

CLINICAS DEL CAMINO REAL, INC.
Specialist Care Professional Services Agreement
AMENDMENT 5

This Fifth Amendment (the “Amendment”) to the Specialist Care Professional Services Agreement dated July 1st, 2019 (“Agreement”) between Clinicas del Camino Real, Inc. (“Clinicas”), a California corporation, with its main offices located at 1040 Flynn Road, Camarillo, CA 93012, and the County of Ventura, a political subdivision of the State of California, including its Ventura County Health Care Agency (“Provider”), effective July 1st, 2023, as follows:

1. The Agreement is extended through December 31, 2025, unless earlier terminated as set forth in the Agreement (the “Extension Term”). Thereafter, the Agreement may be extended, by mutual written agreement by the Parties, for successive one (1) year terms (each a “Renewal Term”).
2. Exhibit A-1, Compensation shall replace in its entirety Exhibit A of the Agreement effective January 1st, 2023. All claims for services provided on or after January 1, 2023 shall be paid under the terms of Exhibit A-1.
3. Clinicas shall pay Provider the rate increases listed in Exhibit A-1 for any and all services rendered on or after January 1, 2023. Any adjustments to previously billed claims shall be jointly reconciled and paid through a lump-sum payment, which shall be made to Provider within forty-five (45) days following the completion of the reconciliation. The reconciliation shall be completed within ninety (90) days following execution of this Amendment.
4. Except as is expressly amended herein, all other terms and conditions of the Agreement shall remain unchanged. In the event there is any inconsistency between the terms of the Agreement and this Amendment, this Amendment shall control.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the parties hereto have executed this amendment as of the date set forth below each signature.

“CLINICAS”

Clinicas del Camino Real, Incorporated

By: _____

Name: Gagan Pawar, M.D.

Title: Chief Executive Officer

Date: _____

“Provider”

County of Ventura

By: _____

Name: Barry L. Zimmerman

Title: HCA Director

Date: _____

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EXHIBIT A-1
Compensation
Effective January 1, 2023

1. **PROVIDER**

Name of Provider: County of Ventura

2. **COVERED SPECIALTY SERVICES.**

Specialty: Multispecialty and Ancillary Services

3. **Compensation.**

- a. Payment for Covered Medical Services rendered by Provider to Plan Members and pre-approved by CLINICAS will be made at Provider's billed charges or the prevailing Fee Schedules Rates provided below as of the date of service, whichever is less. The following Fee for Service rates shall apply to Ancillary Medical Services and professional services, including Hospital Services and Outpatient Hospital Services rendered as Covered Services applicable to the terms of this Agreement for eligible CLINICAS Members when CLINICAS is financially responsible:

Services	Medi-Cal [1]	Medicare [2]	Commercial [2]
Professional Services (Physician and Mid-Level Providers)			
Consults (IP/OP)	% Medi-Cal	% Medicare	% Medicare fee schedule
Surgical/Treatment (IP/OP)	% Medi-Cal	% Medicare	
Telehealth	% Medi-Cal	% Medicare	
Urgent Care	% Medi-Cal	% Medicare	
Emergency Room	% Medi-Cal	% Medicare	
Non-Professional Services – Hospital OP Department and Hospital Based Clinics			
Diagnostics, Ancillary, and Technical Fees	% Medi-Cal	% Medicare	% Medicare fee schedule
Urgent Care	% Medi-Cal	% Medicare	
Drugs[3] [4]	% Billed Charges	% Billed Charges	
Non-Professional Services – FQHC and Other Non-Hospital Based Clinics*			
Diagnostics, Ancillary, and Technical Fees	% Medi-Cal	% Medicare	% Medicare fee schedule
Drugs [3] [4]	% Billed Charges	% Billed Charges	

[1] Rates based on Medi-Cal shall refer to the prevailing Medi-Cal fee schedule as of the date relevant services were rendered, as published by the California Department of Health Care Services, including any additional or supplemental payment(s) that are otherwise payable to Provider under the Medi-Cal Fee-for-Service Program.

[2] Rates based on Medicare shall refer to the prevailing Medicare fee schedule as of the date relevant services were rendered, as published by the Center for Medicaid and Medicare Services, including but not limited to the Medicare Physician Fee Schedule and the Medicare prospective payment system rates, that are otherwise payable to Provider under the traditional Medicare Program.

[3] "Billed Charges" shall refer to Provider's applicable charges as shown in Provider's Charge Description Master in effect as of the date the relevant services were rendered ("Charges").

[4] Rates apply to FDA-approved covered pharmaceuticals as part of an outpatient visit and when CLINICAS has financial responsibility.

- b. For Oncology Services: The initial consultation and three (3) follow-up visits will be authorized. All subsequent visits will require prior authorization. All radiology and laboratory services performed at Provider while patients are receiving treatment do not require authorization.
- c. For all Medical Services with a Relative Value Non-Established (RVNE) procedure and/or unlisted or incompatible CPT/RVRBS, or HCPCS codes, reimbursement shall be paid at percent (%) of Billed Charges or percent (%) of payor(s) Fee Schedule identified in this Agreement, whichever is less.
- d. Provider will provide drugs at the above listed rate at the Charge Master rates as of the Effective Date of the agreement for the duration of the Extension Term. If Provider increases its Charge Master rates for Drugs during the Extension Term, the percentage of bill charges will be adjusted to reflect the same rate as of the Effective Date (e.g., if price for Drug X increases from \$100 to \$105, then the percent of billed charges will reduce from % down to %).
- e. Provider is required to accept payment for services through electronic funds transfer (EFT).
- f. Claims for services rendered shall be submitted within the following timeframes:

- ♦ Medi-Cal: One hundred-eighty (180) days from the date of service.
- ♦ Medicare: Three hundred sixty-five (365) days from the date of service.
- ♦ Commercial: One hundred-eighty (180) days from the date of service.

These timeframes are subject to change based upon State and Federal regulatory requirements. These timeframes may be subject to change if required under State and/or Federal regulation(s).

- g. In the event that Provider identifies an overpayment, duplicate payment or other excess payment ("Overpayment"), Provider shall report within sixty (60) calendar days of the date of identification of the Overpayment as outlined in the Provider Manual. The report shall include the amount of the Overpayment identified and the reason for the Overpayment. Provider shall also make repayment to CLINICAS within sixty (60) calendar days of the date of identification of such Overpayment.
- h. All clean claims will be paid in accordance with Upstream Contractors and Regulatory Agencies.
- i. Prior Authorization Required. Provider recognizes and acknowledges that that except for Emergency Care or as identified above, Prior Authorization by CLINICAS must be obtained on specialty, hospital and certain ancillary services, and that all referrals must be made to CLINICAS contracted providers, unless other arrangements are made prior to services being rendered.
- j. Notwithstanding anything to the contrary, providers have three hundred and sixty-five days (365) after the date of service, date of the explanations of benefits (EOB) or Remittance Advice (RA) delineating specific claims payment, or other claim event to file a claim or claim dispute with CLINICAS. Thereafter, all claims actions will be denied.

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