

**AMENDMENT NO. 1 TO THE
HOSPITAL SERVICES AGREEMENT
AMONG
VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
(dba GOLD COAST HEALTH PLAN
AND
COUNTY OF VENTURA**

This Amendment No. 1 (this “Amendment”) to the Amended and Restated Hospital Services Agreement (the “Agreement”) is made by Ventura County Medi-Cal Managed Care Commission, a public entity doing business as Gold Coast Health Plan (“Health Plan”) and County of Ventura (“Provider”). This Amendment is effective as of October 1, 2024 (the “Amendment Effective Date”).

RECITALS

WHEREAS, the Parties entered into the Agreement to be effective as of July 1, 2023; and

WHEREAS, the Parties desire to amend the Agreement, specifically Attachment D-1 (Compensation Schedule), as provided herein.

NOW, THEREFORE, in consideration of the foregoing premises and the mutual covenants of the Parties set forth herein, the Parties agree as follows:

1. Capitalized terms used but not defined in this Amendment No. 1 have the meanings ascribed to them in the Agreement. The above Recitals are true and correct and incorporated herein and made a part hereof.
2. The Agreement is hereby extended through June 30, 2026. Thereafter, the Agreement may be renewed for additional one (1) year terms upon mutual agreement of the Parties.
3. Attachment D-1 (Compensation Schedule) is deleted in its entirety and replaced with the attached Attachment D-1 (Compensation Schedule).
4. To the extent that the terms set forth in this Amendment No. 1 are inconsistent with the terms of the Agreement, the terms set forth in this Amendment No. 1 shall apply. All other terms and conditions of the Agreement shall remain unchanged.
5. This Amendment No. 1 may be executed in one or more counterparts, each of which is to be deemed an original, and all of which together constitute one and the same instrument. The facsimile, e-mail, or other electronically made and/or delivered signature of a Party is to be deemed to constitute an original signature for all purposes, and facsimile or electronic copies of the Amendment No. 1 are to be deemed to constitute duplicate originals.

*****SIGNATURE PAGE TO FOLLOW*****

The Parties have executed this Amendment No. 1 to be effective as of the Amendment Effective Date.

PROVIDER:

COUNTY OF VENTURA

HEALTH PLAN:

**VENTURA COUNTY MEDI-CAL
MANAGED CARE COMMISSION dba
Gold Coast Health Plan**

Executed by:

Executed by:

Signature

Signature

Printed Name

Printed Name

Title

Title

Date

Date

Address for Notices:

Ventura County Health Care Agency
5851 Thille St. Suite 100
Ventura, CA 93003

Address for Notices:

Gold Coast Health Plan
711 E. Daily Drive, Suite 106
Camarillo, CA 93010-6082

ATTACHMENT D-1 (Compensation Schedule)

Footnotes are noted in [brackets]

SERVICE CATEGORY [1]	TERMS [2]	QUALIFIERS [3]	EFFECTIVE 7/1/24 THROUGH 6/30/25
INPATIENT SERVICES			
All Inpatient Services, except those listed below	Per Medi-Cal APR-DRG payment guidelines, except applicable Inpatient Exclusions and/or “Add-On” rates listed below	APR-DRG including the severity of illness (“SOI”) level	150% of APR-DRG
Order-Related Procedures - Inpatient	Per Medi-Cal APR-DRG payment guidelines, except applicable Inpatient Exclusions	Applicable APR-DRG codes Example: APR-DRG 851-x	200% of APR-DRG
Administrative Day	Level 1 and Level 2: Per DHCS Guidelines All Other Admin Days: Per below definition [7]	Level 1: Revenue Code 0169 Level 2: Revenue Codes 0190, 0199 All Other – Level 1 Revenue Code: 0169	150% of Applicable DHCS Admin Day Rate
INPATIENT EXCLUSIONS			
Implant Exclusion	Applies when eligible cumulative charges for all applicable revenue codes exceed \$15,000 (“Implants Threshold”) [5] and [8]	Revenue Codes 0274-0278	30% of Cumulative Charges for all Applicable Codes
High-Cost Drugs Exclusion	Stratified rates based on Threshold Amount [8]	Revenue Code 0636	If Eligible Billed Charges are: \$1,000 to \$5,000, 25% of eligible cumulative charges for applicable code Up to \$10,000, 20% of eligible cumulative charges for applicable code Exceeding \$10,000, 15% of eligible cumulative charges for applicable code
OUTPATIENT PROCEDURES			

SERVICE CATEGORY [1]	TERMS [2]	QUALIFIERS [3]	EFFECTIVE 7/1/24 THROUGH 6/30/25
Bariatric - OP Surgery	Case Rate, excludes all implants and drugs	Procedure codes in Attachment D-2	\$5,860
Hip/Knee - OP Surgery	Case Rate, excludes all implants and drugs	Hip (Procedure Codes 27125-27138); Knee (Proc Codes 27427-27429, 27438-27447)	\$5,860
Gender-Related Procedures – Outpatient	Case Rate, excludes all implants and drugs	Applicable CPT Codes	Case Rate: \$15,000
Other OP Procedures (Not listed above)	Stratified Case Rates, excluding all implants and drugs	Revenue Codes: 0360-0361, 0369, 0481, 0490, 0499, 0750, 0790	If Eligible Billed Charges are: Up to \$15,000, Case Rate = \$560 More than \$15,000, Case Rate = \$2,500
Outpatient Implants	See “Outpatient Exclusions” Below [5]	See Below	See Below
ADD-ON RATES			
Trauma Activation [6]	Fee applies in addition to other applicable rates; Payable for all trauma levels for inpatient and outpatient cases	Revenue Code 0682	\$6,500
Observation	Per diem rate applies every 1-24 hours; in the event that a patient is admitted on the same calendar day as the patient receives observation services, then the APR-DRG rate will be paid for that calendar day. Otherwise, if the patient is not admitted on a given calendar day and only receives observation services, the per diem rate for observation will be paid	Revenue Code 762	\$3,750
EMERGENCY ROOM			
Emergency Services	Stratified Case Rates apply only if no observation or inpatient services are provided on the same calendar day, as emergency services; Case Rate excludes all implants and drugs	Revenue Codes 0450-0459	If Eligible Billed Charges are: Less than \$2,000, CASE RATE = \$150 \$2,000 to \$10,000, CASE RATE = \$550 More than \$10,000, CASE RATE = \$750
OUTPATIENT EXCLUSIONS			

SERVICE CATEGORY [1]	TERMS [2]	QUALIFIERS [3]	EFFECTIVE 7/1/24 THROUGH 6/30/25
Outpatient Implants	Applies to all outpatient services (“Implants Threshold”) [5] and [8]	Revenue Codes 0274-0278	30% of Billed Charges for all Applicable Codes
Outpatient Drugs	Applies to all outpatient services	Revenue Code: 0636	30% of Billed Charges for Applicable Code
OTHER OUTPATIENT SERVICES [4]			
OP Services Not Listed Above	Multiple of Medi-Cal Rates plus Augmentation [4]	Bill Type 131, except Revenue Codes: 0360-0361, 0369, 0481, 0490, 0499, 0750, 0790, 0450-0459, 0636, 0682, 0762	123% of Medi-Cal X 1.4344 Augmentation
Outpatient Drugs	See “Outpatient Exclusions” Above	See Above	See Above
OP Codes without a Medi-Cal Rate	Applies to outpatient services and OP drugs [8]	Bill Type 131, codes without rate	35% Billed Charges

[1] New Service/Technology

The rates in this compensation Attachment shall not apply to any new service or technology (“New Service/Technology”) that is added by Provider in the future. For purposes of this Agreement, New Service/Technology is defined as “a service, procedure, device, test, or other Covered Service that, as of the first effective date of this Attachment, is not performed by Provider.” The addition of a new code that is assigned as a change to an existing service, procedure, device, test, or Covered Service, does not constitute a New Service/Technology. If Provider offers a New Service/Technology, Provider shall notify Health Plan within thirty (30) days of adding such New Service/Technology. The parties shall enter into good faith negotiations to add new rate(s) and applicable “qualifier” code(s) for the New Service/Technology, as deemed necessary.

[2] Medi-Cal Payment Guidelines

Health Plan shall pay Provider in accordance with the prevailing payment guidelines adopted by DHCS for the Medi-Cal Fee-for-Service Program, including but not limited to the All Patient Refined Diagnosis Related Groups (APR-DRG) version in use by DHCS at the time the service is provided, and the Medi-Cal Outpatient Rates published by DHCS, unless otherwise provided in this compensation Attachment.

[3] Qualifier Code Updates

If any CPT, HCPCS, HCPCS Level III local interim codes reimbursable only by Medi-Cal, ICD-10-CM, and/or Revenue Code is replaced, modified or expanded, the parties will work collaboratively to update the “qualifier” codes listed in this compensation Attachment. The updated codes list will be added to this compensation Attachment upon written approval by both parties (electronic mail deemed acceptable), but a formal amendment shall not be required when there is no material impact to the compensation terms. Except as provided under the New Service/ Technology section above, the parties agree that the contract rate for replacement, modified, or expanded code(s) will be at the then current contract rate for the corresponding code that is replaced, modified or expanded.

[4] Augmentation Rate

Health Plan shall pay the specified multiple of the Medi-Cal Rate in effect at the time of service, increased by the Augmentation Rate for eligible services, as defined by DHCS on its website (“Augmentation Rate”), which is currently 43.44%. The parties agree that the Augmentation Rate will be paid for all outpatient locations covered under Provider’s license and billed under the Hospital’s National Provider Identifier number (NPI #1629167457), consistent with DHCS’ Medi-Cal payment guidelines.

[5] Implants

The implants percentage-based rate (“Implants Percentage Rate”) in this compensation Attachment has been negotiated in good faith based on Provider’s mark-up policy for implants (“Implants Mark-Up Policy”) which is based on cost of implants times three (3). The Implants Percentage Rate reflects Provider’s cost for implants plus a nominal handling fee, as of the effective date of this compensation Attachment. If Provider is contemplating a change in its Implants Mark-Up Policy, Provider shall notify Health Plan in writing at least thirty (30) days prior to the effective date of any such change. Within thirty (30) days of such notice, Health Plan shall provide Hospital with an amendment that adjusts the Implant Percentage Rate to equal the previously agreed-upon rate (i.e., to ensure that any change to Provider’s Implants Mark-up Policy does not result in a relative increase in reimbursement hereunder). The adjusted Implants Percentage Rate shall be effective as of date when Provider changed its Implants Mark-Up Policy. Upon request by Health Plan, Provider shall provide documentation that is reasonably necessary to validate Hospital’s Implants Mark-Up Policy.

[6] Trauma Activation

Health Plan shall pay the Trauma Activation fee in this compensation Attachment only if Provider is certified by the Emergency Medical Services Authority (“EMSA”) as a Level 1, Level 2, Level 3, or Level 4 Trauma Center, and the corresponding Revenue Code has been billed by Provider. Trauma activation shall be done in accordance with nationally recognized standards for trauma activation, including criteria set forth in the Trauma Triage Criteria adopted by the EMSA for the County of Ventura, or the then current Trauma Triage Criteria of the American College of Surgeons (Resources for Optimal Care of the Injured Patient “ROCIP”), if the County has not adopted such criteria. No additional documentation shall be required by Health Plan provided, however, that Health Plan may periodically audit Provider’s medical records to verify Trauma Triage Criteria have been met.

[7] “Administrative Day, All Other”

shall mean every 24-hour period during which a Member cannot be discharged for reasons outside the control of the Hospital (for example, if Member is homeless or is awaiting coordination of home health services). Hospital staff shall contact Plan for authorization of such Administrative Day(s) within twenty-four (24) hours of the business day following the planned discharge date, and Plan shall not unduly withhold authorization. If the discharge was planned for the weekend or a holiday, Plan shall authorize and pay for such day(s) as Administrative Days, as applicable, in accordance with this definition.

[8] “Charge Description Master” CDM

shall mean the list of all the services and supplies Hospital offers, along with their corresponding charges. For the term of this Agreement, Hospital shall not increase its CDM by more than six percent (6%) specific to any services in this Attachment D-1 in which reimbursement is based on a percentage of charges. Hospital shall notify Plan in writing at least sixty (60) days prior to any CMD increases exceeding six percent (6%) to which Plan may update the percent of charges to maintain revenue neutrality (“Charge Master Neutralization”). Plan reserves the right to periodically audit Hospital’s charges to identify any potential CDM increases that impact the revenue neutrality of

the rates in this Attachment D-1. Should a CDM audit result in an identified increase, Hospital agrees to adjust any impacted rates through mutual written amendment to this Attachment D-1.