

**FIRST AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT**

This First Amendment to the Primary Care 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 Primary Care Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

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

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

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


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

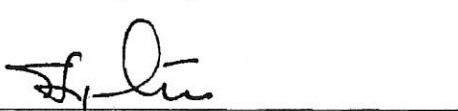
1. Addendum 3, Primary Care Physician Care Based Incentive Program, shall be amended and replaced with the attached Addendum 3, Primary Care Physician Care Based Incentive Program.

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

Plan
Central California Alliance for Health

Provider
Natividad Medical Center, on behalf of its Natividad
Medical Center Specialty Clinic

By: 

By: 

Print Name: Jane Parker

Print Name: Hong Weis

Title: Chair, CCAH

Title: CEO

Date: March 7, 2012

Date: 1/5/12

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

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

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

2. Definitions.

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

- 2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.
- 2.2 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.
- 2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.
- 2.4 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance.
- 2.5 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.
- 2.6 Comparison Group is the group of PCPs to which Provider is compared to determine Provider's percentile ranking within the group. PCPs are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.
- 2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

- 2.8 Eligible Members
- 2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.
- 2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz or Merced Healthy Kids Members; the Monterey County IHSS Members, Monterey County AIM Members, and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.
- 2.9 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the total number of member months each Eligible Member is linked to the PCP during the measurement period, except that member months for a PCP's Linked Medi-Cal Members who are in the Aged, BCCTP, Disabled and Long Term Care Medi-Cal aid code categories are multiplied by four (4) to determine the Eligible Member Months applicable to those Linked Members. Member months are determined by identifying the total number of Linked Members linked to the PCP during each month of the Measurement Period.
- 2.10 Measurement Component shall mean the measures as described in the CBI Table.
- 2.11 Measurement Period is the period for which Plan shall measure data in order to calculate the applicable CBI Incentive Payment.
- 2.12 Methodology is the internally developed methodology, or the source of data utilized by Plan, to measure Provider's performance for each Measurement Component under the CBI.
- 2.13 PCP is the individual or group of PCPs to whom Linked Members are assigned.
- 2.14 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.
- 2.15 Performance Target Measures are those Measurement Components for which the PCP receives points based upon meeting a specified Performance Target.
- 2.16 Plan Goal is the percentage of Eligible Members for whom the PCP provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for all Quality of Care Measures is ninety percent (90%).
- 2.17 Relative Ranking Measures are those Measurement Components for which a PCP receives points based on its ranking relative to performance of other PCPs within the PCP's Comparison Group
3. CBI Incentive Program.
- PCPs are eligible to receive an incentive payment from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each category correlate to each PCP's rank within its Comparison Group for each measure or for the PCP meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.1 through 3.8 below.
- 3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Performance Target Measures will be

reduced by fifty-percent (50%). The Member Reassignment Threshold is not applied to PCPs with less than one hundred (100) Linked Members.

- 3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have a minimum of one hundred (100) Linked Members as of December 31, 2012.
- 3.3 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Linked Members among all prescriptions filled for PCP's Linked Members as determined by a review of claims data.
- 3.4 Quality of Care Measures. The Quality of Care Measures Component are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims and encounter 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 Measures will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measure.
 - 3.4.1 There are nine (9) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) breast cancer screening, (4) cervical cancer screening, (5) diabetes LDL-C screening, (6) diabetes HbA1c screening (7) diabetes medical attention for nephropathy, (8) body mass index (BMI) percentile calculated, and (9) asthma medication ratio.
- 3.5 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have a minimum of one hundred (100) Linked Members as of December 31, 2012.
- 3.6 Rate of Primary Care Visits. This Measurement Component measures the rate of primary care visits provided to PCP's Linked Members on an annual basis. The target for this measure is more than three (3) PCP visits per Linked Member, per Fiscal Year. Partial points may be earned by Provider for visits per Linked Member per Fiscal Year between two and one-quarter (2.25) and three (3) visits per Member per Fiscal Year.
- 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 include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.
 - 3.7.1 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/encounter data include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims/encounter data submitted electronically.
 - 3.7.2 Referral Submittal: This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The target for this

measure is 75% of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. The accounting will be based only on claims and data submitted for dates of service within the CBI Term and received by Plan no later than January 31, 2013. Distributions are made to PCPs following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.
 - 4.1 Relative Ranking Measures. Except as stated below in 4.1.1, PCPs shall be awarded the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile. PCP shall be awarded one-half the maximum number of points for each measure in which the PCP is ranked between the 51st and 75th percentile. PCP shall receive zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.
 - 4.1.1 Quality of Care Measures. For the Quality of Care Measures for which the PCP qualifies, if the PCP meets or exceeds the Plan Goal, the PCP shall be awarded the maximum number of points for the measure even if the PCP is not in the top quartile for the measure.
 - 4.2 Performance Target Measures. PCP shall be awarded the full amount of points if the PCP meets the Performance Target for the Electronic Claims/Encounter Data Submittal Measure. If the PCP falls below the Performance Target for this measure, the PCP earns zero (0) points. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target for the Rate of Primary Care Visits Measure. PCPs shall be awarded partial points if they provide between two and one-quarter (2.25) and three (3) visits per Linked Member per Fiscal Year. If the PCP falls below two (2) visits per Linked Member per Fiscal Year, it will earn zero (0) points.
 - 4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP. In the event that the PCP exceeded the Member Reassignment Threshold by more than two standard deviations, PCP's total CBI Incentive Program points will be reduced by fifty-percent (50%). The total points are multiplied by the number of Eligible Member Months for the PCP during the Fiscal Year to determine the PCP's "Weighted Points". Percentages are then determined by comparison to the totals for PCPs of the same Comparison Group, as follows: Weighted Points for PCP divided by total Weighted Points for all PCPs of the same Comparison Group equals the PCP's "CBI Distribution Percentage".
 - 4.4 PCPs will receive a portion of the applicable CBI Pool (e.g. IM CBI Pool, PED CBI Pool or FP/GP CBI Pool) by multiplying the PCP's CBI Distribution Percentage by the total amount of funds in such CBI Pool.
5. Fee-for-Service Incentives
 - 5.1 Increased preventive and disease management actions. Plan shall pay a fee-for-service incentive for performance of the following:
 - 5.1.1

RATES REDACTED

5.1.2 Healthy Weight for Life Program (HWL).

RATES
REDACTED

- 5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of capitation or the fee-for-service equivalent for non-capitated Programs for holding office hours for at least eight (8) hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCPs under Provider's contract located within a 5 mile radius of the location with extended hours availability if Linked Members may access care during the extended hours at the extended hours location.
- 5.3 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. PCP should submit all Fee-for-Service Incentives within 30 days of the close of each quarter and will not receive payment for any Fee-for-Service Incentives submitted to Plan after January 31, 2013. Distributions are made to PCPs following Plan approval of such accounting. Distributions for the first, second and third quarters are made no later than ninety (90) calendar days after the conclusion of the quarter. The distribution for the fourth quarter Fee-for-Service Incentives shall be made with the distribution of the CBI Incentive Payments no later than one hundred eighty (180) days after the conclusion of the Fiscal Year.
6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.
7. Term of CBI. The term of this CBI shall begin on January 1, 2012 and end on December 31, 2012 (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.

ATTACHMENT 1 – CBI Table

CBI Program Measurement Components	Available Points	Member Requirement	Performance Target/Relative Ranking	Measurement Period	Measurement Data Source	Methodology
<i>Health and Cost Management:</i>	<i>40 total</i>					
Rate of <u>Ambulatory Care Sensitive Admissions</u> Number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year.	30	≥ 100 Linked Members as of 12/31/12.	Relative Ranking ³	FY 2012	Claims	AHRQ ¹
Rate of <u>Generic Prescriptions</u> Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking ³	FY 2012	Claims	IHA P4P ²
<i>Quality of Care (HEDIS):</i>	<i>30 total</i>					
Well Child Visit 3-6 Years	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Breast Cancer Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Cervical Cancer Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Diabetes LDL-C Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Diabetes HbA1c Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
BMI Percentile Calculated	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Asthma Medication Ratio	Per \$4.1	>_5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	IHA P4P ²

ATTACHMENT I – CBI Table

<i>Appropriate Access to Care</i>	<i>25 total</i>		Relative Ranking ³	FY 2012	Claims	Medi-Cal ER Collaborative definition based on NYU study
<u>Rate of Preventable Emergency Department Visits</u> Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	≥ 100 Linked Members as of 12/31/12		FY 2012	Claims	Plan developed
<u>Rate of Primary Care Visits</u> Greater than three (3) Primary Care visits provided by Provider to Linked Members per Fiscal Year. Partial points will be awarded for 2.25 to 3 visits PMPY.	5	None	>3.0 PMPY Performance Target	FY 2012	Claims	
<u>Information Technology</u>	<i>5 total</i>					
<u>Electronic Claims/Encounter Data Submittal</u> 95% of eligible claims/encounter data submitted electronically to the Alliance.	3	None	95% Performance Target	FY 2012	Claims	# eligible electronic claims All eligible claims
<u>Referral Submittal</u> 75% of eligible referrals submitted through Alliance web portal.	2	None	75% Performance Target	FY 2012	Referrals	# eligible referrals All eligible referrals
CBI FFS Incentive Measurement Component			Amount (All paid quarterly)	Member Requirement	Measurement Period	Measurement Data Source
<u>Extended Office Hours</u> Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per PCP covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours location.			5% of Capitation or Case Management Fee-for-Service	None	FY 2012	Administrative Data
<u>Diabetes Services</u> Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, retinal exam, diabetes medical attention for nephropathy ⁵ during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.			<i>RATES</i>			
<u>Healthy Weight for Life (HWL) Program Referral</u> Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85 th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.			<i>REDACTED</i>			

ATTACHMENT 1 – CBI Table

Healthy Weight for Life Program Follow Up Visit Provider to notify Plan by follow up form of the first six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.	:rs aged	FY 2012	HWL Follow Up Form
Asthma Action Plans (AAP) Provider to submit AAP to Plan for Members with Asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Fiscal Year.	:rs ages	FY 2012	Plans Submitted by Providers
Medication Management Agreements (MMA) Provider to submit MMA for members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Fiscal Year.		FY 2012	Plans Submitted by Providers

RATES
REDACTED

¹ <http://www.ahrq.gov/data/safetynet/billappb.htm>

² http://www.ihq.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf

³ For relative ranking measures, PCPs ranked at 100th to 76th percentile amongst peers earn maximum available points, ranked at 75th to 51st percentile earn one-half available points, ranked below 50th percentile earn no points for the measure.

⁴ For HEDIS Measures, the continuously Linked Members must be qualified per HEDIS specifications.

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

Note: If a Provider has 100 or more Linked Members, and the Provider's rate of member reassignment per 1,000 Linked Members exceeds the Plan mean of member reassignment rate per 1,000 Linked Members by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Target Measures will be reduced by 50%.

**SECOND AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT
(For Non-FQHC Providers)**

This Second Amendment to the Primary Care 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 Primary Care Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

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

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

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

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

1. Section 1.6, Covered Services Documentation definition, shall be deleted in its entirety and replaced with the following Section 1.6, Covered Services Documentation definition:

"Covered Services Documentation. Covered Services Documentation means documentation developed by Primary Care Physicians to support the Covered Services, including Primary Care Physician Services, provided hereunder, including, without limitation, claims for payment, discharge summaries, medical records, emergency visit records and diagnostic reports."

2. Section 2.11.2.1 shall be deleted in its entirety.

3. Exhibit H, Section 2.a., Capitation Payment, shall be deleted in its entirety and replaced with the following definition of ACA Primary Care Services:

"ACA Primary Care Services" are Covered Services which are primary care services rendered by eligible physicians as defined, as of January 1, 2013, by 42 U.S.C. Section 1396a(jj) and 42 CFR Section 447.400, as amended from time to time.

4. Exhibit H, Section 2.e., PMPM, shall be deleted in its entirety and replaced with the following definition:

"ACA Primary Care Service Rates" are the minimum payment rates required by Law for payment for ACA Primary Care Services. As of January 1, 2013, such rates are set forth in 42 U.S.C. Section 1396a(a)(13) and 42 CFR Section 447.405(a).

5. Exhibit H, Section 3.b., Case Managed Primary Care Physician Services, shall be deleted in its entirety.
6. Exhibit H, Section 3.c., Other Payment, shall be deleted in its entirety and replaced with the following newly numbered Exhibit H, Section 3.b., Fee-For-Service Payment:

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

i.

RATES
REDACTED

ii.

iii.

iv.

v.

(2)

RATES
REDACTED


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

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

Plan
Central California Alliance for Health

Provider
Natividad Medical Center

By: _____

By:  _____

Print Name: _____

Print Name: Harry Weiss _____

Title: _____

Title: CEO _____

Date: _____

Date: 11/29/12 _____

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

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

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

2. Definitions.

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

- 2.8 Eligible Members
- 2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.
- 2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz or Merced Healthy Kids Members; the Monterey County IHSS Members, Monterey County AIM Members, and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.
- 2.9 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the total number of member months each Eligible Member is linked to the PCP during the measurement period, except that member months for a PCP's Linked Medi-Cal Members who are in the Aged, BCCTP, Disabled and Long Term Care Medi-Cal aid code categories are multiplied by four (4) to determine the Eligible Member Months applicable to those Linked Members. Member months are determined by identifying the total number of Linked Members linked to the PCP during each month of the Measurement Period.
- 2.10 Measurement Component shall mean the measures as described in the CBI Table.
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- 2.13 PCP is the individual or group of PCPs to whom Linked Members are assigned.
- 2.14 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.
- 2.15 Performance Target Measures are those Measurement Components for which the PCP receives points based upon meeting a specified Performance Target.
- 2.16 Plan Goal is the percentage of Eligible Members for whom the PCP provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for each Quality of Care measure is ninety percent (90%).
- 2.17 Relative Ranking Measures are those Measurement Components for which a PCP receives points based on its ranking relative to performance of other PCPs within the PCP's Comparison Group.
3. CBI Incentive Program.
- PCPs are eligible to receive an incentive payment from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each Measurement Component correlate to each PCP's rank within its Comparison Group for each measure or for the PCP meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.1 through 3.9, below.
- 3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than two standard deviations,

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

- 3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions (based upon Plan-identified AHRQ specifications) per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.
- 3.3 Rate of Readmission. This Measurement Component measures the rate of readmissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of readmissions during the CBI Term per 1,000 Linked Members per Fiscal Year. A readmission is any admission of a Linked Member during the CBI Term which occurs within ninety (90) days of the Linked Member's discharge from an inpatient stay which commenced during the CBI Term. The rate of readmissions shall not include admissions or readmissions associated with diagnoses related to transplant or maternity. The rate of readmissions for PCP's Linked Members shall include only those readmissions where the Linked Member is linked to the PCP at both the time of admission and at the time of readmission. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.
- 3.4 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Linked Members among all prescriptions filled for PCP's Linked Members as determined by a review of claims data.
- 3.5 Quality of Care Measures. The Quality of Care Measurement Components are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims and encounter data, not on chart review. In order for a PCP to receive points for a Quality of Care measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications. The total points available for the Quality of Care Measurement Components will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measurement Component.
 - 3.5.1 There are eight (8) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) cervical cancer screening, (4) diabetes LDL-C screening, (5) diabetes HbA1c screening, (6) diabetes medical attention for nephropathy, (7) body mass index (BMI) percentile calculated, and (8) asthma medication ratio.
- 3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.
- 3.7 Rate of Primary Care Visits. This Measurement Component measures the rate of primary care visits provided to PCP's Linked Members on an annual basis. The Performance Target for this measure is more than three (3) PCP visits per Linked Member, per Fiscal Year. Partial points may be earned by Provider for visits per Linked Member per Fiscal Year between two and one-quarter (2.25) and three (3) visits per Member per Fiscal Year.

- 3.8 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 include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The Performance Target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.
- 3.9 Referral Submittal. This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The Performance Target for this measure is 75% of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal.
4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. The accounting will be based only on claims and data submitted for dates of service within the CBI Term and received by Plan no later than January 31, 2014. Distributions are made to PCPs following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.
- 4.1 Relative Ranking Measures. Except as stated below in 4.1.1, PCPs shall be awarded the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile. PCP shall be awarded one-half the maximum number of points for each measure in which the PCP is ranked between the 51st and 75th percentile. PCP shall receive zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.
- 4.1.1 Quality of Care Measures. For the Quality of Care measures for which the PCP qualifies, if the PCP meets or exceeds the Plan Goal, the PCP shall be awarded the maximum number of points for the measure even if the PCP is not in the top quartile for the measure.
- 4.2 Performance Target Measures.
- 4.2.1 Rate of Primary Care Visits Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. PCPs shall be awarded partial points if they provide between two and one-quarter (2.25) and three (3) visits per Linked Member per Fiscal Year. If the PCP falls below two and one-quarter (2.25) visits per Linked Member per Fiscal Year, the PCP will earn zero (0) points.
- 4.2.2 Electronic Claims/Encounter Data Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.
- 4.2.3 Referral Submittal Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.
- 4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP. In the event that the PCP exceeded the Member Reassignment Threshold by more than two standard deviations, PCP's total CBI Incentive Program points will be reduced by fifty-percent (50%). The total points are multiplied by the number of Eligible Member Months for the PCP during the Fiscal Year to determine the PCP's "Weighted Points". Percentages are then determined by comparison to the totals for PCPs of the same Comparison Group, as follows: Weighted Points for PCP divided by total Weighted Points for all PCPs of the same Comparison Group equals the PCP's "CBI Distribution Percentage".

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

5. Fee-for-Service Incentives

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

5.1.1

5.1.2

RATES
REDACTED

5.1.3

5.1.4

- 5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of the fee-for-service amount applicable to those services set forth in the Provider Manual, Primary Care Physician Services – Case Management, excluding Children's Health and Disability Prevention (CHDP) services and Comprehensive Perinatal Services Program (CPSP) services, for holding office hours for at least eight (8) hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCPs under Provider's contract located within a 5 mile radius of the location with extended hours availability if Linked Members may access care during the extended hours at the extended hours location.
- 5.3 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. PCP should submit all Fee-for-Service Incentives within 30 days of the close of each quarter and will

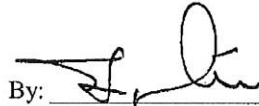
not receive payment for any Fee-for-Service Incentives submitted to Plan after January 31, 2014. Distributions are made to PCPs following Plan approval of such accounting. Distributions for the first, second and third quarters are made no later than ninety (90) calendar days after the conclusion of the quarter. The distribution for the fourth quarter Fee-for-Service Incentives shall be made with the distribution of the CBI Incentive Payments no later than one hundred eighty (180) days after the conclusion of the Fiscal Year.

6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.
7. Term of CBI. The term of this CBI shall begin on January 1, 2013 and end on December 31, 2013 (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.

PLAN
Central California Alliance for Health

PROVIDER
Natividad Medical Center

By: _____

By:  _____

Title: _____

Title: CEO _____

Date: _____

Date: 11/20/12 _____

ATTACHMENT 1 – CBI Table

CBI Program Measurement Components	Available Points	Member Requirement	Performance Target/Relative Ranking	Measurement Period	Measurement Data Source	Methodology
Health and Cost Management:	40 total					
<u>Rate of Ambulatory Care Sensitive Admissions</u> Number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year.	30	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.2.	Relative Ranking ³	FY 2013	Claims	AHRQ ¹
<u>Rate of Readmissions</u> Number of readmissions per 1,000 Linked Members per Fiscal Year.	0	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.3.	Relative Ranking ³	FY 2013	Claims	Per §3.3
<u>Rate of Generic Prescriptions</u> Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking ³	FY 2013	Claims	IHA P4P ²
Quality of Care (HEDIS):	30 total					
Well Child Visit 3-6 Years	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
Cervical Cancer Screening	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
Diabetes LDL-C Screening	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
BMI Percentile Calculated	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	HEDIS
Asthma Medication Ratio	Per §4.1	> 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2013	Claims	IHA P4P ²

ATTACHMENT 1 – CBI Table

<i>Appropriate Access to Care</i>	<i>25 total</i>	<i>Avg. of at least 100 Linked Members in the Measurement Period. Per §3.6.</i>	<i>Relative Ranking³</i>	<i>FY 2013</i>	<i>Claims</i>	<i>Medi-Cal ER Collaborative definition based on NYU study</i>
<u>Rate of Preventable Emergency Department Visits</u> Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	None	>3.0 PMPY Performance Target	FY 2013	Claims	Plan developed
<u>Rate of Primary Care Visits</u> Greater than three (3) Primary Care visits provided by Provider to Linked Members per Fiscal Year. Partial points will be awarded for 2.25 to 3 visits PMPY.	5	None	95% Performance Target	FY 2013	Claims	# eligible electronic claims All eligible claims
<u>Information Technology</u> Electronic Claims/Encounter Data Submittal 95% of eligible claims/encounter data submitted electronically to the Alliance.	3	None	75% Performance Target	FY 2013	Referrals	# eligible referrals All eligible referrals
<u>Referral Submittal</u> 75% of eligible referrals submitted through Alliance web portal.	2	None	5% of Case Management Fee-for-Service	None	Measurement Period	Measurement Data Source
CBI FFS Incentive Measurement Component						
<u>Extended Office Hours</u> Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per PCP covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours location.						
<u>Diabetes Services</u> Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, retinal exam, medical attention for nephropathy ² during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.						

RATES
REDACTED

ATTACHMENT I – CRI Table

	Members aged	FY 2013	HWL Referral Form
<p><u>Healthy Weight for Life (HWL) Program Referral</u> Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.</p>	8	FY 2013	HWL Referral Form
<p><u>Healthy Weight for Life (HWL) Program Follow Up Visit</u> Provider to notify Plan by follow up form of each six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.</p>	8	FY 2013	HWL Follow Up Form
<p><u>Asthma Action Plans (AAP)</u> Provider to submit AAP to Plan for Members with Asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Fiscal Year.</p>	16	FY 2013	Plans Submitted by Providers
<p><u>Medication Management Agreements (MMA)</u> Provider to submit MMA for members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Fiscal Year.</p>	:	FY 2013	Plans Submitted by Providers

RATES
 REDACTED

¹ http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
 Excluding PQI 09

² http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx
 Excluding NQI 01-03 and PDI 01-03 and 05-13

³ http://www.ihq.org/pdfs_documents/p4p_california/MY2011P4PManual_September2011.pdf

⁴ For relative ranking measures, PCPs ranked at 100th to 76th percentile amongst peers earns maximum available points, ranked at 75th to 51st percentile earns one-half available points, ranked below 50th percentile earns no points for the measure.

⁵ For HEDIS measures, the continuously Linked Members must be qualified per HEDIS specifications.

⁶ Medical attention for nephropathy includes: claim/encounter data with relevant CPT or ICD-9 code evidencing treatment of nephropathy, claim submitted by a nephrologist, positive urine macroalbumin test documented by claim/encounter data, evidence of ACE inhibitor/ARB therapy during measurement year.

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



1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500
 339 Pajaro Street, Suite E • Salinas, CA 93901-3400 • (831) 755-6000
 530 West 16th Street, Suite B • Merced, CA 95340-4710 • (209) 381-5300

**Attestation Regarding Extended Office Hours
 2013 Care Based Incentive Program**

Please complete all of the following fields, and sign and date this form at the bottom. The form must be signed by the contract signer. Central California Alliance for Health (the Alliance) will verify this information and if it is determined during any quarter of 2013 that the hours claimed are not available to Alliance members, your practice will be rendered ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2013.

Practice name: _____

Location of site with extended office hours:

Address, City, Zipcode: _____

*No extended hrs
at NMC*

Hours:

Monday	_____ a.m. to _____ p.m.	Friday	_____ a.m. to _____ p.m.
Tuesday	_____ a.m. to _____ p.m.	Saturday	_____ a.m. to _____ p.m.
Wednesday	_____ a.m. to _____ p.m.	Sunday	_____ a.m. to _____ p.m.
Thursday	_____ a.m. to _____ p.m.		

Sites within a 5 mile radius whose members can access care at extended office hours site:

Address, City, Zipcode: _____

Address, City, Zipcode: _____

Address, City, Zipcode: _____

Address, City, Zipcode: _____

I hereby affirm that the information submitted in this Attestation Regarding Extended Office Hours is true, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in my practice being ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2013.

By: _____

Print: _____

Title: _____

Date: _____

**THIRD AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT**

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

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

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

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

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

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

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

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

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

Plan
Central California Alliance for Health

Provider
Natividad Medical Group

By: [Signature]

By: [Signature]

Print Name: Alan McKay

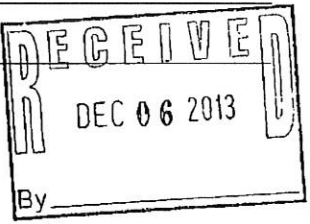
Print Name: Harry W. Davis

Title: CEO

Title: CEO

Date: 12/11/13

Date: 12/3/13



ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

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

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

2. Definitions.

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

- 2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.
- 2.2 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.
- 2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.
- 2.4 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance.
- 2.5 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.
- 2.6 Comparison Group is the group of PCPs to which Provider is compared to determine Provider's percentile ranking within the group. PCPs are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.
- 2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

2.8 Eligible Members

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

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

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

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

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

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

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

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

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

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

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

3. CBI Incentive Program.

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

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

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

- 3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions (based upon Plan-identified AHRQ specifications) per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.
- 3.3 Rate of Readmission. This Measurement Component measures the rate of readmissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of readmissions during the CBI Term per 1,000 Linked Members per Fiscal Year. A readmission is any admission of a Linked Member during the CBI Term which occurs within ninety (90) days of the Linked Member's discharge from an inpatient stay which commenced during the CBI Term. The rate of readmissions shall not include admissions or readmissions associated with diagnoses related to transplant or maternity. The rate of readmissions for PCP's Linked Members shall include only those readmissions where the Linked Member is linked to the PCP at both the time of admission and at the time of readmission. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.
- 3.4 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Linked Members among all prescriptions filled for PCP's Linked Members as determined by a review of claims data.
- 3.5 Quality of Care Measures. The Quality of Care Measurement Components are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims data, not on chart review. In order for a PCP to receive points for a Quality of Care measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications. The total points available for the Quality of Care Measurement Components will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measurement Component.
- 3.5.1 There are eight (8) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) cervical cancer screening, (4) diabetes LDL-C screening, (5) diabetes HbA1c screening, (6) diabetes medical attention for nephropathy, (7) body mass index (BMI) percentile calculated, and (8) asthma medication ratio.
- 3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Linked Members, as determined by the number of months for which PCP was contracted during the Measurement Period.
- 3.7 Electronic Claims Submittal. This Measurement Component measures the percentage of PCP's eligible claims submitted to the Plan electronically. Eligible claims include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The Performance Target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.

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

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

4.1 Relative Ranking Measures.

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

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

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

4.2 Performance Target Measures.

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

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

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

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

5. Fee-for-Service Incentives

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

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5.1.3

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5.1.4

- 5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of the fee-for-service amount applicable to those services set forth in the Provider Manual, Primary Care Physician Services – Case Management, excluding Children’s Health and Disability Prevention (CHDP) services and Comprehensive Perinatal Services Program (CPSP) services, for holding office hours for at least eight (8) hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCPs under Provider’s contract located within a 5 mile radius of the location with extended hours availability if Linked Members may access care during the extended hours at the extended hours location.
- 5.3 Physician Orders for Life Sustaining Treatment (POLST) Form Completion. Plan shall pay Provider one-hundred dollars (\$100) for Plan’s receipt of the first submitted POLST form per PCP’s Linked Medi-Cal Members who are in the Senior and Persons with Disabilities Medi-Cal aid code categories (SPD) and who are age twenty-one (21) or older, per Fiscal Year. The POLST form may be found in the Provider Manual.
- 5.4 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. PCP must submit all Fee-for-Service Incentive forms within twenty-one (21) business days from the date of service. Distributions are made to PCPs following Plan approval of such accounting. Distributions for the first, second and third quarters are made no later than ninety (90) calendar days after the conclusion of the quarter. The distribution for the fourth quarter Fee-for-Service Incentives shall be made with the distribution of the CBI Incentive Payments no later than one hundred eighty (180) days after the conclusion of the Fiscal Year.
6. CBI Payments Determination Final. Plan’s calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan’s calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan’s calculation. Accordingly, in consideration of Plan’s agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan’s determination of payments due under the CBI, including determination of any data or the number of Eligible Members.
7. Term of CBI. The term of this CBI shall begin on January 1, 2014 and end on December 31, 2014 (the “CBI Term”).
8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.

PCP_CBI Addendum 3_2014-081613_FINAL

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

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

NATIVIDAD MEDICAL GROUP

By: [Signature]

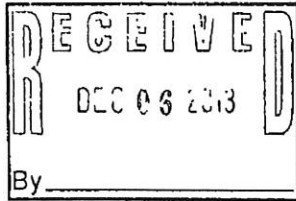
By: [Signature]

Title: CEO

Title: CEO

Date: 12/11/13

Date: 12/3/13



ATTACHMENT 1 – CBI Table

CBI Program Measurement Components	Available Points	Member Requirement	Performance Target/Relative Ranking	Measurement Period	Measurement Data Source	Methodology
Health and Cost Management:	45 total					
<u>Rate of Ambulatory Care Sensitive Admissions</u> Number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year.	30	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.2.	Relative Ranking ³	FY 2014	Claims	AHRQ ¹
<u>Rate of Readmissions</u> Number of readmissions per 1,000 Linked Members per Fiscal Year.	5	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.3.	Relative Ranking ³	FY 2014	Claims	Per §3.3
<u>Rate of Generic Prescriptions</u> Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking ³	FY 2014	Claims	IHA P4p ²
Quality of Care (HEDIS):	30 total					
Well Child Visit 3-6 Years	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
Cervical Cancer Screening	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
Diabetes LDL-C Screening	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
BMI Percentile Calculated	Per §4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	HEDIS
Asthma Medication Ratio	Per §4.1	> 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2014	Claims	IHA P4p ²

ATTACHMENT 1 – CBI Table

Appropriate Access to Care	20 total	Relative Ranking ³	FY 2014	Claims	Medi-Cal ER Collaborative definition based on NYU study
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	Avg. of at least 100 Linked Members in the Measurement Period. Per §3.6.	FY 2014	Claims	
Information Technology	5 total				
<u>Electronic Claims Submittal</u> 95% of eligible claims submitted electronically to the Alliance.	1	95% Performance Target	FY 2014	Claims	# eligible electronic claims All eligible claims
<u>Referral Submittal</u> 75% of eligible referrals submitted through Alliance web portal.	4	75% Performance Target	FY 2014	Referrals	# eligible referrals All eligible referrals
CBI FFS Incentive Measurement Component					
<u>Extended Office Hours</u> Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per PCP covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours location.		Amount (All paid quarterly.)	Member Requirement	Measurement Period	Measurement Data Source
		5% of Case Management Fee-for-Service	None	FY 2014	Administrative Data
<u>Diabetes Services</u> Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, retinal exam, medical attention for nephropathy ⁵ during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.		RATES	Members aged 18 to 64 at date of service.	FY 2014	Claims
<u>Healthy Weight for Life (HWL) Program Referral</u> Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85 th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.		REDACTED	Members aged 18	FY 2014	HWL Referral Form
<u>Healthy Weight for Life (HWL) Program Follow Up Visit</u> Provider to notify Plan by follow up form of each six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.			Members aged 18	FY 2014	HWL Follow Up Form
<u>Asthma Action Plans (AAP)</u> Provider to submit AAP to Plan for Members with asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Fiscal Year.			Members aged 56	FY 2014	Plans Submitted by Providers

ATTACHMENT 1 – CBI Table

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

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¹ http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Excluding PQI 09

² http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx
Excluding NQI 01-03 and PDI 01-03 and 05-13

³ http://www.aha.org/pdfs_documents/p4p_california/MY2011P4PManual_September2011.pdf
⁴ As set forth at Addendum 3, Section 4.1.

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

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

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

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

**FOURTH AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT**

This Fourth Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective January 1, 2015 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, a public entity organized under the laws of California, doing business as the Central California Alliance for Health, hereinafter referred to as "Plan", and the County of Monterey, a political subdivision of the State of California, doing business as Natividad Medical Center, on behalf of its Natividad Medical Group, hereinafter referred to as "Provider," with reference to the following facts:

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

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

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

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

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

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

1. The definitions of ACA Primary Care Services and ACA Primary Care Service Rates shall be deleted in their entirety from Exhibit H, Section 2.
2. Exhibit H, Section 3. Payment for Covered Services Provided to Medi-Cal Members shall be deleted in its entirety and replaced with the following:
 3. Payment for Covered Services Provided to Medi-Cal Members.
 - a. List of Members. Plan will provide Provider with a list of Provider's Medi-Cal Linked Members by the first (1st) day of each month (the "Medi-Cal Linked Members List").
 - b. Fee-For-Service Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., and v.

RATES REDACTED

RATES REDACTED

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

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

Plan
Central California Alliance for Health

Provider
Natividad Medical Group

By: [Signature]
Print Name: Alan McKay
Title: CEO
Date: 6/8/15

By: [Signature]
Print Name: Kelly R. O'Keefe
Title: Interim CEO
Date: 1/12/15

Reviewed as to fiscal provisions

APR 14 2015

[Signature]
Auditor/Controller
County of Monterey 23-V

2
APPROVED BY: [Signature]
A4:PCP:STD-BB:NMC_010115_081414:ALTY
COUNTY OF MONTEREY
COUNTY CLERK

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

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

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

2. Definitions.

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

- 2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.
- 2.2 Care Coordination Measures means Rate of Ambulatory Care Sensitive Admissions, Rate of Readmissions, Rate of Generic Prescriptions, and Rate of Preventable Emergency Department Visits, each as further described in Section 3 to this Addendum 3.
- 2.3 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.
- 2.4 CBI Incentive Payments are the annual payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.
- 2.5 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance as further described in Section 3 to this Addendum 3.
- 2.6 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.
- 2.7 Comparison Group is the group of PCPs to which Provider is compared to determine Provider's percentile ranking within the group. PCPs are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.
- 2.8 Dual Coverage Members are Members who are eligible for Medi-Cal and for coverage from another source, such as Medicare or a commercial health plan.

2.9 Eligible Members

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

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

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

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

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

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

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

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

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

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

3. CBI Incentive Program.

PCPs are eligible to receive an incentive payment under the CBI Incentive Program from a set budget or pool ("CBI Pool"). Funding of the CBI Pool shall be at the sole discretion of Plan. The CBI Pool is divided into three (3) sub-pools, by Comparison Group: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each Measurement Component correlate to each PCP's rank within its Comparison Group for each measure or for the PCP meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.1 through 3.9, below.

- 3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Performance Target Measures will be reduced by fifty-percent (50%). The Member Reassignment Threshold is not applied to PCPs with less than an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period and less than one hundred (100) Eligible Members as of December 31, 2015.
- 3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Eligible Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions (based upon Plan-identified AHRQ specifications) per 1,000 Eligible Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.
- 3.3 Rate of Readmission. This Measurement Component measures the rate of readmissions for PCP's Eligible Members as determined by a review of claims data. The rate is reported by the number of readmissions during the CBI Term per 1,000 Eligible Members per Fiscal Year. A readmission is any admission of a Eligible Member during the CBI Term which occurs within ninety (90) days of the Eligible Member's discharge from an inpatient stay which commenced during the CBI Term. The rate of readmissions shall not include admissions or readmissions associated with diagnoses related to transplant or maternity. The rate of readmissions for PCP's Eligible Members shall include only those readmissions where the Eligible Member is linked to the PCP at both the time of admission and at the time of readmission. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.
- 3.4 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Eligible Members among all prescriptions filled for PCP's Eligible Members as determined by a review of claims data.
- 3.5 Quality of Care Measures. The Quality of Care Measurement Components are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims data, not on chart review. In order for a PCP to receive points for a Quality of Care measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications. The total points available for the Quality of Care Measurement Components will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measurement Component.
- 3.5.1 There are ten (10) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) cervical cancer screening, (4) diabetes LDL-C screening, (5) diabetes HbA1c screening, (6) diabetes medical attention for nephropathy, (7) avoidance of antibiotic treatment in adults with acute bronchitis, (8) asthma medication ratio, (9) use of spirometry testing in the assessment and diagnosis of COPD and, (10) appropriate testing for children with pharyngitis.
- 3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Eligible Members as determined by Plan based upon a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Eligible Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

- 3.7 Electronic Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP's eligible claims and encounter data submitted to the Plan electronically. Eligible claims exclude those for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The Performance Target for this measure is ninety-five percent (95%) of all eligible claims and encounter data submitted electronically. Claims and encounter data must be submitted in accordance with the requirements of Sections 2.11.2 and 2.11.2.1 of the Agreement.
- 3.8 Referral Submittal. This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The Performance Target for this measure is seventy five percent (75%) of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal.
- 3.9 Performance Improvement Measures. This Measurement Component measures a PCP's improvement from the 2014 Measurement Period, or the PCP's ability to meet or exceed the Plan Goal for certain Measurement Components which include the Rate of Ambulatory Care Sensitive Admissions, the Rate of Readmissions, the Rate of Preventable Emergency Department Visits and all of the Quality of Care Measurement Components.

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. The accounting will be based only on claims and data submitted for dates of service within the CBI Term, as defined in Section 7 of this Addendum, and received by Plan no later than January 31, 2016. In the event the ICD-10 code set is mandated for use during the CBI Term, the Plan shall crosswalk ICD-10 data to the appropriate ICD-9 code for claims with dates of service from the effective date of the ICD-10 code set's mandated use through December 31 2015, for the purpose of calculating the CBI Incentive Payments. Plan will perform said crosswalking as set forth by the 2014 Center for Medicare and Medicaid Services' (CMS) General Equivalence Mappings (GEMs). Distributions are made to PCPs following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

4.1 Relative Ranking Measures.

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

<u>Percentile</u>	<u>Points Allocated</u>		
	<u>Rate of Ambulatory Care Sensitive Admissions</u>	<u>Rate of Preventable ED Visits</u>	<u>Rate of Readmission</u>
99 th – 90 th	20	20	10
89 th – 80 th	16	16	8
79 th – 70 th	12	12	6
69 th – 60 th	8	8	4
59 th – 50 th	4	4	2
49 th and below	0	0	0

- 4.1.2 Quality of Care Measures. For the Quality of Care Measurement Components, as set forth in Section 3.5 of this Addendum 3, if the PCP meets or exceeds the Plan Goal, the PCP shall be awarded the maximum number of points for the measure even if the PCP is not ranked in the top quartile within the PCP's Comparison Group for the measure. For PCPs not meeting or exceeding the Plan Goal, each such PCP shall be awarded (i) the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile within the PCP's Comparison Group; (ii) one-half the maximum number of points for each measure in which the PCP is ranked at the 51st through the 75th percentile; and (iii) zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.
- 4.1.3 Rate of Generic Prescriptions. PCP shall be awarded the maximum number of points if the PCP is ranked at or above the 76th percentile within the PCP's Comparison Group. PCP shall be awarded one-half the maximum number of points if the PCP is ranked at the 51st through the 75th percentile. PCP shall receive zero (0) points if the PCP is ranked at the 50th percentile or below.
- 4.2 Performance Target Measures.
- 4.2.1 Electronic Claims Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.
- 4.2.2 Referral Submittal Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.
- 4.2.3 Performance Improvement Measure. PCP shall be awarded points for Performance Improvement Measures in which the PCP improved PCP's performance from the 2014 Measurement Period. For applicable Care Coordination Measures PCP is awarded points for achieving a five percent (5%) reduction in PCP's rate, or by meeting the applicable Plan Goal. For Quality of Care Measures PCP will earn points by improving PCP's ranking by five (5) percentile points within PCP's Comparison Group or by meeting the applicable Plan Goal. The total points available for the Performance Improvement Measure will be allocated across only those measures for which the PCP qualified by meeting the applicable Member requirements in both 2014 and in 2015, but PCP is not required to have earned points for PCP's performance in the measure in either year. Points are earned based on PCP's improved performance or meeting or exceeding the Plan Goal. PCP will earn zero (0) points for each measure for which PCP does not make the requisite improvement and does not achieve the Plan Goal.
- 4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP. In the event that the PCP exceeded the Member Reassignment Threshold by more than two standard deviations, PCP's total CBI Incentive Program points will be reduced by fifty-percent (50%). The total points are multiplied by the number of Eligible Member Months for the PCP during the Fiscal Year to determine the PCP's "Weighted Points". Percentages are then determined by comparison to the totals for PCPs of the same Comparison Group, as follows: Weighted Points for PCP divided by total Weighted Points for all PCPs of the same Comparison Group equals the PCP's "CBI Distribution Percentage".
- 4.4 PCPs will receive a portion of the applicable CBI Pool (e.g. FP/GP CBI Pool, PED CBI Pool or IM CBI Pool) by multiplying the PCP's CBI Distribution Percentage by the total amount of funds in such CBI Pool.

5. Fee-for-Service Incentives

RATES REDACTED

RATES REDACTED

- 6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.
- 7. Term of CBI. The term of this CBI shall begin on January 1, 2015 and end on December 31, 2015 (the "CBI Term").
- 8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.
- 9. Effect of Termination of Agreement. In the event of the termination of the Agreement for any reason prior to the expiration of the CBI Term, no CBI Incentive Payments shall be earned or made hereunder. Provider would, however, be eligible for CBI Fee-For-Service Incentives earned prior to the termination of the Agreement.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

NATIVIDAD MEDICAL GROUP

By: [Signature]
 Title: CEO
 Date: 6/18/15

By: [Signature]
 Title: Interim CEO
 Date: 1/12/15

APPROVED AS TO FORM AND LEGALITY

[Signature]
 DEPUTY COUNTY COUNSEL
 COUNTY OF MONTUCLAY 7

APR 14 2015

ATTACHMENT 1 – CBI Table

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

ATTACHMENT 1 – CBI Table

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

RATES REDACTED

**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 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 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
Central California Alliance for Health

Provider
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: [Signature]
Print Name: Alan McKay
Title: CEO
Date: 11/8/16

By: [Signature]
Print Name: Gary Gray
Title: CEO
Date: 11/6/16

[Signature]

Reviewed as to fiscal provisions
[Signature]
Auditor-Controller
County of Monterey 11-3-15

RECEIVED DEC 16 2015

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 Incentive 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:

<u>Percent Better than Benchmark</u>	<u>Points Allocated</u>			
	<u>Rate of Ambulatory Care Sensitive Admissions</u>	<u>Rate of Preventable ED Visits</u>	<u>Rate of Readmission</u>	<u>Rate of Generic Prescriptions</u>
$\geq 8.00\%$	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

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

5.1.1

RATES REDACTED

5.1.2 Healthy Weight for Life Program (HWL).

5.1.2.1 R.C. 1.01

RATES REDACTED

5.1.3

RATES REDACTED

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performed by a licensed specialist.

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

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

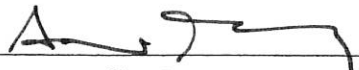
7. Term of CBI. The term of this CBI shall begin on January 1, 2016 and end on December 31, 2016 (the "CBI Term").

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:  _____

Title: CEO _____

Date: 1/8/16 _____

Alan McKay

By:  _____

Title: CEO _____

Date: 1/6/15 _____

RECEIVED DEC 16 2015

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
<i>Care Coordination Measures:</i>	<i>55 total</i>					
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
<i>Quality of Care (HEDIS):</i>	<i>30 total</i>					
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					
<u>Quality of Care and Care Coordination Improvement</u> 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	<u>Quality of Care</u> ≥ 5 continuously Eligible Members ⁵ <u>Care Coordination</u> 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					
<u>Electronic Claims Submittal</u> 95% of eligible claims submitted electronically to the Alliance.	1	None	95% Performance Target	FY 2016	Claims	# eligible electronic claims All eligible claims
<u>Referral Submittal</u> 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						
<u>Asthma Action Plans (AAP)</u> Provider to submit AAP to Plan for Members diagnosed with asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Member per						
			RATES	Member Incentive	Measurement Period	Measurement Data Source
			REDACTED	able Members aged 54	FY 2016	Plans Submitted by Providers

ATTACHMENT 1 – 2016 CBI Table

Fiscal Year				
	<u>Healthy Weight for Life (HWL) Program Referral</u> Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85 th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.		FY 2016	HWL Form
	<u>Healthy Weight for Life (HWL) Program Follow Up Visit</u> Provider to notify Plan by follow up form of each six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.	RATES	FY 2016	HWL Form
	<u>Diabetes Services</u> Provider to ensure provision of all of the following services for Eligible Members with diabetes: HbA1c, retinal exam, medical attention for nephropathy ^o during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.	REDACTED	FY 2016	Claims
	<u>Medication Management Agreements (MMA)</u> Provider to submit MMA for Members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Member per Fiscal Year.		FY 2016	Plans Submitted by Providers
	<u>Increased Prevalence of Extended Office Hours</u> PCP who is available to provide services to Eligible Members for at least 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. is eligible to receive enhanced payment for applicable PCP services. Additional payment is also to be paid to PCPs covered by the Provider's agreement, practicing within a 5 mile radius, if Eligible Members may access applicable PCP services during the extended hours at the extended hours location.	5% of Capitation or Case Management Fee-for-Service	FY 2016	Administrative Data
	<u>Initial Visit Incentive</u> Provider to see Provider's Medi-Cal Linked Members and Administrative Members for an initial visit within 120 days of the Member's enrollment in the Medi-Cal Program.	RATES REDACTED	FY 2016	Claims
	<u>Patient Centered Medical Home Recognition</u> Provider to submit documentation substantiating Provider's achievement of PCMH		FY 2016	Documentation from NCQA or

ATTACHMENT 1 – 2016 CBI Table

recognition. Varying levels of payment apply for the three levels of NCQA PCMH recognition or TJC certification.	type and level of PCMH recognition			TJC
<p><u>Physician Orders for Life Sustaining Treatment (POLST) Form Completion</u></p> <p>Provider to submit POLST form for Members to Plan. Incentive paid to the PCP who first submits the POLST form in the Fiscal Year and is paid only once per Member per Fiscal Year.</p>	<p>RATES</p> <p>Members aged 65 and older, SPD aid linked to order at date of discharge</p>	FY 2016		POLST form
<p><u>Post Discharge Care</u></p> <p>Provider to provide first post-discharge visit for recently hospitalized Members, within 14 days of the Member's discharge. A greater incentive is paid where Provider provides the first post-discharge visit within 7 days of Member's discharge.</p>	<p>RETRACTED</p> <p>Members discharged</p>	FY 2016		Claims
<p><u>Post-partum Care</u></p> <p>Provider to ensure the provision of a post-partum visit to Members who are obstetrical patients to occur from day 21 through day 56 after a delivery. The incentive is paid only once per Member per Fiscal Year.</p>	<p>Members</p>	FY 2016		Claims

¹ As set forth at Addendum 3, Section 4.1.

² As set forth at Addendum 3, Section 4.2.

³ http://www.qualityindicators.ahrq.gov/Modules/PQI_ToolsSpec.aspx
Excluding PQI 09

⁴ http://www.qualityindicators.ahrq.gov/Modules/PQI_ToolsSpec.aspx
Excluding NQI 01-03 and PDI 01-03 and 05-13

⁵ http://www.the.org/pdfs/documents/p4p_california_MY_2014-VBP4P-Manual_20141201.pdf

⁶ For HEDIS measures, the continuously Eligible Members must be qualified per HEDIS specifications.

⁷ Medical attention for nephropathy includes: claim data with relevant CPT or ICD-10 code evidencing treatment of nephropathy, claim submitted by a nephrologist, positive urine protein (macroalbumin) test documented by claim data, evidence of ACE inhibitor/ARB therapy during measurement year.

Note 1: If a Provider has an average of at least 100 Eligible Members during the Measurement Term and a minimum of 100 Eligible Members as of December 31, 2016 (per §3.1), and the Provider's rate of member reassignment per 1,000 Eligible Members exceeds the Plan mean of member reassignment rate per 1,000 Eligible Members by more than two standard deviations, the points awarded to Provider for the Benchmark Ranking, Relative Ranking and Performance Target Measures will be reduced by 50%.

Note 2: References to Section numbers in this Attachment 1 are to sections numbers of Addendum 3 unless otherwise specified.