AMENDMENT 002
TO THE
HOSPITAL SERVICES AGREEMENT
BETWEEN
COUNTY OF VENTURA
AND
AETNA HEALTH OF CALIFORNIA INC. AND AETNA HEALTH MANAGEMENT, LLC.

This Amendment 002 is made as of December 1, 2012 (Effective Date), between Aetna Health of California Inc., a California corporation and Aetna Health Management, LLC., a Delaware limited liability company, on behalf of itself and its Affiliates (hereinafter referred to as "Company") and County of Ventura, (hereinafter referred to as "Hospital").

WHEREAS, the parties have entered into a Managed Care Agreement ("Agreement") originally effective June 1, 2003 to provide health care services to Members;

WHEREAS, the parties wish to amend the Agreement as provided herein;

NOW, THEREFORE, in consideration of the mutual promises and undertakings contained herein, the parties agree to be legally bound as follows:

1. The Hospital Services Compensation Schedule is hereby renamed Commercial Hospital Services Compensation Schedule.

2. A new Medicare Hospital Services and Compensation Schedule is hereby added and incorporated into the Agreement by this reference.

3. A new Medicare Addendum is hereby added and incorporated into the Agreement by this reference.

4. The Plan Participation Schedule of the Agreement is hereby deleted in its entirety and replaced with a new Product Participation Schedule attached hereto and incorporated into the Agreement by this reference.

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 002 and the Agreement, the terms of this Amendment 02 shall govern and control.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed below.

Accepted By:

PROVIDER	**COMPANY**
By:	By:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

FEDERAL TAX I.D. NUMBER:

MEDICARE
HOSPITAL SERVICES
AND
COMPENSATION SCHEDULE

Government Programs:

INPATIENT RATES:

Service	Billing Codes	Rates
DRG	All Active DRG Codes	of Medicare Allowable
CMG	All Active CMG Codes	of Medicare Allowable IRF
Sub-Acute Care: Any Level	**Revenue Codes:** 190-199	Medicare Allowable SNF
Psychiatric Care	**Revenue Codes:** 114, 124, 134, 144, 154, 204	of Medicare Allowable IPF

OUTPATIENT RATES:

Service	Billing Codes	Rates
APC: Hospital Outpatient Services	All Outpatient Services	Medicare Allowable
All Other Outpatient		of Billed Charges

"Government Programs does not include Medicaid Programs or Children's Health Insurance Programs."

PROFESSIONAL COMPONENTS:

Payment for professional services is not included in the rates specified in this Services and Compensation Schedule.

COMPENSATION TERMS AND CONDITIONS:

Definitions:

Medicare Allowable Payment (Inpatient Services) – is the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME). The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a FI for both overpayments and underpayments.

Medicare Allowable Outpatient Definitions:

A. Services or procedures payable pursuant to:

1. The Outpatient Prospective Payment System (OPPS), where applicable payment for these services is geographically adjusted using the providers specific wage index; or;

2. If payment value is not available as set forth in 1, at the applicable fee schedule as defined by CMS.

The Medicare Allowable payment is final and exclusive of cost settlements, reconciliations or any other retroactive adjustments as completed by a FI for both overpayments and underpayments.

B. Services and Supplies not able to paid as set forth in A above: Outpatient services and supplies that are (i) billed in accordance with CMS guidelines; and (ii) that are not considered packaged, composite or concurrent services, are payable a ›illed charges.

Service Groupings – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Compensation Schedule.

General

a) Hospital Services shall include all programs, services, facilities, and equipment necessary for care. Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax, or and other services as may be expressly included in the contracted rates. Any equipment and/or services provided by an alternate facility during the course of an admission shall be the financial responsibility of the Hospital, and will be considered to be included in the rates noted in this compensation schedule.

a1) Hospital shall be paid lesser of eligible billed charges or the applicable contracted rate herein for all services except:

APC: Hospital Outpatient Services
Psychiatric Care
Sub-Acute Care: Any Level
CMG
DRG

a2) The rate applied will be the applicable Agreement rate in effect on the date of discharge.

b) All claims will be handled in accordance with the following payment and processing guidelines.

b1) Multiple Procedure Processing will be applied in accordance with CMS guidelines.
b2) Observation will be handled in accordance with CMS guidelines.

c) Personal comfort and convenience items are not eligible for payment.

d) All professional services billed, including services billed by Participating Providers, under the Hospital's federal tax identification number on a UB-04 (or its equivalent in the event UB-04s are no longer the standard billing form) billing form are not eligible for payment. All professional services billed, including services billed by Participating Providers, under the Hospital's tax identification number on a CMS 1500 or equivalent form shall be paid at the Aetna Market Fee Schedule or applicable contracted rates.

Billing

e) Hospital must submit claims using the same coding rules as traditional Medicare. Providers must follow all Medicare billing guidelines for claims submission and must include all claims information required by Traditional Medicare.

f) When Hospital is compensated on a fee for services basis and if a Government Official imposes a financial adjustment or penalty on Company based on a determination that there is insufficient information or documentation to support an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM" (ICD-10 or successor standard)) diagnosis submitted by Provider to Company for a Medicare Member ("Diagnosis"), Company may recoup the total amount that Company paid to Provider for the nationally recognized codes associated Company will notify Provider upon Company's receipt of a final written audit report from CMS reflecting a CMS finding that there was insufficient documentation to support a Diagnosis submitted by Provider to Company ("CMS Finding"). Company will provide Provider a copy of the chart for which the Diagnosis was listed and reviewed by CMS and recoup from Provider the total amount that Company paid to Provider for the nationally recognized codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis was listed.

Coding

g) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new codes. Such updates may include changes to Service Groupings. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

Charge Master Increases

h) Charge Master Limit. Only applies to All Other Outpatient rate. Refer to the Limit on Charge Master Increases section of the Commercial Hospital Services Compensation Schedule; the same language is applicable for Medicare.

Hospital Inpatient Services

DRG:

All services identified by MS-DRGs are subject to verification by Company using the MEDICARE PROSPECTIVE PAYMENT GROUPER version of grouping software in use by Company on the date of discharge. MS-DRGs submitted by the Hospital that do not coincide with the MS-DRG assigned by Company's grouping software will be paid at the applicable rate for the assigned MS-DRG. Company will update the Medicare IPPS Grouper software within 30 days of the later to occur of (i) the CMS effective date; or (ii) CMS release date. Until updated in Company's systems, Company will pay based upon the prior versions of the Medicare IPPS grouper software.

CMG:

All contracted rates identified by CMG are subject to verification by Company of the submitted CMG by using the MEDICARE INPATIENT REHABILITATION PROSPECTIVE PAYMENT GROUPER version of grouping software in use by Company on the date of discharge. CMGs submitted by Hospital that do not coincide with the CMG produced by Company through the grouping software will be paid at the applicable rate for the CMG identified by Company through the grouping software.

Psychiatric services will be paid in accordance with the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

Skilled Nursing services will be paid in accordance with the Skilled Nursing Facility Prospective Payment System (SNF PPS).

Hospital Outpatient Services

APC:

Services identified by the Ambulatory Payment Classifications (APCs), which are part of the Medicare Outpatient Prospective Payment System (OPPS), are subject to verification by Company using the MEDICARE OUTPATIENT PROSPECTIVE PAYMENT GROUPER. Payment will be based on the version of the software and the applicable Medicare rate file in use by Company on the date of service. Company will update the Medicare Outpatient Prospective Payment System (OPPS) grouping software within 45 days of the later to occur of (i) the CMS effective date; or (ii) CMS release date. Until updated in Company's systems, Company will pay based upon the prior versions of the Medicare rate file and APC Grouper.

MEDICARE HOSPITAL ADDENDUM

Hospital agrees to comply with all applicable Medicare laws, rules and regulations, including, without limitation, instructions issued by the Centers for Medicare and Medicaid Services ("CMS"). Specifically, the following provisions are now part of the Agreement:

1. Hospital agrees to provide Covered Services to those persons who meet all eligibility requirements of the federal Medicare program and who have enrolled in Company's Medicare Plans ("Medicare Members").

2. Hospital agrees to comply with all Medicare laws, rules and regulations, as well as Company requirements designed to ensure Company's compliance with such laws, rules and regulations, including, without limitation, laws, rules and regulations relating to the protection of Medicare Member privacy and confidentiality and the accuracy of Medicare Member health records. Hospital agrees that all services and other activities performed by Hospital under the Agreement will be consistent and comply with Company's obligations under its contract(s) with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Plans. Upon request, Hospital shall immediately provide to Company any information required by Company to meet its reporting obligations to CMS, including, where applicable, physician incentive plan information. Hospital agrees to allow CMS and Company to monitor Hospital's performance under this Agreement on an ongoing basis, in accordance with Medicare laws, rules and regulations.

3. Hospital acknowledges and agrees that all provisions of this Addendum and of the Agreement shall apply equally to any employees, independent contractors and subcontractors of Hospital who provide or may provide Covered Services to Medicare Members, and Hospital represents and warrants that Hospital shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with this Addendum and the Agreement and all applicable laws and regulations, and perform all requirements applicable to Medicare programs.

4. Company agrees to pay Hospital for Covered Services rendered to Medicare Members within forty-five (45) calendar days of actual receipt by Company of a Clean Claim. Payments for non-capitated Covered Services rendered to Medicare Members are subject to any and all valid and applicable Medicare laws related to claims payment. With respect to Medicare Members, Hospital acknowledges that compensation under the Agreement for such Members constitutes receipt of federal funds.

   Hospital shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Medicare Members for which Hospital is financially responsible pursuant to the Agreement.

5. Hospital acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Hospital any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Hospital further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

6. Hospital agrees to cooperate with and participate in internal and external review procedures necessary to process Medicare appeals and grievances.

7. For purposes of this Section 7, "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time. Company is required to obtain risk adjustment data from Hospital for Medicare Members, and Hospital agrees to provide complete and accurate risk adjustment data to Company for Medicare Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data.

Hospital certifies, based on best knowledge, information and belief, that any risk adjustment data that Hospital submits to Company for Medicare Members is accurate, complete and truthful. Hospital agrees to immediately notify Company if any risk adjustment data that was submitted to Company for Medicare Members is erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable laws, rules and regulations and CMS instructions.

Hospital further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Medicare Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations and/or CMS instructions, and allows any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the risk adjustment data collection period; and (3) confirm that the appropriate Hospital's signature and credentials are present ("Medical Records").

Hospital agrees to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of risk adjustment data ("Audit Data"). Hospital agrees to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that CMS conducts a review that includes the validation of risk adjustment data submitted by Hospital, Company will submit to Hospital a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

8. With respect to any Plan offered by Company to Medicare Members, Hospital agrees to provide Company and federal, state and local governmental authorities having jurisdiction, or their designees, upon request, access to all books, records and other papers (including, but not limited to, medical and financial records and contracts) and information relating to the Agreement and to those Covered Services rendered by Hospital and its employees, independent contractors and subcontractors to Medicare Members ("Information and Records"), and that this right of inspection, evaluation and audit will continue for the longer of: (i) a period of ten (10) years from the end of the contract period of any government contract of Company, (ii) the date that the U.S. Department of Health and Human Services (HHS), the Comptroller General or their designees complete an audit, or (iii) the period required under applicable laws, rules or regulations. With respect to any Plan offered by Company to Medicare Members, Hospital also agrees to maintain Information and Records for the longer of: (i) ten (10) years from the end of the contract period of any government contract of Company, (ii) the date HHS, the Comptroller General or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 7 shall survive the termination of the Agreement, regardless of the cause of the termination.

9. Hospital agrees to comply with the following, as applicable and as amended from time to time: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162, and 164, the Americans with Disabilities Act, Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. §§ 3729 *et. seq.*), and the anti-kickback statute (section 1128B(b) of the Social Security Act), and any other laws applicable to recipients of Federal funds.

10. In no event, including without limitation, non-payment by Company, insolvency of Company or breach of the Agreement or this Addendum, shall Hospital bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than the Company) acting on a Medicare Member's behalf for services covered by the Agreement. This provision shall not prohibit collection of deductibles, coinsurance or copayments from Medicare Members in accordance with the terms of the Medicare Member's agreement with Company.

    Hospital further agrees that: (a) this provision shall survive termination of the Agreement and this Addendum regardless of the cause giving rise to termination and shall be construed for the benefit of

Medicare Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Hospital and a Medicare Member or persons acting on a Medicare Member's behalf.
No modification of this provision shall be effective without the prior written approval of the appropriate state and/or federal regulatory entities.

11. In the event of Company's insolvency or other cessation of operations, Hospital shall continue to provide Covered Services to (i) Medicare Members through the period for which premium has been paid to Company, and (ii) those Medicare Members who are confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge.

12. Hospital acknowledges that Company may only delegate activities or functions to Hospital in a manner consistent with Medicare laws, rules and regulations. Hospital acknowledges and agrees that if any of Company's activities or responsibilities under Company's contract with CMS to offer Medicare Plans is delegated by Company to Hospital, such activity or responsibility may be revoked if CMS or Company determines that Hospital has not performed satisfactorily.

Capitalized terms not otherwise defined herein shall have the meaning given such terms in the Agreement. All terms of the Agreement not amended herein remain in full force and effect. If the terms of this Addendum conflict with any term of Agreement, the terms of this Addendum shall prevail.

PRODUCT PARTICIPATION SCHEDULE

Participation under this Managed Care Agreement will include the Aetna Products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Gated Health Benefit Product – Commercial health benefit plan which contains a Primary Care Physician as a component of the Plan design regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or, (ii) an individual Member has selected a Primary Care Physician. Gated Health Benefit Products include but are not limited to: ***HMO, QPOS, Elect Choice, Managed Choice POS, Aetna Choice POS II, and Aetna Select.***

- Non-Gated Health Benefit Product – Commercial health benefit plan which does not allow for the designation and/or use of a Primary Care Physician in the administration of the benefit Plan. Non-Gated Health Benefit Products include but are not limited to: ***Open Choice PPO and National Advantage.***

  Many member ID cards include the National Advantage logo (NAP) in conjunction with Gated and non-Gated Health Benefit Products. In those circumstances the rate applicable to other product (not NAP) on the ID card will apply.

- Government Programs – All plans offered by Company under any government contract serving Medicare beneficiaries. Government Programs include, but are not limited to: ***all Aetna Medicare Advantage HMO, PPO, and POS.***

  Government Programs excludes Medicaid program offered by Company.

- Non-Health Benefit Products – Including but not limited to: *Aetna Workers' Comp Access.*

  As of the effective date of this Agreement, and until such time the Parties amend the Agreement otherwise, Hospital does not participate in the Aetna Workers' Comp Access product.