

**AMENDMENT NO. 2 TO THE  
AMENDED AND RESTATED PROVIDER SERVICES AGREEMENT – PCP  
AMONG  
VENTURA COUNTY MEDICAL MANAGED CARE COMMISSION (dba GOLD  
COAST HEALTH PLAN)  
AND  
COUNTY OF VENTURA**

This Amendment No. 2 (this “Amendment”) to the Amended and Restated Provider Services Agreement – PCP (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 January 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 amended the Agreement, specifically the Attachment D-3 Quality Incentive Pool and Program to increase the amount of advance payment and to make technical amendments; and

**WHEREAS**, the Parties desire to amend the Agreement, specifically the Attachment D-3 Quality Incentive Pool and Program, to expand the QIPP, 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 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. Attachment D-3 Quality Incentive Pool and Program of the Agreement is amended as follows:
  - 2.1. Section 1.13, “**Quality Metrics**” is deleted in its entirety and replaced with the following Section 1.13, “**Quality Metrics**”:

“1.13 “**Quality Metrics**,” shall mean the Performance Tranches, which include criteria for achievement of MPL and HPL and for Improvement as described in Tables 1, 2, and 3 in Section 3.2 of this Attachment D-3.”
  - 2.2. Section 1.17, “**Additional QIPP Funds**” is hereby added to Article 1, Definitions.

“1.17 “**Additional QIPP Funds**” means the amounts of funds in addition to the Schedule 1 QIPP Funds available to Provider through the incentive pool and that may be earned through satisfaction of the Additional QIPP Metrics for MY 2.”

- 2.3. Section 2.5 **QIPP Payments**, is hereby deleted in its entirety and replaced with the following Section 2.5 **QIPP Payments**:

“2.5 **QIPP Payments**

2.5.1 *Schedule 1 of QIPP Payments for MY 1 and MY 2.* Provider shall be eligible to earn up to twenty-five million dollars (\$25,000,000) of QIPP Funds during the term for achievement of the QIPP Metrics or twelve million five hundred thousand dollars (\$12,500,000) for each of MY 1 and MY 2. Eighty percent (80%) of the QIPP Funds described below for each category of funding shall be provided as advance payments for each of MY 1 and MY 2:

2.5.1.1 Three million seven hundred fifty thousand dollars (\$3,750,000) shall be available for implementation of QIA. One million eight hundred seventy-five thousand dollars (\$1,875,000) shall be available for each of MY 1 and MY 2. One million five hundred thousand dollars (\$1,500,000) shall be payable in advance in each of MY 1 and MY 2;

2.5.1.2 Three million seven hundred fifty thousand dollars (\$3,750,000) shall be available for implementation of D/SIA. One million eight hundred seventy-five thousand dollars (\$1,875,000) shall be available for each of MY 1 and MY 2. One million five hundred thousand dollars (\$1,500,000) shall be payable in advance in each of MY 1 and MY 2;

2.5.1.3 Seventeen million five hundred thousand dollars (\$17,500,000) shall be available for achievement of the Quality Metrics. Eight million seven hundred and fifty thousand dollars (\$8,750,000) shall be available for each of MY 1 and MY 2. Seven million dollars (\$7,000,000) shall be payable in advance in each of MY 1 and MY 2;

2.5.1.4 Except for the advance payments described above, the parties understand and agree that there shall be no additional interim payments hereunder for this Schedule 1 of QIPP Funds.

2.5.2 *LSC Bonus Payments.* Provider shall be paid twenty-five dollars (\$25) per lead screening test in any MY in which Providers does not select LSC as an optional measure.

2.5.3 *Schedule 2 of Additional QIPP Payments for MY 2.* Provider shall be

eligible to earn up to five million dollars (\$5,000,000) of Additional QIPP Funds during MY 2 for achievement of the Additional QIPP Metrics for MY 2. Eighty percent (80%) of the Additional QIPP Funds described below for each category of funding shall be provided as advance payments for MY 2:

- 2.5.3.1 Seven hundred fifty thousand dollars (\$750,000) shall be available for additional quality improvement plans for implementation of the QIA for MY 2. Six hundred thousand dollars (\$600,000) shall be payable in advance for MY 2;
- 2.5.3.2 Seven hundred fifty thousand dollars (\$750,000) shall be available for additional activities for implementation of D/SIA for MY 2. Six hundred thousand dollars (\$600,000) shall be payable in advance for MY 2;
- 2.5.3.3 Three million five hundred thousand dollars (\$3,500,000) shall be available for achievement of the Additional Quality Metrics for MY 2. Two million eight hundred thousand dollars (\$2,800,000) shall be payable in advance for MY 2;
- 2.5.3.4 Except for the advance payments described above, the parties understand and agree that there shall be no additional interim payments hereunder for this Schedule 2 of Additional QIPP Funds.”

2.4. Section 2.6.1.1 *Advance Payments*, is hereby deleted and replaced with the following Section 2.6.1.1 *Advance Payments*:

“2.6.1.1 *Advance Payments*. Health Plan shall make the advance payments for Schedule 1 of the QIPP payments to Provider on or before February 15, 2024. Health Plan shall make the advance payments for Schedule 2 of the additional QIPP payments for MY 2 to Provider on or before July 1, 2024.”

2.5. Section 3.1.3, Quality Improvement Work Plan and QI Report is hereby deleted in its entirety and replaced with the following 3.1.3 Quality Improvement Work Plan and QI Report:

“3.1.3 Quality Improvement Work Plan and QI Report.

3.1.3.1. *Work Plan*. Provider shall provide to Health Plan a Quality Improvement Work Plan for MY 1 within thirty (30) days of the Effective Date, and an updated Quality Improvement Work Plan for the Schedule 1 Eligible Measures in Section 3.2.1 for MY 2 on or before January 31, 2024. Provider shall provide an amended Quality Improvement Work Plan for the Schedule 2 Eligible Measures for MY 2 on or before July 1, 2024. The Quality Improvement Work Plan shall describe the activities that Provider will undertake to implement D/SIA and the detailed plan,

timeline and specific strategies for quality improvement activities, including but not limited to Member outreach, access to care, and practice workflows. The Quality Improvement Work Plan is subject to approval by Health Plan. Health Plan shall review and comment on the Quality Improvement Work Plan within thirty (30) days of receipt and shall approve or request additional information.

3.1.3.2 *Provider Quality Improvement Report*. Provider shall provide to Health Plan a quarterly written quality improvement report (“Provider QI Report”) on its progress in achieving the Quality Improvement Work Plan for QIPP, including Provider’s current achievement of the Quality Metrics, challenges encountered, and opportunities for improved partnership with Health Plan on the following dates: September 29, 2023, December 31, 2023, March 29, 2024, June 28, 2024, September 30, 2024, and December 31, 2024. Health Plan’s approval of such reports shall be at Health Plan’s reasonable discretion.”

- 2.6. Subsection “(a)” of section 3.1.4.1.3 *Routine Supplemental Data Submission* is hereby deleted and replaced with the following Subsection “(a)” of section 3.1.4.1.3 *Routine Supplemental Data Submission*:

“3.1.4.1.3 *Routine Supplemental Data Submission*.

(a) For MY 1, Provider shall submit Supplemental Data as an EHR Quality Data File (as described in 3.1.4.1.4) for the core and optional MCAS measures chosen by Provider, as applicable. For MY 2, Provider shall submit Supplemental Data as an EHR Quality Data File (as described in 3.1.4.1.4) for all MCAS measures for which Health Plan is required to satisfy a MPL.”

- 2.7. Subsection “(c)” of section 3.1.4.1.3 *Routine Supplemental Data Submission* is hereby deleted and replaced with the following Subsection “(c)” of section 3.1.4.1.3 *Routine Supplemental Data Submission*:

“(c) EHR Quality Data Files shall be submitted in a tab delimited format (txt) via STFP to Health Plan or Health Plan’s designee monthly on or before the 5<sup>th</sup> of each month commencing in January 2024.”

- 2.8. Subsection “(a)(i) EHR Quality Data File” of Section 3.1.4.1.4 *Data File Formats and Mapping* is hereby deleted and replaced with the following Subsection “(a)(i) EHR Quality Data File” of Section 3.1.4.1.4 *Data File Formats and Mapping*:

“(i) If Provider participates in other quality programs that use data approved by an EQRO auditor, Provider may submit Supplemental Data that has been approved by such EQRO auditor for approval by the Auditor for the QIPP. If Provider elects to submit such audited data, Provider shall first map the Supplemental Data to the corresponding LOINC, SNOMED, CPT, ICD, or other appropriate encounter codes (if not already coded to include appropriate encounter codes). Health Plan shall submit such mapping of Supplemental Data for review by

the Auditor. Subsequent to Auditor approval or Auditor response regarding any required changes to such Supplemental Data, Provider shall produce EHR Quality Data Files that contain data that has been mapped in accordance with the Auditor's requirements. Provider shall provide such Supplemental Data as required or requested by the Auditor to receive approval, whether it be sample data or other. Such mapping of Supplemental Data shall be provided to GCHP on a rolling basis as it becomes available and by no later than November 1 of each Measurement Year, or as otherwise mutually agreed by the parties."

- 2.9. Section 3.2.1, Eligible Measures is hereby deleted in its entirety and replaced by Section 3.2.1, Schedule 1 QIPP Eligible Measures:

"3.2.1. Schedule 1 QIPP Eligible Measures. The MCAS measures and Baseline MCAS Scores for MY 1 are set forth in Exhibit 1 to this Attachment D-3. Exhibit 1 also identifies the Measure Steward that establishes the detailed specifications for the measures and the methodology for calculation of the measure.

3.2.1.1 *Schedule 1 Core Measures*. Quality Metrics are calculated for each of the following five (5) core MCAS measures for MY 1 and MY 2:

3.2.1.1.1 Child and Adolescent Well-Care Visits

3.2.1.1.2 Well Child Visits in the First 30 Months of Life (0 to 15 months)

3.2.1.1.3 Well Child Visits in the First 30 Months of Life (15-30 months)

3.2.1.1.4 Chlamydia Screening in Women

3.2.1.1.5 Cervical Cancer Screening

3.2.1.2 *Additional Measures*. Provider shall select five (5) additional measures for MY 1 from the subset of MCAS measures for which the heading for Column 1 of the table in Exhibit 1 is "Measures Required of MCPs" and the heading for Column 5 is "Held to MPL" for MY 1 and MY 2. For MY2, Provider shall select five (5) additional measures (which may or may not be the same as the measures selected for MY 1) from the MCAS measures required of MCPs and held to MPL for MY 2.

3.2.1.3 *Schedule 2 Additional QIPP Eligible Measures for MY 2*.

3.2.1.3.1. *Core Measures*. Quality Metrics are calculated for each of the following two (2) core MCAS Measures for MY 2.

3.2.1.3.1.1 Asthma Medication Ratio ("AMR")

3.2.1.3.1.2. Follow-Up After ED Visit for Substance Use - 30 days ("FUA")

3.2.1.3.2 *Optional Measures.* Provider may select two (2) additional measures for MY 2 from the list of MCAS measures identified in Section 3.2.1.2.”

- 2.10. Section 3.2.5, Calculation of Quality Metrics, is hereby deleted in its entirety and replaced by Section 3.2.5, Calculation of Quality Metrics:

“3.2.5 Calculation of Quality Metrics.

3.2.5.1 *Method of Calculation of Measures.* Measures will be calculated using the Administrative Method. Transaction data or other administrative data will be used to identify the eligible population and numerator. The Provider MCAS Score is based on all Members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service required for the numerator. The Administrative Method is the method of MCAS measure calculation that requires use of data captured from billing processes, such as claims and encounters, to identify the eligible population and numerator, and includes data captured from supplemental data sources that reflect services provided.

3.2.5.2 *Number of MCAS Scores at HPL or MPL.* The Performance Tranches for the Quality Metrics in Table 1, 2, and 3 below are based in part on Provider’s MCAS Scores and whether they are sufficient to satisfy MPL or HPL. All Quality Metrics calculations shall be rounded to the second decimal place.

**Table 1**  
**Quality Metrics for MY 1**

PERFORMANCE TRANCHE	CRITERIA & REQUIREMENTS					% of Quality Bonus
	At or Above HPL		At or Below MPL*		Improvement** From Prior Year Baseline	
High	2 or more	and	0	and	≥ 5	100%
High-Mid	1 or more	and	0	and	≥ 5	75%
Mid	0	and	0	and	≥ 5	50%
Mid-Low	0	and	1 or 2	and	≥ 5	25%
Low	0	and	3 or more	or	≥ 6 decline	0%

\*See Year 1 Gap Closure Methodology

\*\*Measures other than those accounted for in HPL and MPL counts.

**Table 2**  
**Quality Metrics for MY 2**

PERFORMANCE TRANCHE	CRITERIA & REQUIREMENTS					% of Quality Bonus
	At or Above HPL		At or Below MPL*		Improvement** From Prior Year Baseline	
High	3 or more	and	0	and	≥ 5	100%
High-Mid	2 or more	and	0	and	≥ 5	75%
Mid	0	and	0	and	≥ 5	50%
Mid-Low	0	and	1 or 2	and	≥ 5	25%
Low	0	and	3 or more	or	≥ 6 decline	0%

\*See Year 2 Gap Closure Methodology

\*\*Measures other than those accounted for in HPL and MPL counts.

**Table 3**  
**Additional Quality Metrics for MY 2**

CRITERIA & REQUIREMENTS					
PERFORMANCE TRANCHE	At or Above HPL		At or Below MPL*	Improvement** From Prior Year Baseline	% of Quality Bonus
High	1 <i>or more</i>	and	0	and 4	100%
High-Mid	1 <i>or more</i>	and	0	and 3	75%
Mid	0	and	0	and $\geq 3$	50%
Mid-Low	0	and	0 <i>or</i> 1	and $\geq 2$	25%
Low	0	and	2 <i>or more</i>	or $\geq 3$ decline	0%

\* See Year 2 Gap Closure methodology.

\*\* Measures other than those accounted for in HPL and MPL counts.

**3.2.5.3 Gap Closure Methodology Option.** Health Plan understands that, as of the Effective Date, Provider's performance on some MCAS measures is significantly below MPL and will be difficult to move significantly in a short period of time, and therefore provides for use of the Gap Closure Methodology described in this Section 3.2.5.3. As permitted herein, satisfaction of the Gap Closure Methodology is a substitute for meeting MPL.

**3.2.5.3.1** For MY 1, Provider may Choose up to two (2) core measures for which satisfaction of the Gap Closure Methodology will be considered sufficient for meeting MPL.

**3.2.5.3.2** In MY 2, Provider may choose one (1) core measure for which satisfaction of the Gap Closure Methodology will be considered sufficient for meeting MPL for the QIPP Quality Metrics in Table 2 and one (1) additional measure for which satisfaction of the Gap Closure Methodology will be considered sufficient for meeting MPL for the Additional QIPP Quality Metrics in Table 3.

**3.2.5.3.3** The "Gap" is identified as the difference between the Baseline MCAS Score and the HPL. The target for Gap Closure is ten percent (10%). An example of the ten percent (10%) Gap Closure Methodology is as follows:

**Gap Closure Example:**

HPL (90<sup>th</sup> Percentile) Benchmark for MY for Measures X = 70.0%

Baseline MCAS Score (prior MY performance) for Measure

$$X = 55.0\%$$

$$\text{Gap is equal to } 70\% - 55.0\% = 15\%$$

$$\text{Target Gap Closure is } 10\% \text{ of } 15\% = 1.5\%$$

$$\text{MCAS Score Target for MY} = 55\% \text{ (Baseline)} + 1.5\% \text{ (gap Closure Target)} = 56.5\%$$

3.2.5.4 *Improvement/Decline*. In addition to the number of MCAS measures that satisfy MPL and / or HPL, Provider MCAS Scores must show Improvement in the applicable MY in accordance with Table 1, 2, and Table 3 in order to qualify for the “High,” “High-Mid,” “Mid,” and “Mid-Low” Performance Tranches for Schedule 1.

3.2.4.4.1 Measures for which the Baseline MCAS Score is at or above HPL or Provider MCAS Score for the applicable MY is at or below MPL in the applicable MY do not qualify as satisfying the “Improvement” category except that measures for which the Provider MCAS Score is deemed to have achieved MPL through the Gap Closure Methodology for the applicable MY shall be counted as Improved. Measures for which the Provider MCAS Score is at or above HPL in the applicable MY shall not be counted in the “Decline” category.

3.2.5.5 *Performance Tranches*. Per Tables 1, 2, and 3, the “High,” “High-Mid,” “Mid,” and “Mid-Low” Performance Tranches require each of the specified conditions to be satisfied to meet that tranche.

3.2.5.6 *Calculation of Quality Metrics*. The Quality Metrics shall be calculated as follows: (a) Health Plan shall calculate the Provider MCAS Score. The Provider MCAS Score shall be based on the MCAS scores certified by the Auditor for Health Plan for the applicable MY, based on the Measure Steward’s specifications (as applicable and as described in Exhibit 1); (b) Health Plan shall calculate the number of measures on which Provider’s performance has Improved or Declined by comparing the Provider’s MCAS Score for the MY to its Baseline MCAS Score in accordance with Section 3.2.5.4; (c) Health Plan shall calculate and apply the Gap Closure Methodology described in Section 3.2.5.3; (d) based on a combination of the Provider MCAS Scores and the number of measures that demonstrate Improvement or Decline, Health Plan shall determine which Performance Tranche the Provider satisfies; and (e) Health Plan shall issue a final report that describes the Provider MCAS Scores, number of measures on which it demonstrates improvement, and the Performance Tranche for the applicable MY, which shall be provided as part of the Notice described in Section 2.6.1 of this Attachment D-3.”

3. Exhibit 1, California Department of Healthcare Services, Medi-Cal Accountability Set (MCAS) Measures MY 2023 of Attachment D-3 is hereby deleted and replaced with the attached Exhibit 1, California Department of Healthcare Services, Medi-Cal Accountability Set (MCAS) Measures MY 2024.

4. Exhibit 2, National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set (HEDIS) Specification MY 2023 of Attachment D-3 is hereby deleted and replaced with the attached Exhibit 2, National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set (HEDIS) Specification MY 2024.
5. Exhibit 3, Centers for Medicaid and Medicare Services and Dental Quality Alliance, Children's Measure Specifications MY 2023, of Attachment D-3 is hereby deleted and replaced with the attached Exhibit 3, Centers for Medicaid and Medicare Services and Dental Quality Alliance, Children's Measure Specifications MY 2024.
6. To the extent that the terms set forth in this Amendment are inconsistent with the terms of the Agreement, the terms set forth in this Amendment shall apply. All other terms and conditions of the Agreement shall remain unchanged.
7. This Amendment 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, email, 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 this Amendment are to be deemed to constitute duplicate originals.

*[signature on following page]*

The parties have executed this Amendment, to be effective as of the Amendment Effective Date.

**HEALTH PLAN:**

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

**PROVIDER:**

**COUNTY OF VENTURA**

DocuSigned by:

Nick Liguori

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**Signature**

Nick Liguori

**Printed Name**

Nick Liguori, CEO

**Title**

June 2, 2024 | 21:49:19 PDT

**Date**



**Signature**

**Barry Zimmerman**

**Printed Name:**

**Health Care Agency Director**

**Title:**

5-21-24

**Date**

## **Exhibit 1**

### **California Department of Healthcare Services, Medi-Cal Accountability Set (MCAS) Measures MY 2024**

The California Department of Healthcare Services Medi-Cal Accountability Set (MCAS) for Healthcare Delivery Systems for Measurement Year 2024 and Reporting Year 2025 can be accessed at: <https://www.dhcs.ca.gov/dataandstats/reports/Documents/Managed-Care-Accountability-Set-Reporting-Year-2025.pdf>, which was last updated November 28, 2023. This link and the information therein is hereby incorporated in this Attachment D-3 and this Agreement. A paper copy of the documents referenced in this Exhibit 1 have been furnished to Provider in advance of execution of this Amendment.

## **Exhibit 2**

### **National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set (HEDIS) Specification MY 2024**

The National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS) Specification for MY 2024 Measure Description can be accessed at: <https://www.ncqa.org/wp-content/uploads/HEDIS-MY-2024-Measure-Description.pdf>, which was last updated December 4, 2023. This link and the information therein is hereby incorporated in this Attachment D-3 and this Agreement. A paper copy of the documents referenced in this Exhibit 2 have been furnished to Provider in advance of execution of this Amendment.

### **Exhibit 3**

#### **Centers for Medicare and Medicaid Services and Dental Quality Alliance, Children's Measure Specifications MY 2024**

The Centers for Medicare and Medicaid Services Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) for MY 2024 can be accessed at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1713998782>, which was last updated January 2024. This link and the information therein is hereby incorporated in this Attachment D-3 and this Agreement.

The Dental Quality Alliance User Guide for Pediatric Measures Calculated Using Administrative Claims Data for MY 2024 can be accessed at: [https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024\\_dqa\\_pediatric\\_measures\\_user\\_guide.pdf?rev=6b5c35f29335439db82a245583400ca3&hash=8D43A8DE44A5E0555440407A6287DD9A](https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_dqa_pediatric_measures_user_guide.pdf?rev=6b5c35f29335439db82a245583400ca3&hash=8D43A8DE44A5E0555440407A6287DD9A), which is effective January 1, 2024. This link and the information therein is hereby incorporated in this Attachment D-3 and this Agreement.

A paper copy of the documents referenced in this Exhibit 3 have been furnished to Provider in advance of execution of this Amendment.