AMENDMENT ONE to the AGREEMENT
Between
County of Ventura, owner and operator of Ventura County Medical Center and Santa Paula Hospital and Humana

This Amendment One to the Hospital Participation Agreement ("**Amendment**") is hereby made and entered into by and between County of Ventura, owner and operator of Ventura County Medical Center and Santa Paula Hospital **("Hospital")** and Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite or administer health plans ("**Humana**").

WHEREAS Hospital and **Humana** entered into a Hospital Participation Agreement ("Agreement") which was effective as of October 15, 2013;

WHEREAS, to the extent that this Amendment conflicts with the terms and conditions of the Agreement, including any prior amendments, addenda, exhibits, or attachments, this Amendment controls the relationship between the parties.

WHEREAS, any term not otherwise defined herein shall have the meaning as set forth in the Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree to amend the Agreement as follows:

1. Effective August 1, 2024 **Hospital** agrees to participate as a Participating Provider in Medicare Advantage PPO. Medicare Advantage POS and HMO were previously contracted and remain unchanged.

2. **Section 6.1** of the **TERM AND TERMINATION** is hereby deleted in its entirety and replaced with the following:

    6.1 The term of this Agreement shall commence on October 15, 2013, (the "Effective Date") and shall continue through July 31, 2026 ("Initial Term"). Thereafter, the Agreement may be extended by mutual written agreement of the parties.

3. The **PRODUCT PARTICIPATION LIST ATTACHMENT** is hereby deleted in its entirety and replaced with the **PRODUCT PARTICIPATION LIST ATTACHMENT** incorporated herein.

4. The **REIMBURSEMENT ATTACHMENT A MEDICARE ADVANTAGE ("MA") HMO AND MA HMO/POS** is hereby deleted in its entirety and replaced with the **MEDICARE HOSPITAL REIMBURSEMENT** attached hereto.

5. Reimbursement for Covered Services provided by **Hospital** to Medicare Advantage Members shall be in accordance with the **MEDICARE HOSPITAL REIMBURSEMENT** attached hereto.

6. The **HOSPITAL LOCATIONS ATTACHMENT** is hereby deleted in its entirety and replaced with the **HOSPITAL LOCATIONS ATTACHMENT** attached hereto.

7. The **MEDICARE ADVANTAGE PROVISION ATTACHMENT** is hereby deleted in its entirely and replaced with the **MEDICARE ADVANTAGE PROVISIONS ATTACHMENT** attached hereto.

8. The parties agree that Hospital shall not be liable for reimbursing Humana for any inpatient prospective payment system components paid to Hospital, if any, in error prior to August 1, 2024.

Except as specifically amended hereby, all other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have the authority necessary to bind the entities identified herein and have executed this Amendment to be effective as of .

Hospital

Legal Entity: County of Ventura, owner and operator of Ventura County Medical Center and Santa Paula Hospital

Signature:

Printed Name:

Title:

Date:

Tax ID: 956000944

HUMANA

Signature:

Printed Name:

Title:

Date:

PRODUCT PARTICIPATION LIST

ATTACHMENT

Hospital agrees to participate in the health benefits plan(s) selected below, whether self-funded or fully insured, that are offered or administered by **Humana**.

Health Benefits Plan	**(Check only those which apply)**
Medicare PPO Plans	X
Medicare POS Plans	X
Medicare HMO Plans	X

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MEDICARE HOSPITAL REIMBURSEMENT

Section 1
INPATIENT HOSPITAL SERVICES

1.1 **Hospital** agrees to accept as payment in full from **Humana** for Covered Services one hundred percent (100%) of **Hospital's** Medicare allowable or **Hospital's** billed charges eligible for reimbursement, whichever is less, minus any deductible, copayment, coinsurance, or other amounts that are the responsibility of the Member (hereinafter referred to as "**Cost Share**").
Humana's reimbursement is based on the following factors:

a. The payment rate in effect as of the date the service is rendered
b. The payment rate as adjusted as described in Section 1.2

1.2 Notwithstanding anything to the contrary in the Agreement, the parties agree that **Humana** shall not reimburse **Hospital** for Medicare inpatient prospective payment system components including, but not limited to the items listed in Table 1 below:

1.2.1 The parties agree that **Hospital** will be reimbursed for the Disproportionate Share Hospital (DSH) component.

Table 1:

- Capital Indirect Medical Education (IME)
- Operating Indirect Medical Education (IME)
- Direct Graduate Medical Education
- Nursing School Pass Through

1.3 The parties further agree that **Hospital** will not be reimbursed for bad debt.

1.4 In the event CMS changes its reimbursement policies regarding the Medicare inpatient prospective payment system the parties agree that **Humana's** reimbursement will be automatically adjusted to reflect such change without notice to **Hospital**.

Section 2
OUTPATIENT HOSPITAL SERVICES

2.1 **Hospital** agrees to accept as payment in full from **Humana** for Covered Services one hundred percent (100%) of **Hospital's** Medicare allowable amount in effect as of the date such services are rendered or **Hospital's** billed charges eligible for reimbursement, whichever is less, minus any Cost Share due from Members. Notwithstanding anything to the contrary in the Agreement, the parties agree that **Humana** shall not reimburse **Hospital** for Medicare outpatient prospective payment system components that are eligible to be reimbursed to **Hospital** through the Medicare cost report.

Section 3
ALL OTHER SERVICES FURNISHED WITHIN A SUB-UNIT OR PER CMS DESIGNATION

3.1 Both parties agree that all Covered Services provided by **Hospital** which are performed within a CMS designated sub-unit are included in this Agreement. **Hospital** agrees to accept as payment in full from **Humana** for Covered Services one hundred percent (100%) of **Hospital's** Medicare allowable amount in effect as of the date such services are rendered or **Hospital's** billed charges eligible for reimbursement, whichever is less, less any Cost Share due from Members. Notwithstanding anything to the contrary in the

Agreement, the parties agree that **Humana** shall not reimburse **Hospital** for prospective payment system components that are eligible to be reimbursed to **Hospital** through the Medicare cost report.

Section 4
MEDICARE PAYMENT GUIDELINES

4.1 **Reimbursement: Hospital** agrees to submit claims according to the current billing guidelines outlined in the sources listed below:

A. CMS *Medicare Provider Reimbursement Manual,* Publication 15-1 and 15-2,
B. Medicare Claims Processing Manual, Publication 100-04
C. National Uniform Billing Committee (NUBC),
D. American Medical Association (AMA)/Current Procedural Technology (CPT).
E. UB-04 Data Specifications Manual
F. ICD-9-CM Official Guidelines for Coding and Reporting, or its successor
G. Any applicable published state specific Medicaid guidelines or requirements.
H. Only charges that meet the billing criteria outlined in the above publications, or their successors, will be considered for payment, unless otherwise authorized by Humana. In certain situations, **Humana** may request additional information in order to confirm proper billing. **Hospital** agrees to submit the requested information in a timely manner.

4.2 **Readmissions**: Readmissions for Medicare Advantage Members are processed and paid in accordance with CMS Medicare Advantage laws, rules and regulations.

4.3 **Multiple Surgery**: Claims involving multiple surgeries are processed and paid in accordance with CMS Medicare Advantage laws, rules, and regulations.

4.4 **Global Payment**: No separate payment will be made for Covered Services that are considered to be part of a bundled payment or a global rate when those Covered Services are provided by another physician and/or hospital that is affiliated or has ownership of the provider that received the global payment.

4.5 **Changes to Services Rendered: Hospital** shall notify **Humana** prior to discontinuing a service or subcontracting or outsourcing a Covered Service that is specifically included in a payment rate at the effective date of the Agreement. This includes but is not limited to the technical component of laboratory and/or radiology services.

Hospital further agrees to notify **Humana** if any additional service is introduced that would result in a material financial impact to **Humana's** reimbursement under the Agreement. This also includes new innovations or new technologies that foster the development of a new service or new procedure that is not available as of the Effective Date of this Agreement.

Both parties agree that unless the Agreement is specifically amended to adjust for the change in services rendered, **Humana** will not incur costs in excess of the original contracted payment rate.

4.6 **Audits: Humana** or its designee shall have the right to conduct audits of **Hospital** records, including medical records, itemized bills and other relevant supporting documentation related to services rendered to **Humana** Members. **Hospital** shall allow **Humana** or its designee access to **Hospital's** records to conduct audits at no charge.

Hospital shall obtain from **Humana** Members their authorization for release of medical records to **Humana** along with the **Hospital's** consent to treatment forms, or to waive the requirement if permitted by applicable law**.**

This audit provision shall supersede the **Hospital's** Internal Audit Policy and shall survive the termination or expiration of this Agreement.

If there is no specific rule related to a charge in question, **Humana** will employ CMS billing guidelines as stated in the Medicare Manuals for Medicare cases or cases that pay a Medicare rate, **Humana** Published Policies including Medical Coverage Policies and Code Editing Policies,

National Uniform Billing Guidelines, American Medical Association Current Procedural Terminology (CPT®) guidelines, National Health Care Billing Audit Guidelines, industry standard utilization management criteria and/or care guidelines, Coding Clinic Guidelines and Charge Master Guide guidelines as they relate to and define services billed and any other generally accepted industry standard guidelines

Audits may be performed by either of the following methods:

- **Onsite Audit: Humana** sends an auditor to the **Hospital** to review the medical records.
- **Desk Audit: Humana** requests electronic copies of the medical records prior to payment or on a post-payment basis.

Onsite Audits: Humana will notify **Hospital** of its intent to audit **Hospital** records and identify which claims will be audited within 180 days of the last date of payment by **Humana** on the identified claims. Within thirty (30) days of **Hospital's** receipt of **Humana's** notice of intent to audit, **Hospital** shall provide to **Humana** or its designee an electronic copy of the itemized bill for each identified claim to be audited. **Hospital** shall allow **Humana** access to all **Hospital's** medical records related to the identified claims for audit. **Humana** will complete the audit within 180 days from the date of **Humana's** date of request for audit.

Humana will conduct exit conferences with the **Hospital** within thirty (30) calendar days from the date **Humana** completes the audit. If requested by **Humana**, **Hospital** shall re-submit a corrected claim within sixty (60) days following the exit conference in order to receive additional reimbursement for audited claims, if any is due. **Hospital** shall refund to **Humana** any amounts as determined by the audit that **Humana** has overpaid to **Hospital** with respect to the audited claims. **Hospital** shall refund any overpayments to **Humana** within sixty (60) days following **Hospital's** receipt of notification from **Humana** of such overpayment.

Desk Audits: The purpose of the Desk Audit includes, but is not limited to, determination of either of the following:

- Whether the service meets **Humana's** definition of Medically Necessary.
- Whether the service was billed and/or coded correctly.

Desk Audits will be performed within eighteen (18) months from original date of payment or such other period as may be required or allowed by applicable law. For these situations, **Humana** will request copies of medical records and **Hospital** agrees to send information within thirty (30) days of receipt of request at no charge to **Humana**. If the records are not received, a technical denial notice will be issued in accordance with **Humana's** administrative policies. If **Humana** collects the paid amount for the inability to substantiate charges and **Hospital** later submits the records, **Humana** will repay the collected amount to **Hospital** and conduct the audit. **Hospital** may upload records electronically, or provide the records by mail, or fax.

If **Humana** determines that a coding and/or payment adjustment is applicable, **Hospital** will be informed of the Desk Audit findings, via letter. If **Hospital** disagrees with the adjustment, **Hospital** may request a review of the Desk Audit findings within sixty (60) days following receipt of letter.

4.7 **Hospital Acquired Conditions: Humana**'s claims processing procedures apply the CMS guidelines for Hospital Acquired Conditions for Medicare Plans, which results in an adjustment in the DRG assignment and payment for certain hospital-acquired conditions specified by CMS. **Hospital** will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as if the secondary diagnosis and related procedures were not present.

For services that are not contracted on the DRG-based reimbursement methodology, payment adjustments may be applied for hospital-acquired conditions as specified by CMS. **Hospital** will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as if a secondary diagnosis and related procedures were not present.

Hospital agrees to report all secondary diagnoses that are present on the admission of any **Humana** Medicare Member by utilizing the Present On Admission (POA) indicator on all claim submissions in accordance with CMS regulations.

Hospital acknowledges and agrees that no payment is due by **Humana** or the Member for **Hospital** charges associated with Hospital Acquired Conditions as defined and updated by CMS. **Humana** has the right to recover any payment made in error related to Hospital Acquired Conditions.

4.8 **Exclusions:** The parties agree the Agreement does not cover solid organ and blood and marrow stem cell transplant services and no payment will be made by **Humana** for same under the Agreement Services related to a Ventricular Assist Device ("VAD") Destination Therapy, DRG 001 and DRG 002 are not considered to be transplant exclusion and will be covered by this Agreement.

HOSPITAL LOCATIONS

ATTACHMENT

(To be provided by **Hospital** prior to execution of this Agreement.)

The following is a complete list of the **Hospital's** locations, including address, contact person, telephone number, and tax identification number, for **Hospitals** that will be providing services to **Humana** Members under this Agreement. **Hospital** shall provide **Humana** with no less than thirty (30) days prior written notice of any change of any closing of a location.

In the event **Hospital** begins providing services at other locations either by operating such services locations itself, acquiring, merging or affiliating with an existing provider of services, such additional services or locations will become subject to this agreement only upon the mutual written agreement of the parties.

Hospital Site Name	Service Address & General Phone Number	Claims Payment Address & Phone Number	Hospital's Tax I.D. Number	NPI	Facility Type
Ventura County Medical Center	300 Hillmont Ave. Ventura, CA 93003 (805) 652-6058	800 S. Victoria Ave. L#4640 Ventura, CA 93009 (805) 648-9561	95-6000944	1629167457	Hospital
Santa Paula Hospital	825 N. Tenth St. Santa Paula, CA 93060 (805) 933-8600	800 S. Victoria Ave. L#4640 Ventura, CA 93009 (805) 648-9561	95-6000944	1629167457	Hospital

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MEDICARE ADVANTAGE PROVISIONS

ATTACHMENT

The following additional provisions ("Medicare Advantage Provisions") relate specifically to Medicare Advantage products and plans and are hereby incorporated by reference into the Agreement.

a) **Hospital** agrees to: (i) abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, (ii) ensure that medical information is released only in accordance with applicable state and/or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

b) **Humana** and **Hospital** agree that **Humana** will process all claims for Covered Services which are accurate and complete within thirty (30) days from the date of receipt.

c) **Hospital** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana**'s insolvency or breach of this Agreement, shall **Hospital** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Covered Services provided by **Hospital** for which payment is the legal obligation of **Humana**. This provision shall not prohibit collection by **Hospital** from Member for any non-covered service and/or Copayments in accordance with the terms of this Agreement and the applicable Member health benefits contract. **Hospital** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Hospital** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Hospital**, and **Hospital** shall obtain from such persons specific agreement to this provision.

d) **Hospital's** performance of services under the Agreement shall be consistent and in compliance with **Humana**'s contractual obligations under its Medicare Advantage contract(s). **Hospital** agrees to cooperate with and assist **Humana** in its efforts to comply with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist **Humana** in complying with corrective action plans necessary for **Humana** to comply with such rules and regulations.

e) **Hospital** agrees that nothing in the Agreement shall be construed as relieving **Humana** of its responsibility for performance of duties agreed to through its Medicare Advantage contracts existing now or entered into in the future with CMS.

f) **Hospital** agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation the rights of **Humana** and applicable, federal and state regulatory agencies including, but not limited to, HHS, the Comptroller General or their designees to evaluate, inspect and audit **Hospital**'s operations, books, records, and other documentation and pertinent information related to **Hospital**'s obligations under the Agreement, as well as all other state and federal laws, rules and regulations applicable to individuals and entities receiving federal funds. **Hospital** further agrees that such rights to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between **Humana** and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

g) **Hospital** agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or as related to **Hospital's** obligations under the Agreement for a period of not less than ten (10) years from: (i) each successive December 31; or (ii) the end of the contract period between **Humana** and CMS; or (iii) from the date of completion of any audit, whichever is later.

h) **Hospital** agrees in the event certain identified activity(ies) have been delegated to **Hospital** under the Agreement, any sub-delegation of the noted activity(ies) by **Hospital** requires the prior written approval of **Humana**. Notwithstanding anything to the contrary in the Agreement, **Humana** will monitor **Hospital's** performance of any delegated activity(ies) on an ongoing basis and hereby retains the right to modify, suspend or revoke such delegated activity(ies) in the event **Humana** and/or CMS determines, in their discretion, that **Hospital** is not meeting or has failed to meet its obligations under the Agreement related to such delegated activity(ies). In the event that **Humana** has delegated all or any part of the claims payment process to **Hospital** under the Agreement, **Hospital** shall comply with all prompt payment requirements to which **Humana** is subject. **Humana** agrees that it shall review the credentials of **Hospital** or, if **Humana** has delegated the credentialing process to **Hospital**, **Humana** shall review and approve **Hospital**'s credentialing process and audit it on an ongoing basis.

i) **Hospital** agrees to comply with **Humana**'s policies and procedures and complete general compliance training and fraud, waste, and abuse training as required by CMS.

j) **Hospital** agrees to maintain full participation status in the federal Medicare program. This also includes all of **Hospital**'s employees, subcontractors, and/or independent contractors who will provide services, including, without limitation, health care, utilization review, medical social work, and/or administrative services under the Agreement.

k) **Hospital** agrees that payment from **Humana** for services rendered to **Humana**'s Medicare Advantage Members is derived, in whole or in part, from federal funds received by **Humana** from CMS.

l) **Hospital** agrees to disclose to **Humana**, upon request and within thirty (30) days or such lesser period of time required for **Humana** to comply with all applicable state and/or federal laws, all of the terms and conditions of any payment arrangement that constitutes a "physician incentive plan" as defined by CMS and/or any federal law or regulation. Such disclosure should identify, at a minimum, whether services not furnished by the physician/provider are included, the type of incentive plan including the amount, identified as a percentage, of any withhold or bonus, the amount and type of any stop-loss coverage provided for or required of the physician/provider, and the patient panel size broken down by total group or individual physician/provider panel size, and by the type of insurance coverage (i.e., Commercial HMO, Medicare Advantage HMO, Medicare PPO, and Medicaid HMO).

m) **Hospital** agrees that in the event of **Humana**'s insolvency or termination of **Humana**'s contract with CMS, benefits to Members will continue through the period for which premium has been paid and benefits to Members confined in an inpatient facility will continue until their discharge.

n) **Hospital** agrees to provide or arrange for continued treatment, including, but not limited to, medication therapy, to Medicare Advantage Members upon expiration or termination of the Agreement. In accordance with all applicable state and federal laws, rules and/or regulations, treatment must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Medicare Advantage Member's course of treatment, or until **Humana** has made arrangements for substitute care for the Medicare Advantage Member; and (ii) until the date of discharge for Medicare Advantage Members hospitalized on the effective date of termination or expiration of the Agreement. **Hospital** agrees to accept as payment in full from **Humana** for Covered Services rendered to **Humana**'s Medicare Advantage Members, the rates set forth in the **Hospital** Reimbursement Attachment which are applicable to such Member.

o) **Hospital** agrees to cooperate with the activities and/or requests of any independent quality review and improvement organization utilized by and/or under contract with **Humana** as related to the provision of services to Medicare Advantage Members.

p) **Hospital** agrees to cooperate with **Humana**'s health risk assessment program.

q) **Hospital** agrees to provide to **Humana** accurate and complete information regarding the provision of Covered Services by **Hospital** to Members ("Data") on a complete CMS 1500 or UB 04 form, or their respective successor forms as may be required by CMS, or such other form as may be required by law when submitting claims and encounters in an electronic format, or such other format as is mutually agreed upon by both parties. The Data shall be provided to **Humana** on or before the last day of each month for encounters occurring in the immediately preceding month, or

such lesser period of time as may be required in the Agreement, or as is otherwise agreed upon by the parties in writing. The submission of the Data to **Humana** and/or CMS shall include a certification from **Hospital** that the Data is accurate, complete and truthful. In the event the Data is not submitted to **Humana** by the date and in the form specified above, **Humana** may, in its sole option, withhold payment otherwise required to be made under the terms of the Agreement until the Data is submitted to **Humana**.

r) **Hospital** agrees not to collect or attempt to collect copayments, coinsurance, deductibles or other cost-share amounts from any **Humana** Medicare Advantage Member who has been designated as a Qualified Medicare Beneficiary ("QMB") by CMS.

s) **Hospital** agrees to require its employed and contracted health care providers and health care professionals providing services under the Agreement to comply with the terms and conditions of the Agreement. **Hospital** must maintain written agreements with any contracted health care providers and health care professionals, as applicable, that include terms and conditions that comply with the Medicare Advantage Provisions and all applicable requirements for provider agreements under state and federal laws, rules and regulations including, without limitation, the Medicare Advantage rules and regulations to which **Humana** is subject. In the event of a conflict between the language of such downstream agreements and the Agreement, the language in the Agreement shall control.

t) With respect to any Members who are eligible for both Medicare and Medicaid, **Hospital** agrees that such Members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such Members, **Hospital** agrees to: (i) accept the payment amount from **Humana** as payment in full, or (ii) bill the appropriate State source.

u) **Hospital** certifies that **Hospital** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally-funded health care program. **Hospital** shall review the Office of Inspector General and General Services Administration exclusion files and the CMS Preclusion List and verify on a monthly basis (or as often as required by CMS) that the persons it employs or contracts for the provision of services under the Agreement are in good standing. **Hospital** shall notify **Humana** immediately upon becoming aware that **Hospital** or its principals, employees, agents, or subcontractors have been excluded, suspended, or debarred from participation in any federally-funded health care program.

v) After the expiration of the sixty (60) day time period specified in 42 C.F.R. 422.222, or successor regulation, any individual or entity on the CMS Preclusion List shall: (i) no longer be eligible for payment from **Humana** and shall be prohibited from pursuing payment from the Member, and (ii) hold financial responsibility for services, items, and drugs that are furnished, ordered, or prescribed.

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