Thirteenth (13th) Amendment
to the
Provider Agreement
by and between
Valley Care Physicians IPA Medical Associates, Inc.
and
County of Ventura

This thirteenth (13th) amendment to that certain agreement dated December 1, 2004 by and between Valley Care Physicians IPA Medical Associates, Inc., d.b.a. Valley Care IPA ("Group") and the County of Ventura, owner and operator of Ventura County Medical Center ("VCMC") and Santa Paula Hospital ("SPH"), a campus of VCMC (collectively referred to as "Provider"), as amended ("Agreement"), is made and entered into as of June 1, 2019 ("Amendment").

WHEREAS, Group and Provider entered into the Agreement, whereby Provider agrees to provide Covered Services on behalf of Group to Plan Enrollees assigned to Group by Plans with which Group contracts; and

WHEREAS, Group and Provider wish to amend the Agreement to include Primary Care Physician services, as defined herein;

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the parties hereto agree as follows:

1. Section I, Definitions, is hereby amended to add the following:

   1.26 Primary Care Physician ("PCP") means a Participating Physician, affiliated with Provider, who is assigned to render first contact medical care and to provide "primary care" as that term is defined by Group. PCP may include, as determined by Group, internists, pediatricians, family practitioners and general practitioners.

2. Exhibit A-3, Scope of Services - Primary Care, is hereby added to this Agreement and attached hereto.

3. Exhibit A-4, Primary Care Physician Compensation, is hereby added to this Agreement and attached hereto.

4. Exhibit A-5, List of Primary Care Physicians, is hereby added to this Agreement and attached hereto.

5. Exhibit A-6, Obstetrics/Gynecologist Compensation, is hereby added to this Agreement and attached hereto.

This Amendment shall be deemed to be part of the Agreement and, as modified in accordance herewith, the Agreement is hereby reaffirmed and declared in full force and effect.

In WITNESS WHEREOF, Group and Provider have executed this Amendment as set forth below.

County of Ventura	Valley Care Physicians IPA Medical Associates, Inc., d.b.a. Valley Care IPA
("Provider")	("Group")
	Sonya Araiza, Chief Executive Officer
Print Name & Title	Name and Title
Signature	Signature
Date	Date

EXHIBIT A-3
SCOPE OF SERVICES - PRIMARY CARE SERVICES

This Exhibit A-3 outlines the scope of services each Primary Care Physician office should be capable of providing. It does not define compensation rates. See Exhibit A-4 for PCP compensation.

1) Routine office visits (including after hours visits) and related services of a physician and other health care providers received by Enrollees in Provider's office. This includes evaluation, diagnosis and treatment of illness and/or injury, venipuncture, specimen collection and minor surgical procedures.

2) Visits and examinations. This includes consultation and time for personal attendance with the patient in an emergency room, or during a confinement in a hospital, skilled nursing facility or extended care facility; routine hospital admission and pre-surgical clearance (if medically indicated as determined by Group) and coordination of inpatient care, unless Provider's patients are delegated to the in-hospital team.

3) Immunizations as described in the Enrollee's benefit plan.

4) Administration of injections which Group assesses as appropriate for administration by Provider.

5) Laboratory services shall be performed by Group contracted laboratory. Provider services include only interpretation of results. Provider shall receive no additional compensation for said interpretations.

6) Well-Child Care as customarily provided by Provider.

7) Periodic health appraisal examinations including all routine tests (including, but not limited to EKG, audiology and visual tests) performed in Provider's office.

8) Professional home visits when the nature of illness dictates, determined by Provider. Supervision of complex home care regimen involving ancillary health personnel (i.e., home health, tube feeding, antibiotics) subject to usual utilization review procedures.

9) Referral of Enrollee to appropriate consulting physician or ancillary services as medically necessary and according to guidelines established by Group. Provider will continue to coordinate and manage the patient's care with the consulting physicians.

10) Telephone consultations with Enrollees and referral physicians.

11) X-Ray services shall be performed by Group contracted radiology provider.

12) Twenty-four (24) hour on-call coverage.

13) Coordination for all medical care provided to Enrollees by medical sub-specialists who execute this Agreement.

14) Education and family planning.

Capitated Primary Care services include all Covered Services and supplies provided by the Primary Care Physician to said physician's Enrollees, unless otherwise listed below in this Exhibit A-3 or as approved by Group's Board of Directors.

NON-CAPITATED SERVICES:

Description	Codes	Requires Auth?	Comments
Allergy Serum	95120-95125, 95144-95149, 95130-95134, 95165, 95170, 95180	Yes	
Annual Well Women Exams (pelvic exam with or without pap) Pay at $45.00 flat rate per visit, no copay	Diagnosis code V76.2 or V76.31 combined with 99201-99251 or 99384-99387 or 99394-99397	No	If a pap is done, provider should use V76.2
Bladder Irrigation	51700	No	
Catheter	A4338	No	
Cautery of Cervix; electro or thermal (cryocautery)	57511	No	
Change of cystostomy tube; insertion of bladder catheter	51702, 51705	Yes	
Colposcopy	56820-56821, 57420-57421, 57452, 57454-57456, 57460-57461	Yes	
Emergency Room Care	POS 23	No	
Endometrial Biopsy	58100		
Excision of skin lesions & malignant skin lesions	11400-11463, 11600-11646, 17260-17286, 19120, 56501-56515	No	11100-11313, 17000-17250 are IN cap
Fracture Care	28400-28675, 27750-27848, 27500-27566, 27193-27266, 21310-21497, 22305-22328, 23500-23680, 24500-24685, 25500-25695, 26600-26785	No	Pay xrays for fracture care within 8 weeks of initial treatment, no auth
Home visits	POS 12, 13, 14	Yes	
Hospital Care	POS 21	No	
Injectable Medications, IUDs	90281-90399, J0000-J9999	Yes	• Routine immunization/vaccine do not require prior auth for Anthem BC. • Health Net requires prior auth on injectables. • Routine immunization/vaccine for BC Senior require prior auth except for influenza, pneumococcal & hep B as long as provider deems medically indicated per medical guidelines. SIDE NOTE: Zoster and routine Tdap are part D (prescription drug coverage) – not covered under medical.
Insertion, Removal of IUD	58300-58301	Yes	
Intravenous Hydration	96360	No	
Lacerations	12001-12057, 13100-13160	No	
Newborn Circumcision (if covered)	54150, 54160	Yes	

Description	Codes	Requires Auth?	Comments
Nursing Home Visits	POS 31, 32, 33	Yes	
Orthopedic Supplies (casting materials, braces, splints)	Q4001-Q4051, A4580, A4590	No	
Pulmonary Function Tests (PFTs)	94010 & 94060 only	No	
Removal of Nail Plate, Nail Bed & Drainage of Blood	11730, 11740, 11750	No	
Sigmoidoscopy	45339-45342	Yes	
Treadmill and Stress EKGs	93015	Yes	
UNNA Boot	29580	Yes	
Vaccines	90476-90749	No*	See immunization rate grid for specific rates
Vasectomy (if covered)	55250	Yes	

*Anthem Blue Cross & Health Net require prior authorization for injections/vaccines.

EXHIBIT A-4
PRIMARY CARE PHYSICIAN
COMPENSATION

This Exhibit A-4 contains the compensation payable to Primary Care Physicians (PCP) for the performance of Primary Care Physician Covered services:

I. CAPITATION COMPENSATION:

Commercial Enrollees: On or about the 25th day of each month, Group shall pay Provider a monthly Primary Care Physician Capitation payment for Commercial Enrollees at the following fixed rates Per Enrolled Per Month:

Enrollee Age:

0-23 months: $19.00
24+ months: $14.00

Medicare Advantage Enrollees: On or about the 25th day of each month, Group shall pay Provider a monthly Primary Care Physician Capitation payment for Medicare Advantage Enrollees equal to **twenty percent (20%)** of the capitation Group received from Plan for each Enrollee assigned to Provider.

Payment of the above Capitation shall be for each assigned Enrollee effective on or before the tenth (10th) day of that month and shall not be prorated for partial months. Capitation payment adjustments shall be subject to retro-active additions or deletions of members up to one-hundred eighty (180) days, due to changes in eligibility made by the Plans. Adjustments shall also include retro-active changes to Enrollee Risk Factors assigned by CMS.

II. FEE-FOR-SERVICE RATES:

For services provided outside of the primary care capitation, unless otherwise listed below, Group shall pay Provider in accordance with the CMS payment policies at **one hundred percent (100%)** of the participating Physician level of the current year Medicare Fee Schedule as administered by the appropriate Medicare Carrier for Area 17 and as loaded to Group's system at the time the claim is processed. Group shall deduct Enrollee copayments from the compensation set forth in this section and shall Coordinate Benefits with any other primary coverage the Enrollee may have.

1. Immunizations shall be paid at Average Whole Sale Price ("AWP") plus 10%

2. Drugs shall be reimbursed at one hundred percent (100%) of the current Medicare Average Sale Price ("ASP") Drug Fee Schedule as loaded to Group's system at the time a claim is processed. Drugs not listed in the Medicare Fee Schedule shall be reimbursed at ninety-five percent (95%) of the most current year RedBook AWP.

3. Well Women Exams (pelvic exam with or without pap smear): Forty-five dollar ($45.00) flat visit rate. Copay is not deducted from this payment, but Provider should collect this from the Enrollee.

4. Total OB Care: Compensation rates for the provision of Obstetrical Care by Primary Care Physicians approved to provide such care by Group's Credentialing process shall be as specified in Exhibit A-6.

III. PROCEDURES NOT COVERED BY THE MEDICARE FEE SCHEDULE:

Covered Services not listed in the Medicare Physicians Fee Schedule are deemed not recognized for payment by CMS and therefore Group will not reimburse for those services, unless otherwise authorized in advance or appealed based upon medical necessity to Group's Medical Director or his/her designee. If authorized, or appeal approved, Group shall pay Provider thirty-five percent (35%) of Provider's usual and customary billed charges for such services.

IV. PAYMENT POLICIES:

Group's claim payment policies follow industry standards as defined by The Centers for Medicare and Medicaid Services (CMS). Group follows the Medicare Correct Coding Initiative and applies CMS guidelines to the re-bundling of procedure codes, as well as the application of modifiers for the payment of services involving multiple procedures, bilateral procedures, assistant surgeons, co-surgeons and surgical global periods. In addition, for assistant surgeon services, Group multiplies the applicable contracted rate by an adjustment factor of twenty percent (20%). Group references the standard coding structure based on the AMA's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) for basic coding and description of services provided. Group shall use best efforts to update the coding structure on an annual basis. For payment of Evaluation and Management CPT codes above a level 3 or mid-level (e.g., 99213), Group requires Provider to submit chart documentation supporting the billed code. Clinic charges for Provider office based services will not be paid.

EXHIBIT A-5
LIST OF PRIMARY CARE PHYSICIANS

The following is a list of the physicians who the Group has authorized to serve as Primary Care Physicians (PCPs) under the terms of this Agreement.

Name	NPI	Specialty	Effective Date
Alpern, Ana Flavia MD	1306088711	Pediatrics	6/1/19
Andrade, Alejandro MD	1770713190	Family Practice	6/1/19
Arizmendi, Maria MD	1366641961	Pediatrics	6/1/19
Arndt, Preston MD	1346303336	Family Practice	6/1/19
Bezema, Erik MD	1548419674	Family Practice	6/1/19
Bhutra, Joni MD	1073848123	Pediatrics	6/1/19
Blaze, Allison MD	1750444766	Family Practice	6/1/19
Bohl, Janelle MD	1639228505	Pediatrics	6/1/19
Bray, Darren, MD	1639228505	Pediatrics	6/1/19
Breckenridge, Amelia MD	1801070883	Family Practice	6/1/19
Carlisle, Lisabeth MD	1043473796	Family Practice	6/1/19
Cervantes, Miguel MD	1083777023	Family Practice	6/1/19
Chambers, Darin MD	1316108053	Family Practice	6/1/19
Chawla, Anil MD	1790708998	Family Practice	6/1/19
Cheng, Andrew MD	1639301369	Family Practice	6/1/19
Choudhary, Suneeta MD	1639386691	Family Practice	6/1/19
D'Augustine, Stephanie MD	1558424440	Pediatrics	6/1/19
Davis, Connell MD	1124184445	Family Practice	6/1/19
Day-Scarinci, Morag DO	1568774289	Pediatrics	6/1/19
Donaldson, Jake MD	1801026257	Family Practice	6/1/19
Dorner, Gillian MD	1508082157	Family Practice	6/1/19
El-Sayed, Dena MD	1669758918	Internal Medicine	6/1/19

Name	NPI	Specialty	Effective Date
Finger, Kenneth MD	1396881355	Family Practice	6/1/19
Flom, Sheila MD	1265596761	Family Practice	6/1/19
Garcia, Sonya MD	1922162445	Pediatrics	6/1/19
Gareys, Lyudmyla MD	1932340502	Family Practice	6/1/19
Gibbons, Joanna DO	1922444009	Family Practice	6/1/19
Goldschmidt, Thomas MD	1215943089	Internal Medicine	6/1/19
Gomez, Ramon MD	1023172558	Family Practice	6/1/19
Guinn, Jacqueline MD	1932234887	Pediatrics	6/1/19
Harney, Reis MD	1215360813	Pediatrics	6/1/19
Hemmer, Sarah MD	1659526630	Pediatrics	6/1/19
Ippolito, John MD	1376607846	Family Practice	6/1/19
Jones, Amy MD	1407982622	Family Practice	6/1/19
Kapadia, Ashmeeta MD	1538474093	Family Practice	6/1/19
Karra, Annapurna MD	1356728463	Family Practice	6/1/19
Kehoe, Nicole MD	1255497434	Family Practice	6/1/19
Kim, Joanne MD	1477829448	Family Practice	6/1/19
Kochav, Margalit MD	1568606564	Pediatrics	6/1/19
Krishnankutty, Rekha MD	1982768396	Pediatrics	6/1/19
Laba, Michelle MD	1134283559	Pediatrics	6/1/19
Lee, Sun MD	1295913523	Pediatrics	6/1/19
Lin, Amy MD	1770511081	Family Practice	6/1/19
Lu, Daniel MD	1275723264	Pediatrics	6/1/19
Lu, Nancy MD	1659513414	Family Practice	6/1/19
Lyons, Morgan DO	1578790135	Internal Medicine	6/1/19
Mandal, Smita MD	1285876854	Internal Medicine	6/1/19

Name	NPI	Specialty	Effective Date
McBride, Clinton MD	1518372457	Family Practice	6/1/19
Meshriky, Joseph MD	1386813434	Family Practice	6/1/19
Morris, Carolyn MD	1699945436	Family Practice	6/1/19
Mueller, Khristina MD	1750584926	Family Practice	6/1/19
Munoz, Michelle MD	1730455536	Family Practice	6/1/19
Nariai, Shiori MD	1437564127	Pediatrics	6/1/19
Niazi, Suhad MD	1730243965	Pediatrics	6/1/19
Noah, Jerold, MD	1073680336	Family Practice	6/1/19
O'Bryan-Becerra, Carlos MD	1649422338	Family Practice	6/1/19
Pakala, Shilpa MD	1851412696	Family Practice	6/1/19
Parola, Kenneth DO	1275551806	Family Practice	6/1/19
Patterson, Stanley MD	1548324700	Family Practice	6/1/19
Phang, Samuel MD	1346516143	Family Practice	6/1/19
Ramirez, Carmen MD	1134508211	Family Practice	6/1/19
Rockney, Lynn MD	1659435741	Family Practice	6/1/19
Rogers, Anna MD	1083049357	Family Practice	6/1/19
Ruiz, Melissa MD	1376795377	Pediatrics	6/1/19
Serrano, Vladimir MD	1275978447	Family Practice	6/1/19
Sheahan, Teresa DO	1811292030	Pediatrics	6/1/19
Solinas, Lisa MD	1841354990	Family Practice	6/1/19
Sportelli, Marisa MD	1033273099	Family Practice	6/1/19
Underwood, Scott DO	1033273099	Internal Medicine	6/1/19
Underwood, Shirley DO	1497919872	Pediatrics	6/1/19
Walls, Anthony MD	1770859571	Family Practice	6/1/19

Subject to any and all required credentialing and approval by Group, additional Primary Care Physicians may be added to this Exhibit A-5.

EXHIBIT A-6
OBSTETRICS/GYNECOLOGIST
COMPENSATION

This Exhibit A-6 contains the compensation payable to obstetrics/gynecologists for the performance of Covered Services as set forth below. The Total OB Care rates herein shall also apply to Primary Care Physicians when providing obstetrical services.

Group shall compensate Provider at the lesser of, the rate set forth in this Exhibit A-6 or Provider's customary billed charge. Compensation shall be less any applicable copayment, coinsurance or deductible due from an Enrollee for those authorized Covered Services provided by the Provider to such Enrollee. Provider is solely responsible for collecting the applicable copayment, coinsurance or deductible directly from Enrollee. Provider must request a written authorization prior to rendering Covered Services to an Enrollee, in accordance with Group's UM Program. Failure of Provider to receive said prior written authorization may result, at Group's option, in Group's nonpayment for those Covered Services provided to said Enrollee.

COMPENSATION:

General Services: Except as otherwise indicated below, Group shall compensate Provider for those authorized Covered Services provided to Enrollee to which this Agreement pertains in accordance with The Centers for Medicare and Medicaid Services (CMS) payment policies of the Participating Physician level at **one hundred percent (100%)** of the current Medicare Fee Schedule, as administered by the appropriate Medicare Carrier for Area 17 and as loaded to Group's system at the time the claim is processed. Covered Services not listed in the Medicare Fee Schedule are deemed not recognized for payment by CMS and therefore group will not reimburse for those services, unless otherwise authorized in advance by Group's Medical Director or his/her designee. If authorized, Group shall pay Provider thirty-five percent (35%) of Provider's usual and custom billed charges.

Total OB Care: Group shall pay the global (case rate) fee for Total Obstetrical Care as follows. In the event Provider does not provide services for the entire pregnancy, the global fee shall be pro-rated in accordance with the Group's policy:

TOTAL OB CARE: $1,550.00[1]

Antepartum[2]

- Full history and physical
- Pre-natal visits
- Administration of injection
- Routine office laboratory services (pre-natal lab screen done through capitated laboratory provider)
- First OB ultrasound (if medical necessary)

Delivery

- Vaginal or cesarean delivery
- Vaginal birth after cesarean section (VBAC)
- Forceps
- Vacuum extraction

Total OB Footnotes

[1] Any other diagnostic testing or procedures which would be billed separately (beyond the global fee) must have prior authorization through the Group's utilization management process.

[2] Any services provided during antepartum which are billed separately and/or performed outside of the physician's office requires prior authorization through the Group's utilization management process.

- Episiotomy
- Induction and augmentation
- Retained placenta (manual delivery)
- Versions

Drugs shall be reimbursed at one hundred percent (100%) of the current Medicare Average Sale Price (ASP) Fee Schedule as loaded to Group's system at the time a claim is processed. Drugs not listed in the Medicare Fee Schedule shall be reimbursed at ninety-five percent (95%) of the most current year RedBook Average Wholesale Price (AWP).

Payment Policies: Group's claim payment policies follow industry standards as defined by The Centers for Medicare and Medicaid Services (CMS). Group follows the Medicare Correct Coding Initiative and applies CMS guidelines to the re-bundling of procedure codes, as well as the application of modifiers for the payment of services involving multiple procedures, bilateral procedures, assistant surgeons, co-surgeons and surgical global periods. In addition, for assistant surgeon services, Group multiplies the applicable contracted rate by an adjustment factor of twenty percent (20%). Group references the standard coding structure based on the AMA's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) for basic coding and description of services provided. Group shall use best efforts to update the coding structure on an annual basis. For payment of Evaluation and Management CPT codes above a level 3 or mid-level (e.g., 99213), Group requires Provider to submit chart documentation supporting the billed code. Clinic charges for professional office based services will not be paid.