AMENDMENT TWO (2) TO
HOSPITAL SERVICES AGREEMENT
BETWEEN
HERITAGE PROVIDER NETWORK, INC.
AND
THE COUNTY OF VENTURA

This second amendment ("Amendment Two (2)") to the Hospital Services Agreement ("Agreement") is made and entered into effective October 1, 2023 by and between Heritage Provider Network, Inc. ("HPN"), a California corporation, and the County of Ventura, owner and operator of Ventura County Medical Center with campuses in the cities of Ventura and Santa Paula (collectively referred to as "Hospital") dated August 1, 2006.

RECITALS

WHEREAS, HPN has executed, and may execute in the future additional written agreements with self insured Plans, full service Health Care Services Plans and Federally Qualified Health Maintenance Organizations ("Plan(s)") who may pay HPN on a global capitated or risk or other basis under the laws of the State of California in accordance with the licensure of HPN, including but not limited to the Knox-Keene Health Care Service Plan Act of 1975, as amended and the provision of the enacted federal statutes, including but not limited to the Balanced Budget Act of 1997, as amended, for the provision of health care services to persons enrolled as Beneficiaries / Enrollees ("Enrollees") of Plans, and

WHEREAS, the Plans do require HPN to incorporate specific language into provider agreements.

WHEREAS, both parties now desire to amend certain provisions of the Agreement.

AGREEMENT

NOW THEREFORE, in consideration of the mutual covenants and agreements, and subject to the conditions and limitations set forth, both parties agree to amend the Agreement as follows:

1. Exhibit A (Compensation Agreement) in the base Agreement effective on August 15, 2006 is hereby deleted in its entirety;

2. Amendment One (1) effective November 1, 2009 is deleted in its entirety;

3. A new Exhibit A, is attached and incorporated by reference into the Agreement effective October 1, 2023.

4. Section 6.1 of the Agreement ("Term) is deleted in its entirety and replaced with the following:

   6.1 Term – This Agreement, with an original effective date of August 1, 2006, shall be extended through September 30, 2026, unless earlier terminated as set forth in the Agreement. Thereafter, the Agreement may be extended by mutual written agreement of the parties.

5. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect. In the event of any inconsistency between the terms of this Amendment Two (2) and the Agreement, the terms of this Amendment Two shall govern and control.

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

HPN	**Hospital**
By:_____ *(Signature)*	By: _____ *(Signature)*
Name:_____ *(Please print)*	Name: Barry L. Zimmerman *(Please print)*
Title:_____	Title: HCA Director
Date:_____	Date: _____

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EXHIBIT A

To The

Compensation Agreement

Between

Heritage Provider Network

and

The County of Ventura, owner and operator of Ventura County Medical Center

Effective: October 1, 2023

For Covered Hospital Services rendered by Hospital on behalf of eligible Members enrolled with and/or managed by HPN, HPN shall pay the lesser of Hospital's billed charges, or the contracted rates herein for Commercial Members and California Exchange Members, or Medicare rates for Medicare Advantage Members, or Medi-Cal rates for Medi-Cal Managed Care Members, in each case less Member's copayment, deductible or coinsurance, as applicable.

COMMERCIAL HMO, POINT OF SERVICE and COVERED CALIFORNIA EXCHANGE ENROLLEES

Inpatient Services: % of the prevailing and fully loaded Hospital-specific Medicare Severity Diagnosis-Related Group (MS-DRG) rates, which shall include all Medicare inpatient prospective payment system components, such as outlier, pass-through, and disproportionate share payment.

Outpatient Services: % of the prevailing Medicare rates, including but not limited to Outpatient Prospective Payment System (OPPS) and Medicare Ambulatory Payment Classification (APC) rates.

Unlisted Codes: % of Hospital's billed charges not to exceed $ for Covered Services for which Medicare has not established a reimbursement rate.

Other Payment Provisions:

1) HPN retains the right to review all medical records related to Beneficiary/Enrollee.

2) Reimbursement shall be the lesser of Hospital's billed charges or the rates listed herein.

3) All claims will be adjudicated based on CMS billing, adjudication and payment rules and guidelines.

4) The rates contained herein are for Hospital Services only, and Professional Services are excluded.

MEDICARE ENROLLEES

Inpatient Services: % of the prevailing and fully loaded Hospital-specific Medicare Severity Diagnosis-Related Group (MS-DRG) rates, which shall include all Medicare inpatient prospective payment system components, such as outlier, pass-through, and disproportionate share payment.

Outpatient Services: % of the prevailing Medicare rates, including but not limited to Outpatient Prospective Payment System (OPPS) and Medicare Ambulatory Payment Classification (APC) rates.

Unlisted Codes: % of Hospital's billed charges not to exceed $ for Covered Services for which Medicare has not established a reimbursement rate.

Other Payment Provisions:

1) HPN retains the right to review all medical records related to Beneficiary/Enrollee.

2) Reimbursement shall be the lesser of Hospital's billed charges or the rates listed herein.

3) All claims will be adjudicated based on CMS billing, adjudication and payment rules and guidelines.

4) The rates contained herein are for Hospital Services only, and Professional Services are excluded.

MEDI-CAL ENROLLEES

***Inpatient Services*:** % of the State of California Medi-Cal All Patient Refined Diagnosis Related Groups ("APR-DRG") Fee Schedule, inclusive of Administrative Days, Level 1 (Revenue Code 169) and Level 2 (Revenue Codes 190, 199), which shall be authorized and paid to Hospital separately in accordance APR-DRG guidelines. Administrative Day Level 2 services will be paid to Hospital at the corresponding rate published by California Department of Health Care Services ("DHCS") in the applicable version of the "Medi-Cal DRG Pricing Calculator" for DRG-reimbursed hospitals in the County of Ventura.

***Outpatient Services*:** % of the State of California Outpatient Medi-Cal fee schedule, inclusive of the augmentation rate for eligible services, as defined by DHCS on its website ("Augmentation Rate") for the period in which the services are provided. The parties agree that the Augmentation Rate will be paid for all outpatient locations covered under Hospital's license and billed under the Hospital's National Provider Identifier number, consistent with DHCS' Medi-Cal payment guidelines.

Other Payment Provisions:

1) All claims will be adjudicated based on State of California Medi-Cal billing, adjudication and payment rules and guidelines.

2) HPN retains the right to review all medical records related to Beneficiary/Enrollee.

3) Reimbursement shall be the lesser of Hospital's billed charges or the rates listed herein.

4) The rates contained herein are for Hospital Services only, and Professional Services are excluded.

OTHER – COMPENSATION TERMS AND CONDITIONS:

a) New Service / Technology. HPN agrees that the rates in **Exhibit A** shall not apply to any new service or technology ("New Service / Technology") that is added by Hospital in the future. For purposes of this Agreement, New Service/Technology is defined as: a service, procedure, device, test, or other Covered Service that, as of the first effective date of this Exhibit A, is not performed by Hospital. The addition of a new code that is assigned as a change to an existing service, procedure, device, test, or Covered Service, does not constitute a New Service / Technology. If Hospital offers a New Service / Technology, Hospital shall notify HPN within sixty (60) days of adding such New Service / Technology and the parties shall enter into good faith negotiations to add new rate(s) and applicable "qualifier" code(s) for the New Service / Technology, as deemed necessary.

b) Aberrancy. Hospital agrees that HPN shall not pay for "Never Events" and/or Hospital Acquired Conditions (HACs) as defined by CMS and/or the National Quality Forum (NQF). Never Events, formally known as Serious Reportable Events (SREs), are errors in medical care that are of concern to both the public and healthcare professionals and providers, clearly identifiable, measurable and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization. Hospital Acquired-Conditions (HACs) are conditions that are: high cost or high volume or both, and (a) identified through ICD-10-CM coding as a complicating/major condition that, when present as a secondary diagnosis at discharge, results in payment at a higher MS-DRG and (b) could reasonably have been prevented by the hospital through the application of evidence-based guidelines.

Hospital also acknowledges that Hospital services should be provided in an efficient manner to ensure patient safety and quality, which are consistent with the principles of managed care. Thus, HPN shall also not pay for any delays in rendering care or extending length of stay unnecessarily due to the Hospital's direct action(s) or inaction. Circumstances considered inadequate causes for delays in care or which extend the length of stay that are reasonably preventable through the application of evidence-based guidelines by the hospital include but are not limited to:

- When hospital's services, medications and/or equipment required to provide medically necessary care at the orders of the attending physician are not available i.e. Catheterization lab closed due to hospital's operating hours or equipment failures;

- Hospital staff shortage or absenteeism i.e. PT evaluations neglected because therapist not working to administer;

- Nurse(s) failure to follow a physician orders critical to a physician's ability to perform a procedure or discharge patient, i.e., nurse feeding patient when orders instruct

to withhold oral food and fluids (NPO);

- Hospital's refusal to cooperate after two (2) written requests from HPN when patient requires transfer to an alternate facility and beneficiary / enrollee's physician agrees that the patient is medically stable for transfer.