

**SECOND AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT**

This Second Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective January 1, 2012 ("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:

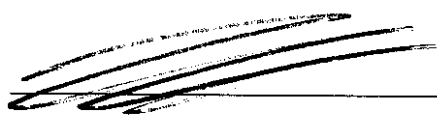
1. Addendum 3, Primary Care Physician Care Based Incentive Program, shall be amended and replaced with the attached Addendum 3, Primary Care Physician Care Based Incentive Program.

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
Central California Alliance for Health

Provider
Monterey County Clinic Services

By: 
Print Name: Jane Parker
Title: Chair, CCAH
Date: 1/17/2012

By: 
Print Name: Ray Bullick
Title: Director of Health
Date: 12/5/11

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(Signature page continued)

PROVIDER
MONTEREY COUNTY CLINIC SERVICES

By: 

Mike Derr, Contracts/Purchasing Officer

Date: 12-20-11

Approved as to Legal Form:

By: 

Stacy Saetta, Deputy County Counsel

Date: 12/7/11

Approved as to Fiscal Provisions:

By: 

Gary Giboney, Auditor-Controller

Date: 12-7-11

Second Amendment to the Central California Alliance
Primary Care Physician Services Agreement

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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 for the CBI Incentive Program is separate for the Medi-Cal and Healthy Families Programs. The budget and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Families, Healthy Kids, Alliance Care IHSS, Alliance Care AIM and Alliance Care Individual Conversion 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 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.
- 2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.
- 2.4 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.
- 2.5 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.
- 2.6 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.
- 2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

2.8 Eligible Members

2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.

2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz or Merced Healthy Kids Members; the Monterey County IHSS Members, Monterey County AIM Members, and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.

2.9 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the total number of member months each Eligible Member is linked to the PCP during the measurement period, except that member months for a PCP's Linked Medi-Cal Members who are in the Aged, BCCTP, Disabled and Long Term Care Medi-Cal aid code categories are multiplied by four (4) to determine the Eligible Member Months applicable to those Linked Members. Member months are determined by identifying the total number of Linked Members linked to the PCP during each month of the Measurement Period.

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

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

2.12 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.

2.13 PCP is the individual or group of PCPs to whom Linked Members are assigned.

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

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

2.16 Plan Goal is the percentage of Eligible Members for whom the PCP provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for all Quality of Care Measures is ninety percent (90%).

2.17 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 from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each category 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 3.8 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 one hundred (100) Linked Members.

- 3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have a minimum of one hundred (100) Linked Members as of December 31, 2012.
- 3.3 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Linked Members among all prescriptions filled for PCP's Linked Members as determined by a review of claims data.
- 3.4 Quality of Care Measures. The Quality of Care Measures Component are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims and encounter 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 Measures will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measure.
- 3.4.1 There are nine (9) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) breast cancer screening, (4) cervical cancer screening, (5) diabetes LDL-C screening, (6) diabetes HbA1c screening (7) diabetes medical attention for nephropathy, (8) body mass index (BMI) percentile calculated, and (9) asthma medication ratio.
- 3.5 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have a minimum of one hundred (100) Linked Members as of December 31, 2012.
- 3.6 Rate of Primary Care Visits. This Measurement Component measures the rate of primary care visits provided to PCP's Linked Members on an annual basis. The target for this measure is more than three (3) PCP visits per Linked Member, per Fiscal Year. Partial points may be earned by Provider for visits per Linked Member per Fiscal Year between two and one-quarter (2.25) and three (3) visits per Member per Fiscal Year.
- 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 include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.
- 3.7.1 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/encounter data include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims/encounter data submitted electronically.
- 3.7.2 Referral Submittal: This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The target for this

measure is 75% of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal

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 and received by Plan no later than January 31, 2013. 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. Except as stated below in 4.1.1, PCPs shall be awarded the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile. PCP shall be awarded one-half the maximum number of points for each measure in which the PCP is ranked between the 51st and 75th percentile. PCP shall receive zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.

4.1.1 Quality of Care Measures. For the Quality of Care Measures for which the PCP qualifies, 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 in the top quartile for the measure.

4.2 Performance Target Measures. PCP shall be awarded the full amount of points if the PCP meets the Performance Target for the Electronic Claims/Encounter Data Submittal Measure. If the PCP falls below the Performance Target for this measure, the PCP earns zero (0) points. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target for the Rate of Primary Care Visits Measure. PCPs shall be awarded partial points if they provide between two and one-quarter (2.25) and three (3) visits per Linked Member per Fiscal Year. If the PCP falls below two (2) visits per Linked Member per Fiscal Year, it will earn zero (0) points.

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. IM CBI Pool, PED CBI Pool or FP/GP 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 Linked Member, ages three (3) to fifty-six (56), per Fiscal Year. Payment shall be made to the first Primary Care Provider to submit the Asthma Action Plan in the Fiscal Year if a Linked Member switches PCPs during the Fiscal Year.

- 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 Linked 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 six-month follow up visit for each Linked 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 Linked 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 by December 31, 2012 and only if Linked Member is linked to PCP on the date(s) all such services are provided: HbA1c, LDL-C, retinal exam, and diabetes 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 Linked Member per Fiscal Year.
- 5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of capitation or the fee-for-service equivalent for non-capitated Programs 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 quarter. 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 Linked Members may access care during the extended hours at the extended hours location.
- 5.3 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 should submit all Fee-for-Service Incentives within 30 days of the close of each quarter and will not receive payment for any Fee-for-Service Incentives submitted to Plan after January 31, 2013. 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, 2012 and end on December 31, 2012 (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.

ATTACHMENT 1 – CBI Table

CBI Program Measurement Components	Available Points	Member Requirement	Performance Target/Relative Ranking	Measurement Period	Measurement Data Source	Methodology
Health and Cost Management:	40 total					
Rate of Ambulatory Care Sensitive Admissions Number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year.	30	≥ 100 Linked Members as of 12/31/12.	Relative Ranking ³	FY 2012	Claims	AHRQ ¹
Rate of Generic Prescriptions Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking ³	FY 2012	Claims	IHA P4P ²
Quality of Care (HEDIS):	30 total					
Well Child Visit 3-6 Years	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Breast Cancer Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Cervical Cancer Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Diabetes LDL-C Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Diabetes HbA1c Screening	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
BMI Percentile Calculated	Per \$4.1	≥ 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	HEDIS
Asthma Medication Ratio	Per \$4.1	> 5 continuously Linked Members ⁴	Relative Ranking ³	FY 2012	Claims	IHA P4P ²

ATTACHMENT 1 – CBI Table

<i>Appropriate Access to Care</i>	<i>25 total</i>							
<u>Rate of Preventable Emergency Department Visits</u> Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	≥ 100 Linked Members as of 12/31/12	Relative Ranking ³	FY 2012	Claims	Medi-Cal ER Collaborative definition based on NYU study		
<u>Rate of Primary Care Visits</u> Greater than three (3) Primary Care visits provided by Provider to Linked Members per Fiscal Year. Partial points will be awarded for 2.25 to 3 visits PMPY.	5	None	>3.0 PMPY Performance Target	FY 2012	Claims	Plan developed		
<u>Information Technology</u>	<i>5 total</i>							
<u>Electronic Claims/Encounter Data Submittal</u> 95% of eligible claims/encounter data submitted electronically to the Alliance.	3	None	95% Performance Target	FY 2012	Claims	# eligible electronic claims All eligible claims		
<u>Referral Submittal</u> 75% of eligible referrals submitted through Alliance web portal.	2	None	75% Performance Target	FY 2012	Referrals	# eligible referrals All eligible referrals		
<u>CBI FFS Incentive Measurement Component</u>			Amount (All paid quarterly)	Member Requirement	Measurement Period	Measurement Data Source		
<u>Extended Office Hours</u> Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per PCP covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours location.			5% of Capitation or Case Management Fee-for-Service	None	FY 2012	Administrative Data		
<u>Diabetes Services</u> Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, retinal exam, diabetes 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.			\$100 PM/PY	Members ages 21 and older, linked to Provider at date of service for each service.	FY 2012	Claims		
<u>Healthy Weight for Life (HWL) Program Referral</u> Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85 th 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.			\$15 PM/PY	Members aged 2 to 18	FY 2012	HWL Referral Form		

ATTACHMENT 1 – CBI Table

Healthy Weight for Life Program Follow Up Visit Provider to notify Plan by follow up form of the first six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.	\$15 PM/PY	Members aged 2 to 18	FY 2012	HWL Follow Up Form
<u>Asthma Action Plans (AAP)</u> 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 Fiscal Year.	\$35 PM/PY	Members ages 3 to 56	FY 2012	Plans Submitted by Providers
<u>Medication Management Agreements (MMA)</u> 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 Fiscal Year.	\$50 PM/PY	None	FY 2012	Plans Submitted by Providers

¹ <http://www.ahrq.gov/data/safetynet/billappb.htm>

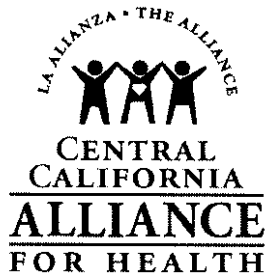
² http://www.ihf.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf

³ For relative ranking measures, PCPs ranked at 100th to 76th percentile amongst peers earn maximum available points, ranked at 75th to 51st percentile earn one-half available points, ranked below 50th percentile earn no points for the measure.

⁴ For HEDIS Measures, the continuously Linked Members must be qualified per HEDIS specifications.

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

Note: If a Provider has 100 or more Linked Members, and the Provider's rate of member reassignment per 1,000 Linked Members exceeds the Plan mean of member reassignment rate per 1,000 Linked Members by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Target Measures will be reduced by 50%.



1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500
339 Pajaro Street, Suite E • Salinas, CA 93901-3400 • (831) 755-6000
530 West 16th Street, Suite B • Merced, CA 95340-4710 • (209) 381-5300

February 6, 2012

Ray Bullick
Monterey County Clinic Services
1615 Bunker Hill Way, Ste. 100
Salinas, CA 93906

Dear Mr. Bullick:

Please find enclosed for your records a copy of the fully executed Second Amendment to the Primary Care Physician Services Agreement Services Agreement with the Santa Cruz-Monterey-Merced Managed Medical Care Commission effective January 1, 2012.

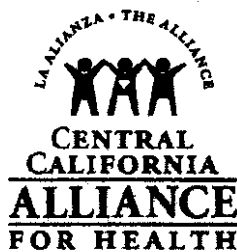
We appreciate your partnership with the Alliance and your willingness to provide quality health care to our plan members.

Sincerely,

Laura Alderman
Contracts Specialist

Enclosure

Rec'd 2/16/12
SM



1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500
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**Attestation Regarding Extended Office Hours
 2012 Care Based Incentive Program**

Please complete all of the following fields, and sign and date this form at the bottom. The form must be signed by the contract signer. Central California Alliance for Health (the Alliance) will verify this information and if it is determined during any quarter of 2012 that the hours claimed are not available to Alliance members, your practice will be rendered ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

Practice name: Seaside Family Health Center

Location of site with extended office hours:

Address, City, Zipcode: 1150 Fremont Blvd., Seaside 93955

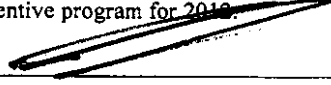
Hours:

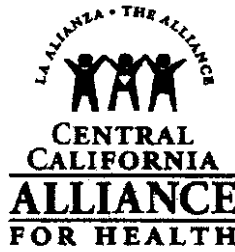
Monday	<u>7:00</u> a.m. to <u>7:00</u> p.m.	Friday	<u>8:00</u> a.m. to <u>5:00</u> p.m.
Tuesday	<u>7:00</u> a.m. to <u>7:00</u> p.m.	Saturday	_____ a.m. to _____ p.m.
Wednesday	<u>8:00</u> a.m. to <u>5:00</u> p.m.	Sunday	_____ a.m. to _____ p.m.
Thursday	<u>7:00</u> a.m. to <u>7:00</u> p.m.		

Sites within a 5 mile radius whose members can access care at extended office hours site:

Address, City, Zipcode: _____
Address, City, Zipcode: _____
Address, City, Zipcode: _____
Address, City, Zipcode: _____

I hereby affirm that the information submitted in this Attestation Regarding Extended Office Hours is true, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in my practice being ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

By: 
 Print: Ray Bullick
 Title: Director of Health
 Date: 12/5/11



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**Attestation Regarding Extended Office Hours
 2012 Care Based Incentive Program**

Please complete all of the following fields, and sign and date this form at the bottom. The form must be signed by the contract signer. Central California Alliance for Health (the Alliance) will verify this information and if it is determined during any quarter of 2012 that the hours claimed are not available to Alliance members, your practice will be rendered ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

Practice name: Alisal Health Center

Location of site with extended office hours:

Address, City, Zipcode: 559 East Alisal Street, Suite 201, Salinas 93905

Hours:

Monday	<u>8:00</u> a.m. to <u>5:00</u> p.m.	Friday	<u>8:00</u> a.m. to <u>5:00</u> p.m.
Tuesday	<u>7:00</u> a.m. to <u>7:00</u> p.m.	Saturday	_____ a.m. to _____ p.m.
Wednesday	<u>8:00</u> a.m. to <u>5:00</u> p.m.	Sunday	_____ a.m. to _____ p.m.
Thursday	<u>7:00</u> a.m. to <u>7:00</u> p.m.		

Sites within a 5 mile radius whose members can access care at extended office hours site:

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 151, Suite 16, Salinas 93906

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 101, Salinas 93906

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 103, Salinas 93906

Address, City, Zipcode: _____

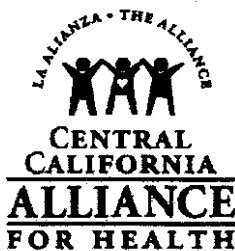
I hereby affirm that the information submitted in this Attestation Regarding Extended Office Hours is true, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in my practice being ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

By: 

Print: Ray Bullick

Title: Director of Health

Date: 10/5/11



1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500
339 Pajaro Street, Suite E • Salinas, CA 93901-3400 • (831) 755-6000
530 West 16th Street, Suite B • Merced, CA 95340-4710 • (209) 381-5300

Attestation Regarding Extended Office Hours 2012 Care Based Incentive Program

Please complete all of the following fields, and sign and date this form at the bottom. The form must be signed by the contract signer. Central California Alliance for Health (the Alliance) will verify this information and if it is determined during any quarter of 2012 that the hours claimed are not available to Alliance members, your practice will be rendered ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

Practice name: Laurel Family Practice

Location of site with extended office hours:

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 103, Salinas 93906

Hours:

Monday 7:00 a.m. to 6:00 p.m.

Friday 7:30 a.m. to 5:00 p.m.

Tuesday 7:00 a.m. to 6:00 p.m.

Saturday _____ a.m. to _____ p.m.

Wednesday 7:00 a.m. to 6:00 p.m.

Sunday _____ a.m. to _____ p.m.

Thursday 7:00 a.m. to 6:00 p.m.

Sites within a 5 mile radius whose members can access care at extended office hours site:

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 151, Suite 16, Salinas 93906

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 101, Salinas 93906

Address, City, Zipcode: 559 East Alisal Street, Suite 201, Salinas 93905

Address, City, Zipcode: _____

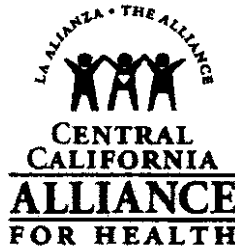
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By: 

Print: Ray Bullick

Title: Director of Health

Date: 12/5/11



1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500
339 Pajaro Street, Suite E • Salinas, CA 93901-3400 • (831) 755-6000
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Attestation Regarding Extended Office Hours 2012 Care Based Incentive Program

Please complete all of the following fields, and sign and date this form at the bottom. The form must be signed by the contract signer. Central California Alliance for Health (the Alliance) will verify this information and if it is determined during any quarter of 2012 that the hours claimed are not available to Alliance members, your practice will be rendered ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

Practice name: Laurel Internal Medicine

Location of site with extended office hours:

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 151, Suite 16, Salinas 93906

Hours:

Monday	<u>7:30</u> a.m. to <u>6:00</u> p.m.	Friday	<u>7:30</u> a.m. to <u>6:00</u> p.m.
Tuesday	<u>7:30</u> a.m. to <u>6:00</u> p.m.	Saturday	_____ a.m. to _____ p.m.
Wednesday	<u>7:30</u> a.m. to <u>6:00</u> p.m.	Sunday	_____ a.m. to _____ p.m.
Thursday	<u>7:30</u> a.m. to <u>6:00</u> p.m.		

Sites within a 5 mile radius whose members can access care at extended office hours site:

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 101, Salinas 93906

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 103, Salinas 93906

Address, City, Zipcode: 559 East Alisal Street, Suite 201, Salinas 93905

Address, City, Zipcode: _____

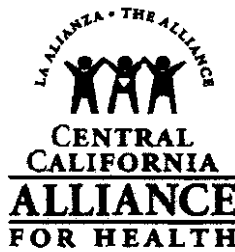
I hereby affirm that the information submitted in this Attestation Regarding Extended Office Hours is true, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in my practice being ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

By: 

Print: Ray Bullick

Title: Director of Health

Date: 10/5/11



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**Attestation Regarding Extended Office Hours
 2012 Care Based Incentive Program**

Please complete all of the following fields, and sign and date this form at the bottom. The form must be signed by the contract signer. Central California Alliance for Health (the Alliance) will verify this information and if it is determined during any quarter of 2012 that the hours claimed are not available to Alliance members, your practice will be rendered ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

Practice name: Laurel Pediatrics

Location of site with extended office hours:

Address, City, Zipcode: 1441 Constitution Blvd., Bldg. 200, Fl. One, Suite 101, Salinas 93906

Hours:

Monday	<u>7:00</u> a.m. to <u>6:00</u> p.m.	Friday	<u>7:00</u> a.m. to <u>5:00</u> p.m.
Tuesday	<u>7:00</u> a.m. to <u>6:00</u> p.m.	Saturday	_____ a.m. to _____ p.m.
Wednesday	<u>7:00</u> a.m. to <u>6:00</u> p.m.	Sunday	_____ a.m. to _____ p.m.
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Address, City, Zipcode: _____

I hereby affirm that the information submitted in this Attestation Regarding Extended Office Hours is true, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in my practice being ineligible to receive funds for the Extended Office Hours measure of the Care Based Incentive program for 2012.

By: 

Print: Ray Bullick

Title: Director of Health

Date: 10/5/11



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November 8, 2011

Ray Bullick
Monterey County Clinic Services
1615 Bunker Hill Way, Ste. 100
Salinas, CA 93906

Dear Mr. Bullick:

Enclosed please find an amendment to your Primary Care Provider Services Agreement which adds the Alliance's 2012 Care Based Incentive Program (CBI) to your agreement.

The Alliance began operating CBI on January 1, 2011 to help make local health care a more satisfying experience for providers. CBI is intended to promote good health and encourage the patient centered medical home model and to provide an avenue for us all, including members, to step up to the national challenge to improve value and manage cost in health care.

In 2012, the Alliance will operate CBI as the sole incentive program for our primary care providers. The Alliance's primary care Utilization Management Incentive (UMI) and Quality Based Incentive (QBI) programs expire on December 31, 2011 and will not be renewed for 2012.

Your participation and ability to earn incentive funds in CBI 2012 requires that you sign this amendment and the accompanying Addendum 3 and return to the Plan for countersignature by December 15, 2011. If we do not receive the signed Amendment and Addendum, you will not be eligible for incentives in 2012. *

Also enclosed for your review and signature is an "Attestation Regarding Extended Hours" form for 2012 which is required if you wish to participate in the Extended Hours CBI incentive for the 2012 CBI Term. The Extended Hours incentive pays primary care providers 5% of their capitation or fee for service equivalent if they have more than 8 hours beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. available to their linked members. If you offer extended hours to your Alliance members, please complete, sign and return the 2012 Attestation along with your signed Amendment and Addendum 3. *

CBI 2012 continues with many of the same measures and with limited changes made based on what we learned from operating the program in 2011. The changes are identified in summary below. You can also review the updated Appendix 12: Care Based Incentives from the Provider Manual, posted in the What's New section of the Provider page on our website.

Rate of Ambulatory Care Sensitive Admissions

The measure formerly known as "Preventable Inpatient Admissions" continues with the same methodology, but with a new title to align with nationally recognized standards.

Quality of Care Measures

The most significant change to the Quality of Care Measures is that in 2012, a provider will always be eligible for the full amount of available points. A set point value is not assigned to any one measure in the Quality of Care Measures. Instead, the total points will be allocated across only those measures for which a provider meets the basic qualifications. The provider will still have to perform to earn the points, but will not lose out on points because they do not have enough qualifying members for a particular measure.

In addition, in 2012, the total available points for the Quality of Care measures increases from 25 to 30 points. The additional 5 points come from the inclusion of the Asthma Medication Ratio measure, the measure formerly known as "Rate of Controller Med. For Asthma Cases". Finally, you will note that the title of the measure formerly known as "Diabetes Monitoring for Diabetic Nephropathy" changed to "Diabetes Medical Attention for Nephropathy".

Electronic Data Submissions

We added a new target measure for the submission of referrals through the Alliance web portal. Providers who submit 75% of eligible referrals through the web portal will receive 2 points. The electronic claims/encounter data measure remains, and is now worth 3 points.

Asthma Action Plans

We expanded the eligible member age for Asthma Action Plans to three (3) to fifty-six (56) from the former zero (0) to eighteen (18).

Healthy Weight for Life

We have expanded the 2011 fee-for-service BMI Notification measure to the Healthy Weight for Life Program (HWL). In 2012, providers will be eligible for a total of \$30 for their participation in this program; half when they initially refer a member whose BMI is at or above the 85th percentile and provide education and counseling to the member regarding the Plan's program, exercise and nutrition, and half for a follow up visit at six months documented on the plan's form.

Changes to Calculation and Payment

We have clarified that claims and forms must be received by January 31, 2013 to be included in the calculation of CBI 2012 payment.

In addition, in recognition of the higher case management responsibility and complexity of providing services to members whose Medi-Cal Aid code is Aged, BCCTP, Disabled or LTC, we added language which weighs the member months for members in those aid code categories 4:1 of members in all other aid code categories.

Finally, we have adjusted the Member Reassignment Threshold so that in 2012, any provider who exceeds the Plan mean by more than 2 standard deviations will have their earned points reduced by one-half, rather than receiving no incentive from the programmatic measures.


The Provider Services Department is hosting a number of workshops regarding CBI in November and December 2011. You will receive an invitation to the workshops and we hope you will join us to learn more about this exciting new program. Our staff is also happy to meet with your office individually to discuss the program for 2012.

As always, we appreciate the high quality of service you provide to Alliance members. We look forward to working with you to ensure appropriate access to care for Alliance members, improving medical outcomes while also increasing your satisfaction with the Plan. If you have any questions about the CBI program, please contact your Provider Services Representative at the numbers listed below:

Santa Cruz and Monterey County Providers
Merced County Providers

(831) 430-5504
(800) 700-3874 ext. 5514

Sincerely,



Angelique Milhouse
Provider Services Network Manager

Encl.