FIFTH AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

This Fifth Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective the first day of the month following the date the Amendment is fully executed ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, a public entity organized under the laws of California, doing business as the Central California Alliance for Health, hereinafter referred to as "Plan", and the County of Monterey, a political subdivision of the State of California, on behalf of its Monterey County Clinic Services, hereinafter referred to as "Provider," with reference to the following facts:

WHEREAS, Plan is a public entity organized pursuant to Welfare and Institutions Code section 14087.54, Santa Cruz County Code Chapter 7.58, Monterey Municipal Code section 2.45.010, and Merced County Code Chapter 9.43;

WHEREAS, Plan and Provider entered into the Primary Care Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, both Plan and Provider desire to change certain compensation terms of the Agreement;

WHEREAS, subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment; and

WHEREAS, references to Sections and Exhibits below are references to sections and exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Section 1.6, Covered Services Documentation definition, shall be deleted in its entirety and replaced with the following Section 1.6, Covered Services Documentation definition:

> "Covered Services Documentation. Covered Services Documentation means documentation developed by Primary Care Physicians to support the Covered Services, including Primary Care Physician Services, provided hereunder, including, without limitation, claims for payment, encounter data, discharge summaries, medical records, emergency visit records and diagnostic reports."

2. Section 2.11.2.1, included below shall be added.

> "Without limiting Section 2.11.2 above, Provider shall provide encounter data in the format of a claim to Plan within thirty (30) days of the provision of Case Managed Services to Provider's Linked Members, if Provider is paid capitation for such Members. Such encounter data shall contain the elements and shall be on the form and in the format as set forth in the Provider Manual."

3. The definition of ACA Primary Care Services shall be deleted in its entirety from Exhibit H, Section 2 and the following definition shall be added to Exhibit H, Section 2:

> "Capitation Payment" shall mean the PMPM amount, as set forth in this Exhibit H, paid to Provider for the provision of Primary Care Physician Services subject to Case Management as described in the Provider Manual.
>
> "PMPM" means per Medi-Cal Linked Member per month.

4. Exhibit H, Section 3.Payment for Covered Services Provided to Medi-Cal Members shall be deleted in its entirety and replaced with Exhibit H, Section 3.Payment for Covered Services Provided to Medi-Cal Members:

"3. Payment for Covered Services Provided to Medi-Cal Members.

a. List of Members. Plan will provide Provider with a list of Provider's Medi-Cal Linked Members by the first (1st) day of each month (the "Medi-Cal Linked Members List").

b. Case Managed Primary Care Physician Services. Plan will pay Provider for Case Managed Services provided to Medi-Cal Members on Provider's Medi-Cal Linked Members List as set forth below in subsections i., ii., and iii.

i. Capitation Payments. Plan will pay Provider for Case Managed Services provided to Medi-Cal Members on Provider's Medi-Cal Linked Members List by the fifteen (15th) day of each month. The Capitation Payments by Medi-Cal Member type and by age/sex/eligibility categories is as follows:

	Santa Cruz County Medi-Cal Linked Members $/PMPM	**Monterey County Medi-Cal Linked Members $/PMPM**	**Merced County Medi-Cal Linked Members $/PMPM**
Public Assistance: Aged			
Female:			
<1-19	[redacted]	[redacted]	[redacted]
20-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			
<1-19	[redacted]	[redacted]	[redacted]
20-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Public Assistance: Disabled			
Female:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Public Assistance: Family			
Female:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			

	Santa Cruz County Medi-Cal Linked Members $/PMPM	Monterey County Medi-Cal Linked Members $/PMPM	Merced County Medi-Cal Linked Members $/PMPM
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Medically Needy: Aged			
Female:			
<1-19	[redacted]	[redacted]	[redacted]
20-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			
<1-19	[redacted]	[redacted]	[redacted]
20-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Medically Needy: Disabled			
Female:			
<1-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			
<1-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Medically Needy: Family			
Female:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Medically Indigent: Child			
Female:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
Male:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]

	Santa Cruz County Medi-Cal Linked Members $/PMPM	Monterey County Medi-Cal Linked Members $/PMPM	Merced County Medi-Cal Linked Members $/PMPM
Other:			
Female:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45+	[redacted]	[redacted]	[redacted]
Male:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45+	[redacted]	[redacted]	[redacted]
% Poverty:			
Female:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Male:			
<1	[redacted]	[redacted]	[redacted]
1-4	[redacted]	[redacted]	[redacted]
5-19	[redacted]	[redacted]	[redacted]
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
65+	[redacted]	[redacted]	[redacted]
Adult Expansion			
Female:			
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]
Male:			
20-44	[redacted]	[redacted]	[redacted]
45-64	[redacted]	[redacted]	[redacted]

ii. Fee-For-Service Payment. If Provider's submittal of encounter data in accordance with Section 2.11.2.1 for Provider's Medi-Cal Linked Members during any full twelve (12) month period indicates less than an average of 1.47 visits per Medi-Cal Linked Member per twelve (12) month period ("Data Benchmark"), Plan shall provide written notice to Provider that Provider shall be subject to a corrective action plan. The purpose of the corrective action plan will be to ensure that Provider has adopted policies and practices that ensure that Medi-Cal Linked Members have sufficient access to Provider and are receiving Medically Necessary Primary Care Physician Services. If during the 180- day notice period Provider is able to take steps to achieve the Data Benchmark, Plan will continue to compensate Provider at the Capitation Payment rate specified in Section 3.b. above during and following the expiration of the 180-day corrective action period. If Provider does not achieve the Data Benchmark within one hundred eighty (180) days, Plan will compensate Provider for Case Managed Services

provided to Provider's Medi-Cal Linked Members at one hundred percent (100%) of the Medi-Cal Rate following the expiration of the 180-day corrective action period.

iii. Reversion to Capitation Payment. If Provider's submittal of encounter data for Provider's Medi-Cal Linked Members during any full twelve (12) month period following the change to fee-for-service payment as specified in Section 3.b.ii. above becomes equal to or greater than an average of 1.47 visits per Medi-Cal Linked Member per twelve (12) month period, Plan will provide Provider with sixty (60) days prior written notice that Plan will compensate Provider at the Capitation Payment rates specified in Section 3.b. above. Payment shall revert to the Capitation Payments as of the date specified in the Plan's notice to Provider.

c. Other Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members and not covered by Section 3.b. above as set forth below in subsections i., ii., iii. and iv.

i. Plan shall pay Provider for Covered Services provided to Medi-Cal Members who are not Provider's Medi-Cal Linked Members, and for Primary Care Physician Services that are not Case Managed Services provided to Provider's Medi-Cal Linked Members at one hundred fifty percent (150%) of the Medi-Cal Rate in effect on the date the Covered Service was rendered.

ii. Durable Medical Equipment and Medical Supplies. Plan will pay Provider for Covered Services that are durable medical equipment and medical supplies provided to Medi-Cal Members at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

iii. Physician-Administered Drugs. Plan will pay Provider for Covered Services that are physician-administered drugs provided to Medi-Cal Members at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

iv. Outpatient Clinical Laboratory Services. Plan shall pay Provider for Outpatient Clinical Laboratory Services provided to Medi-Cal Members as set forth below in subsections (1) and (2).

(1) Providers with a CLIA certificate of waiver. Plan shall pay Providers granted waived status under CLIA for Outpatient Clinical Laboratory Services that are listed in the Provider Manual and are not Case Managed Services at one hundred percent (100%) of the Medi-Cal Rate in effect on the date such service is rendered. All other Outpatient Clinical Laboratory Services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

(2) Providers with a CLIA certificate of provider-performed microscopy procedures (PPMP), a CLIA certificate of compliance, or a CLIA certificate of accreditation. Plan shall pay Providers granted a CLIA certificate of performed microscopy procedures (PPMP), a CLIA certificate of compliance, or a CLIA certificate of accreditation for Outpatient Clinical Laboratory Services that are not Case Managed Services, including for CLIA waived tests as listed in the Provider Manual, at one hundred and two percent (102%) of the Medi-Cal Rate in effect on the date such service is rendered. All other Outpatient Clinical Laboratory Services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan."

5. Addendum 3, Primary Care Physician Care Based Incentive Program, shall be amended and replaced with the attached Addendum 3, Primary Care Physician Care Based Incentive Program. In order for Addendum 3 to be effective, Provider is required to execute both this Amendment, on the signature page below, and the signature page of Addendum 3.

All other terms and provisions of the Agreement shall remain in full force and effect so that all rights, duties and obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Amendment and the Agreement, then the terms of this Amendment shall govern. Terms used in this Amendment shall have the meanings assigned to them in the Agreement, unless otherwise specified in this Amendment.

Plan	Provider
Central California Alliance for Health	County of Monterey, Monterey County Clinic Services
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

APPROVED AS TO FORM AND LEGALITY
DEPUTY COUNTY COUNSEL
COUNTY OF MONTEREY

Reviewed as to fiscal provisions
Auditor-Controller
County of Monterey 1-21-15

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

This Addendum sets forth the terms of care based incentives offered to PCPs by Plan. The program is designed to compensate PCPs for efforts undertaken to improve the care provided to Eligible Members as reflected by data measured by Plan, all as described herein (the "Care-Based Incentive" or the "CBI").

The CBI consists of two components: (1) the CBI Incentive Program and (2) the CBI Fee-for-Service Incentive. The CBI continues for a limited term, as described in Section 7 of this Addendum 3, unless it is specifically extended by mutual written agreement of the parties hereto. The budget and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Kids, Alliance Care IHSS, and Alliance Care AIM Programs.

2. Definitions.

In addition to other terms defined in this Addendum 3 or in the Agreement, the following terms shall have the meanings set forth below:

2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.

2.2 Care Coordination Measures means Rate of Ambulatory Care Sensitive Admissions, Rate of Readmissions, Rate of Generic Prescriptions, and Rate of Preventable Emergency Department Visits, each as further described in Section 3 to this Addendum 3.

2.3 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.

2.4 CBI Incentive Payments are the annual payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.

2.5 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance as further described in Section 3 to this Addendum 3.

2.6 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.

2.7 Comparison Group is the group of PCPs to which Provider is compared to determine Provider's percentile ranking within the group. PCPs are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.

2.8 Dual Coverage Members are Members who are eligible for Medi-Cal and for coverage from another source, such as Medicare or a commercial health plan.

2.9 Eligible Members

2.9.1 With respect to the CBI Incentive Program, Eligible Members are Linked Members enrolled in the Medi-Cal Program in Santa Cruz, Monterey or Merced Counties, excluding Dual Coverage Members.

2.9.2 With respect to the CBI Fee-For Service Program, Eligible Members are Linked Members enrolled in the Medi-Cal Program in Santa Cruz, Monterey or Merced Counties; the Santa Cruz Healthy Kids Members; the Monterey County IHSS Members; and the Monterey County AIM Members, excluding Dual Coverage Members.

2.10 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the sum total of the number of months each Eligible Member is linked to the PCP during the measurement period, except the number of months for a PCP's Linked Medi-Cal Members who are in the Aged, Breast and Cervical Cancer Treatment Program (BCCTP), Disabled and Long Term Care Medi-Cal aid code categories are multiplied by three (3) to determine the Eligible Member Months applicable to those Eligible Members. Member months are determined by identifying the total number of Eligible Members linked to the PCP during each month of the Measurement Period.

2.11 Measurement Component shall mean the measures as described in the CBI Table.

2.12 Measurement Period is the period for which Plan shall measure data in order to calculate the applicable CBI Incentive Payment.

2.13 Methodology is the internally developed methodology, or the source of data utilized by Plan, to measure Provider's performance for each Measurement Component under the CBI.

2.14 PCP is the individual or group of PCPs to whom Eligible Members are assigned.

2.15 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.

2.16 Performance Target Measures are those Measurement Components for which the PCP receives points based upon meeting a specified Performance Target.

2.17 Plan Goal. The Plan Goal for each Quality of Care measure is the NCQA HEDIS national 90th percentile for the measurement year. The Plan Goal for each Performance Improvement-Care Coordination Measure is as follows: Rate of Ambulatory Care Sensitive Admissions 1.9 per one-thousand Eligible Members per year (PKPY), Rate of Readmission 6.0 PKPY, and Rate of Preventable Emergency Department (ED) Visits 58 PKPY.

2.18 Relative Ranking Measures are those Measurement Components for which a PCP receives points based on its ranking relative to performance of other PCPs within the PCP's Comparison Group.

3. CBI Incentive Program.

PCPs are eligible to receive an incentive payment under the CBI Incentive Program from a set budget or pool ("CBI Pool"). Funding of the CBI Pool shall be at the sole discretion of Plan. The CBI Pool is divided into three (3) sub-pools, by Comparison Group: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each Measurement Component correlate to each PCP's rank within its Comparison Group for each measure or for the PCP meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.1 through 3.9, below.

3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Performance Target Measures will be reduced by fifty-percent (50%). The Member Reassignment Threshold is not applied to PCPs with less than an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period and less than one hundred (100) Eligible Members as of December 31, 2015.

3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Eligible Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions (based upon Plan-identified AHRQ specifications) per 1,000 Eligible Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

3.3 Rate of Readmission. This Measurement Component measures the rate of readmissions for PCP's Eligible Members as determined by a review of claims data. The rate is reported by the number of readmissions during the CBI Term per 1,000 Eligible Members per Fiscal Year. A readmission is any admission of a Eligible Member during the CBI Term which occurs within ninety (90) days of the Eligible Member's discharge from an inpatient stay which commenced during the CBI Term. The rate of readmissions shall not include admissions or readmissions associated with diagnoses related to transplant or maternity. The rate of readmissions for PCP's Eligible Members shall include only those readmissions where the Eligible Member is linked to the PCP at both the time of admission and at the time of readmission. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

3.4 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Eligible Members among all prescriptions filled for PCP's Eligible Members as determined by a review of claims data.

3.5 Quality of Care Measures. The Quality of Care Measurement Components are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims data, not on chart review. In order for a PCP to receive points for a Quality of Care measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications. The total points available for the Quality of Care Measurement Components will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measurement Component.

3.5.1 There are ten (10) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) cervical cancer screening, (4) diabetes LDL-C screening, (5) diabetes HbA1c screening, (6) diabetes medical attention for nephropathy, (7) avoidance of antibiotic treatment in adults with acute bronchitis, (8) asthma medication ratio, (9) use of spirometry testing in the assessment and diagnosis of COPD and, (10) appropriate testing for children with pharyngitis.

3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Eligible Members as determined by Plan based upon a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Eligible Members per Fiscal Year. To qualify for this measure, a PCP must have at least an average of one hundred (100) Eligible Members, as determined by the number of months for which PCP was contracted during the Measurement Period or a minimum of one hundred (100) Eligible Members as of December 31, 2015.

3.7 Electronic Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP's eligible claims and encounter data submitted to the Plan electronically. Eligible claims exclude those for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The Performance Target for this measure is ninety-five percent (95%) of all eligible claims and encounter data submitted electronically. Claims and encounter data must be submitted in accordance with the requirements of Sections 2.11.2 and 2.11.2.1 of the Agreement.

3.8 Referral Submittal. This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The Performance Target for this measure is seventy five percent (75%) of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal.

3.9 Performance Improvement Measures. This Measurement Component measures a PCP's improvement from the 2014 Measurement Period, or the PCP's ability to meet or exceed the Plan Goal for certain Measurement Components which include the Rate of Ambulatory Care Sensitive Admissions, the Rate of Readmissions, the Rate of Preventable Emergency Department Visits and all of the Quality of Care Measurement Components.

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. The accounting will be based only on claims and data submitted for dates of service within the CBI Term, as defined in Section 7 of this Addendum, and received by Plan no later than January 31, 2016. In the event the ICD-10 code set is mandated for use during the CBI Term, the Plan shall crosswalk ICD-10 data to the appropriate ICD-9 code for claims with dates of service from the effective date of the ICD-10 code set's mandated use through December 31 2015, for the purpose of calculating the CBI Incentive Payments. Plan will perform said crosswalking as set forth by the 2014 Center for Medicare and Medicaid Services' (CMS) General Equivalence Mappings (GEMs). Distributions are made to PCPs following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

4.1 Relative Ranking Measures.

4.1.1 Rate of Ambulatory Care Sensitive Admissions, Rate of Preventable ED Visits and Rate of Readmission. PCPs shall be awarded the points for each measure based on the PCP's rank within their Comparison Group for that measure. Points will be allocated in the following manner:

Percentile	Points Allocated		
	Rate of Ambulatory Care Sensitive Admissions	Rate of Preventable ED Visits	Rate of Readmission
$99^{th} – 90^{th}$	20	20	10
$89^{th} – 80^{th}$	16	16	8
$79^{th} – 70^{th}$	12	12	6
$69^{th} – 60^{th}$	8	8	4
$59^{th} – 50^{th}$	4	4	2
49^{th} and below	0	0	0

4.1.2 Quality of Care Measures. For the Quality of Care Measurement Components, as set forth in Section 3.5 of this Addendum 3, if the PCP meets or exceeds the Plan Goal, the PCP shall be awarded the maximum number of points for the measure even if the PCP is not ranked in the top quartile within the PCP's Comparison Group for the measure. For PCPs not meeting or exceeding the Plan Goal, each such PCP shall be awarded (i) the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile within the PCP's Comparison Group; (ii) one-half the maximum number of points for each measure in which the PCP is ranked at the 51st through the 75th percentile; and (iii) zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.

4.1.3 Rate of Generic Prescriptions. PCP shall be awarded the maximum number of points if the PCP is ranked at or above the 76th percentile within the PCP's Comparison Group. PCP shall be awarded one-half the maximum number of points if the PCP is ranked at the 51st through the 75th percentile. PCP shall receive zero (0) points if the PCP is ranked at the 50th percentile or below.

4.2 Performance Target Measures.

4.2.1 Electronic Claims Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.

4.2.2 Referral Submittal Measure. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target. If the PCP falls below the Performance Target, the PCP will earn zero (0) points.

4.2.3 Performance Improvement Measure. PCP shall be awarded points for Performance Improvement Measures in which the PCP improved PCP's performance from the 2014 Measurement Period. For applicable Care Coordination Measures PCP is awarded points for achieving a five percent (5%) reduction in PCP's rate, or by meeting the applicable Plan Goal. For Quality of Care Measures PCP will earn points by improving PCP's ranking by five (5) percentile points within PCP's Comparison Group or by meeting the applicable Plan Goal. The total points available for the Performance Improvement Measure will be allocated across only those measures for which the PCP qualified by meeting the applicable Member requirements in both 2014 and in 2015, but PCP is not required to have earned points for PCP's performance in the measure in either year. Points are earned based on PCP's improved performance or meeting or exceeding the Plan Goal. PCP will earn zero (0) points for each measure for which PCP does not make the requisite improvement and does not achieve the Plan Goal.

4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP. In the event that the PCP exceeded the Member Reassignment Threshold by more than two standard deviations, PCP's total CBI Incentive Program points will be reduced by fifty-percent (50%). The total points are multiplied by the number of Eligible Member Months for the PCP during the Fiscal Year to determine the PCP's "Weighted Points". Percentages are then determined by comparison to the totals for PCPs of the same Comparison Group, as follows: Weighted Points for PCP divided by total Weighted Points for all PCPs of the same Comparison Group equals the PCP's "CBI Distribution Percentage".

4.4 PCPs will receive a portion of the applicable CBI Pool (e.g. FP/GP CBI Pool, PED CBI Pool or IM CBI Pool) by multiplying the PCP's CBI Distribution Percentage by the total amount of funds in such CBI Pool.

5. Fee-for-Service Incentives

5.1 Increased preventive and disease management actions. Plan shall pay a fee-for-service incentive for performance of the following:

5.1.1 Asthma Action Plans. Plan shall pay each Provider thirty-five dollars ($35) per Asthma Action Plan submitted per Eligible Member, ages five (5) to sixty-four (64) per Fiscal Year. Payment shall be made to the first Primary Care Provider to submit the Asthma Action Plan in the Fiscal Year if an Eligible Members switches PCPs during the Fiscal Year. The Asthma Action Plan form may be found in the Provider Manual.

5.1.2 Healthy Weight for Life Program (HWL).

5.1.2.1. Referral to HWL. Plan shall pay Provider fifteen dollars ($15) per Fiscal Year for the first HWL referral received by the Plan per Eligible Member between the ages of two (2) and eighteen (18) years of age that indicates a BMI at or above the 85th percentile and counseling of the Member regarding nutrition, physical activity and the HWL. Such notification shall be made on the Plan's HWL referral form which may be found in the Provider Manual.

5.1.2.2. Program Follow Up Visit. Plan shall pay Provider fifteen dollars ($15) per Fiscal Year for the submission of the Plan's HWL follow up form completed at the first, and subsequent, six-month follow up visit(s) which occur during the CBI Term for each Eligible Member referred to the Plan's HWL program. The HWL form must document the Member's BMI percentile at the time of each six month follow up visit and further patient education regarding nutrition, physical activity and the Plan's HWL program. The HWL follow up form may be found in the Provider Manual.

5.1.3 Diabetes Services. Plan shall pay Provider per Eligible Member, ages 21 years old or older, one hundred dollars ($100) per Fiscal Year for the performance of all four (4) of the following elements of care between January 1, 2015 and December 31, 2015 and only if Eligible Member is linked to PCP on the date(s) all such services are provided: HbA1c, LDL-C, retinal exam, and medical attention for nephropathy.

5.1.4 Medication Management Agreements. Plan shall pay Provider fifty-dollars ($50) for Plan's receipt of the first submitted Medication Management Agreement per Eligible Member per Fiscal Year. The Medication Management Agreement form may be found in the Provider Manual.

5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of Capitation Payments or of the fee-for-service amount for applicable Primary Care Physician Case Managed Services as set forth in the Provider Manual, for holding office hours for at least eight (8) hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the entire quarter. Provider shall demonstrate its office hours through submission of the Plan's Extended Hours Attestation Form. Plan shall pay Provider the enhanced payment for all PCPs under Provider's contract located within a 5 mile radius of the location with extended hours availability if Eligible Members may access applicable Primary Care Physician Case Managed Services during the extended hours at the extended hours location.

5.3 Physician Orders for Life Sustaining Treatment (POLST) Form Completion. Plan shall pay Provider one-hundred dollars ($100) for Plan's receipt of the first submitted POLST form per PCP's Medi-Cal Linked Members who are in the Senior and Persons with Disabilities Medi-Cal

aid code categories (SPD) and who are age twenty-one (21) or older, per Fiscal Year. The POLST form may be found in the Provider Manual.

5.4 Post-Partum Care. Plan shall pay Provider twenty-five dollars ($25) for Plan's receipt of the first submitted post-partum care form documenting a post-partum visit provided to an Eligible Member who is an obstetrical patient from day 21 through day 56 following delivery. The Post-partum Care form may be found in the Provider Manual.

5.5 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. PCP must submit all Fee-for-Service Incentive forms and other relevant evidence in accordance with Plan instructions within twenty-one (21) business days from the date of service. Distributions are made to PCPs following Plan approval of such accounting. Distributions for the first, second and third quarters are made no later than ninety (90) calendar days after the conclusion of the quarter. The distribution for the fourth quarter Fee-for-Service Incentives shall be made with the distribution of the CBI Incentive Payments no later than one hundred eighty (180) days after the conclusion of the Fiscal Year.

6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.

7. Term of CBI. The term of this CBI shall begin on January 1, 2015 and end on December 31, 2015 (the "CBI Term").

8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.

9. Effect of Termination of Agreement. In the event of the termination of the Agreement for any reason prior to the expiration of the CBI Term, no CBI Incentive Payments shall be earned or made hereunder. Provider would; however, be eligible for CBI Fee-For-Service Incentives earned prior to the termination of the Agreement.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	COUNTY OF MONTEREY, MONTEREY COUNTY CLINIC SERVICES
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

ATTACHMENT 1 – CBI Table						
CBI Program **Measurement Components**	**Available Points**	**Member Requirement**	**Performance Target/Relative Ranking**	**Measurement Period**	**Measurement Data Source**	**Methodology**
Care Coordination Measures:	***55 total***					
Rate of Ambulatory Care Sensitive Admissions Number of ambulatory care sensitive admissions per 1,000 Eligible Members per Fiscal Year.	20	Per §3.2.	Relative Ranking[1]	FY 2015	Claims	AHRQ[2]
Rate of Readmissions Number of readmissions per 1,000 Eligible Members per Fiscal Year.	10	Per §3.3.	Relative Ranking[1]	FY 2015	Claims	Per §3.3
Rate of Generic Prescriptions Percent of generic prescriptions among all prescriptions, regardless of prescriber.	5	None.	Relative Ranking[1]	FY 2015	Claims	IHA P4P[3]
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Eligible Members per Fiscal Year.	20	Per §3.6.	Relative Ranking[1]	FY 2015	Claims	Medi-Cal ER Collaborative definition based on NYU study
Quality of Care (HEDIS):	**30 total**					
Well Child Visit 3-6 Years	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Cervical Cancer Screening	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Diabetes LDL-C Screening	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS

ATTACHMENT 1 – CBI Table						
Asthma Medication Ratio	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	IHA P4P[3]
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Appropriate Testing for Children with Pharyngitis	Per §4.1	≥ 5 continuously Eligible Members[4]	Relative Ranking[1]	FY 2015	Claims	HEDIS
Performance Improvement Measures	***10 total***					
Quality of Care and Care Coordination Improvement Quality of Care Measures - an improvement in ranking of 5 percentile points over prior Measurement Period or achievement of the Plan Goal. Care Coordination Measures (excluding Rate of Generic Prescriptions) - a 5% reduction in rate for applicable Care Coordination measures or achievement of the Plan Goal	10	Quality of Care ≥ 5 continuously Eligible Members[4] Care Coordination Per §§ 3.2, 3.3 and 3.6 of Addendum A.	Performance Target	FY 2015 compared to FY 2014	Claims	NCQA Per §2.16
Information Technology	***5 total***					
Electronic Claims Submittal 95% of eligible claims submitted electronically to the Alliance.	1	None	95% Performance Target	FY 2015	Claims	# eligible electronic claims All eligible claims
Referral Submittal 75% of eligible referrals submitted through Alliance web portal.	4	None	75% Performance Target	FY 2015	Referrals	# eligible referrals All eligible referrals
CBI FFS Incentive Measurement Component			**Amount (All paid quarterly.)**	**Member Requirement**	**Measurement Period**	**Measurement Data Source**
Extended Office Hours PCP who is available to provide services to Eligible Members for at least 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m is eligible to receive enhanced			5% of Capitation or Case Management Fee-for-Service	None	FY 2015	Administrative Data

ATTACHMENT 1 – CBI Table				
payment for applicable PCP services. Additional payment is also to be paid to PCPs covered by the Provider's agreement, practicing within a 5 mile radius, if Eligible Members may access applicable PCP services during the extended hours at the extended hours location.				
Diabetes Services Provider to ensure provision of all of the following services for Eligible Members with diabetes: HbA1c, LDL-C, retinal exam, medical attention for nephropathy[5] during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.	[redacted]	Eligible Members ages 21 and older, linked to Provider at date of service for each service.	FY 2015	Claims
Healthy Weight for Life (HWL) Program Referral Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.	[redacted]	Eligible Members aged 2 to 18	FY 2015	HWL Referral Form
Healthy Weight for Life (HWL) Program Follow Up Visit Provider to notify Plan by follow up form of each six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.	[redacted]	Eligible Members aged 2 to 18	FY 2015	HWL Follow Up Form
Asthma Action Plans (AAP) Provider to submit AAP to Plan for Members with asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Member per Fiscal Year.	[redacted]	Eligible Members aged 5 to 64	FY 2015	Plans Submitted by Providers
Medication Management Agreements (MMA) Provider to submit MMA for Members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Member per Fiscal Year.	[redacted]	None	FY 2015	Plans Submitted by Providers
Physician Orders for Life Sustaining Treatment (POLST) Form Completion Provider to submit POLST form for Members to Plan. Incentive paid to the PCP who first submits the POLST form in the Fiscal Year and is paid only once per Member per Fiscal Year.	[redacted]	Eligible Members aged 21 and older, with SPD aid code, linked to Provider at date of service	FY 2015	POLST form
Post-partum Care. Provider to ensure the provision of a post-partum visit to Members who are obstetrical patients to occur from day 21 through day 56 after a delivery. Incentive paid to the PCP who first submits the form to the Plan in the Fiscal Year and is paid only once per Member per Fiscal Year.	[redacted]	Members	FY 2015	Postpartum Care Form

[1] As set forth at Addendum 3, Section 4.1.
[2] http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx

Excluding PQI 09
http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx
Excluding NQI 01-03 and PDI 01-03 and 05-13

[3] http://www.iha.org/pdfs_documents/p4p_california/MY2011P4PManual_September2011.pdf

[4] For HEDIS measures, the continuously Eligible Members must be qualified per HEDIS specifications.

[5] Medical attention for nephropathy includes: claim data with relevant CPT or ICD-9 code evidencing treatment of nephropathy, claim submitted by a nephrologist, positive urine macroalbumin test documented by claim data, evidence of ACE inhibitor/ARB therapy during measurement year.

Note 1: If a Provider has an average of at least 100 Eligible Members during the Measurement Term (per §3.1), and the Provider's rate of member reassignment per 1,000 Eligible Members exceeds the Plan mean of member reassignment rate per 1,000 Eligible Members by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Performance Target Measures will be reduced by 50%.

Note 2: References to Section numbers in this Attachment 1 are to sections numbers of Addendum 3 unless otherwise specified.