FOURTH AMENDMENT TO THE PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

This Fourth Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective January 1, 2015 ("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. The definitions of ACA Primary Care Services and ACA Primary Care Service Rates shall be deleted in their entirety from Exhibit H, Section 2.

2. Exhibit H, Section 3.Payment for Covered Services Provided to Medi-Cal Members shall be deleted in its entirety and replaced with the following:

"3. Payment for Covered Services Provided to Medi-Cal Members.

a. List of Members. Plan will provide Provider with a list of Provider's Medi-Cal Linked Members by the first (1st) day of each month (the "Medi-Cal Linked Members List").

b. Fee-For-Service Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., and v.

RATES REDACTED

RATES REDACTED

3. 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

By: _____

Print Name: Alan McKay

Title: CEO

Date: 6/8/15

Reviewed as to fiscal provisions

APR APR 14 2015

Auditor-Controller
County of Monterey

2.3-V

Provider
Natividad Medical Group

By: _____

Print Name: Kelly R. O'Keefe

Title: Interim CEO

Date: 1/12/15

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APPROVED AS TO FORM AND LEGALITY

DEPUTY COUNTY COUNSEL
COUNTY OF MONTEREY

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 and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Kids, Alliance Care IHSS, and Alliance Care AIM 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 Care Coordination Measures means Rate of Ambulatory Care Sensitive Admissions, Rate of Readmissions, Rate of Generic Prescriptions, and Rate of Preventable Emergency Department Visits, each as further described in Section 3 to this Addendum 3.

2.3 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.

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

2.5 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 as further described in Section 3 to this Addendum 3.

2.6 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.

2.7 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.

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

2.9 Eligible Members

2.9.1 With respect to the CBI Incentive Program, Eligible Members are Linked Members enrolled in the Medi-Cal Program in Santa Cruz, Monterey or Merced Counties, excluding Dual Coverage Members.

2.9.2 With respect to the CBI Fee-For Service Program, Eligible Members are Linked Members enrolled in the Medi-Cal Program in Santa Cruz, Monterey or Merced Counties; the Santa Cruz Healthy Kids Members; the Monterey County IHSS Members; and the Monterey County AIM Members, excluding Dual Coverage Members.

2.10 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the sum total of the number of months each Eligible Member is linked to the PCP during the measurement period, except the number of months for a PCP's Linked Medi-Cal Members who are in the Aged, Breast and Cervical Cancer Treatment Program (BCCTP), Disabled and Long Term Care Medi-Cal aid code categories are multiplied by three (3) to determine the Eligible Member Months applicable to those Eligible Members. Member months are determined by identifying the total number of Eligible Members linked to the PCP during each month of the Measurement Period.

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

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

2.13 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.

2.14 PCP is the individual or group of PCPs to whom Eligible Members are assigned.

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

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

2.17 Plan Goal. The Plan Goal for each Quality of Care measure is the NCQA HEDIS national 90th percentile for the measurement year. The Plan Goal for each Performance Improvement-Care Coordination Measure is as follows: Rate of Ambulatory Care Sensitive Admissions 1.9 per one-thousand Eligible Members per year (PKPY), Rate of Readmission 6.0 PKPY, and Rate of Preventable Emergency Department (ED) Visits 58 PKPY.

2.18 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 under the CBI Incentive Program from a set budget or pool ("CBI Pool"). Funding of the CBI Pool shall be at the sole discretion of Plan. The CBI Pool is divided into three (3) sub-pools, by Comparison Group: (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 3.9, 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) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period and less than one hundred (100) Eligible Members as of December 31, 2015.

3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Eligible 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 Eligible Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

3.3 Rate of Readmission. This Measurement Component measures the rate of readmissions for PCP's Eligible 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 Eligible Members per Fiscal Year. A readmission is any admission of a Eligible Member during the CBI Term which occurs within ninety (90) days of the Eligible 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 Eligible Members shall include only those readmissions where the Eligible 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) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

3.4 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Eligible Members among all prescriptions filled for PCP's Eligible 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 ten (10) 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) avoidance of antibiotic treatment in adults with acute bronchitis, (8) asthma medication ratio, (9) use of spirometry testing in the assessment and diagnosis of COPD and, (10) appropriate testing for children with pharyngitis.

3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Eligible Members as determined by Plan based upon a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Eligible Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

3.7 Electronic Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP's eligible claims and encounter data submitted to the Plan electronically. Eligible claims exclude those 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 and encounter data submitted electronically. Claims and encounter data must be submitted in accordance with the requirements of Sections 2.11.2 and 2.11.2.1 of the Agreement.

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 seventy five percent (75%) of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal.

3.9 Performance Improvement Measures. This Measurement Component measures a PCP's improvement from the 2014 Measurement Period, or the PCP's ability to meet or exceed the Plan Goal for certain Measurement Components which include the Rate of Ambulatory Care Sensitive Admissions, the Rate of Readmissions, the Rate of Preventable Emergency Department Visits and all of the Quality of Care Measurement Components.

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, as defined in Section 7 of this Addendum, and received by Plan no later than January 31, 2016. In the event the ICD-10 code set is mandated for use during the CBI Term, the Plan shall crosswalk ICD-10 data to the appropriate ICD-9 code for claims with dates of service from the effective date of the ICD-10 code set's mandated use through December 31 2015, for the purpose of calculating the CBI Incentive Payments. Plan will perform said crosswalking 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
$99^{th} - 90^{th}$	20	20	10
$89^{th} - 80^{th}$	16	16	8
$79^{th} - 70^{th}$	12	12	6
$69^{th} - 60^{th}$	8	8	4
$59^{th} - 50^{th}$	4	4	2
49^{th} and below	0	0	0

4.1.2 Quality of Care Measures. For the Quality of Care Measurement Components, as set forth in Section 3.5 of this Addendum 3, 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 ranked in the top quartile within the PCP's Comparison Group for the measure. For PCPs not meeting or exceeding the Plan Goal, each such PCP shall be awarded (i) the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile within the PCP's Comparison Group; (ii) one-half the maximum number of points for each measure in which the PCP is ranked at the 51st through the 75th percentile; and (iii) zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.

4.1.3 Rate of Generic Prescriptions. PCP shall be awarded the maximum number of points if the PCP is ranked at or above the 76th percentile within the PCP's Comparison Group. PCP shall be awarded one-half the maximum number of points if the PCP is ranked at the 51st through the 75th percentile. PCP shall receive zero (0) points if 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.

4.2.3 Performance Improvement Measure. PCP shall be awarded points for Performance Improvement Measures in which the PCP improved PCP's performance from the 2014 Measurement Period. For applicable Care Coordination Measures PCP is awarded points for achieving a five percent (5%) reduction in PCP's rate, or by meeting the applicable Plan Goal. For Quality of Care Measures PCP will earn points by improving PCP's ranking by five (5) percentile points within PCP's Comparison Group or by meeting the applicable Plan Goal. The total points available for the Performance Improvement Measure will be allocated across only those measures for which the PCP qualified by meeting the applicable Member requirements in both 2014 and in 2015, but PCP is not required to have earned points for PCP's performance in the measure in either year. Points are earned based on PCP's improved performance or meeting or exceeding the Plan Goal. PCP will earn zero (0) points for each measure for which PCP does not make the requisite improvement and does not achieve the Plan Goal.

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. FP/GP CBI Pool, PED CBI Pool or IM 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

RATES REDACTED

RATES REDACTED

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, 2015 and end on December 31, 2015 (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. Provider would; however, be eligible for CBI Fee-For-Service Incentives earned prior to the termination of the Agreement.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

By: _____

Title: CEO

Date: 4/8/15

NATIVIDAD MEDICAL GROUP

By: _____

Title: Interim CEO

Date: 1/12/15

APPROVED AS TO FORM AND LEGALITY

DEPUTY COUNTY COUNSEL

COUNTY OF MONTEREY

APR 14 2015

ATTACHMENT 1 – CBI Table						
CBI Program Measurement Components	**Available Points**	**Member Requirement**	**Performance Target/Relative Ranking**	**Measurement Period**	**Measurement Data Source**	**Methodology**
Care Coordination Measures:	*55 total*					
Rate of Ambulatory Care Sensitive Admissions Number of ambulatory care sensitive admissions per 1,000 Eligible Members per Fiscal Year.	20	Per §3.2.	Relative Ranking[1]	FY 2015	Claims	AHRQ[2]
Rate of Readmissions Number of readmissions per 1,000 Eligible Members per Fiscal Year.	10	Per §3.3.	Relative Ranking[1]	FY 2015	Claims	Per §3.3
Rate of Generic Prescriptions Percent of generic prescriptions among all prescriptions, regardless of prescriber.	5	None.	Relative Ranking[1]	FY 2015	Claims	IHA P4P[3]
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Eligible Members per Fiscal Year.	20	Per §3.6.	Relative Ranking[1]	FY 2015	Claims	Medi-Cal ER Collaborative definition based on NYU study
Quality of Care (HEDIS):	**30 total**					
Well Child Visit 3-6 Years	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Cervical Cancer Screening	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Diabetes LDL-C Screening	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS

ATTACHMENT 1 – CBI Table						
Asthma Medication Ratio	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	IHA P4P[3]
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Appropriate Testing for Children with Pharyngitis	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Performance Improvement Measures	***10 total***					
Quality of Care and Care Coordination Improvement Quality of Care Measures - an improvement in ranking of 5 percentile points over prior Measurement Period or achievement of the Plan Goal. Care Coordination Measures (excluding Rate of Generic Prescriptions) - a 5% reduction in rate for applicable Care Coordination measures or achievement of the Plan Goal	10	Quality of Care ≥ 5 continuously Eligible Members[4] Care Coordination Per §§ 3.2, 3.3 and 3.6 of Addendum A.	Performance Target	FY 2015 compared to FY 2014	Claims	NCQA Per §2.16
Information Technology	***5 total***					
Electronic Claims Submittal 95% of eligible claims submitted electronically to the Alliance.	1	None	95% Performance Target	FY 2015	Claims	# eligible electronic claims / All eligible claims
Referral Submittal 75% of eligible referrals submitted through Alliance web portal.	4	None	75% Performance Target	FY 2015	Referrals	# eligible referrals / All eligible referrals
CBI FFS Incentive Measurement Component			**Amount (All paid quarterly.)**	**Member Requirement**	**Measurement Period**	**Measurement Data Source**

RATES REDACTED