitioning to the community; children/youth up to age 21 that are high utilizers; persons with Serious Emotional Disturbance (SED), identified to be at clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis; persons enrolled with CCS/CCS Whole Child Model (WCM) with additional needs beyond CCS, involved in child welfare (including those with a history of involvement; persons in foster care up to age 26); or as otherwise defined or revised by DHCS.

#### II. ENHANCED CARE MANAGEMENT CORE REQUIREMENTS AND SERVICES

- 2.1 **ECM Provider Experience and Qualifications.** ECM Provider shall:
- 2.1.1 Be experienced in serving the ECM Population(s) of Focus it will serve;
  - 2.1.2 Have experience and expertise with the services it will provide;
  - 2.1.3 Comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS MCP ECM and CS Contract associated guidance;

- 2.1.4 Have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Enrolled Members to critical appointments when necessary;
- 2.1.5 Be able to communicate to Enrolled Members in culturally and linguistically appropriate and accessible ways;
- 2.1.6 Have formal arrangements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including CS Providers, to coordinate care as appropriate to each Enrolled Member;
- 2.1.7 Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social services, and administrative data and information from other entities to support the management and maintenance of an Enrolled Member's care plan that can be shared with other Providers and organizations involved in each Enrolled Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Enrolled Member goals and goal attainment status; develop and assign care team tasks; define and support Enrolled Member care coordination and care management needs; gather information from other sources to identify Enrolled Member needs and support care team coordination and communication and support notifications regarding Enrolled Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

**2.2 Medicaid Enrollment/Vetting for ECM Providers.**

- 2.2.1 ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
- 2.2.2 If APL 19-004 does not apply to ECM Provider, ECM Provider must comply with Health Net's vetting process, which may extend to individuals employed by or delivering services on behalf of ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.
- 2.2.3 ECM Provider shall participate in and comply with all Health Net Policies requirements as it relates to Medicaid Enrollment and Vetting for ECM Providers. ECM Provider acknowledges that it has had the opportunity to review the Health Net Policies.

**2.3 Identifying Members for ECM.** ECM Provider is encouraged to identify potential eligible Health Net Medi-Cal Beneficiaries who would benefit from ECM and send a request to Health Net to determine if the Health Net Medi-Cal Beneficiary is eligible.

**2.4 Member Assignment to an ECM Provider.**

- 2.4.1 Health Net shall provide an Engagement List to ECM Provider as soon as possible, but in any event no later than ten business days after ECM referral.
- 2.4.2 ECM Provider shall immediately accept all Assigned Members on the Engagement List, unless ECM Provider is at its pre-determined capacity.
- 2.4.3 ECM Provider shall immediately alert Health Net if it does not have the capacity to accept an Assigned Member.
- 2.4.4 ECM Provider will assess the Assigned Member to determine the appropriate needs of the Assigned Member, and enroll the Assigned Member.
- 2.4.5 ECM Provider will notify Health Net of the Enrolled Member and the effective date of enrollment into ECM.
- 2.4.6 Upon enrollment, ECM Provider shall ensure each Enrolled Member has a Lead Care Manager who interacts directly with the Enrolled Member 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 services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any CS, and other services that address social determinants of health (SDOH) needs, regardless of setting.
- 2.4.7 ECM Provider shall conduct a comprehensive assessment that identifies the Enrolled Member's physical, mental health, substance use, palliative, trauma-informed care, and social service needs. ECM Provider shall start an Enrolled Member's assessment within 30 days of the Enrolled Member's enrollment in ECM and complete the assessment within 60 days of the Enrolled Member's enrollment in ECM.
- 2.4.8 ECM Provider shall advise the Enrolled Member on the process for changing ECM Providers, which is permitted at any time.
  - 2.4.8.1 ECM Provider shall notify Health Net if an Enrolled Member wishes to change ECM Providers.
  - 2.4.8.2 Health Net shall implement any requested ECM Provider changes within thirty days.

**2.5 ECM Provider Staffing.** At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each Enrolled Member consistent with this Exhibit, the DHCS-MCP ECM CS Contract, and any other related DHCS guidance.

**2.6 ECM Provider Outreach and Member Enrollment.**

2.6.1 ECM Provider shall be responsible for conducting outreach to each Assigned Member on the Engagement List and enrolling each Assigned Member into ECM in accordance with Health Net Policies.

2.6.2 ECM Provider shall prioritize outreach of Assigned Members based on the highest level of risk and need for ECM.

2.6.3 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, where appropriate and with the Enrolled Member's consent.

2.6.3.1 ECM Provider shall use the following modalities, as appropriate, and as authorized by the Enrolled Member, if in-person modalities are unsuccessful or to reflect an Enrolled Member's stated contact preferences:

2.6.3.1.1 Mail

2.6.3.1.2 Email

2.6.3.1.3 Texts

2.6.3.1.4 Telephone calls

2.6.3.1.5 Telehealth

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

**2.7 Initiating Delivery of ECM.**

2.7.1 ECM Provider shall obtain, document and manage Enrolled Member authorization for the sharing of Personally Identifiable Information between Health Net ECM, CS, and other Providers involved in the provision of Enrolled Member care to the extent required by federal law.

2.7.2 Enrolled Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.

2.7.3 When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Enrolled Member authorization for such data sharing back to Health Net.

2.7.4 ECM Provider shall notify Health Net to discontinue ECM under the following circumstances:

2.7.4.1 The Enrolled Member has met their care plan goals for ECM;

2.7.4.2 The Enrolled Member is ready to transition to a lower level of care;

2.7.4.3 The Enrolled Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or

2.7.4.4 ECM Provider has not had any contact with the Enrolled Member despite multiple attempts.

2.7.5 When ECM is discontinued, or will be discontinued, Health Net is responsible for sending a Notice of Action (NOA) notifying the Enrolled Member of the discontinuation of the ECM benefit and ensuring the Enrolled Member is informed of their right to appeal and the appeals process. ECM Provider shall communicate to the Enrolled Member other benefits or programs that may be available to the Enrolled Member, as applicable (e.g., Complex Care Management, Basic Care Management).

**2.8 Comprehensive Transitional Care.**

2.8.1 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.

2.8.1.1 If ECM Provider subcontracts with other entities to administer ECM functions, ECM Provider shall ensure the subcontractors are bound to the terms and conditions set forth herein and the DHCS-MCP ECM CS Contract.

2.8.2 To the extent Health Net offers CS or other coordinated services, ECM Provider shall:

2.8.2.1 Ensure each Enrolled Member has a Lead Care Manager;

2.8.2.2 Coordinate across all sources of care management in the event that an Enrolled Member is receiving care management from multiple sources;

2.8.2.3 Alert Health Net to ensure non-duplication of services in the event that an Enrolled Member is receiving care management or duplication of services from multiple sources; and

2.8.2.4 Follow Health Net's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

2.8.3 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 Enrolled Member care.

2.8.4 ECM Provider shall provide all core service components of ECM to each Enrolled Member, in compliance with Health Net Policies as follows:

2.8.4.1 Outreach and Engagement of Health Net Medi-Cal Beneficiaries into ECM.

2.8.4.2 Comprehensive assessment and care management plan, which shall include, but is not limited to:

2.8.4.2.1 Engaging with each Enrolled Member .

2.8.4.2.2 Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Enrolled Member health status and gaps in care, and may be needed to inform the development of an individualized care plan.

2.8.4.2.3 Developing a comprehensive, individualized, person-centered care plan by working with the Enrolled Member 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;

2.8.4.2.4 Incorporating into the Enrolled Member's care 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;

2.8.4.2.5 Ensuring the care plan is reassessed at a frequency appropriate for the Enrolled Member's individual progress or changes in needs and/or as identified in the Care Management plan; and

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

2.8.4.3 Enhanced Coordination of Care, which shall include, but is not limited to:

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

2.8.4.3.2 Maintaining regular contact with all providers that are identified as being a part of the Enrolled Member's multi-disciplinary care team;

2.8.4.3.3 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;

2.8.4.3.4 Engaging the Enrolled Member 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 Enrolled Member engagement in treatment;

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

2.8.4.3.6 Ensuring regular contact with the Enrolled Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

2.8.4.4 Health Promotion, 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:

2.8.4.4.1 Working with Enrolled Members to identify and build on success and potential family and/or support networks;

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

2.8.4.4.3 Supporting Enrolled Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

2.8.4.5 Comprehensive Transitional Care, which shall include, but is not limited to:

2.8.4.5.1 Developing strategies to reduce avoidable Enrolled Member admissions and readmissions;

2.8.4.5.2 For Enrolled Members who are experiencing, or who are likely to experience a care transition:

- i. Developing and regularly updating a transition of care plan;
  - ii. Evaluating medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
  - iii. Tracking 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;
  - iv. Coordinating medication review/reconciliation; and
  - v. Providing adherence support and referral to appropriate services.
- 2.8.4.6 Member and Family Support, which shall include, but are not limited to:
  - 2.8.4.6.1 Documenting an Enrolled Member'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 among ECM Provider, the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), and Health Net, as applicable;
  - 2.8.4.6.2 Activities to ensure the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Enrolled Member's condition(s) with the overall goal of improving the Enrolled Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;
  - 2.8.4.6.3 Ensuring ECM Provider serves as the primary point of contact for the Enrolled Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);
  - 2.8.4.6.4 Identifying support needed for the Enrolled Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Enrolled Member's condition and assist them in accessing needed support services;
  - 2.8.4.6.5 Providing for appropriate education of the Enrolled Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Enrolled Member; and
  - 2.8.4.6.6 Ensuring that the Enrolled Member has a copy of their care plan and information about how to request updates.
- 2.8.4.7 Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
  - 2.8.4.7.1 Determining appropriate services to meet the needs of Enrolled Members, including services that address SDOH needs, including housing, and services offered by Health Net as CS services; and
  - 2.8.4.7.2 Coordinating and referring Enrolled Members to available community resources and following up with Enrolled Members to ensure services were rendered (i.e., "closed loop referrals").

**2.9 Training.** ECM Provider shall participate in all mandatory, provider-focused ECM trainings and technical assistance provided by Health Net, including in-person sessions, webinars, and/or calls.

**2.10 Data Sharing to Support ECM.**

- 2.10.1 Health Net will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:
  - 2.10.1.1 Enrolled Member files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
  - 2.10.1.2 Encounter and/or claims data;
  - 2.10.1.3 Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all Enrolled Members; and
  - 2.10.1.4 Reports of performance on quality measures and/or metrics, as requested.
  - 2.10.1.5 Engagement List to aid ECM Provider with prioritizing outreach to Assigned Members based on highest level of risk and need for ECM services.
  - 2.10.1.6 Additional reports and/or guidance as identified by Health Net or DHCS.

**2.11 Quality and Oversight.**

2.11.1 ECM Provider acknowledges Health Net will conduct oversight of its participation in ECM to ensure the quality of services provided and ongoing compliance with benefit requirements, which may include audits and/or corrective actions.

2.11.2 ECM Provider shall respond to all Health Net requests for information and documentation to permit ongoing monitoring of ECM.

**2.12 Enhanced Care Management Benefit Costs.** In order to monitor the impact of the benefit and effectiveness of the intervention in improving health outcomes from Enrolled Member and reducing overall health care costs, upon request from Health Net, ECM Provider shall provide ECMs Provider's cost data as requested by Health Net or DHCS to monitor the impact of the benefit and effectiveness of the intervention in improving health outcomes from Enrolled Member and reducing overall health care costs.

**III. ECM CLAIMS, PAYMENT AND REIMBURSEMENT**

**3.1 Claims Submission and Reporting.**

3.1.1 ECM Provider shall submit claims for the provision of ECM-related services to Health Net using the national standard specifications and code sets to be defined by DHCS.

3.1.2 In the event ECM Provider is unable to submit claims to Health Net for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to Health Net with a minimum set of data elements (to be defined by DHCS) necessary for Health Net to convert the invoice to an encounter for submission to DHCS.

**3.2 Payment for ECM.**

3.2.1 Health Net shall pay ECM Provider for the provision of ECM services in accordance with the rates established in this Exhibit.

3.2.2 Health Net shall pay 90 percent of all clean claims within 30 days of date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Health Net 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.

**3.3 Reimbursement for ECM Services.** The following Healthcare Common Procedure Coding System (HCPCS) codes must be used for ECM services. The HCPCS code and modifier combined define the service as ECM. For example, HCPCS code G9008 by itself does not define the service as an ECM service. HCPCS code G9008 must be reported with a modifier U1 for the care coordination service to be defined and categorized as an ECM service. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy. Provider shall accept the payment in full as listed in Tables 1 and 2 below from Health Net for ECM services provided to Enrolled Members assigned to Provider.

**Table 1 – ECM RATES**

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rates
G9007	Multidisciplinary Team Conference: Provided/Initiated by ECM Provider's Clinical Staff	No Modifiers	Used to indicate when a multidisciplinary team conference occurs between the Member's ECM lead care manager and one or more other Providers involved with managing a Member's care. No modifier is required for the use of this code because it is assumed that these interactions will either be initiated by or involve participation of clinical staff.	\$93.00 Per visit

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rates
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 Enhanced Care Management services	\$129.28 per unit
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 Enhanced Care Management services.	\$89.50 per unit
G9012	ECM In-Person: Provided by Non-Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services	\$69.66 per unit
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U2, GQ	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services.	\$48.23 per unit

\*\* 1 unit = 1 hour

ECM Provider shall be paid at rates listed in Table 2 below for conducting outreach to Assigned Members in accordance with section 2.6 of this Exhibit. ECM Provider shall receive one (1) outreach payment for each Assigned Member.

**Table 2 - OUTREACH RATE**

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rates
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 Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.	\$200.00 (one-time payment per new member)
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 Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management. 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.	\$200.00 (one-time payment per new member)



HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rates
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 Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.	\$200.00 (one-time payment per new member)
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 Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management. 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.	\$200.00 (one-time payment per new member)

**3.4 Adjustment to Payment Rates.** ECM Provider understands and agrees that the State of California may adjust ECM related Medi-Cal payments to Health Net.

- a. If the State of California adjusts such payments to Health Net and such adjustment impacts any services in ECM that are part of this Exhibit, Health Net shall use best efforts to give ECM Provider sixty (60) days' notice of its right to adjust rate amounts under this Exhibit in a proportional manner to Health Net's payments and effective as of the date the State of California adjusted the payments to Health Net.
- b. In the event ECM Provider declines the rate adjustment, ECM Provider shall notify Health Net in writing at least thirty (30) days prior to the date the rate adjustment will be made of their intent to decline the adjustment and terminate this Exhibit. Health Net may, at its option, immediately begin to transition Enrolled Members to another ECM Provider.
- c. In the event of a retroactive reduction, ECM Provider shall reimburse Health Net the amount owed based on the State of California's adjustment effective date and rate amounts within thirty (30) business days from the date Health Net notifies ECM Provider.
- d. After the Initial Term, Health Net reserves the right to annually adjust ECM Provider's rates based on the review of ECM Provider's Complete Encounters, ECM costs, and ECM Provider's ability to effectively provide ECM care to meet specific Enrolled Member needs.