FIFTH AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

This Fifth Amendment to the Primary Care 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, 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, Plan desires to 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 parties hereby amend the terms of the Agreement as follows:

1. 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."

2. 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.

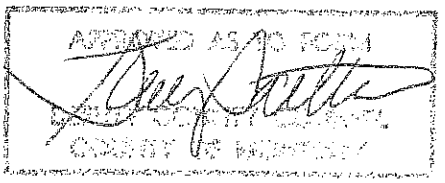
3. Exhibit H, Compensation Schedule, all references to "AIM" shall be replaced with "Medi-Cal Access Program".

4. 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.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective duly authorized representatives.

Plan	Provider
Central California Alliance for Health	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
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____



Reviewed as to fiscal provisions

Auditor-Controller
County of Monterey

11-3-15

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 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 Medi-Cal Access 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 Administrative Member is a Member who is not a Linked Member.

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

2.3 Benchmark Ranking Measures are those Measurement Components for which a PCP receives points based on its ranking relative to Plan Benchmarks.

2.4 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.

2.5 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.

2.6 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.

2.7 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets, Plan Benchmarks and a Comparison Group. PCPs are eligible for incentive payment based upon their performance as further described in Section 3 to this Addendum 3.

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

2.9 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. Where PCPs from the same Provider are classified in different Comparison Groups, the Provider will be compared against the FP/GP Comparison Group.

2.10 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.

2.11 Eligible Members

2.11.1 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.

2.11.2 With respect to all CBI Fee-For-Service Program measures, except for the Initial Visit Incentive, 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 Medi-Cal Access Program Members, excluding Dual Coverage Members. Eligible Members for the Initial Visit Inventive measure are Linked Members or Administrative Members enrolled in the Medi-Cal Program in Santa Cruz, Monterey or Merced Counties, excluding both Dual Coverage Members and Members previously enrolled in the Medi-Cal Program with less than a 12 month lapse in eligibility.

2.12 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.

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

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

2.15 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.

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

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

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

2.19 Plan Goal. The Plan Goal for each Quality of Care ("QOC") Measure, set forth in Section 3.5, is the NCQA HEDIS national 90th percentile for the 2015 reporting year (2014 measurement year). The Plan Goal for the Rate of Ambulatory Care Sensitive Admissions, the Rate of Readmission and the Rate of Preventable Emergency Department Visits measures is a 10.5% improvement over the PCP's Comparison Group's 2014 Measurement Period median score for the applicable measure.

2.20 Plan Benchmark. The Plan Benchmark for the Rate of Ambulatory Care Sensitive Admissions, the Rate of Readmission and the Rate of Preventable Emergency Department Visits measures is a

2.5% improvement over the PCP's Comparison Group's 2014 Measurement Period median score for the applicable measure. The Plan Benchmark for the Rate of Generic Prescriptions measure is the PCP's comparison group's 2014 Measurement Period median score. The Plan Benchmark for the Benchmark Ranked (NCQA Medicaid) QOC Measures, as set forth in Section 3.5.2, is the NCQA HEDIS national 51st percentile for the 2015 reporting year (2014 measurement year).

2.21 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 Benchmark Ranking, Relative Ranking and Performance Target Measures may be reduced by fifty-percent (50%). The Member Reassignment Threshold is not applied to PCPs with either (i) 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 or (ii) less than one hundred (100) Eligible Members as of December 31, 2016.

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 Plan through 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 either (i) 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 (ii) a minimum of one hundred (100) Eligible Members as of December 31, 2016.

3.3 Rate of Readmission. This Measurement Component measures the rate of hospital 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 an Eligible Member during the CBI Term which occurs within ninety (90) days of the Eligible Member's discharge from a hospital 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 either (i) 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 (ii) a minimum of one hundred (100) Eligible Members as of December 31, 2016.

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. The measure is based on generic medications as defined by the Integrated Healthcare Association (IHA) California Pay for Performance Program (P4P).

3.5 Quality of Care Measures. The Quality of Care Measurement Components are HEDIS 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. There are ten clinical performance measures separated into two categories: those calculated based on how the PCP's performance compared to the PCP's Comparison Group (Comparison Group Ranked QOC Measures) and those calculated based on how the PCP's performance compares to the National NCQA Medicaid Benchmark (Benchmark Ranked (NCQA Medicaid) QOC Measures).

3.5.1 Comparison Group Ranked QOC Measures: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) cervical cancer screening, (4) diabetes retinal exam, (5) diabetes HbA1c screening, and (6) diabetes medical attention for nephropathy.

3.5.2 Benchmark Ranked (NCQA Medicaid) QOC Measures: (1) asthma medication ratio, (2) avoidance of antibiotic treatment in adults with acute bronchitis, (3) appropriate testing for children with pharyngitis, and (4) use of spirometry testing in the assessment and diagnosis of COPD.

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 either (i) 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 (ii) a minimum of one hundred (100) Eligible Members as of December 31, 2016.

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 Measurement Component. This Measurement Component measures a PCP's improvement from the 2015 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, 2017. 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 Benchmark Ranking Measures.

4.1.1 Care Coordination Measures. PCP shall be awarded points for each measure in which the PCP performed better than the applicable Plan Benchmark, as defined in Section 2.20. As is illustrated below, the number of points PCP is awarded for a measure will be relative to the extent to which the PCP out-performed the Plan Benchmark for that measure. Points will be allocated in the following manner:

Percent Better than Benchmark	Points Allocated			
	Rate of Ambulatory Care Sensitive Admissions	Rate of Preventable ED Visits	Rate of Readmission	Rate of Generic Prescriptions
≥ 8.00%	20	20	10	5
6.00-7.99%	16	16	8	4
4.00-5.99%	12	12	6	3
2.00-3.99%	8	8	4	2
0.00-1.99%	4	4	2	1
Below Benchmark	0	0	0	0

4.1.2 Benchmark Ranked (NCQA Medicaid) QOC Measures. For the Benchmark Ranked (NCQA Medicaid) QOC Measures, as set forth in Section 3.5.2 of this Addendum 3, PCP shall be awarded (i) the maximum number of points for each measure, in accordance with Section 3.5, in which the PCP is ranked at or above the NCQA HEDIS national 90th percentile for the 2015 reporting year (2014 measurement year); (ii) three-quarters the maximum number of points for each measure in which the PCP is ranked 76th through the 89th percentile; (iii) one-half the maximum number of points for each measure in which the PCP is ranked at the 51st through the 75th percentile; and (iv) zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.

4.2 Relative Ranking Measures

4.2.1 Comparison Group Ranked QOC Measures. For the Comparison Group QOC Measures, as set forth in Section 3.5.1 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.

4.3 Performance Target Measures.

4.3.1 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.

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

4.3.3 Performance Improvement Measurement Component. PCP shall be awarded points for Performance Improvement Measures as described in this section. The total points available for the Performance Improvement Measurement Component will be allocated across only those Performance Improvement Measures for which the PCP qualified by meeting the applicable Member requirement in 2016 (Qualified Performance Improvement Measures). PCP will be awarded points for Qualified Performance Improvement Measures for which the Plan Goal was achieved. Additionally, for Qualified Performance Improvement Measures for which the Plan Goal was not achieved, PCP will be awarded points for Qualified Performance Improvement Measures for which PCP met the eligible Member requirement in both 2015 and 2016 and made the requisite improvement over PCP's prior year performance. PCP must achieve a five percent (5%) reduction in PCP's rate for applicable Care Coordination Measures or improve PCP's ranking by five (5) percentile points for Quality of Care Measures, to be awarded points for improvement from PCP's prior year performance. PCP will earn zero (0) points for each Qualified Performance Improvement Measure for which PCP does not achieve the Plan Goal or make the requisite improvement.

4.4 After the assignment of points for the Benchmark Ranking Measures, 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 may 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".

4.5 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, 2016 and end on December 31, 2016 (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	NATIVIDAD MEDICAL GROUP
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

ATTACHMENT 1 – 2016 CBI Table						
CBI Program Measurement Components	**Available Points**	**Member Requirement**	**Benchmark Ranking/Relative Ranking/Performance Target**	**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.	Benchmark Ranking[1]	FY 2016	Claims	AHRQ[3]
Rate of Readmissions Number of readmissions per 1,000 Eligible Members per Fiscal Year.	10	Per §3.3.	Benchmark Ranking[1]	FY 2016	Claims	Per §3.3
Rate of Generic Prescriptions Percent of generic prescriptions among all prescriptions, regardless of prescriber.	5	None.	Benchmark Ranking[1]	FY 2016	Claims	IHA P4P[4]
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Eligible Members per Fiscal Year.	20	Per §3.6.	Benchmark Ranking[1]	FY 2016	Claims	Medi-Cal ER Collaborative definition based on NYU study
Quality of Care (HEDIS):	**30 total**					
Well Child Visit 3-6 Years	Per §4.2.1	≥ 5 continuously Eligible Members[5]	Relative Ranking[2]	FY 2016	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.2.1	≥ 5 continuously Eligible Members[5]	Relative Ranking[2]	FY 2016	Claims	HEDIS
Cervical Cancer Screening	Per §4.2.1	≥ 5 continuously Eligible Members[5]	Relative Ranking[2]	FY 2016	Claims	HEDIS
Diabetes Retinal Exam	Per §4.2.1	≥ 5 continuously Eligible Members[5]	Relative Ranking[2]	FY 2016	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.2.1	≥ 5 continuously Eligible Members[5]	Relative Ranking[2]	FY 2016	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.2.1	≥ 5 continuously Eligible Members[5]	Relative Ranking[2]	FY 2016	Claims	HEDIS

ATTACHMENT 1 – 2016 CBI Table						
Asthma Medication Ratio	Per §4.1.2	≥ 5 continuously Eligible Members[5]	Benchmark Ranking[1]	FY 2016	Claims	HEDIS
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Per §4.1.2	≥ 5 continuously Eligible Members[5]	Benchmark Ranking[1]	FY 2016	Claims	HEDIS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Per §4.1.2	≥ 5 continuously Eligible Members[5]	Benchmark Ranking[1]	FY 2016	Claims	HEDIS
Appropriate Testing for Children with Pharyngitis	Per §4.1.2	≥ 5 continuously Eligible Members[5]	Benchmark Ranking[1]	FY 2016	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[5] Care Coordination Per §§ 3.2, 3.3 and 3.6 of Addendum A.	Performance Target	FY 2016 compared to FY 2015	Claims	NCQA, §4.3.3
Information Technology	***5 total***					
Electronic Claims Submittal 95% of eligible claims submitted electronically to the Alliance.	1	None	95% Performance Target	FY 2016	Claims	# eligible electronic claims / All eligible claims
Referral Submittal 75% of eligible referrals submitted through Alliance web portal.	4	None	75% Performance Target	FY 2016	Referrals	# eligible referrals / All eligible referrals
CBI FFS Incentive Measurement Component			**Amount (All paid quarterly.)**	**Member Requirement**	**Measurement Period**	**Measurement Data Source**

RATES REDACTED