

**AMENDMENT NO. 1 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. 1 (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 amended and restated Agreement to be effective as of July 1, 2023; and

WHEREAS, the Parties desire to amend the Agreement, specifically the Attachment D-3 Quality Incentive Pool and Program, 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 1.4 **High Performance Level** or **HPL**, is hereby deleted and replaced with the following Section 1.4:

“1.4 **High Performance Level**” or “**HPL**” is defined as the National Committee for Quality Assurance (“NCQA”) Quality Compass® Medicaid HMO 90th percentile. For measures included in the Managed Care Accountability Set with measure stewards other than NCQA (e.g., CMS, DQA), the HPL shall be the HPL as defined by the measure steward for a given measure, or if the HPL is not defined by the measure steward, by DHCS for the given measure.”
 - 2.2. Section 1.8 **Minimum Performance Level** or **MPL**, is hereby deleted and replaced with the following Section 1.8:

1.8. “**Minimum Performance Level**” or “**MPL**” is defined as the NCQA Quality Compass® Medicaid HMO 50th percentile. For measures included in the Managed Care Accountability Set with measure stewards other than NCQA (e.g.,

CMS, DQA), the MPL shall be the MPL as defined by the measure steward for a given measures, or if MPL is not defined by the measure steward, by DHCS for the given measure.”

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

“ 2.5 **QIPP Payments**

2.5.1 *QIPP Payments*. 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 dollars (\$12,500,000) for each of MY1 and MY2. Eighty percent (80%) of the QIPP Funds described below for each category of funding shall be provided as advance payments for each of MY1 and MY2:

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 MY1 and MY2. One million five hundred thousand dollars (\$1,500,000) shall be payable in advance in each of MY1 and MY2;

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 MY1 and MY2. One million five hundred thousand dollars (\$1,500,000) shall be payable in advance in each of MY1 and MY2;

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 MY1 and MY2. Seven million dollars (\$7,000,000) shall be payable in advance in each of MY1 and MY2;

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.

2.5.2 *LSC Bonus Payments*.

2.5.2.1 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 Health Plan shall make payments to Provider quarterly based upon claims and/or encounters submitted for point-of-care or laboratory tests.”

- 2.4. Section 2.6 **Timing of Payment** is hereby deleted and replaced with the following

Section 2.6 **Timing of Payment:**

“2.6 **Timing of Payment**

2.6.1 **QIPP Payments**

2.6.1.1 *Advance Payments.* Health Plan shall make the advance payments to Provider on or before February 15, 2024 .

2.6.1.3 *Final Payment and Reconciliation.*

2.6.1.3.1 Within sixty (60) days of Health Plan’s receipt of its certified MCAS score for each of MY1 and MY2 from the External Quality Review Organization contracted by DHCS (“Auditor”), Health Plan shall send a written notice to Provider of Provider’s achievement on the QIPP Metrics and the total amount of QIPP Funds due Provider for the given MY (“Notice”). Health Plan shall reconcile any amounts paid as advance payments with any payments due or payable upon evidence of completion of the QIPP Metrics as follows:

(a) If Provider earned QIPP Funds in an amount in excess of the advance payments, then Health Plan shall pay Provider the difference between the advance payment(s) and the earned amount for each MY in accordance with the terms of this Attachment D-3; and

(b) If Provider earned QIPP Funds in an amount that is less than the advance payments, then Provider shall pay Health Plan the difference between the advance payment(s) and the earned amount for each MY in accordance with the terms of this Attachment D-3.

(c) Notwithstanding any other provision set of the Agreement or this Attachment D-3, Health Plan shall not be required or obligated to pay any QIPP Funds to Provider for any QIPP Metrics that have not been satisfied at the end of the applicable MY.

2.6.1.3.2 Any payments as described in this Section 2.6.1 shall be paid by the applicable party within sixty (60) days of Health Plan’s Notice as described above.

2.6.2 **Overpayment.** Should Provider fail to return any amounts due Health Plan in accordance with the reconciliation for each MY, Health Plan may demand repayment of any partial or full payments of QIPP Funds in accordance with Section 2.12(f) of the Agreement and may recoup funds by means of an offset against future payments under this Attachment D-3 or the Agreement.”

2.5. Section 3.1.3.4, **Final Quarterly Reports**, is hereby deleted and replaced with

Section 3.1.3.4, **Annual Provider QI Report:**

“3.1.3.4. Within sixty (60) days after the end of MY 1 and MY 2 respectively, Provider shall present an Annual Provider QI Report for the given MY for Health Plan’s acceptance or rejection. Health Plan’s approval of the Annual Provider QI Report shall be at Health Plan’s reasonable discretion.”

- 2.6. Section 3.2., **Table 2 Quality Metrics for MY2, QIPP Quality Metrics** is hereby deleted and replaced with the following **Table 2, Quality Metrics for MY2**.

Table 2
Quality Metrics for MY2

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.*

3. 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.
4. 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.

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

HEALTH PLAN:

PROVIDER:

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

COUNTY OF VENTURA

Signature

Signature

Printed Name

Printed Name:

Title

Title:

Date

Date