FIRST AMENDMENT TO REFERRAL PHYSICIAN SERVICES AGREEMENT

(LOW INCOME HEALTH PROGRAM)

This first Amendment to the Referral Physician Services Agreement ("Amendment") is made this first day of March, 2013, 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 Center Specialty Clinic 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, Provider and Plan have entered into the Referral Physician Services Agreement ("Agreement") effective January 1, 2011, as amended, for the provision of health care services;

WHEREAS, the Low Income Health Program ("LIHP") is a county-based elective program that is operated pursuant to, and governed by, the Special Terms and Conditions and Expenditure Authorities for the California Section 1115(a) Demonstration (waiver 11-W-00193/9), entitled "California's Bridge to Reform," effective November 1, 2010, Part 3.6 (commencing with Section 15909) of the Welfare and Institutions Code, and the applicable LIHP Contract entered into between participating entities and the California Department of Health Care Services. The terms of the LIHP define, among other things, the benefits payable, any and all conditions applicable to or limiting payment of benefits, and the persons entitled to receive benefits;

WHEREAS, County of Monterey, as a participating entity in the LIHP, has elected to contribute the non-federal share of LIHP expenditures, thereby assuming liability for the funding of services described in the LIHP;

WHEREAS, Plan has entered into an agreement with the County of Monterey ("County") and has agreed to provide health care management and administrative support services, including claims adjudication and payment functions, on behalf of County for County's LIHP;

WHEREAS, Provider desires to participate as a Participating Provider for the County Low Income Health Plan, and acknowledges that County as the LIHP participating entity is responsible for funding payments for Covered Services that are provided to LIHP Members in accordance with the terms of this 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, Plan and Provider hereby agree as follows:

1. Section 5.12, Termination of LIHP Without Cause, shall be added to state in full as follows:

5.12 Termination of LIHP Without Cause. Either party may terminate the Agreement at any time with respect to the Low Income Health Program (LIHP) only and without impacting the remainder of the Agreement by giving the other party at least one hundred twenty (120) days prior written notice.

2. Exhibit A, Schedule of Programs, shall be deleted in its entirety and replaced with the Exhibit A, Schedule of Programs, attached hereto, and incorporated into this Agreement.

3. Exhibit I-2, Low Income Health Program (LIHP) Attachment, attached hereto, is added as a new exhibit and incorporated into the Agreement.

4. Exhibit I-2-A, Low Income Health Program Compensation Schedule, attached hereto, is added as a new exhibit and incorporated into the Agreement.

5. The Effective Date of Amendment shall be March 1, 2013, as determined by County in accordance with the County's contract with the State of California.

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	Provider
Central California Alliance for Health	Natividad Medical Center, on behalf of its Natividad Medical Center Specialty Clinic
By: _____	By: _____
Print Name: Alan McKay	Print Name: Harry Weis
Title: Executive Director	Title: CEO
Date: 2/28/13	Date: 2/27/13

APPROVED AS TO FORM AND LEGALITY
Stacy Saetta 2/26/13
DEPUTY COUNTY COUNSEL
COUNTY OF MONTEREY

Reviewed as to fiscal provisions
_____
Auditor-Controller
County of Monterey

EXHIBIT A

SCHEDULE OF PROGRAMS

Provider has been approved to provide Covered Services, including Referral Physician Services, under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

Medi-Cal Program: is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Santa Cruz, Monterey, and Merced Counties.

Healthy Families Program: is a state- and federally-funded Program pursuant to a contract between the Plan and the California Managed Risk Medical Insurance Board ("MRMIB") for coverage of Members who meet Healthy Families Program eligibility requirements, as determined by MRMIB. The Healthy Families Program is, as of the Commencement Date, offered in Monterey and Santa Cruz Counties.

Alliance Care IHSS Health Program: is a state- and federally-funded Program pursuant to a contract between the Plan and the County of Monterey for coverage of Members who meet Alliance Care IHSS Health Program eligibility requirements, as determined by the County of Monterey. As of the Commencement Date, the Alliance Care IHSS Health Program is offered in Monterey County.

Healthy Kids Program: is a county-funded Program pursuant to contracts between the Plan and First 5 Santa Cruz County, the County of Santa Cruz, the Community Foundation of Santa Cruz County, and the Pajaro Valley Community Health Trust for coverage of Members who meet Healthy Kids Program eligibility requirements, as determined by Santa Cruz County. As of the Commencement Date, the Healthy Kids Program is offered in Santa Cruz County.

Healthy Kids Merced Program: Provider is not participating in this Program with Plan.

Alliance Care Access for Infants and Mothers (AIM) Program: is a state-funded Program pursuant to a contract between the Plan and the California Managed Risk Medical Insurance Board ("MRMIB") for coverage of Members who meet AIM Program eligibility requirements as determined by MRMIB. As of the Commencement Date, the AIM Program is offered in Monterey County.

Alliance Care Individual Conversion Program: is a Program offered by the Plan to the Plan's Alliance Care IHSS Members when IHSS Members are no longer eligible to continue participation in the Plan's Alliance Care IHSS Program through COBRA or Cal-COBRA. As of the Commencement Date, the Alliance Care Individual Conversion Program is offered in Monterey County.

Monterey County Low Income Health Program ("LIHP"): is a Program adopted by Monterey County ("County") and funded by County and federal funds for coverage of Members eligible for the LIHP, pursuant to the California Bridge to Reform section 1115(a) Medicaid Demonstration ("Demonstration"). At a minimum, the LIHP shall include coverage for individuals between 19 and 64 years of age who have family incomes at or below 100 percent of the federal poverty level and meet the income standards as established for the LIHP, are not eligible for the Medi-Cal Program or Health Families Program, and who were enrolled after November 1, 2010. County may elect to expand eligibility for the LIHP to individuals with family incomes up to 200 percent of the federal poverty level and shall make such election on an annual basis.

EXHIBIT I-2

LOW INCOME HEALTH PROGRAM (LIHP) ATTACHMENT

This Exhibit I-2 sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Low Income Health Program (LIHP). For purposes of this Exhibit I-2, "County" shall mean County of Monterey.

1. Covered Services. With respect to the LIHP, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under County's contract with DHCS for the LIHP. Information regarding Covered Services and excluded services are also set forth in the LIHP Evidence of Coverage and the Provider Manual.

2. County Responsibility for Funding Payments. County has elected to be responsible for funding Covered Services for the LIHP, including applicable disbursements or payments for Referral Physician Services or other Covered Services provided in accordance with the terms of this Agreement. Plan shall act as the third party administrator for County pursuant to an administrative services agreement between Plan and County, to, among other things, establish a network of Participating Providers and administer fund disbursements and payments for Covered Services rendered by Provider from designated County funds. Plan shall be responsible for administration of disbursements and payments from available County funds. All references in the Agreement to a Plan obligation to pay for Referral Physician Services or Covered Services shall be revised, for purposes of the LIHP only, to specify that County as the LIHP participating entity is responsible for the adequate funding of LIHP Covered Services payable under this Agreement. County shall be entitled to the same rights and subject to the same obligations as Plan in connection with payment terms and conditions under the Agreement. Any overpayments received by Provider shall be returned to Plan as the County's administrator.

3. Provider Manual. For purposes of the LIHP, the Provider Manual shall incorporate policies and procedures adopted by County related to the LIHP.

4. QI Program and UM Program. Provider shall comply with the QI Program and UM Program as set forth in the Provider Manual in connection with the LIHP. Plan and County reserve the right to amend the QI Program and UM Program solely for the LIHP to address County-specific quality improvement and utilization management programs. Any such changes shall be adopted through amendments to the Provider Manual.

5. Continuation of Care. Section 3.6, Continuation of Care, shall not apply to the LIHP.

6. Audit and Recovery. County shall have the same rights as specified for Plan under Section 4.3.2, Audits and Recovery.

7. Grievance, Hearings and Appeals. In addition to its obligations under Section 6.3, Provider shall cooperate with Plan and County in administering Member grievance, hearing and appeal rights required by the LIHP and as may be set forth in the Provider Manual.

8. Amendments. Notwithstanding Section 6.8 of the Agreement, the Plan may amend this Agreement at any time in order to comply with any change to the LIHP as adopted by County and/or DHCS, including any change in payment amounts or policies. Such amendment shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

9. Medical Home. Plan will assign each Member to a Medical Home in accordance with policies adopted by County consistent with Welfare & Institutions Code Section 15910.2(b)(2). "Medical Home" means a single provider, facility, or health care team that maintains an individual's medical information, and coordinates health care services for enrolled individuals. Provider shall comply with the requirements set forth in the Provider Manual and in the Agreement with respect to Members assigned to a Medical Home.

10. Member Copayments. Contractor shall collect Member Copayments to the extent they are included as part of the LIHP.

11. Books and Records. With respect to the LIHP and LIHP Members, Contractor shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying: (a) by DHCS, the United States Department of Health and Human Services, and the United States Department of Justice; (b) at all reasonable times at the Contractor's place of business, or at such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; (d) for a term of at least five (5) years from the close of the current fiscal year for the last year in this the Agreement is in effect and in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created, or such longer period as required by Law; and (e) including all expenditure, and utilization data, including encounter data for a period of at least five (5) years, or such longer period as required by Law.

12. Hold Harmless. Contractor agrees to hold harmless both the state of California and LIHP Members in the event County cannot or will not pay for services performed by Contractor.

13. Requirements. Contractor shall comply with all applicable requirements of DHCS and the LIHP.

14. Medical Decision-making. Contractor shall ensure that medical decisions are not unduly influenced by fiscal and administrative management. Compensation to individuals or

entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any LIHP Member.

15. UM Data. Contractor shall provide utilization data to Plan which allows County to meet its administrative functions and the requirements related to submission of utilization data as set forth in the County's contract with DHCS for the LIHP.

16. No Balance Billing. Contractor may not bill LIHP Members any amount greater than would be owed if the Contractor provided the services directly to the Member (i.e., no balance billing by Contractor).

17. Right of Inspection, Monitoring and Audit. Through the end of the records retention period specified in this Exhibit 3, Section F. 13, Contractor shall allow the DHCS, the United States Department of Health and Human Services, the Comptroller General of the United States, and other authorized State agencies, to monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the County's contract with DHCS for the LIHP, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by Contractor pertaining to the services provided under the County's contract with DHCS for the LIHP or this Agreement at any time during normal business hours with at least 72 hours notice. For purposes of this section, books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance of this Agreement and the County's contract with DHCS for the LIHP, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in this Exhibit 3, Section F. 13, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at County's sole expense.

18. No Use of Member Information. With respect to any identifiable information concerning a LIHP Member under the County's contract with DHCS for the LIHP that is obtained by Contractor, Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to Plan all requests for disclosure of such information, except requests for medical records or PHI in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by the Agreement or in accordance with applicable law, any such information to any person or entity other than DHCS without DHCS' prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 and (4) will, at the termination of the Agreement, return all such information to Plan or maintain such information according to written procedures sent to the Contractor by Plan for this purpose.

19. Secure Medical Records. Contractor shall ensure that an individual is responsible for securing and maintaining medical records at each Contractor site.

20. Nondiscrimination. Contractor shall not discriminate against Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Agreement, discriminations on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include, but are not limited to, the following:

(a) Denying any LIHP Member any Covered Services or availability of a Contractor facility;

(b) Providing to an LIHP Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members except where medically indicated;

(c) Subjecting a LIHP Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

(d) Restricting a LIHP Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a LIHP Member differently from others in determining whether he or she satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

(e) The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability of the participants to be served.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

EXHIBIT I-2-A

LOW INCOME HEALTH PROGRAM COMPENSATION SCHEDULE

A. DISBURSEMENT OF COUNTY FUNDS

Provider is a public entity for which federal financial participation for LIHP Covered Services costs will be based in part upon certified public expenditures. The County of Monterey will provide public funds to Provider to support the provision of LIHP Covered Services ("County Funds"). The Plan will disburse the County Funds on behalf of the County to Provider as set forth below. All references in this Agreement to "payment," "payment of claims" and "paid claims" for LIHP Covered Services or similar references shall mean, with respect to Provider, such disbursement of County Funds for LIHP Covered Services.

1. Covered Services Provided to Low Income Health Program Members.

a. Fee-for-Service Payment. Plan shall disburse County Funds to Provider for Covered Services provided to Low Income Health Program Members as set forth below in subsections i., ii., iii., iv., and v.

i.

RATES

REDACTED

ii.

iii.

iv.

RATES

v.

Providers granted waived status under CLIA for Outpatient

(2) REDACTED

B. OTHER TERMS

The incentive programs set forth in the addendum or addenda hereto shall not be applicable to the LIHP.

SECOND AMENDMENT TO THE REFERRAL PHYSICIAN SERVICES AGREEMENT

This Second Amendment to the Referral Physician Services Agreement ("Amendment") is effective January 1, 2012 ("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 Center Specialty Clinic, 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 Referral Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, Plan desires to continue the Referral Physician Utilization Management Incentive Program for the year 2012 and to amend the Agreement for purposes of the revised term;

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

WHEREAS, Section 6.8.4 of the Agreement allows the Plan to amend non-material terms of the Agreement effective upon written notice to the Provider; and

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

NOW, THEREFORE, the Plan hereby amends the terms of the Agreement by written notice as follows:

1. Addendum 1, Referral Physician Utilization Management Incentive Program, shall be amended and replaced with the attached Addendum 1, Referral Physician Utilization Management Incentive Program.

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.

ADDENDUM 1

REFERRAL PHYSICIAN UTILIZATION MANAGEMENT INCENTIVE PROGRAM

A. Definitions. For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to this Addendum and in Article I to the Agreement.

"**Inpatient Hospital Services**" are Covered Services provided to a Member who is admitted as a registered bed patient in a hospital, excluding physician services, unless such services are listed as inclusions in the hospital's agreement with Plan.

"**Other Services**" are Covered Services that are not Primary Care Physician Services, Referral Services or Inpatient Hospital Services.

B. Risk Sharing.

1. Budgeting

Plan shall periodically determine in its sole discretion amounts representing the average budgeted expenditures for Covered Services for Medi-Cal Members and Healthy Families Members. Health care costs shall be budgeted by three service categories: 1) Primary Care Physician Services, 2) Referral Physician and Other Services, and 3) Inpatient Hospital Services. Account totals will consist of the sum of the balances in the accounts for these three service categories. Amounts equal to health care expenditures for Covered Services made on behalf of each Medi-Cal Member and each Healthy Families Member shall be allocated against the budgeted amounts. Health care expenditures for Covered Services include, but are not limited to, fee-for-service claims; the incurred cost of Inpatient Hospital Services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; other capitation payments; and estimated costs for services incurred but not yet reported (IBNR). Budgeting and allocations will occur separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members, and Merced Medi-Cal Members.

2. Accounting

An account of the transactions and operations of health care expenditures for Covered Services shall be rendered by Plan annually four (4) months after the conclusion of the Fiscal Year and shall be certified by its financial officer. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Providers following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Policy regarding actual and proposed budget and cost allocations is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of balances.

3. Deficit Funding

Any risk sharing account that is in surplus shall be used to fund deficits in other Plan risk sharing accounts. Provider amounts held in reserve shall then be used to fund deficits in the accounts. After the funding of deficits, Provider amounts held in reserve shall be distributed to the extent that the applicable accounts are in surplus. Deficit accounting and funding shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

4. Surplus Balance

(a) If a Referral Physician and Other Services account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	ten percent (10%) of the total surplus balance in the Referral Physician and Other Services accounts

and

(b) If an Inpatient Hospital Services account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	six and two thirds percent (6 2/3%) of the total surplus balance in the Inpatient Hospital Services account

Plan shall determine in its sole discretion what constitutes an acceptance for a Member course of treatment, which shall be determined separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members and Merced Medi-Cal Members. Surplus accounting and sharing shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

C. Distribution of Amounts Held in Reserve and Surplus Sharing in Event of Termination.

If this Agreement is terminated before the end of Plan's Fiscal Year by Provider or by Plan, Provider will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in this Addendum 1 Section B.4.

D. Term of Referral Physician Medi-Cal Utilization Management Incentive Program.

The term of this Referral Physician Medi-Cal Utilization Management Incentive Program, as described in this Addendum 1, shall begin on January 1, 2012 and end on December 31, 2012 (the "UMIP Term").

E. UMIP Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement utilization management incentive programs for periods after completion of the UMIP 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 UMIP Term, no such program shall be binding upon Plan.

THIRD AMENDMENT TO THE REFERRAL PHYSICIAN SERVICES AGREEMENT

This Third Amendment to the Referral Physician Services Agreement ("Amendment") is effective January 1, 2013 ("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 Center Specialty Clinic, 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 Referral Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, Plan desires to continue the Referral Physician Utilization Management Incentive Program for the year 2013 and to amend the Agreement for purposes of the revised term, pursuant to Section 6.8.4 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 Plan hereby amends the terms of the Agreement by written notice as follows:

1. Addendum 1, Referral Physician Utilization Management Incentive Program, shall be amended and replaced with the attached Addendum 1, Referral Physician Utilization Management Incentive Program.

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.

ADDENDUM 1

REFERRAL PHYSICIAN UTILIZATION MANAGEMENT INCENTIVE PROGRAM

A. **Definitions.** For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to this Addendum and in Article I to the Agreement.

"**Inpatient Hospital Services**" are Covered Services provided to a Member who is admitted as a registered bed patient in a hospital, excluding physician services, unless such services are listed as inclusions in the hospital's agreement with Plan.

"**Other Services**" are Covered Services that are not Primary Care Physician Services, Referral Services or Inpatient Hospital Services.

B. **Risk Sharing.**

1. Budgeting

Plan shall periodically determine in its sole discretion amounts representing the average budgeted expenditures for Covered Services for Medi-Cal Members and Healthy Families Members. Health care costs shall be budgeted by three service categories: 1) Primary Care Physician Services, 2) Referral Physician and Other Services, and 3) Inpatient Hospital Services. Account totals will consist of the sum of the balances in the accounts for these three service categories. Amounts equal to health care expenditures for Covered Services made on behalf of each Medi-Cal Member and each Healthy Families Member shall be allocated against the budgeted amounts. Health care expenditures for Covered Services include, but are not limited to, fee-for-service claims; the incurred cost of Inpatient Hospital Services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; other capitation payments; and estimated costs for services incurred but not yet reported (IBNR). Budgeting and allocations will occur separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members, and Merced Medi-Cal Members.

2. Accounting

An account of the transactions and operations of health care expenditures for Covered Services shall be rendered by Plan annually four (4) months after the conclusion of the Fiscal Year and shall be certified by its financial officer. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Providers following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Policy regarding actual and proposed budget and cost allocations is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of balances.

3. Deficit Funding

Any risk sharing account that is in surplus shall be used to fund deficits in other Plan risk sharing accounts. Provider amounts held in reserve shall then be used to fund deficits in the accounts. After the funding of deficits, Provider amounts held in reserve shall be distributed to the extent that the applicable accounts are in surplus. Deficit accounting and funding shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

4. Surplus Balance

(a) If a Referral Physician and Other Services account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	ten percent (10%) of the total surplus balance in the Referral Physician and Other Services accounts

and

(b) If an Inpatient Hospital Services account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	six and two thirds percent (6 2/3%) of the total surplus balance in the Inpatient Hospital Services account

Plan shall determine in its sole discretion what constitutes an acceptance for a Member course of treatment, which shall be determined separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members and Merced Medi-Cal Members. Surplus accounting and sharing shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

C. **Distribution of Amounts Held in Reserve and Surplus Sharing in Event of Termination.**

If this Agreement is terminated before the end of Plan's Fiscal Year by Provider or by Plan, Provider will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in this Addendum 1 Section B.4.

D. **Term of Referral Physician Medi-Cal Utilization Management Incentive Program.**

The term of this Referral Physician Medi-Cal Utilization Management Incentive Program, as described in this Addendum 1, shall begin on January 1, 2013 and end on December 31, 2013 (the "UMIP Term").

E. **UMIP Programs for Future Periods.**

Plan, in its sole and absolute discretion, may implement utilization management incentive programs for periods after completion of the UMIP 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 UMIP Term, no such program shall be binding upon Plan.

FOURTH AMENDMENT TO THE
REFERRAL PHYSICIAN SERVICES AGREEMENT

This Fourth Amendment to the Referral 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, on behalf of its Monterey County Clinic Services, 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 Referral Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, Plan desires to continue the Referral Physician Utilization Management Incentive Program for the year 2014 and to amend the Agreement for purposes of the revised term, pursuant to Section 6.8.4 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 Plan hereby amends the terms of the Agreement by written notice as follows:

1. Addendum 1, Referral Physician Utilization Management Incentive Program, shall be amended and replaced with the attached Addendum 1, Referral Physician Utilization Management Incentive Program.

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.

ADDENDUM 1

REFERRAL PHYSICIAN UTILIZATION MANAGEMENT INCENTIVE PROGRAM

A. **Definitions.** For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to this Addendum and in Article I to the Agreement.

"**Inpatient Hospital Services**" are Covered Services provided to a Member who is admitted as a registered bed patient in a hospital, excluding physician services, unless such services are listed as inclusions in the hospital's agreement with Plan.

"**Other Services**" are Covered Services that are not Primary Care Physician Services, Referral Services or Inpatient Hospital Services.

B. **Risk Sharing.**

1. Budgeting

Plan shall periodically determine in its sole discretion amounts representing the average budgeted expenditures for Covered Services for Medi-Cal Members and Healthy Families Members. Health care costs shall be budgeted by three service categories: 1) Primary Care Physician Services, 2) Referral Physician and Other Services, and 3) Inpatient Hospital Services. Account totals will consist of the sum of the balances in the accounts for these three service categories. Amounts equal to health care expenditures for Covered Services made on behalf of each Medi-Cal Member and each Healthy Families Member shall be allocated against the budgeted amounts. Health care expenditures for Covered Services include, but are not limited to, fee-for-service claims; the incurred cost of Inpatient Hospital Services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; other capitation payments; and estimated costs for services incurred but not yet reported (IBNR). Budgeting and allocations will occur separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members, and Merced Medi-Cal Members.

2. Accounting

An account of the transactions and operations of health care expenditures for Covered Services shall be rendered by Plan annually four (4) months after the conclusion of the Fiscal Year and shall be certified by its financial officer. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Providers following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Policy regarding actual and proposed budget and cost allocations is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of balances.

3. Deficit Funding

Any risk sharing account that is in surplus shall be used to fund deficits in other Plan risk sharing accounts. Provider amounts held in reserve shall then be used to fund deficits in the accounts. After the funding of deficits, Provider amounts held in reserve shall be distributed to the extent that the applicable accounts are in surplus. Deficit accounting and funding shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

4. Surplus Balance

(a) If a Referral Physician and Other Services account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	ten percent (10%) of the total surplus balance in the Referral Physician and Other Services accounts

and

(b) If an Inpatient Hospital Services account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians	X	six and two thirds percent (6 2/3%) of the total surplus balance in the Inpatient Hospital Services account

Plan shall determine in its sole discretion what constitutes an acceptance for a Member course of treatment, which shall be determined separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members and Merced Medi-Cal Members. Surplus accounting and sharing shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

C. Distribution of Amounts Held in Reserve and Surplus Sharing in Event of Termination.

If this Agreement is terminated before the end of Plan's Fiscal Year by Provider or by Plan, Provider will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in this Addendum 1 Section B.4.

D. Term of Referral Physician Medi-Cal Utilization Management Incentive Program.

The term of this Referral Physician Medi-Cal Utilization Management Incentive Program, as described in this Addendum 1, shall begin on January 1, 2014 and end on December 31, 2014 (the "UMIP Term").

E. UMIP Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement utilization management incentive programs for periods after completion of the UMIP 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 UMIP Term, no such program shall be binding upon Plan.

FIFTH AMENDMENT TO THE
REFERRAL PHYSICIAN SERVICES AGREEMENT

This Fifth Amendment to the Referral Physician Services Agreement ("Amendment") is effective January 1, 2013 ("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 Center Specialty Clinic, 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 Referral 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 following definitions shall be added to Exhibit H, Section 2:

"ACA Primary Care Services" are Covered Services which are primary care services, as defined in 42 CFR Section 447.400(c), rendered by ACA Primary Care Physicians.

"ACA Primary Care Physicians" are eligible physicians as defined by 42 CFR Section 447.400(a), as may be amended from time to time, and who are listed on the DHCS list of providers that have submitted ACA Self Attestation Forms (SAF) and have been found by DHCS to be so qualified.

"ACA Primary Care Service Rates" are the minimum payment rates required by Law for payment for ACA Primary Care Services. Such rates are set forth in 42 U.S.C. Section 1396a(a)(13) and 42 CFR Section 447.405(a), as may be amended from time to time.

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 Exhibit H, Section 3.Payment for Covered Services Provided to Medi-Cal Members:

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

a. Fee-for-Service Payment for Covered Services Provided between January 1, 2013 and December 31, 2014. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., v. and vi.

i. Plan shall pay Provider ACA Primary Care Service Rates for ACA Primary Care Services provided to Medi-Cal Members from January 1, 2013 through December 31, 2014. For

ii.

RATES

iii.

REDACTED

iv.

v.

vi.

b. Fee-for-S
Provider
ii., iii., iv

i.

RATES

ii.

REDACTED

iii.

iv.

v.

service is rendered. All other Outpatient Clinical Laboratory Services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan."

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.

SIXTH AMENDMENT TO THE REFERRAL PHYSICIAN SERVICES AGREEMENT

This Sixth Amendment to the Referral 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 Center Specialty Clinic, 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 Referral Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, Plan desires to implement the Referral Physician Specialty Care Incentive Program for the year 2015 and update the Agreement to reflect changes to the Program previously known as the Alliance Care Access for Infants and Mothers Program;

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 Plan hereby amends the terms of the Agreement by written notice as follows:

1. Section 4.11 Incentive Programs., shall be deleted and replaced with the following Section 4.11 Incentive Programs.

> "4.11 Incentive Programs. Provider shall participate in Plan's Specialty Care Incentive Program, as described in Addendum 1 hereto, for the term of such program."

2. Exhibit A, Schedule of Programs, the paragraph beginning "Alliance Care Access for Infants and Mothers (AIM) Program", shall be deleted in its entirety and replaced with the following:

> "Medi-Cal Access Program: is a state-funded Program pursuant to a contract between the Plan and the California Department of Health Care Services ("DHCS") for coverage of Members who meet Medi-Cal Access Program eligibility requirements as determined by DHCS. As of the Commencement Date, the Medi-Cal Access Program is offered in Monterey County."

3. Exhibit F, Alliance Care Access for Infants and Mothers Program Attachment, shall be deleted and replaced with the attached Exhibit F, Medi-Cal Access Program Attachment.

4. Exhibit H, Compensation Schedule, all references to "AIM" shall be replaced with "Medi-Cal Access Program".

5. Addendum 1, Referral Physician Utilization Management Incentive Program, shall be deleted and replaced with the attached Addendum 1, Referral Physician Specialty Care Incentive Program.

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.

EXHIBIT F

MEDI-CAL ACCESS PROGRAM ATTACHMENT

This Exhibit F sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Medi-Cal Access Program.

1. With respect to the Medi-Cal Access Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Medi-Cal Access Program Member Group Contract and are included in Section 2699.300 of Title 10 of the California Code of Regulations. Any services listed in Section 2699.301 of Title 10 of the California Code of Regulations shall not be considered Covered Services. Covered Services for Medi-Cal Access Program Members, including Primary Care Physician Services, are set forth in the Medi-Cal Access Program Evidence of Coverage, and are also described in the Plan's Provider Manual.

2. With respect to the Medi-Cal Access Program, the term "Emergency Services" shall mean health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), which is manifested by acute symptoms of sufficient severity, active labor or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

3. Provider agrees that the Department of Health Care Services, the Department of Managed Health Care and the Bureau of State Audits, or their designated representatives, shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated or required by Law. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records.

4. During the performance of this Agreement, Provider as well as its agents and employees, shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (over 40), marital status, and use of family and medical care leave pursuant to state or federal law. Provider, as well as its agents and employees, shall ensure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, as well as its agents and employees, will comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2, California Code of Regulations, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider will give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

5. Provider shall keep accurate books and records connected with the performance of this Agreement during and for three (3) years after the term of this Agreement, or until the final payment under this Agreement, whichever is later. If an audit, review, examination or evaluation is commenced during the time specified herein for the maintenance of books and records, Provider shall continue to maintain all relevant books and records until the audit, review, examination or evaluation is completed.

6. Provider shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Commencement Date, on an annual basis, upon any change in information, and upon request, if required by law or by Plan's Member Group Contracts. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Provider shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by Plan's Member Group Contracts. Such Debarment Certification and its instructions are set forth in the Provider Manual.

ADDENDUM 1

REFERRAL PHYSICIAN SPECIALTY CARE INCENTIVE PROGRAM

1. Introduction

This Addendum sets forth the terms of the Specialty Care Incentive program ("SCI Program") offered by Plan. The SCI Program compensates Referral Physicians for Alliance Member access to certain specialty medical services, defined herein as Eligible Encounters. It is designed to improve Alliance Member access to specialty care services and encourage specialty care physician participation in the Alliance Medi-Cal program.

2. Definitions

For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to this Addendum and in Article I to the Agreement.

2.1 Eligible Encounters – Eligible Encounters means encounters in which a SCI Eligible Provider provides Referral Services to an Eligible Member, properly billed in accordance with the Referral Physician Services Agreement, with dates of service within the SCI term, defined in Section 6 herein. The following are not considered Eligible Encounters: i) the interpretation or reading of tests, imaging or pathology; ii) emergency department physician services; iii) obstetrical services; iv) anesthesiology services that are not intra-partum epidurals, pain management procedures or consults; v) encounters provided by individuals who are not physicians or Non-Physician Medical Practitioners; vi) administration of allergy shots; vii) administration of sleep studies; and viii) surgical assisting. Plan shall determine in its sole discretion what constitutes an Eligible Encounter.

2.2 Eligible Members – Eligible Members are Alliance Medi-Cal members, excluding members with other health care coverage.

2.3 Initial Encounters – Initial Encounters are Eligible Encounters properly billed, in accordance with Current Procedural Terminology (CPT®) guidelines, as initial consultations.

2.4 Non-Physician Medical Practitioner – Non-Physician Medical Practitioner is a nurse practitioner, physician assistant, or nurse midwife.

2.5 SCI Eligible Provider – SCI Eligible Provider is a Plan Participating Provider that has entered into a Referral Physician Services Agreement, or a physician or Non-Physician Medical Practitioner of a group that has entered into a Referral Physician Services Agreement, with the Alliance, that is in effect at the end of the SCI Term. SCI Eligible Providers exclude emergency department physicians, hospitalists, pathologists and radiologists.

2.6 Subsequent Encounters – Subsequent Encounters are Eligible Encounters properly billed, in accordance with Current Procedural Terminology (CPT®) guidelines, not as initial consultations.

3. Specialty Care Incentive Program Funding

3.1 Budgeting. Provider has the opportunity to earn incentive payment under the SCI Program from a set budget or pool established by the Plan ("SCI Pool") should funds be allocated to the SCI Pool for the SCI program year. Funding of the SCI Pool shall be at the sole discretion of Plan.

3.2 Accounting. An accounting of SCI Payments shall be made by Plan annually four (4) months after the conclusion of the SCI Term and shall be certified by its Chief Financial Officer. The accounting will be based only on paid claims and data submitted for dates of service within the SCI Term, as defined in Section 6 of this Addendum, and received by Plan no later than January 31, 2016. Such annual accounting shall be based on the calendar year. Distributions are made to Providers following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of the SCI Term.

Policies regarding actual and proposed budget and cost allocations are subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of incentive payments.

4. Calculation of Specialty Care Incentive

Providers receive points under the SCI Program for Eligible Encounters with Eligible Members ("SCI Points"). Two points are earned for Initial Encounters and one point is earned for Subsequent Encounters.

Provider's total SCI Points are determined by adding all SCI Points Provider earned for Initial and Subsequent Encounters during the SCI Term ("Provider's Total SCI Points"). The portion of the SCI Pool Provider receives ("Provider's SCI Share") is calculated by dividing Provider's SCI Points by the sum of the SCI Points earned by all SCI Eligible Providers during the SCI Term ("Total SCI Points of all Providers"). The payment amount Provider receives under the SCI Program ("SCI Payment") is calculated by multiplying Provider's SCI Share by the SCI Pool. Calculation of Provider's SCI Share and Provider's SCI Payment are illustrated below.

Calculation of Provider's SCI Share

Provider's Total SCI Points	÷	Total SCI Points of all Providers	=	Provider's SCI Share

Calculation of Provider's SCI Payment

Provider's SCI Share	x	SCI Pool	=	Provider's SCI Payment

4.1 SCI Payments Determination Final. Plan's calculation of payments under the SCI shall be final. Provider recognizes that the measurement of the SCI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the SCI if Plan's calculation of payments under the SCI 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 SCI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the SCI, including determination of any data or the number of Eligible Encounters.

5. Distribution of SCI in Event of Termination

If the Agreement is terminated before the end of the SCI Term by Provider, or by Plan, Provider will not be eligible for SCI Payment.

6. Term of Specialty Care Incentive Program.

The term of the SCI Program, as described in this Addendum 1, shall begin on January 1, 2015 and end on December 31, 2015 (the "SCI Term").

7. Specialty Care Incentive Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement Specialty Care Incentive Programs for periods after completion of the SCI 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 SCI Term, no such program shall be binding upon Plan.

SEVENTH AMENDMENT TO THE REFERRAL PHYSICIAN SERVICES AGREEMENT

This Seventh Amendment to the Referral Physician Services Agreement ("Amendment") is effective January 1, 2016 ("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, on behalf of Natividad Medical Center (NMC), on behalf of NMC's 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 Referral Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, Plan desires to implement the Referral Physician Specialty Care Incentive Program for the year 2016;

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 Plan hereby amends the terms of the Agreement by written notice as follows:

1. Addendum 1, Referral Physician Specialty Care Incentive Program, shall be deleted and replaced with the attached Addendum 1, Referral Physician Specialty Care Incentive Program.

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.

ADDENDUM 1

REFERRAL PHYSICIAN SPECIALTY CARE INCENTIVE PROGRAM

1. Introduction

This Addendum sets forth the terms of the Specialty Care Incentive program ("SCI Program") offered by Plan. The SCI Program compensates Referral Physicians for Alliance Member access to certain specialty medical services, defined herein as Eligible Encounters. It is designed to improve Alliance Member access to specialty care services and encourage specialty care physician participation in the Alliance Medi-Cal program.

2. Definitions

For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to this Addendum and in Article I to the Agreement.

2.1 Eligible Encounters – Eligible Encounters means encounters in which a SCI Eligible Provider provides Referral Services to an Eligible Member, properly billed in accordance with the Referral Physician Services Agreement, with dates of service within the SCI term, defined in Section 6 herein. The following are not considered Eligible Encounters: i) the interpretation or reading of tests, imaging or pathology; ii) emergency department physician services; iii) obstetrical services; iv) anesthesiology services that are not intra-partum epidurals, pain management procedures or consults; v) encounters provided by individuals who are not physicians and are not Non-Physician Medical Practitioners; vi) administration of allergy shots; vii) administration of sleep studies; and viii) surgical assisting. Plan shall determine in its sole discretion what constitutes an Eligible Encounter.

2.2 Eligible Members – Eligible Members are Alliance Medi-Cal members, excluding members with other health care coverage.

2.3 Initial Encounters – Initial Encounters are Eligible Encounters properly billed, in accordance with Current Procedural Terminology (CPT®) guidelines, as initial consultations.

2.4 Non-Physician Medical Practitioner – Non-Physician Medical Practitioner is a nurse practitioner, physician assistant, or nurse midwife.

2.5 SCI Eligible Provider – SCI Eligible Provider is a Plan Participating Provider that has entered into a Referral Physician Services Agreement, or a physician or Non-Physician Medical Practitioner of a group that has entered into a Referral Physician Services Agreement, with the Alliance, that is in effect at the end of the SCI Term. SCI Eligible Providers exclude emergency department physicians, hospitalists, pathologists and radiologists.

2.6 Subsequent Encounters – Subsequent Encounters are Eligible Encounters properly billed, in accordance with Current Procedural Terminology (CPT®) guidelines, not as initial consultations.

3. Specialty Care Incentive Program Funding

3.1 Budgeting. Provider has the opportunity to earn incentive payment under the SCI Program from a set budget or pool established by the Plan ("SCI Pool") should funds be allocated to the SCI Pool for the SCI program year. Funding of the SCI Pool shall be at the sole discretion of Plan.

3.2 Accounting. An accounting of SCI Payments shall be made by Plan annually four (4) months after the conclusion of the SCI Term and shall be certified by its Chief Financial Officer. The accounting will be based only on paid claims and data submitted for dates of service within the SCI Term, as defined in Section 6 of this Addendum, and received by Plan no later than January 31, 2017. Such annual accounting shall be based on the calendar year. Distributions are made to Providers following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of the SCI Term.

Policies regarding actual and proposed budget and cost allocations are subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of incentive payments.

4. **Calculation of Specialty Care Incentive**

Providers receive points under the SCI Program for Eligible Encounters with Eligible Members ("SCI Points"). Two points are earned for Initial Encounters and one point is earned for Subsequent Encounters.

Provider's total SCI Points are determined by adding all SCI Points Provider earned for Initial and Subsequent Encounters during the SCI Term ("Provider's Total SCI Points"). The portion of the SCI Pool Provider receives ("Provider's SCI Share") is calculated by dividing Provider's SCI Points by the sum of the SCI Points earned by all SCI Eligible Providers during the SCI Term ("Total SCI Points of all Providers"). The payment amount Provider receives under the SCI Program ("SCI Payment") is calculated by multiplying Provider's SCI Share by the SCI Pool. Calculation of Provider's SCI Share and Provider's SCI Payment are illustrated below.

Calculation of Provider's SCI Share

Provider's Total SCI Points	÷	Total SCI Points of all Providers	=	Provider's SCI Share

Calculation of Provider's SCI Payment

Provider's SCI Share	x	SCI Pool	=	Provider's SCI Payment

4.1 SCI Payments Determination Final. Plan's calculation of payments under the SCI shall be final. Provider recognizes that the measurement of the SCI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the SCI if Plan's calculation of payments under the SCI 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 SCI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the SCI, including determination of any data or the number of Eligible Encounters.

5. **Distribution of SCI in Event of Termination**

If the Agreement is terminated before the end of the SCI Term by Provider, or by Plan, Provider will not be eligible for SCI Payment.

6. **Term of Specialty Care Incentive Program.**

The term of the SCI Program, as described in this Addendum 1, shall begin on January 1, 2016 and end on December 31, 2016 (the "SCI Term").

7. **Specialty Care Incentive Programs for Future Periods.**

Plan, in its sole and absolute discretion, may implement Specialty Care Incentive Programs for periods after completion of the SCI 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 SCI Term, no such program shall be binding upon Plan.