HEALTH PLAN-PROVIDER AGREEMENT

PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

AMENDMENT ELEVEN

This Eleventh Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement (the "Agreement") is made this 13th day of April 2012 {month/year}, 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 Natividad Medical Center, a County Hospital, hereinafter referred to as "PROVIDER".

RECITALS:

WHEREAS, PLAN and PROVIDER have previously entered into the Agreement effective July 1, 2007;

WHEREAS, Section 9.5 of such Agreement provides for amending such Agreement;

WHEREAS, PLAN has been created by its County Boards of Supervisors to negotiate exclusive contracts with the California Department of Health Care Services ("State DHCS") and to arrange for the provision of Medi-Cal health care services to qualifying individuals in Monterey County and PLAN is a public entity, created pursuant to Welfare and Institutions Code 14087.54 and Chapter 7.58 of the Santa Cruz County Code, Chapter 2.45 of the Monterey County Code, and Chapter 9.43 of the Merced County Code;

WHEREAS, PROVIDER, an acute care medical center owned and operated by the County of Monterey ("County"), provides hospital services to PLAN enrollees pursuant to the Agreement, under which it is referred to as "Contractor"; and

WHEREAS, PLAN and PROVIDER desire to amend the Agreement to provide for Medi-Cal managed care capitation rate increases to PLAN as a result of intergovernmental transfers ("IGTs") from the County of Monterey to State DHCS to maintain the availability of Medi-Cal health care services to Medi-Cal beneficiaries.

NOW, THEREFORE, PLAN and PROVIDER hereby agree as follows:

Exhibit 2 of the Agreement is amended by adding Section F at the end to read as follows:

IGT MEDI-CAL MANAGED CARE CAPITATION RATE RANGE INCREASES

1. IGT Capitation Rate Range Increases to PLAN

A. Payment

Should PLAN receive any Medi-Cal managed care capitation rate increases from State DHCS where the nonfederal share is funded by the County of Monterey, on behalf of PROVIDER, specifically pursuant to the provisions of the Intergovernmental Agreement Regarding Transfer of Public Funds ("Intergovernmental Agreement") effective for the period July 1, 2010 through June 30, 2011 for Intergovernmental Transfer Medi-Cal Managed Care Rate Range Increases ("IGT MMCRRIs"), PLAN shall pay to PROVIDER the amount of the IGT MMCRRIs received from State DHCS, in accordance with paragraph 1.E below regarding the form and timing of Local Medi-Cal Managed Care Rate Range ("LMMCRR") IGT Payments. LMMCRR IGT Payments paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by PLAN.

B. Health Plan Retention

(1) Managed Care Organizations Tax

The PLAN shall be responsible for any Managed Care Organization ("MCO") tax due pursuant to the Revenue and Taxation Code Section 12201 relating to any IGT MMCRRIs. If the PLAN receives any capitation rate increases for MCO taxes based on the IGT MMCRRIs, PLAN may retain an amount equal to the amount of such MCO tax that PLAN is required to pay to the State DHCS, and shall pay, as part of the LMMCRR IGT Payments, the remaining amount of the capitation rate increase to PROVIDER.

(2) PLAN will not retain any other portion of the IGT MMCRRIs received from the State DHCS other than those mentioned above.

C. Conditions for Receiving Local Medi-Cal Managed Care Rate Range IGT Payments

As a condition for receiving LMMCRR IGT Payments, PROVIDER shall, as of the date the particular LMMCRR Payment is due:

(1) remain a participating provider in the PLAN and not issue a notice of termination of the Agreement;

(2) maintain its current emergency room licensure status and not close its emergency room;

(3) maintain its current inpatient surgery suites and not close these facilities.

D. **Schedule and Notice of Transfer of Non-Federal Funds**

(1) PROVIDER shall provide PLAN with a copy of the schedule regarding the transfer of funds to State DHCS, referred to in the Intergovernmental Agreement, within fifteen (15) calendar days of establishing such schedule with the State DHCS. Additionally, PROVIDER shall notify PLAN, in writing, no less than seven (7) calendar days prior to any changes to an existing schedule including, but not limited to, changes in the amounts specified therein.

(2) PROVIDER shall provide PLAN with written notice of the amount and date of the transfer within seven (7) calendar days after funds have been transferred to State DHCS for use as the nonfederal share of any IGT MMCRRIs.

E. **Form and Timing of Payments**

PLAN agrees to pay LMMCRR IGT Payments to PROVIDER in the following form and according to the following schedule:

(1) PLAN agrees to pay the LMMCRR IGT Payments to PROVIDER using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

(2) PLAN will pay the LMMCRR IGT Payments to PROVIDER no later than thirty (30) calendar days after receipt of the IGT MMCRRIs from State DHCS.

F. **Consideration**

(1) As consideration for the LMMCRR IGT Payments, PROVIDER shall use the LMMCRR IGT Payments for the following purposes and shall treat the LMMCRR IGT Payments in the following manner:

(a) The LMMCRR IGT Payments shall represent compensation for Medi-Cal services rendered to Medi-Cal PLAN members by PROVIDER and shall represent compensation for Medi-Cal services to Medi-Cal PLAN members during the State fiscal year to which the LMMCRR IGT Payments apply.

(b) To the extent that total payments received by PROVIDER in any State fiscal year under the Agreement exceed the cost of Medi-Cal services provided to Medi-Cal beneficiaries by PROVIDER during that fiscal year, any remaining LMMCRR Payment amounts shall be retained by PROVIDER to be expended for health care services. Retained LMMCRR Payment amounts may be used by the PROVIDER in either the State fiscal year received or subsequent State fiscal years.

(2) For purposes of subsection (1) (b) above, if the LMMCRR IGT Payments are not used by PROVIDER in the State fiscal year received, retention of funds by PROVIDER will be established by demonstrating that the retained earnings account of PROVIDER at the end of any State fiscal year in which it received payments based on LMMCRR IGT Payments funded pursuant to the Intergovernmental Agreement, has increased over the unspent portion of the prior

State fiscal year's balance by the amount of LMMCRR IGT Payments received, but not used. These retained PROVIDER funds may be commingled with other County of Monterey funds for cash management purposes provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

(3) Both parties agree that none of these funds, either from the County of Monterey or federal matching funds will be recycled back to the County of Monterey general fund, the State, or any other intermediary organization. Payments made by the health plan to providers under the terms of this Amendment constitute patient care revenues.

G. PLAN's Oversight Responsibilities

PLAN's oversight responsibilities regarding PROVIDER's use of the LMMCRR IGT Payments shall be limited as described in this paragraph. PLAN shall request, within thirty (30) calendar days after the end of each State fiscal year in which LMMCRR IGT Payments were transferred to PROVIDER, a written confirmation that states whether and how PROVIDER complied with the provisions set forth in Paragraph 1.F above. In each instance, PROVIDER shall provide PLAN with written confirmation of compliance within thirty (30) calendar days of PLAN's request.

H. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the LMMCRR IGT Payments, PROVIDER and PLAN agree to work together in all respects to support and preserve the LMMCRR IGT Payments to the full extent possible on behalf of the safety net in Monterey County.

I. Reconciliation

Within one hundred twenty (120) calendar days after the end of each of PLAN's fiscal years in which LMMCRR IGT Payments were made to PROVIDER, PLAN shall perform a reconciliation of the LMMCRR IGT Payments transmitted to the PROVIDER during the preceding fiscal year to ensure that the supporting amount of IGT MMCRRIs were received by PLAN from State DHCS. PROVIDER agrees to return to PLAN any overpayment of LMMCRR IGT Payments made in error to PROVIDER within thirty (30) calendar days after receipt from PLAN of a written notice of the overpayment error, unless PROVIDER submits a written objection to PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8.1 of the Agreement. The reconciliation processes established under this paragraph are distinct from the indemnification provisions set forth below. PLAN agrees to transmit to the PROVIDER any underpayment of LMMCRR IGT Payments within thirty (30) calendar days of PLAN's identification of such underpayment.

J. Indemnification

PROVIDER shall indemnify PLAN in the event that State DHCS, the Department of Health and Human Services or any other federal or state agency recoups, offsets, or otherwise withholds any monies from or fails to provide any monies to PLAN, or PLAN is denied any monies to which it otherwise would have been entitled, as a direct result of the IGT MMCRRIs

arising from the Intergovernmental Agreement. Recovery by PLAN pursuant to this section shall include, but not be limited to, reduction in future LMMCRR IGT Payments to PROVIDER in an amount equal to the amount of IGT MMCRRI Payments withheld or recovered from PLAN, or by reduction of any other amounts owed by PLAN to PROVIDER. This provision shall survive the termination of this Amendment.

2. **Term**

The term of this Amendment shall commence on July 1, 2010 and shall terminate on October 28, 2013.

All other terms and provisions of said 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.

SIGNATURES

HEALTH PLAN: CCAH Date: 4-13-12

By: Title: Chair, James B Parker

PROVIDER: [signature] Date: 4/3/12

By: Title: Chief Executive Officer Harry Weis

TWELFTH AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Twelfth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is made this 1st day of March, 2013, by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended (the "Agreement").

B. Both Plan and Contractor desire to change certain terms of the Agreement.

C. Plan has entered into an agreement with the County of Monterey ("County") and has agreed to provide administrative support services on behalf of County for County's Low Income Health Program ("LIHP").

D. Contractor desires to participate as a Participating Provider for the County Low Income Health Program and agrees to look solely to County for payment for Covered Services provided to Low Income Health Program Members.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

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

1. Section 4.7, Termination of LIHP Without Cause, shall be added to state in full as follows:

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

2. Exhibit 4, Low Income Health Program (LIHP) Attachment, attached hereto, is added as a new Exhibit and incorporated into the Agreement.

3. Exhibit 4-A, Rate Schedule for LIHP Members, attached hereto, is added as a new Exhibit and incorporated into the Agreement.

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

5. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

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

Plan Central California Alliance for Health	Contractor Natividad Medical Center
By: _____	By: _____
Print Name: Alan McKay	Print Name: Harry Weis
Title: Executive Director	Title: CEO
Date: 2/28/13	Date: 2/25/13

Reviewed as to fiscal provisions

_____
Auditor-Controller
County of Monterey

APPROVED AS TO FORM AND LEGALITY

_____ 2/26/13
DEPUTY COUNTY COUNSEL
COUNTY OF MONTEREY

EXHIBIT 4

LOW INCOME HEALTH PROGRAM (LIHP) ATTACHMENT

This Exhibit 4 sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Low Income Health Program (LIHP). For purposes of this Exhibit 4, "County" shall mean County of Monterey.

1. LIHP Members. LIHP Members are Other Members. LIHP Members include Monterey LIHP Members.

   (a) Monterey LIHP Member means any person who is enrolled in and determined to be eligible for the LIHP Program.

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

3. County Responsibility for Funding Payments. For Covered Services for the LIHP, County shall be solely responsible for providing funding for payments for Hospital Services. Plan shall assist County, pursuant to an administrative services agreement between Plan and County, in, among other things, establishment of a network of Providers and administering payments for Covered Services rendered by Contractor from accounts established by County. However, Plan shall have no responsibility for payment and Contractor shall hold Plan harmless from such obligation. All references in the Agreement to a Plan obligation to pay for Hospital Services or Covered Services shall be revised, for purposes of the LIHP only, to specify that obligations to pay Contractor shall be the sole responsibility of County. County shall be entitled to the same rights and subject to the same obligations as Plan in connection with payment terms and conditions under the Agreement. Plan shall be responsible for administration of payments to the extent County funds are made available, and any overpayments received by Contractor shall be returned to Plan as the County's administrator.

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

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

6. Effect of Termination and Survival. Section 4.5(a), Effect of Termination and Survival, shall not apply to the LIHP.

7. Adjustments to Payment Rate. County shall have the same rights as specified for Plan under Section 3.3, Adjustments to Payment Rate.

8. Grievance, Hearings and Appeals. In addition to its obligations under Section 8.2 (a), Member Complaints, Grievances, Inquiries and Claims, Contractor shall cooperate with Plan and County in administering Member grievance, hearing and appeal rights required by the LIHP and as may be set forth in the Provider Manual.

9. Amendments. Notwithstanding Section 9.5 of the Agreement, the Plan may amend this Agreement at any time in order to comply with any change to the LIHP, as adopted by County and/or DHCS, including any change in payment amounts or policies. Such amendment shall be effective upon written notice to Contractor and shall not require the written consent of Contractor.

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

11. Medi-Cal Program. All Medi-Cal program provisions set forth in the Agreement, shall also be applicable to the LIHP, except that in the event of any Medi-Cal program inconsistencies between the Agreement and this Exhibit 4, the terms of this Exhibit 4 shall prevail.

EXHIBIT 4-A
RATE SCHEDULE FOR LIHP MEMBERS

I. Hospital Services Rate Schedule.

A. Hospital Inpatient Services Reimbursement.

(1)

may be subject to adjustment as described in Section 3.3 of this Agreement.

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (h). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment for Covered Services for mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child

(children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174.

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169.

B. Hospital Outpatient and Emergency Room Services Reimbursement. Plan shall pay

HEALTH PLAN-PROVIDER AGREEMENT

PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

AMENDMENT THIRTEEN

This Thirteenth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement (the "Agreement") is made this 25th day of March 2013 {month/year}, 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 Natividad Medical Center, a County Hospital, hereinafter referred to as "PROVIDER".

RECITALS:

WHEREAS, PLAN and PROVIDER have previously entered into the Agreement effective July 1, 2007;

WHEREAS, Section 9.5 of such Agreement provides for amending such Agreement;

WHEREAS, PLAN has been created by its County Boards of Supervisors to negotiate exclusive contracts with the California Department of Health Care Services ("State DHCS") and to arrange for the provision of Medi-Cal health care services to qualifying individuals in Monterey County and PLAN is a public entity, created pursuant to Welfare and Institutions Code 14087.54 and Chapter 7.58 of the Santa Cruz County Code, Chapter 2.45 of the Monterey County Code, and Chapter 9.43 of the Merced County Code;

WHEREAS, PROVIDER, an acute care medical center owned and operated by the County of Monterey ("County"), provides hospital services to PLAN enrollees pursuant to the Agreement, under which it is referred to as "Contractor"; and

WHEREAS, PLAN and PROVIDER desire to amend the Agreement to provide for Medi-Cal managed care capitation rate increases to PLAN as a result of intergovernmental transfers ("IGTs") from the County of Monterey to State DHCS to maintain the availability of Medi-Cal health care services to Medi-Cal beneficiaries.

NOW, THEREFORE, PLAN and PROVIDER hereby agree as follows:

Exhibit 2 of the Agreement is amended by adding Section F at the end to read as follows:

IGT MEDI-CAL MANAGED CARE CAPITATION RATE RANGE INCREASES

1. IGT Capitation Rate Range Increases to PLAN

A. Payment

Should PLAN receive any Medi-Cal managed care capitation rate increases from State DHCS where the nonfederal share is funded by the County of Monterey, on behalf of PROVIDER, specifically pursuant to the provisions of the Intergovernmental Agreement Regarding Transfer of Public Funds ("Intergovernmental Agreement") effective for the period July 1, 2011 through June 30, 2012 for Intergovernmental Transfer Medi-Cal Managed Care Rate Range Increases ("IGT MMCRRIs"), PLAN shall pay to PROVIDER the amount of the IGT MMCRRIs received from State DHCS, in accordance with paragraph 1.E below regarding the form and timing of Local Medi-Cal Managed Care Rate Range ("LMMCRR") IGT Payments. LMMCRR IGT Payments paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by PLAN.

B. Health Plan Retention

(1) Managed Care Organizations Tax

The PLAN shall be responsible for any Managed Care Organization ("MCO") tax due pursuant to the Revenue and Taxation Code Section 12201 relating to any IGT MMCRRIs. If the PLAN receives any capitation rate increases for MCO taxes based on the IGT MMCRRIs, PLAN may retain an amount equal to the amount of such MCO tax that PLAN is required to pay to the State DHCS, and shall pay, as part of the LMMCRR IGT Payments, the remaining amount of the capitation rate increase to PROVIDER.

(2) PLAN will not retain any other portion of the IGT MMCRRIs received from the State DHCS other than those mentioned above.

C. Conditions for Receiving Local Medi-Cal Managed Care Rate Range IGT Payments

As a condition for receiving LMMCRR IGT Payments, PROVIDER shall, as of the date the particular LMMCRR Payment is due:

(1) remain a participating provider in the PLAN and not issue a notice of termination of the Agreement;

(2) maintain its current emergency room licensure status and not close its emergency room;

(3) maintain its current inpatient surgery suites and not close these facilities.

D. Schedule and Notice of Transfer of Non-Federal Funds

(1) PROVIDER shall provide PLAN with a copy of the schedule regarding the transfer of funds to State DHCS, referred to in the Intergovernmental Agreement, within fifteen (15) calendar days of establishing such schedule with the State DHCS. Additionally, PROVIDER shall notify PLAN, in writing, no less than seven (7) calendar days prior to any changes to an existing schedule including, but not limited to, changes in the amounts specified therein.

(2) PROVIDER shall provide PLAN with written notice of the amount and date of the transfer within seven (7) calendar days after funds have been transferred to State DHCS for use as the nonfederal share of any IGT MMCRRIs.

E. Form and Timing of Payments

PLAN agrees to pay LMMCRR IGT Payments to PROVIDER in the following form and according to the following schedule:

(1) PLAN agrees to pay the LMMCRR IGT Payments to PROVIDER using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

(2) PLAN will pay the LMMCRR IGT Payments to PROVIDER no later than thirty (30) calendar days after receipt of the IGT MMCRRIs from State DHCS.

F. Consideration

(1) As consideration for the LMMCRR IGT Payments, PROVIDER shall use the LMMCRR IGT Payments for the following purposes and shall treat the LMMCRR IGT Payments in the following manner:

(a) The LMMCRR IGT Payments shall represent compensation for Medi-Cal services rendered to Medi-Cal PLAN members by PROVIDER during the State fiscal year to which the LMMCRR IGT Payments apply.

(b) To the extent that total payments received by PROVIDER in any State fiscal year under this amendment exceed the cost of Medi-Cal services provided to Medi-Cal beneficiaries by PROVIDER during that fiscal year, any remaining LMMCRR Payment amounts shall be retained by PROVIDER to be expended for health care services. Retained LMMCRR Payment amounts may be used by the PROVIDER in either the State fiscal year received or subsequent State fiscal years.

(2) For purposes of subsection (1) (b) above, if the LMMCRR IGT Payments are not used by PROVIDER in the State fiscal year received, retention of funds by PROVIDER will be established by demonstrating that the retained earnings account of PROVIDER at the end of any State fiscal year in which it received payments based on LMMCRR IGT Payments funded pursuant to the Intergovernmental Agreement, has increased over the unspent portion of the prior State fiscal year's balance by the amount of LMMCRR IGT Payments received, but not used.

These retained PROVIDER funds may be commingled with other County of Monterey funds for cash management purposes provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

(3) Both parties agree that none of these funds, either from the County of Monterey or federal matching funds will be recycled back to the County of Monterey general fund, the State, or any other intermediary organization. Payments made by the health plan to providers under the terms of this Amendment constitute patient care revenues.

G. PLAN's Oversight Responsibilities

PLAN's oversight responsibilities regarding PROVIDER's use of the LMMCRR IGT Payments shall be limited as described in this paragraph. PLAN shall request, within thirty (30) calendar days after the end of each State fiscal year in which LMMCRR IGT Payments were transferred to PROVIDER, a written confirmation that states whether and how PROVIDER complied with the provisions set forth in Paragraph 1.F above. In each instance, PROVIDER shall provide PLAN with written confirmation of compliance within thirty (30) calendar days of PLAN's request.

H. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the LMMCRR IGT Payments, PROVIDER and PLAN agree to work together in all respects to support and preserve the LMMCRR IGT Payments to the full extent possible on behalf of the safety net in Monterey County.

I. Reconciliation

Within one hundred twenty (120) calendar days after the end of each of PLAN's fiscal years in which LMMCRR IGT Payments were made to PROVIDER, PLAN shall perform a reconciliation of the LMMCRR IGT Payments transmitted to the PROVIDER during the preceding fiscal year to ensure that the supporting amount of IGT MMCRRIs were received by PLAN from State DHCS. PROVIDER agrees to return to PLAN any overpayment of LMMCRR IGT Payments made in error to PROVIDER within thirty (30) calendar days after receipt from PLAN of a written notice of the overpayment error, unless PROVIDER submits a written objection to PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8.1 of the Agreement. The reconciliation processes established under this paragraph are distinct from the indemnification provisions set forth below. PLAN agrees to transmit to the PROVIDER any underpayment of LMMCRR IGT Payments within thirty (30) calendar days of PLAN's identification of such underpayment.

J. Indemnification

PROVIDER shall indemnify PLAN in the event that State DHCS, the Department of Health and Human Services or any other federal or state agency recoups, offsets, or otherwise withholds any monies from or fails to provide any monies to PLAN, or PLAN is denied any monies to which it otherwise would have been entitled, as a direct result of the IGT MMCRRIs arising from the Intergovernmental Agreement. Recovery by PLAN pursuant to this section

shall include, but not be limited to, reduction in future LMMCRR IGT Payments to PROVIDER in an amount equal to the amount of IGT MMCRRI Payments withheld or recovered from PLAN, or by reduction of any other amounts owed by PLAN to PROVIDER. This provision shall survive the termination of this Amendment.

2. **Term**

The term of this Amendment shall commence on July 1, 2011 and shall terminate on October 28, 2013.

All other terms and provisions of said 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.

SIGNATURES

HEALTH PLAN: Central California Alliance for Health Date: 3/25/13

By: Title: Chair, _____, CEO

PROVIDER: Natividad Medical Center Date: 3/25/13

By: Title: Chief Executive Officer _____

Reviewed as to fiscal provisions

Michael L. Miller 3/7/13

Auditor-Controller
County of Monterey

APPROVED AS TO FORM AND LEGALITY

DEPUTY COUNTY COUNSEL
COUNTY OF MONTEREY

NW PROVIDER

PLAN

FOURTEENTH ~~THIRTEENTH~~ AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Fourteenth ~~Thirteenth~~ Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is entered into and is effective this first day of January, 2013 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended. The Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement as a result of the Fifth Amendment, effective August 1, 2009.

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

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

PROVIDER

PLAN

RECEIVED
MAY 09 2013
By
~~AFS_NMC_2013 OLI_031213~~
A14

1. Exhibit 5, Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members, shall be amended and replaced with the attached Exhibit 5, Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members.

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

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

Plan Central California Alliance for Health	Contractor Natividad Medical Center
By: _____	By: _____
Print Name: Alan McKay	Print Name: Hamid Khan
Title: Chief Executive Officer	Title: CEO
Date: 6/7/13	Date: 4/25/13

PROVIDER

PLAN

EXHIBIT 5

HOSPITAL OUTPATIENT CLINICAL LABORATORY INCENTIVE PROGRAM FOR MEDI-CAL MEMBERS

A. Introduction.

This Exhibit sets forth the terms of the hospital outpatient clinical laboratory incentive program offered to Hospitals by Plan. This program is designed to compensate Hospital outpatient clinical laboratories for reported valid HEDIS Laboratory Test Results for all Medi-Cal Members on such forms and within such times as requested by Plan, as described herein (the "Outpatient Laboratory Incentive" or the "OLI").

The OLI continues for a limited term as described in Section G of this Exhibit 5, unless it is specifically extended by mutual written agreement of the parties hereto.

B. Definitions.

For the purposes of this Exhibit, the following definitions are applicable. Additional terms are defined in other sections of this Exhibit and in the Agreement.

1. HEDIS Laboratory Test Results are a set of standardized performance measures maintained by the National Committee for Quality Assurance. These measures may change annually.

2. Technical Participation Requirements are those requirements that must be met by Contractor's outpatient clinical laboratory to ensure the confidentiality and validation of data that are received by the Plan. Therefore, Contractor's outpatient clinical laboratory must have the ability to meet the following Technical Participation Requirements:

   a. Establish communications through the internet with the Plan's system;

   b. Create and transmit documents in the proper format and with the required detail as determined by Plan;

   c. Receive reports from the Plan; and

   d. Return corrected and/or missing data, when necessary.

PROVIDER

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C. **Laboratory Test Results.**

Contractor shall submit the following HEDIS Laboratory Test Results for Medi-Cal Members for the outpatient laboratory procedure codes as specified in the chart below:

HEDIS Outpatient Laboratory Test	HEDIS Laboratory Procedure Code
HbA1c	CPT 83036, 83037 CPT Category II 3044F, 3045F, 3046F LOINC 4548-4, 4549-2, 17856-6, 59261-8, 62388-4
LDL-C	CPT 80061, 83700, 83701, 83704, 83721 CPT Category II 3048F, 3049F, 3050F LOINC 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2
Urine Macroalbuminuria	CPT 81000-81003, 81005 CPT Category II 3062F LOINC 5804-0, 20454-5, 50561-0, 53525-2, 57735-3

D. **Submission of Data.**

Contractor's outpatient clinical laboratory shall submit valid HEDIS Laboratory Test Results to Plan, according to specific data interchange requirements of Plan, on a regular basis in a Microsoft Excel spreadsheet, CSV (comma-separated values) file format, or text file.

E. **Payment.**

F. **OLI Payment Determination Final.**

Plan's calculation of payments under the OLI shall be based upon valid HEDIS Laboratory Test Results and shall be final. Contractor acknowledges that Plan would not be willing to offer the OLI if Plan's calculation of payments under the OLI 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 OLI to Contractor,

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Contractor agrees that Contractor will have no right to dispute Plan's determination of payments due under the OLI, including determination of valid HEDIS Laboratory Test Results.

G. Term of Hospital Outpatient Clinical Laboratory Incentive Program.

The OLI shall cover HEDIS Laboratory Test Results for those HEDIS laboratory tests performed beginning January 1, 2013 and continuing through December 31, 2013 ("OLI Term"). All HEDIS Laboratory Test Results must be submitted by January 31, 2014 in order to be compensated under the OLI.

H. Incentive Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement incentive programs for the reporting of HEDIS Laboratory Test Results for periods after completion of the OLI Term. Any such programs shall be on terms determined by Plan. Until Plan and Contractor enter into a written agreement with respect to any such new incentive program extending beyond the OLI Term, no such incentive program shall be binding upon Plan.

I. Effect of Termination of Agreement.

In the event of the termination of the Agreement for any reason prior to the expiration of the OLI Term, OLI incentive payments shall be made only for those calendar quarters in which the Agreement was in effect for the full three (3) months. No OLI incentive payments shall be earned for any quarter during which the Agreement is terminated or for any future quarter.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	NATIVIDAD MEDICAL CENTER
By:	By:
Print Name: Alan McKay	Print Name: Harry Jai
Title: Executive Director	Title: CEO
Date: JUL 05 2013	Date: 7/25/13

PROVIDER

PLAN

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FIFTEENTH AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Fifteenth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is entered into and is effective this first day of November, 2013 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended. The Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement as a result of the Fifth Amendment, effective August 1, 2009.

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

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

1. Delete Exhibit 2 Section A. in its entirety and replace it with the following Exhibit 2 Section A.:

A. Hospital Inpatient Services Reimbursement Effective November 1, 2013.

(1)

(2) Definitions of Days of Service

(a) 'Acute Medical/Surgical/Pediatric Day' shall mean an Inpatient Day approved by Plan in a Hospital for the provision of medical, surgical, or pediatric Inpatient Hospital Services not specifically designated as another Day of Service category set forth in this Section (2) (b) through (i). Such Services shall be billed using inpatient revenue codes 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 150, 151, 153, 157 and 159.

(b) 'Maternity Day' shall mean an Inpatient Day approved by Plan in a Hospital for a mother delivering a baby(ies), through normal or C-Section delivery. The related per diem rate includes payment

for Covered Services for mother only. Such Services shall be billed using inpatient revenue codes 112, 122, 132, and 152.

(c) 'Nursery Level I Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level I Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue codes 170 and 171.

(d) 'Nursery Level II Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level II Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 172.

(e) 'Nursery Level III Day' shall mean an Inpatient Day approved by Plan in a Hospital for a baby(ies), delivered by a mother through normal or C-Section delivery when the newborn child (children) is an inpatient at Contractor and is receiving Level III Nursery care. The related per diem rate includes payment for Covered Services for newborn child (children) only. Such Services shall be billed using inpatient revenue code 173 and 174.

(f) 'ICU Day' shall mean an Inpatient Day approved by Plan in a Hospital for ICU Services. Such Services shall be billed using inpatient revenue codes 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, and 219.

(g) 'Acute Rehabilitation Day' shall mean an Inpatient Day approved by Plan in a Hospital for acute rehabilitation Services. Such Services shall be billed using inpatient revenue codes 118, 128, 138, and 158.

(h) 'Laparoscopic Gastric Banding Surgery Day One' shall mean an Inpatient Day approved by Plan in a Hospital for the first day of laparoscopic gastric banding surgery (lap banding) Services. Such Services shall be billed using inpatient revenue code 126. Inpatient Days approved by Plan for laparoscopic gastric banding surgery (lap banding) Services beyond the first Inpatient Day shall

be defined as an Acute Medical/Surgical/Pediatric Day and reimbursed at the Acute Medical/Surgical/Pediatric per diem rate.

(i) 'Administrative Day' shall mean an Inpatient Day approved by Plan in a Hospital for which acute inpatient care is not required. Such Services shall be billed using inpatient revenue code 169.

2. Delete Exhibit 2 Section B., Hospital Outpatient and Emergency Room Services, in its entirety, and replace it with the following Exhibit 2 Section B., Hospital Outpatient and Emergency Room Services, effective November 1, 2013.

B.

3. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all

prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

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

Plan	Contractor
Central California Alliance for Health	Natividad Medical Center
By:	By:
Print Name: Alan McKay	Print Name:
Title: CEO	Title: CEO
Date: 2/6/14	Date: 1/29/14

SIXTEENTH AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Sixteenth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is entered into and is effective this first day of January, 2014 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended. The Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement as a result of the Fifth Amendment, effective August 1, 2009.

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

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

1. Exhibit 5, Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members, shall be amended and replaced with the attached Exhibit 5, Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members.

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

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

Plan	Contractor
Central California Alliance for Health	Natividad Medical Center
By: _____	By: _____
Print Name: Alan McKay	Print Name: _____
Title: CEO	Title: CEO
Date: 3/20/14	Date: 2/24/14

EXHIBIT 5

HOSPITAL OUTPATIENT CLINICAL LABORATORY

INCENTIVE PROGRAM FOR MEDI-CAL MEMBERS

A. Introduction.

This Exhibit sets forth the terms of the hospital outpatient clinical laboratory incentive program offered to Hospitals by Plan. This program is designed to compensate Hospital outpatient clinical laboratories for reported valid HEDIS Laboratory Test Results for all Medi-Cal Members on such forms and within such times as requested by Plan, as described herein (the "Outpatient Laboratory Incentive" or the "OLI").

The OLI continues for a limited term as described in Section G of this Exhibit 5, unless it is specifically extended by mutual written agreement of the parties hereto.

B. Definitions.

For the purposes of this Exhibit, the following definitions are applicable. Additional terms are defined in other sections of this Exhibit and in the Agreement.

1. HEDIS Laboratory Test Results are a set of standardized performance measures maintained by the National Committee for Quality Assurance. These measures may change annually.

2. Technical Participation Requirements are those requirements that must be met by Contractor's outpatient clinical laboratory to ensure the confidentiality and validation of data that are received by the Plan. Therefore, Contractor's outpatient clinical laboratory must have the ability to meet the following Technical Participation Requirements:

   a. Establish communications through the internet with the Plan's system;

   b. Create and transmit documents in the proper format and with the required detail as determined by Plan;

   c. Receive reports from the Plan; and

   d. Return corrected and/or missing data, when necessary.

C. **Laboratory Test Results.**

Contractor shall submit the following HEDIS Laboratory Test Results for Medi-Cal Members for the outpatient laboratory procedure codes as specified in the chart below:

HEDIS Outpatient Laboratory Test	HEDIS Laboratory Procedure Code
HbA1c	CPT 83036, 83037 CPT Category II 3044F, 3045F, 3046F LOINC 4548-4, 4549-2, 17856-6, 59261-8, 62388-4, 71875-9
LDL-C	CPT 80061, 83700, 83701, 83704, 83721 CPT Category II 3048F, 3049F, 3050F LOINC 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2
Urine Macroalbuminuria	CPT 81000-81003, 81005 CPT Category II 3062F, 3061F LOINC 5804-0, 20454-5, 50561-0, 53525-2, 57735-3

D. **Submission of Data.**

Contractor's outpatient clinical laboratory shall submit valid HEDIS Laboratory Test Results to Plan, according to specific data interchange requirements of Plan, on a regular basis in a Microsoft Excel spreadsheet, CSV (comma-separated values) file format, or text file.

E. **Payment.**

F. **OLI Payment Determination Final.**

Plan's calculation of payments under the OLI shall be based upon valid HEDIS Laboratory Test Results and shall be final. Contractor acknowledges that Plan would not be willing to offer the OLI if Plan's calculation of payments under the OLI 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 OLI to Contractor, Contractor agrees that Contractor will have no right to dispute Plan's determination of payments due under the OLI, including determination of valid HEDIS Laboratory Test Results.

G. Term of Hospital Outpatient Clinical Laboratory Incentive Program.

The OLI shall cover HEDIS Laboratory Test Results for those HEDIS laboratory tests performed beginning January 1, 2014 and continuing through December 31, 2014 ("OLI Term"). All HEDIS Laboratory Test Results must be submitted by January 31, 2015 in order to be compensated under the OLI.

H. Incentive Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement incentive programs for the reporting of HEDIS Laboratory Test Results for periods after completion of the OLI Term. Any such programs shall be on terms determined by Plan. Until Plan and Contractor enter into a written agreement with respect to any such new incentive program extending beyond the OLI Term, no such incentive program shall be binding upon Plan.

I. Effect of Termination of Agreement.

In the event of the termination of the Agreement for any reason prior to the expiration of the OLI Term, OLI incentive payments shall be made only for those calendar quarters in which the Agreement was in effect for the full three (3) months. No OLI incentive payments shall be earned for any quarter during which the Agreement is terminated or for any future quarter.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	NATIVIDAD MEDICAL CENTER
By: _____	By: _____
Print Name: Alan McKay	Print Name: Harry Weis
Title: CEO	Title: CEO
Date: 3/13/14	Date: 2/24/14

HEALTH PLAN-PROVIDER AGREEMENT

PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

AMENDMENT SEVENTEEN

This Seventeenth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement (the "Agreement") is made this 25 day of July, 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 Natividad Medical Center, a County Hospital, hereinafter referred to as "PROVIDER".

RECITALS:

WHEREAS, PLAN and PROVIDER have previously entered into the Agreement effective July 1, 2007;

WHEREAS, Section 9.5 of such Agreement provides for amending such Agreement;

WHEREAS, PLAN has been created by its County Boards of Supervisors to negotiate exclusive contracts with the California Department of Health Care Services ("State DHCS") and to arrange for the provision of Medi-Cal health care services to qualifying individuals in Monterey County and PLAN is a public entity, created pursuant to Welfare and Institutions Code 14087.54 and Chapter 7.58 of the Santa Cruz County Code, Chapter 2.45 of the Monterey County Code, and Chapter 9.43 of the Merced County Code;

WHEREAS, PROVIDER, an acute care medical center owned and operated by the County of Monterey ("County"), provides hospital services to PLAN enrollees pursuant to the Agreement, under which it is referred to as "Contractor"; and

WHEREAS, PLAN and PROVIDER desire to amend the Agreement to provide for Medi-Cal managed care capitation rate increases to PLAN as a result of intergovernmental transfers ("IGTs") from the County of Monterey to State DHCS to maintain the availability of Medi-Cal health care services to Medi-Cal beneficiaries.

NOW, THEREFORE, PLAN and PROVIDER hereby agree as follows:

Exhibit 2 of the Agreement is amended by adding Section G at the end to read as follows:

IGT MEDI-CAL MANAGED CARE CAPITATION RATE RANGE INCREASES

1. IGT Capitation Rate Range Increases to PLAN

A. Payment

Should PLAN receive any Medi-Cal managed care capitation rate increases from State DHCS where the nonfederal share is funded by the County of Monterey, on behalf of PROVIDER, specifically pursuant to the provisions of the Intergovernmental Agreement Regarding Transfer of Public Funds ("Intergovernmental Agreement") effective for the period July 1, 2012 through June 30, 2013 for Intergovernmental Transfer Medi-Cal Managed Care Rate Range Increases ("IGT MMCRRIs"), PLAN shall pay to PROVIDER the amount of the IGT MMCRRIs received from State DHCS, in accordance with paragraph 1.E below regarding the form and timing of Local Medi-Cal Managed Care Rate Range ("LMMCRR") IGT Payments. LMMCRR IGT Payments paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by PLAN.

B. Health Plan Retention

(1) Managed Care Organizations Tax

The PLAN shall be responsible for any Managed Care Organization ("MCO") tax due pursuant to the Revenue and Taxation Code Section 12201 relating to any IGT MMCRRIs. If the PLAN receives any capitation rate increases for MCO taxes based on the IGT MMCRRIs, PLAN may retain an amount equal to the amount of such MCO tax that PLAN is required to pay to the State DHCS, and shall pay, as part of the LMMCRR IGT Payments, the remaining amount of the capitation rate increase to PROVIDER.

(2) PLAN will not retain any other portion of the IGT MMCRRIs received from the State DHCS other than those mentioned above.

C. Conditions for Receiving Local Medi-Cal Managed Care Rate Range IGT Payments

As a condition for receiving LMMCRR IGT Payments, PROVIDER shall, as of the date the particular LMMCRR Payment is due:

(1) remain a participating provider in the PLAN and not issue a notice of termination of the Agreement;

(2) maintain its current emergency room licensure status and not close its emergency room;

(3) maintain its current inpatient surgery suites and not close these facilities.

D. Schedule and Notice of Transfer of Non-Federal Funds

(1) PROVIDER shall provide PLAN with a copy of the schedule regarding the transfer of funds to State DHCS, referred to in the Intergovernmental Agreement, within fifteen (15) calendar days of establishing such schedule with the State DHCS. Additionally, PROVIDER shall notify PLAN, in writing, no less than seven (7) calendar days prior to any changes to an existing schedule including, but not limited to, changes in the amounts specified therein.

(2) PROVIDER shall provide PLAN with written notice of the amount and date of the transfer within seven (7) calendar days after funds have been transferred to State DHCS for use as the nonfederal share of any IGT MMCRRIs.

E. Form and Timing of Payments

PLAN agrees to pay LMMCRR IGT Payments to PROVIDER in the following form and according to the following schedule:

(1) PLAN agrees to pay the LMMCRR IGT Payments to PROVIDER using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

(2) PLAN will pay the LMMCRR IGT Payments to PROVIDER no later than thirty (30) calendar days after receipt of the IGT MMCRRIs from State DHCS.

F. Consideration

(1) As consideration for the LMMCRR IGT Payments, PROVIDER shall use the LMMCRR IGT Payments for the following purposes and shall treat the LMMCRR IGT Payments in the following manner:

(a) The LMMCRR IGT Payments shall represent compensation for Medi-Cal services rendered to Medi-Cal PLAN members by PROVIDER during the State fiscal year to which the LMMCRR IGT Payments apply.

(b) To the extent that total payments received by PROVIDER for any State fiscal year under this amendment exceed the cost of Medi-Cal services provided to Medi-Cal beneficiaries by PROVIDER during that fiscal year, any remaining LMMCRR IGT Payment amounts shall be retained by PROVIDER to be expended for health care services. Retained LMMCRR IGT Payment amounts may be used by the PROVIDER in either the State fiscal year received or subsequent State fiscal years.

(2) For purposes of subsection (1) (b) above, if the LMMCRR IGT Payments are not used by PROVIDER in the State fiscal year received, retention of funds by PROVIDER will be established by demonstrating that the retained earnings account of PROVIDER at the end of any State fiscal year in which it received payments based on LMMCRR IGT Payments funded pursuant to the Intergovernmental Agreement, has increased over the unspent portion of the prior State fiscal year's balance by the amount of LMMCRR IGT Payments received, but not used. These retained PROVIDER funds may be commingled with other County of Monterey funds for cash management purposes provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

(3) Both parties agree that none of these funds, either from the County of Monterey or federal matching funds will be recycled back to the County of Monterey general fund, the State, or any other intermediary organization. Payments made by the health plan to providers under the terms of this Amendment constitute patient care revenues.

G. PLAN's Oversight Responsibilities

PLAN's oversight responsibilities regarding PROVIDER's use of the LMMCRR IGT Payments shall be limited as described in this paragraph. PLAN shall request, within thirty (30) calendar days after the end of each State fiscal year in which LMMCRR IGT Payments were transferred to PROVIDER, a written confirmation that states whether and how PROVIDER complied with the provisions set forth in Paragraph 1.F above. In each instance, PROVIDER shall provide PLAN with written confirmation of compliance within thirty (30) calendar days of PLAN's request.

H. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the LMMCRR IGT Payments, PROVIDER and PLAN agree to work together in all respects to support and preserve the LMMCRR IGT Payments to the full extent possible on behalf of the safety net in Monterey County.

I. Reconciliation

Within one hundred twenty (120) calendar days after the end of each of PLAN's fiscal years in which LMMCRR IGT Payments were made to PROVIDER, PLAN shall perform a reconciliation of the LMMCRR IGT Payments transmitted to the PROVIDER during the preceding fiscal year to ensure that the supporting amount of IGT MMCRRIs were received by PLAN from State DHCS. PROVIDER agrees to return to PLAN any overpayment of LMMCRR IGT Payments made in error to PROVIDER within thirty (30) calendar days after receipt from PLAN of a written notice of the overpayment error, unless PROVIDER submits a written objection to PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8.1 of the Agreement. The reconciliation processes established under this paragraph are distinct from the indemnification provisions set forth below. PLAN agrees to transmit to the PROVIDER any underpayment of LMMCRR IGT Payments within thirty (30) calendar days of PLAN's identification of such underpayment.

J. Indemnification

PROVIDER shall indemnify PLAN in the event that State DHCS, the Department of Health and Human Services or any other federal or state agency recoups, offsets, or otherwise withholds any monies from or fails to provide any monies to PLAN, or PLAN is denied any monies to which it otherwise would have been entitled, as a direct result of the IGT MMCRRIs arising from the Intergovernmental Agreement. Recovery by PLAN pursuant to this section shall include, but not be limited to, reduction in future LMMCRR IGT Payments to PROVIDER in an amount equal to the amount of IGT MMCRRI Payments withheld or recovered from PLAN, or by reduction of any other amounts owed by PLAN to PROVIDER. This provision shall survive the termination of this Amendment.

2. Term

The term of this Amendment shall commence on July 1, 2012 and shall terminate on September 30, 2015.

All other terms and provisions of said 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.

Signatures

HEALTH PLAN: Central California Alliance for Health Date: 6/27/14

By: Title: Chief Executive Officer _____

PROVIDER: Natividad Medical Center Date: 6/25/14

By: Title: Chief Executive Officer _____

EIGHTEENTH AMENDMENT TO THE PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

This Eighteenth Amendment to the Primary Hospital and Outpatient Laboratory Services Agreement ("Amendment") is entered into and is effective this first day of January, 2015 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as the Central California Alliance for Health, a public entity organized under the laws of the State of California, hereinafter referred to as "Plan", and Natividad Medical Center, a County Hospital, hereinafter referred to as "Contractor".

RECITALS

A. The Santa Cruz/Monterey Managed Medical Care Commission and Contractor entered into the Primary Hospital Services Agreement effective July 1, 2007, as amended. The Agreement became the Primary Hospital and Outpatient Laboratory Services Agreement as a result of the Fifth Amendment, effective August 1, 2009.

B. On April 22, 2009, all rights and duties of the Santa Cruz/Monterey Managed Medical Care Commission were transferred to the Santa Cruz-Monterey-Merced Managed Medical Care Commission, pursuant to California Welfare and Institutions Code Section 14087.54, Merced County Code Chapter 9.43, Monterey County Code Chapter 2.45, and Santa Cruz County Code Chapter 7.58. The Santa Cruz-Monterey-Merced Managed Medical Care Commission filed with the California Secretary of State to do business as Central California Alliance for Health, effective July 1, 2009.

C. Both Plan and Contractor desire to change certain terms of the Agreement.

D. Subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment set forth above.

E. References to Sections and Exhibits below are to Sections and Exhibits, respectively, of the Agreement.

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

APR 14 2015

1. Exhibit 5, Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members, shall be amended and replaced with the attached Exhibit 5, Hospital Outpatient Clinical Laboratory Incentive Program for Medi-Cal Members.

2. In all other respects, the provisions of the Agreement are ratified and reconfirmed. In the event there is any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control. The Agreement, as amended, is the entire agreement of the parties and supersedes all prior negotiations, proposals or understandings relating to the subject matter of the Agreement.

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

Plan	Contractor
Central California Alliance for Health	Natividad Medical Center
By:	By:
Print Name: Alan McKay	Print Name: Kelly R O'Keefe
Title: CEO	Title: Interim CEO
Date: 4/27/15	Date: 1/12/17 CC 1/12/15

APPROVED AS TO FORM AND LEGALITY
DEPUTY COUNTY COUNSEL
COUNTY OF MONTEREY

Reviewed as to fiscal provisions
Auditor-Controller
County of Monterey 2-3-15

APR 14 2015

EXHIBIT 5

HOSPITAL OUTPATIENT CLINICAL LABORATORY

INCENTIVE PROGRAM FOR MEDI-CAL MEMBERS

A. Introduction.

This Exhibit sets forth the terms of the hospital outpatient clinical laboratory incentive program offered to Hospitals by Plan. This program is designed to compensate Hospital outpatient clinical laboratories for reported valid HEDIS Laboratory Test Results for all Medi-Cal Members on such forms and within such times as requested by Plan, as described herein (the "Outpatient Laboratory Incentive" or the "OLI").

The OLI continues for a limited term as described in Section G of this Exhibit 5, unless it is specifically extended by mutual written agreement of the parties hereto.

B. Definitions.

For the purposes of this Exhibit, the following definitions are applicable. Additional terms are defined in other sections of this Exhibit and in the Agreement.

1. HEDIS Laboratory Test Results are a set of standardized performance measures maintained by the National Committee for Quality Assurance. These measures may change annually.

2. Technical Participation Requirements are those requirements that must be met by Contractor's outpatient clinical laboratory to ensure the confidentiality and validation of data that are received by the Plan. Therefore, Contractor's outpatient clinical laboratory must have the ability to meet the following Technical Participation Requirements:

   a. Establish communications through the internet with the Plan's system;

   b. Create and transmit documents in the proper format and with the required detail as determined by Plan;

   c. Receive reports from the Plan; and

   d. Return corrected and/or missing data, when necessary.

C. **Laboratory Test Results.**

Contractor shall submit the following HEDIS Laboratory Test Results for Medi-Cal Members for the outpatient laboratory procedure codes as specified in the chart below:

HEDIS Outpatient Laboratory Test	HEDIS Laboratory Procedure Code
HbA1c	CPT 83036, 83037 CPT Category II 3044F, 3045F, 3046F LOINC 4548-4, 4549-2, 17856-6, 59261-8, 62388-4, 71875-9
LDL-C	CPT 80061, 83700, 83701, 83704, 83721 CPT Category II 3048F, 3049F, 3050F LOINC 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2
Urine Macroalbuminuria	CPT 81000-81003, 81005 CPT Category II 3062F, 3061F LOINC 5804-0, 20454-5, 50561-0, 53525-2, 57735-3

D. **Submission of Data.**

Contractor's outpatient clinical laboratory shall submit valid HEDIS Laboratory Test Results to Plan, according to specific data interchange requirements of Plan, on a regular basis in a Microsoft Excel spreadsheet, CSV (comma-separated values) file format, or text file.

E. **Payment.**

RATES REDACTED

F. **OLI Payment Determination Final.**

Plan's calculation of payments under the OLI shall be based upon valid HEDIS Laboratory Test Results and shall be final. Contractor acknowledges that Plan would not be willing to offer the OLI if Plan's calculation of payments under the OLI 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 OLI to Contractor, Contractor agrees that Contractor will have no right to dispute Plan's determination of payments due under the OLI, including determination of valid HEDIS Laboratory Test Results.

G. Term of Hospital Outpatient Clinical Laboratory Incentive Program.

The OLI shall cover HEDIS Laboratory Test Results for those HEDIS laboratory tests performed beginning January 1, 2015 and continuing through December 31, 2015 ("OLI Term"). All HEDIS Laboratory Test Results must be submitted by January 31, 2016 in order to be compensated under the OLI.

H. Incentive Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement incentive programs for the reporting of HEDIS Laboratory Test Results for periods after completion of the OLI Term. Any such programs shall be on terms determined by Plan. Until Plan and Contractor enter into a written agreement with respect to any such new incentive program extending beyond the OLI Term, no such incentive program shall be binding upon Plan.

I. Effect of Termination of Agreement.

In the event of the termination of the Agreement for any reason prior to the expiration of the OLI Term, OLI incentive payments shall be made only for those calendar quarters in which the Agreement was in effect for the full three (3) months. No OLI incentive payments shall be earned for any quarter during which the Agreement is terminated or for any future quarter.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	NATIVIDAD MEDICAL CENTER
By: [signature]	By: [signature]
Print Name: Alan McKay	Print Name: Kelly R. O'Keefe
Title: CEO	Title: Interim COO
Date: 4/27/15	Date: 1/12/15

 APR 14 2015

HEALTH PLAN-PROVIDER AGREEMENT

PRIMARY HOSPITAL AND OUTPATIENT LABORATORY SERVICES AGREEMENT

AMENDMENT NINETEEN

This Amendment is made this 12 day of June 2015 {month/year}, 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 Natividad Medical Center, a County Hospital, hereinafter referred to as "PROVIDER".

RECITALS:

WHEREAS, PLAN and PROVIDER have previously entered into an Agreement effective July 1, 2007;

WHEREAS, Section 9.5 of such Agreement provides for amending such Agreement;

WHEREAS, PLAN has been created by its County Boards of Supervisors to negotiate exclusive contracts with the California Department of Health Care Services ("State DHCS") and to arrange for the provision of Medi-Cal health care services to qualifying individuals in Monterey County and PLAN is a public entity, created pursuant to Welfare and Institutions Code 14087.54 and Chapter 7.58 of the Santa Cruz County Code, Chapter 2.45 of the Monterey County Code, and Chapter 9.43 of the Merced County Code;

WHEREAS, PROVIDER, an acute care medical center owned and operated by the County of Monterey ("County"), provides hospital services to PLAN enrollees pursuant to the Agreement, under which it is referred to as "Contractor"; and

WHEREAS, PLAN and PROVIDER desire to amend the Agreement to provide for Medi-Cal managed care capitation rate increases to PLAN as a result of intergovernmental transfers ("IGTs") from the County of Monterey to the California Department of Health Care Services ("State DHCS") to maintain the availability of Medi-Cal health care services to Medi-Cal beneficiaries.

NOW, THEREFORE, PLAN and PROVIDER hereby agree as follows:

Exhibit 2 of the Agreement is amended by adding Section H at the end to read as follows:

IGT MEDI-CAL MANAGED CARE CAPITATION RATE RANGE INCREASES

1. IGT Capitation Rate Range Increases to PLAN

A. Payment

Should PLAN receive any Medi-Cal managed care capitation rate increases from State DHCS where the nonfederal share is funded by the County of Monterey, on behalf of PROVIDER specifically pursuant to the provisions of the Intergovernmental Agreement Regarding Transfer of Public Funds ("Intergovernmental Agreement") effective for the period July 1, 2013 through June 30, 2014 for Intergovernmental Transfer Medi-Cal Managed Care Rate Range Increases ("IGT MMCRRIs"), PLAN shall pay to PROVIDER the amount of the IGT MMCRRIs received from State DHCS, in accordance with paragraph 1.E below regarding the form and timing of Local Medi-Cal Managed Care Rate Range ("LMMCRR") IGT Payments. LMMCRR IGT Payments paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by PLAN.

B. Health Plan Retention

(1) Medi-Cal Managed Care Seller's Tax

The PLAN shall be responsible for any Medi-Cal Managed Care Seller's ("MMCS") tax due pursuant to the Revenue and Taxation Code Section 6175 relating to any IGT MMCRRIs through June 30, 2014. If the PLAN receives any capitation rate increases for MMCS taxes based on the IGT MMCRRIs, PLAN may retain an amount equal to the amount of such MMCS tax that PLAN is required to pay to the State Board of Equalization, and shall pay, as part of the LMMCRR IGT Payments, the remaining amount of the capitation rate increase to PROVIDER.

(2) PLAN will not retain any other portion of the IGT MMCRRIs received from the State DHCS other than those mentioned above.

C. Conditions for Receiving Local Medi-Cal Managed Care Rate Range IGT Payments

As a condition for receiving LMMCRR IGT Payments, PROVIDER shall, as of the date the particular LMMCRR IGT Payment is due:

(1) remain a participating provider in the PLAN and not issue a notice of termination of the Agreement;

(2) maintain its current emergency room licensure status and not close its emergency room;

(3) maintain its current inpatient surgery suites and not close these facilities.

D. Schedule and Notice of Transfer of Non-Federal Funds

(1) PROVIDER shall provide PLAN with a copy of the schedule regarding the transfer of funds to State DHCS, referred to in the Intergovernmental Agreement, within fifteen (15) calendar days of establishing such schedule with the State DHCS. Additionally, PROVIDER shall notify PLAN, in writing, no less than seven (7) calendar days prior to any changes to an existing schedule including, but not limited to, changes in the amounts specified therein.

(2) PROVIDER shall provide PLAN with written notice of the amount and date of the transfer within seven (7) calendar days after funds have been transferred to State DHCS for use as the nonfederal share of any IGT MMCRRIs.

E. Form and Timing of Payments

PLAN agrees to pay LMMCRR IGT Payments to PROVIDER in the following form and according to the following schedule:

(1) PLAN agrees to pay the LMMCRR IGT Payments to PROVIDER using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

(2) PLAN will pay the LMMCRR IGT Payments to PROVIDER no later than thirty (30) calendar days after receipt of the IGT MMCRRIs from State DHCS.

F. Consideration

(1) As consideration for the LMMCRR IGT Payments, PROVIDER shall use the LMMCRR IGT Payments for the following purposes and shall treat the LMMCRR IGT Payments in the following manner:

(a) The LMMCRR IGT Payments shall represent compensation for Medi-Cal services rendered to Medi-Cal PLAN members by PROVIDER during the State fiscal year to which the LMMCRR IGT Payments apply.

(b) To the extent that total payments received by PROVIDER for any State fiscal year under this Amendment exceed the cost of Medi-Cal services provided to Medi-Cal beneficiaries by PROVIDER during that fiscal year, any remaining LMMCRR IGT Payment amounts shall be retained by PROVIDER to be expended for health care services. Retained

LMMCRR IGT Payment amounts may be used by the PROVIDER in either the State fiscal year for which the payments are received or subsequent State fiscal years.

(2) For purposes of subsection (1) (b) above, if the retained LMMCRR IGT Payments, if any, are not used by PROVIDER in the State fiscal year received, retention of funds by PROVIDER will be established by demonstrating that the retained earnings account of PROVIDER at the end of any State fiscal year in which it received payments based on LMMCRR IGT Payments funded pursuant to the Intergovernmental Agreement, has increased over the unspent portion of the prior State fiscal year's balance by the amount of LMMCRR IGT Payments received, but not used. These retained PROVIDER funds may be commingled with other County of Monterey funds for cash management purposes provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

(3) Both parties agree that none of these funds, either from the County of Monterey or federal matching funds will be recycled back to the County of Monterey general fund, the State, or any other intermediary organization. Payments made by the health plan to providers under the terms of this Amendment constitute patient care revenues.

G. PLAN's Oversight Responsibilities

PLAN's oversight responsibilities regarding PROVIDER's use of the LMMCRR IGT Payments shall be limited as described in this paragraph. PLAN shall request, within thirty (30) calendar days after the end of each State fiscal year in which LMMCRR IGT Payments were transferred to PROVIDER, a written confirmation that states whether and how PROVIDER complied with the provisions set forth in Paragraph 1.F above. In each instance, PROVIDER shall provide PLAN with written confirmation of compliance within thirty (30) calendar days of PLAN's request.

H. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the LMMCRR IGT Payments, PROVIDER and PLAN agree to work together in all respects to support and preserve the LMMCRR IGT Payments to the full extent possible on behalf of the safety net in Monterey County.

I. Reconciliation

Within one hundred twenty (120) calendar days after the end of each of PLAN's fiscal years in which LMMCRR IGT Payments were made to PROVIDER, PLAN shall perform a reconciliation of the LMMCRR IGT Payments transmitted to the PROVIDER during the preceding fiscal year to ensure that the supporting amount of IGT MMCRRIs were received by PLAN from State DHCS. PROVIDER agrees to return to PLAN any overpayment of LMMCRR

IGT Payments made in error to PROVIDER within thirty (30) calendar days after receipt from PLAN of a written notice of the overpayment error, unless PROVIDER submits a written objection to PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8.1 of the Agreement. The reconciliation processes established under this paragraph are distinct from the indemnification provisions set forth below. PLAN agrees to transmit to the PROVIDER any underpayment of LMMCRR IGT Payments within thirty (30) calendar days of PLAN's identification of such underpayment.

J. Indemnification

PROVIDER shall indemnify PLAN in the event that State DHCS, the Department of Health and Human Services or any other federal or state agency recoups, offsets, or otherwise withholds any monies from or fails to provide any monies to PLAN, or PLAN is denied any monies to which it otherwise would have been entitled, as a direct result of the IGT MMCRRIs arising from the Intergovernmental Agreement. Recovery by PLAN pursuant to this section shall include, but not be limited to, reduction in future LMMCRR IGT Payments to PROVIDER in an amount equal to the amount of IGT MMCRRI Payments withheld or recovered from PLAN, or by reduction of any other amounts owed by PLAN to PROVIDER. This provision shall survive the termination of this Amendment.

2. Term

The term of this Amendment shall commence on July 1, 2013 and shall terminate on September 30, 2016.

All other terms and provisions of said 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.

SIGNATURES

HEALTH PLAN: Central California Alliance for Health Date: 6/12/15

By: Title: Chief Executive Officer _____

PROVIDER: Natividad Medical Center Date: 6/10/15

By: Title: Chief Executive Officer _____