THIRD AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

This Third Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective January 1, 2014 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, a public entity organized under the laws of California, doing business as the Central California Alliance for Health, hereinafter referred to as "Plan", and the County of Monterey, a political subdivision of the State of California, doing business as Natividad Medical Center, on behalf of its Natividad Medical Group, hereinafter referred to as "Provider," with reference to the following facts:

WHEREAS, Plan is a public entity organized pursuant to Welfare and Institutions Code section 14087.54, Santa Cruz County Code Chapter 7.58, Monterey Municipal Code section 2.45.010, and Merced County Code Chapter 9.43;

WHEREAS, Plan and Provider entered into the Primary Care Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, both Plan and Provider desire to change certain compensation terms of the Agreement;

WHEREAS, subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment; and

WHEREAS, references to Sections and Exhibits below are references to sections and exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Addendum 3, Primary Care Physician Care Based Incentive Program, shall be amended and replaced with the attached Addendum 3, Primary Care Physician Care Based Incentive Program. In order for Addendum 3 to be effective, Provider is required to execute both this Amendment, on the signature page below, and the signature page of Addendum 3.

All other terms and provisions of the Agreement shall remain in full force and effect so that all rights, duties and obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Amendment and the Agreement, then the terms of this Amendment shall govern. Terms used in this Amendment shall have the meanings assigned to them in the Agreement, unless otherwise specified in this Amendment.

Plan Central California Alliance for Health	Provider Natividad Medical Group
By:	By:
Print Name: Alan McKay	Print Name: Harry Weis
Title: CEO	Title: CEO
Date: 12/1/13	Date: 12/3/13

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By

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

This Addendum sets forth the terms of care based incentives offered to PCPs by Plan. The program is designed to compensate PCPs for efforts undertaken to improve the care provided to Eligible Members as reflected by data measured by Plan, all as described herein (the "Care-Based Incentive" or the "CBI").

The CBI consists of two components: (1) the CBI Incentive Program and (2) the CBI Fee-for-Service Incentive. The CBI continues for a limited term, as described in Section 7 of this Addendum 3, unless it is specifically extended by mutual written agreement of the parties hereto. The budget for the CBI Incentive Program is separate for the Medi-Cal and Healthy Families Programs. The budget and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Families, Healthy Kids, Alliance Care IHSS, Alliance Care AIM and Alliance Care Individual Conversion Programs.

2. Definitions.

In addition to other terms defined in this Addendum 3 or in the Agreement, the following terms shall have the meanings set forth below:

2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.

2.2 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.

2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.

2.4 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance.

2.5 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.

2.6 Comparison Group is the group of PCPs to which Provider is compared to determine Provider's percentile ranking within the group. PCPs are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.

2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

2.8 Eligible Members

2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.

2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz Healthy Kids Members; the Monterey County IHSS Members; the Monterey County AIM Members; and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.

2.9 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the total number of member months each Eligible Member is linked to the PCP during the measurement period, except that member months for a PCP's Linked Medi-Cal Members who are in the Aged, BCCTP, Disabled and Long Term Care Medi-Cal aid code categories are multiplied by four (4) to determine the Eligible Member Months applicable to those Linked Members. Member months are determined by identifying the total number of Linked Members linked to the PCP during each month of the Measurement Period.

2.10 Measurement Component shall mean the measures as described in the CBI Table.

2.11 Measurement Period is the period for which Plan shall measure data in order to calculate the applicable CBI Incentive Payment.

2.12 Methodology is the internally developed methodology, or the source of data utilized by Plan, to measure Provider's performance for each Measurement Component under the CBI.

2.13 PCP is the individual or group of PCPs to whom Linked Members are assigned.

2.14 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.

2.15 Performance Target Measures are those Measurement Components for which the PCP receives points based upon meeting a specified Performance Target.

2.16 Plan Goal is the percentage of Eligible Members for whom the PCP provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for each Quality of Care measure is ninety percent (90%).

2.17 Relative Ranking Measures are those Measurement Components for which a PCP receives points based on its ranking relative to performance of other PCPs within the PCP's Comparison Group.

3. CBI Incentive Program.

PCPs are eligible to receive an incentive payment from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each Measurement Component correlate to each PCP's rank within its Comparison Group for each measure or for the PCP meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.1 through 3.8, below.

3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than two standard deviations,

the points awarded to Provider for the Relative Ranking and Performance Target Measures will be reduced by fifty-percent (50%). The Member Reassignment Threshold is not applied to PCPs with less than an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.

3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions (based upon Plan-identified AHRQ specifications) per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.

3.3 Rate of Readmission. This Measurement Component measures the rate of readmissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of readmissions during the CBI Term per 1,000 Linked Members per Fiscal Year. A readmission is any admission of a Linked Member during the CBI Term which occurs within ninety (90) days of the Linked Member's discharge from an inpatient stay which commenced during the CBI Term. The rate of readmissions shall not include admissions or readmissions associated with diagnoses related to transplant or maternity. The rate of readmissions for PCP's Linked Members shall include only those readmissions where the Linked Member is linked to the PCP at both the time of admission and at the time of readmission. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.

3.4 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Linked Members among all prescriptions filled for PCP's Linked Members as determined by a review of claims data.

3.5 Quality of Care Measures. The Quality of Care Measurement Components are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims data, not on chart review. In order for a PCP to receive points for a Quality of Care measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications. The total points available for the Quality of Care Measurement Components will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measurement Component.

3.5.1 There are eight (8) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) cervical cancer screening, (4) diabetes LDL-C screening, (5) diabetes HbA1c screening, (6) diabetes medical attention for nephropathy, (7) body mass index (BMI) percentile calculated, and (8) asthma medication ratio.

3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.

3.7 Electronic Claims Submittal. This Measurement Component measures the percentage of PCP's eligible claims submitted to the Plan electronically. Eligible claims include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The Performance Target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.

3.8 Referral Submittal. This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The Performance Target for this measure is 75% of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal.

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. The accounting will be based only on claims and data submitted for dates of service within the CBI Term and received by Plan no later than January 31, 2015. For claims with dates of service from October 1, 2014 through December 31, 2014 and for the purpose of calculating the CBI Incentive payments, the Plan will crosswalk any ICD-10 data to the appropriate ICD-9 code as set forth by the 2014 Center for Medicare and Medicaid Services' (CMS) General Equivalence Mappings (GEMs). Distributions are made to PCPs following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

4.1 Relative Ranking Measures.

4.1.1 Rate of Ambulatory Care Sensitive Admissions, Rate of Preventable ED Visits and Rate of Readmission. PCPs shall be awarded the points for each measure based on the PCP's rank within their Comparison Group for that measure. Points will be allocated in the following manner:

Percentile	Points Allocated		
	Rate of Ambulatory Care Sensitive Admissions	Rate of Preventable ED Visits	Rate of Readmission
99th – 90th	30	20	5
89th – 80th	24	16	4
79th – 70th	18	12	3
69th – 60th	12	8	2
59th – 50th	6	4	1
49th and below	0	0	0

4.1.2 Quality of Care and Other Relative Ranking Measures. For the Quality of Care and other Relative Ranking Measures, excluding those set forth above at section 4.1.1, for which the PCP qualifies, if the PCP meets or exceeds the Plan Goal, the PCP shall be awarded the maximum number of points for the measure even if the PCP is not in the top quartile for the measure. For PCPs not meeting or exceeding the Plan Goal, such PCP shall be awarded the maximum number of points for each measure in which the PCP's is ranked at or above the 76th percentile. PCP shall be awarded one-half the maximum number of points for each measure in which the PCP is ranked between the 51st and 75th percentile. PCP shall receive zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.

4.2 Performance Target Measures.

4.2.1 Electronic Claims Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.

4.2.2 Referral Submittal Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.

4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP. In the event that the PCP exceeded the Member Reassignment Threshold by more than two standard deviations, PCP's total CBI Incentive Program points will be reduced by fifty-percent (50%). The total points are multiplied by the number of Eligible Member Months for the PCP during the Fiscal Year to determine the PCP's "Weighted Points". Percentages are then determined by comparison to the totals for PCPs of the same Comparison Group, as follows: Weighted Points for PCP divided by total Weighted Points for all PCPs of the same Comparison Group equals the PCP's "CBI Distribution Percentage".

4.4 PCPs will receive a portion of the applicable CBI Pool (e.g. IM CBI Pool, PED CBI Pool or FP/GP CBI Pool) by multiplying the PCP's CBI Distribution Percentage by the total amount of funds in such CBI Pool.

5. Fee-for-Service Incentives

5.1 Increased preventive and disease management actions. Plan shall pay a fee-for-service incentive for performance of the following:

5.1.3

5.1.4

5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of the fee-for-service amount applicable to those services set forth in the Provider Manual, Primary Care Physician Services – Case Management, excluding Children's Health and Disability Prevention (CHDP) services and Comprehensive Perinatal Services Program (CPSP) services, for holding office hours for at least eight (8) hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCPs under Provider's contract located within a 5 mile radius of the location with extended hours availability if Linked Members may access care during the extended hours at the extended hours location.

5.3 Physician Orders for Life Sustaining Treatment (POLST) Form Completion. Plan shall pay Provider one-hundred dollars ($100) for Plan's receipt of the first submitted POLST form per PCP's Linked Medi-Cal Members who are in the Senior and Persons with Disabilities Medi-Cal aid code categories (SPD) and who are age twenty-one (21) or older, per Fiscal Year. The POLST form may be found in the Provider Manual.

5.4 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. PCP must submit all Fee-for-Service Incentive forms within twenty-one (21) business days from the date of service. Distributions are made to PCPs following Plan approval of such accounting. Distributions for the first, second and third quarters are made no later than ninety (90) calendar days after the conclusion of the quarter. The distribution for the fourth quarter Fee-for-Service Incentives shall be made with the distribution of the CBI Incentive Payments no later than one hundred eighty (180) days after the conclusion of the Fiscal Year.

6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.

7. Term of CBI. The term of this CBI shall begin on January 1, 2014 and end on December 31, 2014 (the "CBI Term").

8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.

9. Effect of Termination of Agreement. In the event of the termination of the Agreement for any reason prior to the expiration of the CBI Term, no CBI Incentive Payments shall be earned or made hereunder.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	NATIVIDAD MEDICAL GROUP
By: _____	By: _____
Title: CEO	Title: CEO
Date: 12/11/13	Date: 12/9/13

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ATTACHMENT 1 – CBI Table						
CBI Program Measurement Components	**Available Points**	**Member Requirement**	**Performance Target/Relative Ranking**	**Measurement Period**	**Measurement Data Source**	**Methodology**
Health and Cost Management:	***45 total***					
Rate of Ambulatory Care Sensitive Admissions Number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year.	30	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.2.	Relative Ranking[3]	FY 2014	Claims	AHRQ[1]
Rate of Readmissions Number of readmissions per 1,000 Linked Members per Fiscal Year.	5	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.3.	Relative Ranking[3]	FY 2014	Claims	Per §3.3
Rate of Generic Prescriptions Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking[3]	FY 2014	Claims	IHA P4P[2]
Quality of Care (HEDIS):	**30 total**					
Well Child Visit 3-6 Years	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
Cervical Cancer Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
Diabetes LDL-C Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
BMI Percentile Calculated	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	HEDIS
Asthma Medication Ratio	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2014	Claims	IHA P4P[2]

ATTACHMENT 1 – CBI Table						
Appropriate Access to Care	*20 total*					
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.6.	Relative Ranking[3]	FY 2014	Claims	Medi-Cal ER Collaborative definition based on NYU study
Information Technology	*5 total*					
Electronic Claims Submittal 95% of eligible claims submitted electronically to the Alliance.	1	None	95% Performance Target	FY 2014	Claims	# eligible electronic claims / All eligible claims
Referral Submittal 75% of eligible referrals submitted through Alliance web portal.	4	None	75% Performance Target	FY 2014	Referrals	# eligible referrals / All eligible referrals
CBI FFS Incentive Measurement Component			**Amount (All paid quarterly.)**	**Member Requirement**	**Measurement Period**	**Measurement Data Source**
Extended Office Hours Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per PCP covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours location.			5% of Case Management Fee-for-Service	None	FY 2014	Administrative Data
Diabetes Services Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, retinal exam, medical attention for nephropathy[5] during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.				bers ages d older, l to der at date vice for service.	FY 2014	Claims
Healthy Weight for Life (HWL) Program Referral Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.				bers aged 8	FY 2014	HWL Referral Form
Healthy Weight for Life (HWL) Program Follow Up Visit Provider to notify Plan by follow up form of each six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.				bers aged 8	FY 2014	HWL Follow Up Form
Asthma Action Plans (AAP) Provider to submit AAP to Plan for Members with asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Fiscal Year.				bers aged 56	FY 2014	Plans Submitted by Providers

ATTACHMENT 1 – CBI Table			
Medication Management Agreements (MMA) Provider to submit MMA for Members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Fiscal Year.		FY 2014	Plans Submitted by Providers
Physician Orders for Life Sustaining Treatment (POLST) Form Completion Provider to submit POLST form for Members to Plan. Incentive paid to the PCP who first submits the POLST form in the Fiscal Year and is paid only once per Fiscal Year.	-Cal bers aged d older, SPD aid linked to der at date vice	FY 2014	POLST form

[1] http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Excluding PQI 09
http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx
Excluding NQI 01-03 and PDI 01-03 and 05-13

[2] http://www.iha.org/pdfs_documents/p4p_california/MY2011P4PManual_September2011.pdf

[3] As set forth at Addendum 3, Section 4.1.

[4] For HEDIS measures, the continuously Linked Members must be qualified per HEDIS specifications.

[5] Medical attention for nephropathy includes: claim data with relevant CPT or ICD-9 code evidencing treatment of nephropathy, claim submitted by a nephrologist, positive urine macroalbumin test documented by claim data, evidence of ACE inhibitor/ARB therapy during measurement year.

Note 1: If a Provider has an average of at least 100 Linked Members during the Measurement Term (per §3.1), and the Provider's rate of member reassignment per 1,000 Linked Members exceeds the Plan mean of member reassignment rate per 1,000 Linked Members by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Performance Target Measures will be reduced by 50%.

Note 2: After the implementation of ICD-10, effective October 1, 2014, and for any measures for which ICD-9 codes are utilized, Plan will cross-walk ICD-10 codes to ICD-9 codes, as set forth by the 2014 Center for Medicare and Medicaid Services' (CMS) General Equivalence Mappings (GEMs), to ensure consistency in methodology throughout the CBI Term.