

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

This Fourth Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective January 1, 2015 ("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, doing business as Natividad Medical Center, on behalf of its Natividad Medical Group, 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. The definitions of ACA Primary Care Services and ACA Primary Care Service Rates shall be deleted in their entirety from Exhibit H, Section 2.

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

"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. Fee-For-Service Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., and v.

i. Plan shall pay Provider for Case Managed Services provided to Provider's Medi-Cal Linked Members at one hundred percent (100%) of the Medi-Cal Rate in effect on the date the Covered Service was rendered.

ii. 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.

iii. 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.

- iv. 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.
- v. 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."

3. 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  
Central California Alliance for Health

Provider  
Natividad Medical Group

By: \_\_\_\_\_

By: Kelly R. O'Keefe

Print Name: \_\_\_\_\_

Print Name: Kelly R. O'Keefe

Title: \_\_\_\_\_

Title: Interim CEO

Date: \_\_\_\_\_

Date: 1/12/15

Reviewed as to fiscal provisions

[Signature]  
Auditor-Controller  
County of Monterey 23-V

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APPROVED AS TO FORM AND LEGALITY

[Signature]  
DEPUTY COUNTY COUNSEL  
COUNTY OF MONTEREY

### 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 90<sup>th</sup> 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		
	<u>Rate of Ambulatory Care Sensitive Admissions</u>	<u>Rate of Preventable ED Visits</u>	<u>Rate of Readmission</u>
99 <sup>th</sup> – 90 <sup>th</sup>	20	20	10
89 <sup>th</sup> – 80 <sup>th</sup>	16	16	8
79 <sup>th</sup> – 70 <sup>th</sup>	12	12	6
69 <sup>th</sup> – 60 <sup>th</sup>	8	8	4
59 <sup>th</sup> – 50 <sup>th</sup>	4	4	2
49 <sup>th</sup> 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 51<sup>st</sup> through the 75<sup>th</sup> 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 51<sup>st</sup> through the 75<sup>th</sup> 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

NATIVIDAD MEDICAL GROUP

By: \_\_\_\_\_

By: Uelby Rosulem

Title: \_\_\_\_\_

Title: Interim CEO

Date: \_\_\_\_\_

Date: 1/12/15

APPROVED AS TO FORM AND LEGALITY

Haydée  
DEPUTY COUNTY COUNSEL  
COUNTY OF MONTEREY

**ATTACHMENT 1 – CBI Table**

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

**ATTACHMENT 1 – CBI Table**

Asthma Medication Ratio	Per §4.1	≥ 5 continuously Eligible Members <sup>4</sup>	Relative Ranking <sup>1</sup>	FY 2015	Claims	IHA P4P <sup>3</sup>
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Per §4.1	≥ 5 continuously Eligible Members <sup>4</sup>	Relative Ranking <sup>1</sup>	FY 2015	Claims	HEDIS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Per §4.1	≥ 5 continuously Eligible Members <sup>4</sup>	Relative Ranking <sup>1</sup>	FY 2015	Claims	HEDIS
Appropriate Testing for Children with Pharyngitis	Per §4.1	≥ 5 continuously Eligible Members <sup>4</sup>	Relative Ranking <sup>1</sup>	FY 2015	Claims	HEDIS
<b><i>Performance Improvement Measures</i></b>	<b><i>10 total</i></b>					
<u>Quality of Care and Care Coordination Improvement</u> 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	<u>Quality of Care</u> ≥ 5 continuously Eligible Members <sup>4</sup> <u>Care Coordination</u> Per §§ 3.2, 3.3 and 3.6 of Addendum A.	Performance Target	FY 2015 compared to FY 2014	Claims	NCQA Per §2.16
<b><i>Information Technology</i></b>	<b><i>5 total</i></b>					
<u>Electronic Claims Submittal</u> 95% of eligible claims submitted electronically to the Alliance.	1	None	95% Performance Target	FY 2015	Claims	# eligible <u>electronic claims</u> All eligible claims
<u>Referral Submittal</u> 75% of eligible referrals submitted through Alliance web portal.	4	None	75% Performance Target	FY 2015	Referrals	# eligible <u>referrals</u> All eligible referrals
<b>CBI FFS Incentive Measurement Component</b>			<b>Amount (All paid quarterly.)</b>	<b>Member Requirement</b>	<b>Measurement Period</b>	<b>Measurement Data Source</b>
<u>Extended Office Hours</u> 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.				
<u>Diabetes Services</u> Provider to ensure provision of all of the following services for Eligible Members with diabetes: HbA1c, LDL-C, retinal exam, medical attention for nephropathy <sup>5</sup> 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	Eligible Members ages 21 and older, linked to Provider at date of service for each service.	FY 2015	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 <sup>th</sup> 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	Eligible Members aged 2 to 18	FY 2015	HWL Referral Form
<u>Healthy Weight for Life (HWL) Program Follow Up Visit</u> 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.	\$15 PM/PY	Eligible Members aged 2 to 18	FY 2015	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 Member per Fiscal Year.	\$35 PM/PY	Eligible Members aged 5 to 64	FY 2015	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 Member per Fiscal Year.	\$50 PM/PY	None	FY 2015	Plans Submitted by Providers
<u>Physician Orders for Life Sustaining Treatment (POLST) Form Completion</u> 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.	\$100 PM/PY	Eligible Members aged 21 and older, with SPD aid code, linked to Provider at date of service	FY 2015	POLST form
<u>Post-partum Care.</u> 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.	\$25 PM/PY	Members	FY 2015	Postpartum Care Form

<sup>1</sup> As set forth at Addendum 3, Section 4.1.

<sup>2</sup> [http://www.qualityindicators.ahrq.gov/Modules/PQI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx)

Excluding PQI 09

[http://www.qualityindicators.ahrq.gov/Modules/PDI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx)

Excluding NQI 01-03 and PDI 01-03 and 05-13

<sup>3</sup> [http://www.iha.org/pdfs\\_documents/p4p\\_california/MY2011P4PManual\\_September2011.pdf](http://www.iha.org/pdfs_documents/p4p_california/MY2011P4PManual_September2011.pdf)

<sup>4</sup> For HEDIS measures, the continuously Eligible Members must be qualified per HEDIS specifications.

<sup>5</sup> 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.



1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • (831) 430-5500  
 950 East Blanco Road, Suite 101 • Salinas, CA 93901-4419 • (831) 755-6000  
 530 West 16th Street, Suite B • Merced, CA 95340-4710 • (209) 381-5300

**Attestation Regarding Extended Office Hours  
 2015 Care Based Incentive (CBI) Program**

The Alliance provides incentive for qualifying Primary Care Providers who offer their linked members access to primary care services outside of standard business hours. The incentive is earned for the site at which the extended hours are available (the extended hours office) and can be earned for qualifying additional primary care sites. To qualify as an extended hours office the office must be open to provide primary care services for at least eight hours outside of standard business hours (Monday through Friday 8:00 a.m. to 5:00 p.m.) and have received a Facility Site Review as part of its credentialing with the Alliance. To qualify as an additional primary care site the office must be located within five miles of the extended hours office, be contracted under the same contract as the extended hours office, and members linked to the site must have access to primary care services at the extended hours office, outside of standard business hours.

Please complete all of applicable fields below, 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 2015 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 CBI program for 2015.

**Practice name:** \_\_\_\_\_

**Extended Hours Office**

Address, City, Zip code: \_\_\_\_\_

**Hours:**

Monday	_____ a.m. to _____ p.m.	Friday	_____ a.m. to _____ p.m.
Tuesday	_____ a.m. to _____ p.m.	Saturday	_____ a.m. to _____ p.m.
Wednesday	_____ a.m. to _____ p.m.	Sunday	_____ a.m. to _____ p.m.
Thursday	_____ a.m. to _____ p.m.		

**Additional Primary Care Sites**

Address, City, Zip code: \_\_\_\_\_  
 Address, City, Zip code: \_\_\_\_\_  
 Address, City, Zip code: \_\_\_\_\_  
 Address, City, Zip code: \_\_\_\_\_

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 CBI program for 2015.

By: \_\_\_\_\_  
 Print: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Date: \_\_\_\_\_



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## FORM INSTRUCTIONS

### EFT/ACH CREDIT AUTHORIZATION FORM AUTHORIZATION AGREEMENT FOR ELECTRONIC PAYMENTS (ACH CREDITS)

Please note that you must be signed up to receive your Remittance Advice (RA) electronically in order to be enrolled with direct deposit. There are two available options for you to do so: via EDI 835 transaction – Electronic Remittance Advice, or via the Provider Web Portal, by downloading your RAs in PDF format.

**Once you have enrolled with EFTs, you will no longer be receiving paper RAs via mail.**

If you are not yet enrolled to receive your RAs electronically, or if you have other questions, please contact the Provider Services Web & EDI Specialist at (831) 430-5518 or our main Provider Services line at (831) 430-5504.

**All fields are required**

#### PROVIDER INFORMATION

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it.
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Provider Address - Street	The number and street name where a person or organization can be found.
City	City associated with provider address field.
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.

ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
Provider Contact Name	Name of a contact in provider office for handling EFT issues.
Telephone Number	Associated with contact person.
Email Address	An electronic mail address at which the health plan might contact the provider.

### FINANCIAL INSTITUTION INFORMATION

Financial Institution Name	Official name of the provider's financial institution.
Financial Institution Address - Street	Street address associated with receiving depository financial institution name field.
City	City associated with receiving depository financial institution address field.
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments (Checking or Savings).
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited.
Account Number Linkage to Provider Identifier	Provider preference for grouping of claim payments – must match preference for v5010 X12 835 remittance advice (by TIN or by NPI).

### SUBMISSION INFORMATION

Reason for Submission	Select New Enrollment, Change Enrollment, or Cancel Enrollment.
Include with Enrollment Submission	Please include one of the following items for verification purposes with your enrollment request: <u>Voided Check:</u> A voided check is attached to provide confirmation of Identification/Account Numbers. <u>Bank Letter:</u> A letter on bank letterhead that formally certifies the account owners routing and account numbers.

### AUTHORIZED SIGNATURE

Written Signature of Person Submitting Enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Submission Date	The date on which the enrollment is submitted.





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## FACSIMILE TRANSMITTAL SHEET

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**Date:**

**Time:**

**To:** ATTN: Eugenia Tsuei, Finance

**Company:** Central California Alliance for Health

**Fax Number:** (831) 430-5871

**Sender:**

**Sender Phone #:**

**Sender Fax #:**

**Pages including cover:**

**Notes/Comments:**

**Important Warning:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender immediately and arrange for the destruction of these documents.

**EFT/ACH CREDIT AUTHORIZATION FORM**  
**AUTHORIZATION AGREEMENT FOR ELECTRONIC PAYMENTS (ACH CREDITS)**

I hereby authorize Santa Cruz, Monterey, and Merced Managed Medical Care commission, doing business as Central California Alliance for Health (herein after referred to as CCAH) to deposit any amounts owed by initiating credit entries to the account at the financial institution (herein after referred to as Bank) indicated below. Further, I authorize the Bank to accept and to credit entries indicated by CCAH to my accounts.

This authorization is to remain in full force and effect until CCAH and Bank have received written notice of its termination in such time and in such manner as to afford CCAH and Bank to reasonable opportunity to act on it.

**All fields are required**

**PROVIDER INFORMATION**

Provider Name		Provider Federal Tax Identification Number (TIN)	
Doing Business As Name (DBA)		National Provider Identifier (NPI)	
Provider Address - Street	City	State/Province	ZIP Code/ Postal Code
Provider Contact Name	Telephone Number (     )	Email Address	

**FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name			
Financial Institution Address - Street	City	State/Province	ZIP Code/Postal Code

Financial Institution Routing Number:

Type of Account at Financial Institution:       Checking       Savings

Provider's Account Number with Financial Institution:

Account Number Linkage to Provider Identifier:       Provider Tax Identification Number (TIN)       National Provider Identifier (NPI)

**SUBMISSION INFORMATION**

Reason for Submission:       New Enrollment       Change Enrollment       Cancel Enrollment

Include with Enrollment Submission:       Voided Check       Bank Letter

**Please attach a voided check or a letter on bank letterhead that formally certifies the account owner's routing and account numbers. Your request will not be processed without one of these items included.**

**AUTHORIZED SIGNATURE**

Written Signature of Person Submitting Enrollment	Submission Date
---	-----------------

Please FAX completed applications to:  
 (831) 430-5871, ATTN: Eugenia Tsuei, Finance

For questions about this form, please contact:  
 (800) 700-3874 x5510