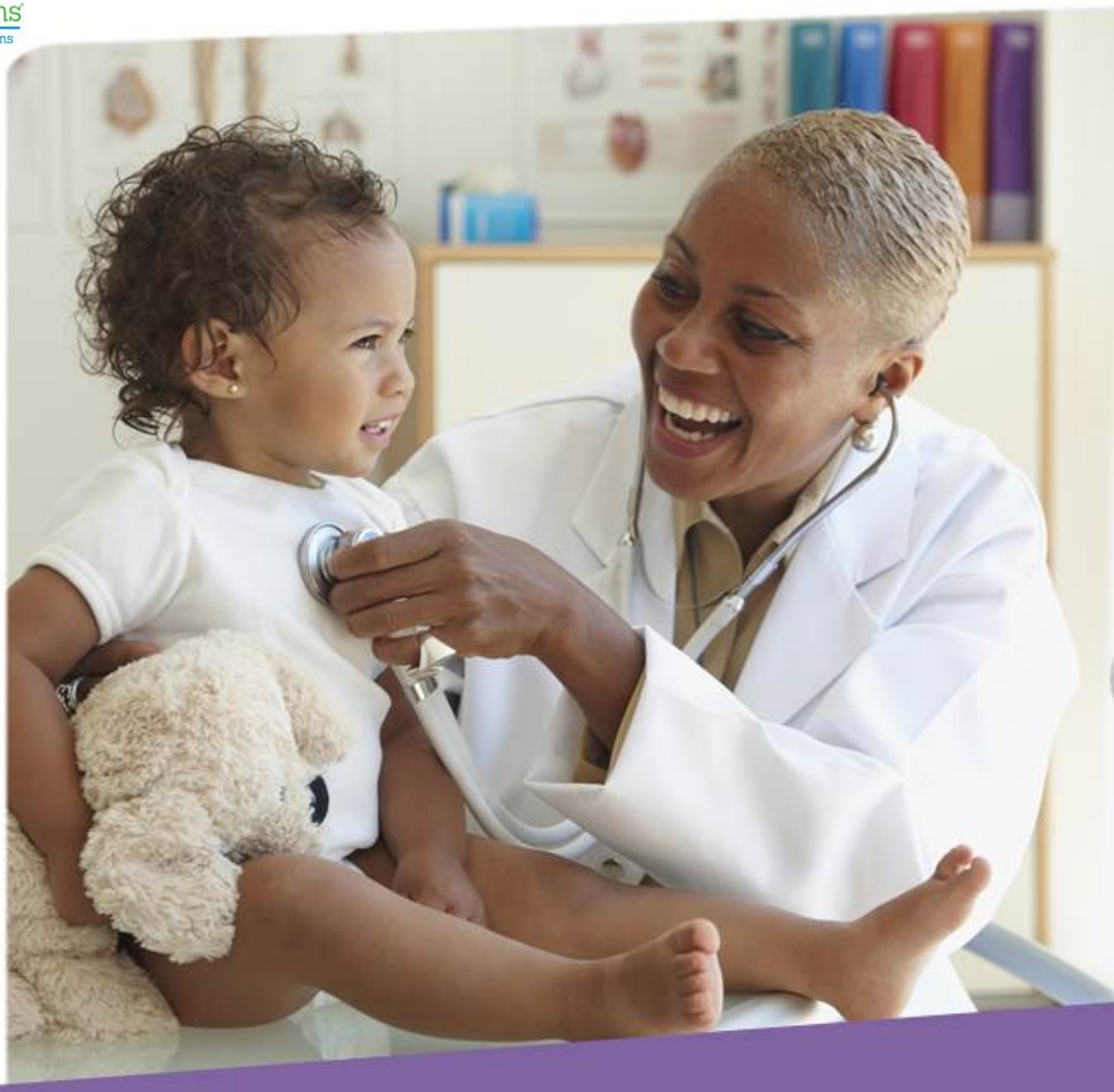
Amerigroup RealSolutions
Medicare Advantage Plans



Program Description
for the Enhanced Personal Health Care Essentials Program

Known nationally as Blue Distinction Total Care

January 2018

Introduction

As the nation's health system transitions from one built around fee-for-service payment to one that is value-based and patient-centered, Amerigroup is changing too. Our centerpiece payment innovation program, Enhanced Personal Health Care, is helping thousands of doctors and hospitals succeed under the new models of care delivery and health care payment. Amerigroup wants to expand access to these models of care and payment to include providers of all sizes who are at varying stages of practice transformation and adoption of value-based care. Enhanced Personal Health Care Essentials is a natural extension of our core program. It is designed for providers who have smaller Amerigroup membership populations.

At Amerigroup, we are working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. More than 73 million people are served by our affiliated companies, including nearly 40 million within our family of health plans.

Amerigroup is committed to collaborating with providers to adopt value-based payment and patient-centered care across the health care delivery system, and we offer practices comprehensive support as they take on this challenge with us.

Amerigroup understands that creating a high-functioning health care system requires a concerted effort and active support from all key stakeholders in the delivery system to create an environment conducive for change. This includes:

- A redesign of current payment models to align financial incentives and provide value based compensation beyond the volume-driven fee for service model
- Support for risk-stratified care management
- The sharing of meaningful information regarding patients that goes beyond the information captured in the physicians' medical record
- Providing physicians with the knowledge, information and tools they need to leverage the benefits of new payment models, along with support services and information exchange to transform the way they deliver care

Our Enhanced Personal Health Care Essentials Program (the "Program") is designed to build upon the success of existing patient-centered programs and foster a collaborative relationship between Amerigroup (also referred to as "we" or "us" in this document) and the contracted Provider (also referred to as "you," and includes Represented Primary Care Providers, Represented Primary Care Physicians and Represented Physicians, as applicable, in this document). This relationship enables both parties to leverage the other party's unique assets –, whether clinical, administrative, or data – to support coordinated care with a focus on risk stratified care management, wellness and prevention, improved access and shared decision-making with patients and their caregivers.

Where we collaborate with Blues Plans across the country to offer customers access to value-based programs similar to Enhanced Personal Health Care Essentials, our offering is known as Blue Distinction Total Care. Your participation in Blue Distinction Total Care does not require a separate contractual relationship. You may be listed as a participating provider in Blue Distinction Total Care by virtue of your participation in Enhanced Personal Health Care Essentials.

This Program Description is meant to serve as a reference regarding the operation of the Program and to further describe all parties' rights and obligations, including details about the financial benefits of the Program, our commitment to participating physicians to provide reporting and other useful tools, and our expectations for participating physicians under the Program. We have organized this Program Description into sections by topic as outlined in the Table of Contents.

We have also included definitions of frequently used terms. All of these terms also are defined when they are first used in either the Attachment or this Program Description.

If you have any questions or comments regarding this Program Description, please send an e-mail to the mailbox associated with your market as identified below. Your e-mail request should include your name, provider practice name, and phone number with area code.

Market	Mailbox
California	CAEPHC@Anthem.com
Colorado	COEPHC@Anthem.com
Connecticut	CTEPHC@Anthem.com
Georgia	GAEPHC@Anthem.com
Indiana	INEPHC@Anthem.com
Kentucky	KYEPHC@Anthem.com
Maine	MEEPHC@Anthem.com
Missouri	MOEPHC@Anthem.com
Nevada	NVEPHC@Anthem.com
New Hampshire	NHEPHC@Anthem.com
New York	NYEPHC@EmpireBlue.com
Ohio	OHEPHC@Anthem.com
Virginia	VAEPHC@Anthem.com
Wisconsin	WIEPHC@Anthem.com

Program Communications

Communications regarding Program changes, updates, and activities will be available via Amerigroup's Population Health Platform. Please ensure that you complete Amerigroup's Population Health Platform registration so that you will receive important communications. Please review the contact information that we have on file on a quarterly basis and update as needed.

Important Note About Program Information, Resources and Tools

The information, resources, and tools that Amerigroup provides to you through the Enhanced Personal Health Care Program are intended for general educational purposes only, and should not be interpreted as directing, requiring, or recommending any type of care or treatment decision for Amerigroup Covered Individuals or any other patient. Amerigroup cannot guarantee that the information provided is absolutely accurate, current or exhaustive since the field of health is constantly changing.

The information contained in presentations that Amerigroup makes available to you is compiled largely from publicly available sources and does not necessarily represent the opinions of Amerigroup or its personnel delivering the presentations.

If Amerigroup provides links to or examples of information, resources or tools not owned, controlled or developed by Amerigroup this does not constitute or imply an endorsement by Amerigroup. Additionally, we do not guarantee the quality or accuracy of the information presented in, or derived from, any non-health plan resources and tools.

We do not advocate the use of any specific product or activity identified in this educational material, and you may choose to use items not represented in the materials provided to you. Trade names of commonly used medications and products are provided for ease of education but are not intended as particular endorsement.

None of the information, resources or tools provided is intended to be required for use in your practice or infer any kind of obligation on you in exchange for any value you may receive from the program. Physicians and other health professionals must rely on their own expertise in evaluating information, tools, or resources to be used in their practice. The information, tools, and resources provided for your consideration are never a substitute for your professional judgment.

With respect to the issue of coverage, each Amerigroup Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. If Members have any questions concerning their benefits, they may call the Member Services number listed on the back of their ID card.

Contents

Section 1: Program Overview

Objectives

The ***objectives*** of the Program are to:

- Support the transition from a fragmented and episodic health care delivery system to a patient-centered system. Focus our delivery system on, improving patient health by investing in primary care that allows primary care.
- Provide physicians with tools, resources and meaningful information that promote the key elements of patient-centered care access, shared decision-making, proactive health management, coordinated care delivery, adherence to evidence-based guidelines and care planning – all built around the needs of the individual patient.
- Redesign the current payment model to move from volume-based to value-based payment, aligning financial incentives and providing financial support for the work and tools that facilitate patient centered care.
- Improve the patient experience by:
    - Facilitating better access to a primary care physician who will care for the "whole person" and will become each patient's health care champion and help patients navigate the complex health care system,
    - Inviting patients' active participation in their health care through shared decision-making.
    - Focus Providers' attention on opportunities to lower cost of care while improving quality outcomes.

Scope

The Program applies to Provider and Amerigroup participating Represented Primary Care Providers, Represented Primary Care Physicians and/or Represented Physicians, as applicable, who are in good standing, and who have signed or are covered under our Enhanced Personal Health Care Essentials Program Attachment for Primary Care and/or Comprehensive Primary Care Plus that includes the EPHC Essentials Performance Payment Model(s) and/or Medicare Advantage or any agreement that incorporates an Enhanced Personal Health Care Essentials Attachment for Primary Care (collectively, the "Attachment").

Roles and Responsibilities

Roles at Amerigroup

We make several Program resources available to support and collaborate with you to achieve successful outcomes and reach Program goals. The following section describes roles developed to support the Program.

Network Director for Payment Innovation Programs

The Network Director for Payment Innovation Programs ("Network Director") is responsible for the strategy and implementation of the Program. The Network Director is a point of contact for the provider practice to address overall contracting performance and operational elements for the Program.

Contract Advisor

The Contract Advisor provides support for contract amendments, practice operations, implementation and ongoing maintenance of the Program. The Contract Advisor is a point of contact for the provider practice to address overall contracting performance and operational elements for the Program

Roles in Your Practice

The following roles inside your Provider practice are recommended to support your practices' transformation under the Program. Once you register for access to Amerigroup's Population Health Platform, please provide the contact names and information for each role. Please review the contact information you provided on a quarterly basis and update as applicable.

Provider Champion

The Provider Champion is a physician, or in some cases an Advanced Practice Registered Nurse in a leadership position in your Provider practice who is the leader of your Provider practice's patient-centered care approach. This individual has the authority to support and influence transformation to patient-centered care, and supports the needed activities, provides resources and communicates to other physicians about the Program.

Transformation Coordinator(s)

The Transformation Coordinator(s) are individual(s) in your practice who manage the day-to-day activities of the practice, facilitate care coordination and care plan creation for patients using recognized quality improvement methodologies. He or she also should use the virtual tools available to Essentials practices, including but not limited to the Practice Essentials virtual curriculum and, Amerigroup's Population Health Platform to help coordinate Attributed Members' health outcomes.

Section 2: Program Expectations and Resources

The requirements and measures listed in Appendix A-1 of the Medicare Enhanced Personal Health Care Essentials Program, as applicable, are the most important and fundamental responsibilities for Providers participating in Enhanced Personal Health Care Essentials. The Program requirements are meant to promote patient engagement, practice transformation, and population health management.

To help participants successfully deliver on their commitments, Amerigroup has made a wide range of virtual tools available including the Practice Essentials virtual curriculum, documents and training tools located in the Provider Toolkit and reports available through Amerigroup's Population Health Platform.

Practice Essentials

Developed specifically for primary care practices, the Practice Essentials curriculum guides participants step-by-step through quality improvement. The course offers expert guidance around achieving sustainable changes and improving patient satisfaction, improved clinical outcomes and efficiency. Participants can earn education credits from The American Academy of Family Physicians (AAFP). The curriculum includes the following sessions:

Introduction and Overview of Tools - Learn how to incorporate valuable practice tools already at your fingertips, such as our Enhanced Personal Health Care Provider Toolkit and Collaborative Learning sessions.

Basic Practice Improvement Infrastructure (1 AAFP Prescribed CME credit) - Explore creating a practice improvement infrastructure and cultivating a culture of process improvement in your practice. Learn how to develop a care team and establish a culture of process improvement to implement the Chronic Care Model. Create a process map to document current, future, and ideal states for your practice.

The Model for Improvement (1 AAFP Prescribed CME credit) - Learn how to use the Model for Improvement to accelerate change, including the importance of defining an area of focus in your practice and establishing guidelines on writing Global Aim and Specific Aim statements. This session also covers planning and implementing small tests of change to determine if the changes your practice makes lead to improvements.

Actualizing the Triple Aim - Impacting Cost of Care (1 AAFP Prescribed CME credit) - Learn how reducing the cost of care can make a positive difference for providers and patients when clinical quality remains a top priority. Learn to maximize incentive payments and benefits, and navigate the valuable tools available to practices offering guidance and insight into inpatient, outpatient, pharmacy, and cost of care.

Registry Use and Population Health Management (1 AAFP Prescribed CME credit) - Dive into the implementation of patient registries within the Chronic Care Model including the use of the core features of registry functionality, defining registry use and identifying registry resources.

Sustaining Change and Moving Forward (1 AAFP Prescribed CME credit) - Review the six key components for sustaining change and learn to identify the characteristics of a learning practice. Learn how to create Sustainability Plan, and how to remove barriers to sustaining change.

Collaborative Learning Events

To help ensure Program success, a culture of learning is deemed essential for participants. To meet this Program component, participants shall provide an email contact for learning event pre-registration with the expectation that at least one participant from the practice participate in scheduled events. The email contact

provided shall be a designated person in the practice who helps to champion a culture of learning. Learning events include (but are not limited to) the following:

- A National Transformation webinar series that features state of the art practice transformation topics delivered by national experts.
- A pediatric-focused learning series that features practice transformation topics delivered by national pediatric experts.
- A Medicare Advantage learning series that features priority topics pertaining to your Medicare population.
- Additional series that support practices by providing an education in areas that are crucial to your Program success including risk adjustment, documentation and coding in addition to behavioral health and other areas frequently requested by practices.
- All sessions are recorded and added to our extensive recording library in order to offer viewing at a time that is convenient for learners.

Program participation in learning events is tracked to ensure that each participating provider adopts a culture of learning.

Provider Toolkit

The Provider Toolkit, found on the Enhanced Personal Health Care Essentials webpage, serves to provide you with research and tools that will support your practice during transformation activities. These resources are available to help enhance your practice's performance, quality, operations and establishment of care coordination and care management processes, as well as maximizing health information technology, including registry functionality. The Provider Toolkit offers resources that address self-management support, motivational interviewing, and enhanced access to care for your patients. Your local market team is available to answer additional questions and provide you with more information about the Provider Toolkit and its contents.

> Note: To help ensure Program success, a culture of learning is considered critical for participants. To meet this Program component, participants shall provide an email contact during the registration process for Amerigroup's Population Health Platform tool. We expect that at least one participant from the practice participate in scheduled events. The email contact provided shall be a designated person in the practice who helps to champion a culture of learning. All Collaborative Learning sessions are recorded in order to offer viewing at a time that is convenient for learners. Recorded events can be accessed through the eCatalog of Collaborative Learning options.

Care Coordination

Care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of patients and their families or care givers. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

Practices are expected to perform care coordination activities that invoke a holistic patient approach, which include:

- Helping patients choose specialists and obtain medical tests when necessary. The team informs specialists of any necessary accommodations for the patient's needs.

- Tracking referrals and test results, sharing such information with patients, helping to ensure that patients receive appropriate follow-up care, and helping patients understand results and treatment recommendations.
- Promoting smooth care transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home.
- Developing systems to help prevent errors when multiple clinicians, hospitals, or other providers are caring for the same patient, including medication reconciliation and shared medical records.[1]
- Identification and referral of patients into appropriate programs and community resources.

You must ensure that there are personnel supporting care coordination and care management in your provider practice. You are expected to develop and implement processes to ensure that Attributed Members' health care needs are coordinated by designating a primary contact to effectively organize all aspects of care. Your designated primary contact should collaborate with Attributed Members, Attributed Members' caregivers, and multiple providers during the coordination process.

In order to support successful care coordination and care management within the Program, you must make best effort to:

- Identify high-risk Attributed Members with the support of Amerigroup reporting to ensure Attributed Members are receiving appropriate care delivery services,
- Facilitate planned interactions with Attributed Members with the use of up-to-date information provided by Amerigroup,
- Perform regular outreach to Attributed Members based on their personal preference, which could include mail, e-mail, text messaging (as allowed under applicable state regulation or state medical licensing requirements) or phone calls,
- Provide information on self-management support,
- Use population health registry functionality to support care opportunities, and
- Adhere to a team-based approach to care, which drives proactive care delivery.

Care Planning

The Attachment identifies care planning expectations for participating physicians under the Program. The information below provides you with the details you need to fully understand and meet these expectations.

Care planning is a detailed approach to care that is customized to an individual patient's needs. Often, care plans are needed in circumstances where patients can benefit from personalized physician instruction and feedback regarding management of their condition(s).

Care plans include, but are not limited to, the following:

- Prioritized goals for a patient's health status,
- Established timeframes for reevaluation,

[1] http://www.improvingchroniccare.org/downloads/executive_summary_reducing_care_fragmentation_.pdf

- Resources to be utilized, including the appropriate level of care,
- Planning for continuity of care, including transition of care, and
- Collaborative approaches to be used, including family participation.

For more details on care plan format and content, determining when a care plan is appropriate, and a list of care plan assessment "domains", access the Provider Toolkit.

Self-Management Support

Self-management support means educating Attributed Members so that they may take a greater role and level of responsibility for improving their own health outcomes.

Self-management support is the assistance caregivers offer to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership. The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment."[2]

You should encourage self-management through the following:

- Describing and promoting self-management by emphasizing the Attributed Member's central role in managing his/her health,
- Including family members in this process, at the Attributed Member's discretion,
- Building a relationship with each Attributed Member and family member,
- Exploring a Attributed Member's values, preferences and cultural and personal beliefs to optimize instruction,
- Sharing information and communicating in a way that meets the Attributed Member's and family's needs and preferences,
- Informing and connecting Attributed Members to community programs to sustain healthy behaviors,
- Collaboratively setting goal(s) and developing action plans,
- Documenting the patient's confidence in achieving goals, and
- Using skill building and problem-solving strategies that help the Attributed Member and family identify and overcome barriers to reaching goals.[3]

Reporting

As part of our commitment to sharing actionable data with Enhanced Personal Health Care Essentials Providers, reports offering detailed information about your Attributed patient population are available on Amerigroup's Population Health Platform. Through alerts, dashboards, and reports, Amerigroup's Population Health Platform supports both population management as well as Program-specific financial performance management.

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[2] Tom Bodenheimer, Helping Patients Manage Their Chronic Conditions, www.chcf.org , 2005

[3] http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf

To support population management the tool will help you stratify your membership based on risk and prevalence of chronic conditions; and offer actionable clinical insights, such as care gap messaging and preemptive flagging of Attributed Members with high risk for readmission, potentially preventable visits (ER) as well as inpatient visits with Ambulatory Sensitive Conditions. To support performance management, the tool will help you monitor and improve your performance in the Program's payment model, connecting the dots for you between the actionable activities that tie to the Program's financial incentives. Additional detail about the tool and information we plan to make available to you is supplied below.

Amerigroup strives to produce the most accurate and timely reports possible – including those contained in Amerigroup's Population Health Platform. In the event that any errors are identified in a report, information will be refreshed or restated as appropriate and practicable. As a condition of participation in the Program, you accept the limitations that are inherent in our systems, data processing, and time constraints. For example, if data for BlueCard Attributed Members is delayed or incomplete, or data is incomplete due to the need to reprocess a set of Claims, reports will be processed using the information available at the time the reports are generated, and will only be restated if determined by Amerigroup to be administratively feasible within technical processing schedule constraints.

The following information will be available through Amerigroup's Population Health Platform:

- Attributed Patient View
- Hot Spotter Chronic Condition and Hot Spotter Readmission View
- New Patient View
- Inpatient Authorization View
- Emergency Room Visit View
- Care Opportunity Dashboard View
- Inactive Patients View
- Lab Referral View
- ETG® Results View
- Performance Summary
- Performance Scorecard

Note: ETG® (Episode Treatment Group) noted throughout the document is a registered trademark of Optum Inc.

Report Registration and Questions

Your Contract Advisor can work with you as needed to complete the registration process. If you have questions regarding Amerigroup's Population Health Platform, please forward an e-mail to the mailbox indicated for your state under the Introduction section of this Program Description. In your message, please include the following information:

- Your name
- Your phone number
- Your provider practice name
- Name, date and details of view(s)
- Description of issue or question

Section 3: EPHC Essentials Performance Payment Model Program Definitions

Payment –Medicare Advantage EPHC Essentials Performance Payment Model- Definitions

Note: The definitions only pertains to providers who have Enhanced Personal Health Care Attachments that specifically include their participation in our Medicare Advantage EPHC Essentials Performance Payment Model. All terms and provisions in this and all Medicare Advantage EPHC Essentials Performance Payment Model designated subsections shall refer only to Medicare Advantage EPHC Essentials Performance Payment Model.

Definitions

All capitalized terms will have the meanings given to such terms as shown below or in the Provider Agreement or, if not defined, will be interpreted using the commonly accepted definition of such terms.

"Actual Performance" means the PMPM earned by a Provider Group based on performance during the Measurement Period and paid out after the Measurement Period. It is calculated as the sum of the PMPM earned on each Performance Scorecard measure.

"Allowed Amount" means the maximum eligible amount paid for a service, including the amount paid by Amerigroup and any Covered Individual copayments and deductibles.

"Baseline Period" means a defined twelve (12) month period preceding a Measurement Period. To ensure all Claims have been received and processed by Amerigroup, there will be a minimum of three (3) months paid Claims run-out between the end of the Baseline Period and the beginning of the Measurement Period plus generally a three (3) month period to perform calculations. The Baseline Period is the timeframe which is used to set Targets.

"Episode Treatment Grouper (ETG®) Cost Efficiency Ratio" means the value, determined by Amerigroup, derived from dividing observed total Allowed Amounts for episodes of care for a Provider's Attributed Members during the Measurement Period by the expected total Allowed Amounts for those episodes. Expected total Allowed Amounts are based on average Allowed Amounts for the same types and severity of episodes for peers within the Provider's market or sub-market during the Measurement Period. Further details on this calculation are provided in Section 5 below.

"EPHC Essentials Performance Payment" is the total dollar amount earned by a Provider Group in the Program during a given Measurement Period. It is calculated as Actual Performance in each Measurement Period multiplied aggregated Member Months in the same Measurement Period calculated by Amerigroup based on Attributed Member population for the Provider Group.

""High Target" means the high range of PMPM threshold set for each Performance Scorecard measure based on peer level performance that the Provider must meet to earn a high tier incentive in the Program during the Measurement Period.

"Incentive Gate" means a minimum threshold of performance on the Persistent Condition Validation Improvement measure] that must be achieved during MA Measurement Period to have the opportunity to earn an incentive in the Program. To meet the Incentive Gate, Provider must meet one of the following criteria:

1. Provider's Persistent Condition Validation Improvement rate must be above the threshold defined by Amerigroup.
2. Provider's MA Measurement Period PCV% must be equal to or greater than 90%.

"Low Target" means the lower range of PMPM threshold set for each Performance Scorecard measure based on peer level performance that the Provider must meet to earn a low tier incentive in the Program during the Measurement Period.

"MA Measurement Period PCV%" means the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that persist from year to year, due to the non-acute, chronic status of the condition itself. Asthma, Chronic Obstructive Pulmonary Disease and Diabetes are examples of chronic conditions that, persist from year to year. Details regarding the calculation of the MA Measurement Period PCV% can be found in Section 5 of this Program Description.

"Medicare Advantage Measurement Period(s) ("MA Measurement Period(s)")" means the twelve (12) month calendar year period(s) during which performance will be measured for purposes of calculating Annual EPHC Essentials Performance Payment between Amerigroup and the Provider. The Medicare Advantage Measurement Period(s) for Provider's participation in the Program is set forth in the Program Description.

"Member Population" means the group of Medicare Advantage Attributed Members assigned to the Program, as applicable; and whose quality performance under the relevant Amerigroup products(s) will be used to calculate EPHC Essentials Performance Payment pursuant to the Program (subject to criteria established by Amerigroup).

"Member Months" means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Amerigroup product(s) during a Measurement Period as determined by Amerigroup.

"Quality Gate" means a minimum threshold of performance on Stars quality measures that must be achieved to have the opportunity to earn a portion of the EPHC Essentials Performance Payment. The Quality Gate is a threshold defined by Amerigroup, and is set so that performance on the Stars Quality Composite must be above a predetermined threshold of the market performance.

Performance Scorecard" means the aggregate set of Performance Measures used to determine Provider's Actual Performance. The Performance Scorecard is described within this Program Description.

"Performance Measures" means the quality, utilization and cost measures described in this Program Description that will be evaluated after each Measurement Period to determine Provider success under EPHC Essentials. Performance Measures may be based on HEDIS® standards or on standards established or adopted by Amerigroup related to appropriateness, cost or utilization of medical services or administrative requirements.

"Persistent Condition Validation Improvement" means the year over year improvement in the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that persist from year to year due to the non-acute, chronic status of the condition itself and are properly documented in the Members' medical record. Asthma, Chronic Obstructive Pulmonary Disease and Diabetes are examples of chronic conditions that, persist from year to year. Details regarding the calculation of Persistent Condition Validation Improvement can be found within Section 5 of this Program Description.

"Persistent Condition Validation Percentage ("PCV%")" means the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that persist from year to year due to the non-acute, chronic status of the condition itself. Asthma, Chronic Obstructive Pulmonary Disease and Diabetes are

examples of chronic conditions that, persist from year to year. Details regarding the calculation of the PCV% can be found within Section 5 of this Program Description.

Potential Performance" means the maximum PMPM that a Provider Group can earn based on thresholds defined by Amerigroup in the Performance Scorecard during the Measurement Period.

"Provider Group" means the defined group of providers used for scoring purposes. All performance scored measures are evaluated at this aggregate level.

"Stars Quality Composite" is the combination of specific Medicare based Performance Measures into a single performance result. The Stars Quality Composite is calculated as an observed to expected ratio, where the observed value is the average of the performance rates during the Measurement Period for eligible Performance Measures and the expected value is the average of Medicare Stars 4 and 5 level performance as determined by Amerigroup. The Performance Measures included in the Stars Quality Composite are located in Section 5 of this document.

"Target(s)" means thresholds set for each Performance Scorecard measure.

Section 4: Attribution

Attribution is a process used to assign Covered Individuals to a provider based on their historical health care utilization, or, in some instances, based on his/her own selection or selection performed on the Covered Individual's behalf. This process is critical to achieve the objectives of the Program, including transparent and actionable data exchange for the purposes of identifying opportunities for improvement and incenting desired medical outcomes. In this section, as is the case in the Incentive Program section of this Program Description, "Attribution" is the collective term used for assignment of Covered Individuals to a provider.

Depending on the product, Amerigroup will use an Attribution algorithm that most appropriately assigns Covered Individuals to participating providers. Based on this algorithm, Amerigroup offers providers a list of patients who have been assigned to them and will be available in Amerigroup's Population Health Platform. Provided below is an overview of the Program's Attribution algorithm for: (1) a product where Covered Individuals selects a PCP or a PCP is selected on their behalf, and (2) visit based attribution.

The visit-based Attribution process, as described on the following pages, may be used exclusively for certain Covered Individuals, and is based on historical Claims data.

Due to certain contract restrictions, customer requirements, Program specific product limitations, and technological limitations, etc., it will not be possible to include all Covered Individuals as Attributed Members in the Program. For example, if an employer group prohibited us from including their employees in the Program, these Covered Individuals would not be Attributed Members. Also, there are Programs that focus on specific product inclusion and therefore members of other products wouldn't be included as Attributed Members. Therefore, certain lines of business, employer groups or Covered Individuals may be excluded from the Program at Amerigroup's sole discretion. Covered Individuals whose Amerigroup coverage is secondary under applicable laws or coordination of benefit rules or whose coverage is provided under a supplemental policy (e.g., Medicare supplement) shall never be Attributed Members. It is Amerigroup's goal to continue to expand the Covered Individuals included in the Program as operationally feasible and contractually permitted.

Non-Amerigroup BlueCard members who are eligible to participate in Enhanced Personal Health Care Essentials at the start of your Measurement Period will be the only non- Amerigroup BlueCard membership that will be attributed to you throughout your entire Measurement Period. This limitation shall not, however, apply in those instances where Amerigroup or one of its affiliates are both the "home" and "host" plans for an Attributed Member under the BlueCard rules. For example, if on January 1st, 200 non-Amerigroup BlueCard members are eligible to participate in Enhanced Personal Health Care Essentials those 200 non-Amerigroup BlueCard members will be the only non Amerigroup BlueCard members included in the Program for that Measurement Period, and no additional non- Amerigroup BlueCard members would be eligible to be attributed to your participating physicians until the start of the next Measurement Period.

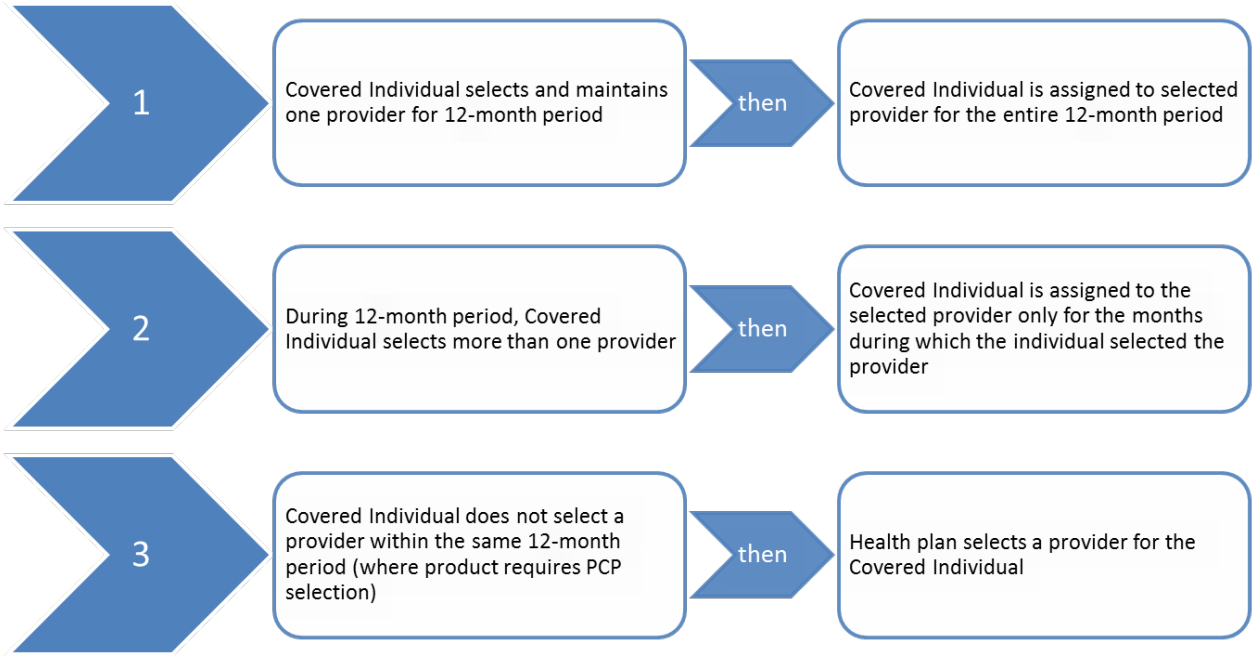
The exception to this would be the instance whereby a non-Amerigroup BlueCard member is already attributed to one practice, and that practice's Measurement Period started on or before your practice's Measurement Period, and the member then moves to your practice during the Measurement Period. In this instance, if this member is then attributed to your practice, this member would also be included in your current Measurement Period.

Conversely, a non-Amerigroup BlueCard member originally attributed to your practice could be moved to a different practice during the Measurement Period based on normal attribution rules, and after that, would no longer be your Attributed Member.

Attribution with PCP selection

A Covered Individual will be considered an Attributed Member for you in cases where the Covered Individual selects you as their PCP or you are selected as the PCP for the Covered Individual.

With regard to the Payment Program, Attributed Members who select a PCP will be identified as follows:

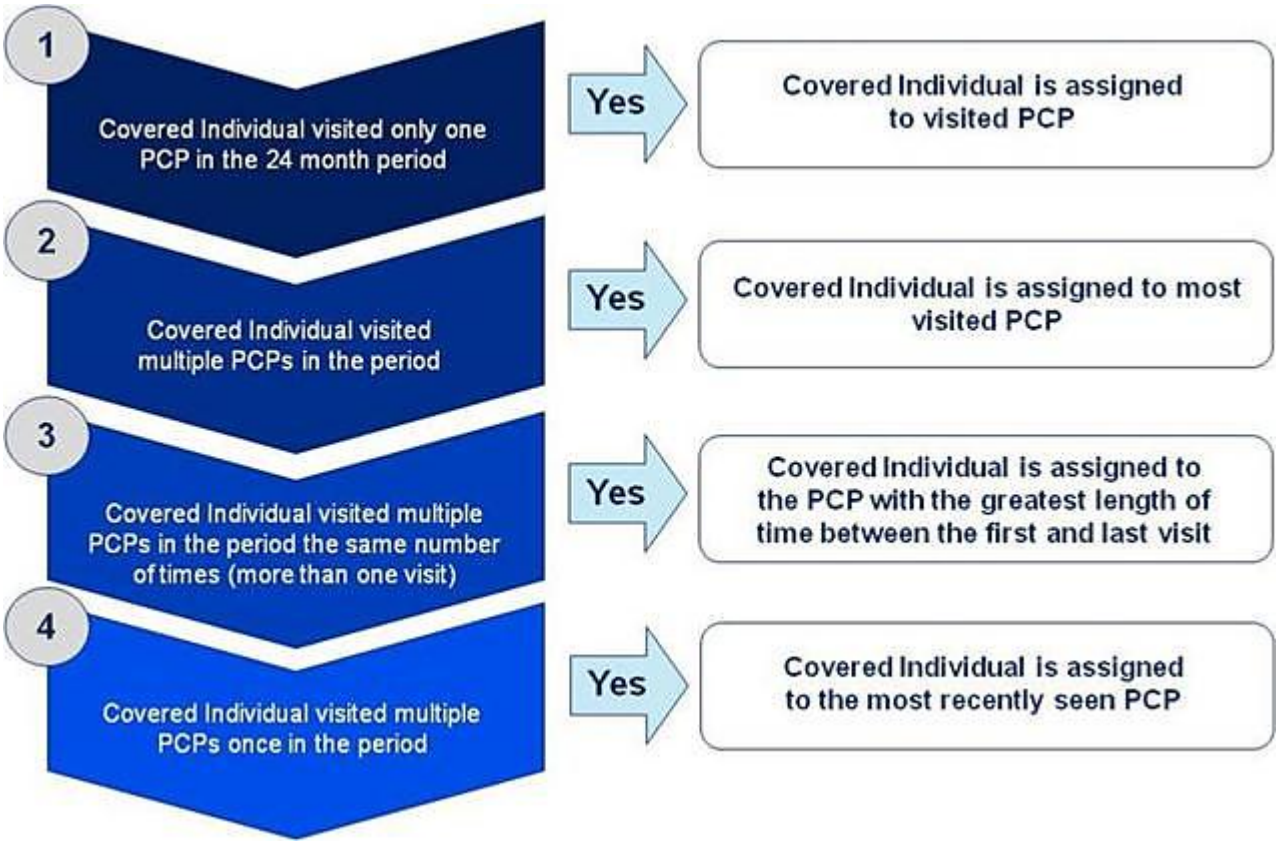


Note: If visit-based Attribution is used exclusively for a Covered Individual, the method on the following page will apply.

Visit-based Attribution

In an open access product (for example PPO and indemnity), Amerigroup uses a visit-based approach to attribute Covered Individuals based on historical Claims data. Exceptions to the visit-based rule may be made if an Attributed Member notifies Amerigroup that a certain provider should be considered his/her PCP. This Attribution algorithm reviews office based evaluation and management visits, and attribution priority is given to PCP visits. When PCP visits (or applicable specialist visits for groups including specialists participating in the Program) are not available, the Covered Individual may not be attributed. As mentioned previously, Claims-based attribution may be used exclusively in certain circumstances.

Initially, Amerigroup reviews available historical Claims data incurred during a 24 month period, with three months of Claim run-out, to assign Covered Individuals. For this scenario, Covered Individuals must have active coverage for at least three (3) months in the entire 24 month period (irrespective of product) and currently be Covered Individuals.* Upon initial assignment to a provider, attribution for an open access product is re-run on a quarterly basis to ensure that the most recent Claims information is utilized for attributing Covered Individuals.



Attribution Distinctions

It is important to note that there are differences between the Attribution Methodology used in the Population Health Platform and the Attribution Methodology used for EPHC Essentials Performance Payments. For example, Attribution in the Population Health Platform is based on current Attributed Membership in a given month. Reimbursement for EPHC Essentials Performance Payments is retrospective, based on Member Months for Attributed Membership during the associated Measurement Period. Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such provider in order to promote cost-effective distribution of payments. Such payment will be made to the provider one month after it would otherwise have been paid even if the total amount payable to the provider at that time is still less than $5.

Attribution for EPHC Essentials Performance Payment

The following distinctions are applicable for the Member Months used for the EPHC Essentials Performance Payment:

- An Attributed Member who has Member Months associated with him/her in the Baseline Period may not have Member Months attributed to him/her in the Measurement Period if, for example, the Attributed Member changed PCPs or visit patterns during the Measurement Period.
- The total retrospective Member Months for an Attributed Member during a completed Measurement Period may be higher than the sum of months that the Attributed Member appeared on PHP reports, which are prospective. For example, when a Covered Individual is attributed to a physician during a Measurement Period using visit-based attribution, that Covered Individual may be attributed to a physician for the full Measurement Period as long as he/she had medical coverage in those months, even if the member was not included in the monthly PHP attribution reports for those months.
- When a physician with Attributed Members leaves a practice, the Attributed Members for that physician may stay with the practice as long as the Attributed Members do not select a different PCP or have record of visiting another provider in the practice. In this circumstance, the Attributed Members will remain attributed to the practice for purposes of clinical coordination payments, but will not be counted as an Attributed Member for the EPHC Essentials Performance Payment calculations.
- Attribution for the EPHC Essentials Performance Payment is based on retrospective Member Months for Attributed Membership during the associated Measurement Period. Attribution is not prorated for partial months; rather, it is determined by eligibility as of the last day of the month. If an Attributed Member is active as of the last day of a month, a Member Month will be counted for the Attributed Member. If an Attributed Member is not active as of the last day of a month, a Member Month will not be counted for the Attributed Member.

Section 5: Program Methodology

*References to performance assessment in this section refer to performance during the Measurement Period unless otherwise specified.

Metrics-Quality Measures And Performance Metrics

The measurement of quality and performance metrics is a key component of successful performance improvement and patient-centered care programs. Under the Program, quality and performance standards must be achieved in order for you to be eligible to receive additional amounts described further below in the Payment section. The scoring measures, methodology, calculations and other related parameters and criteria associated with quality measures and performance assessments may be updated from time to time.

Medicare Advantage EPHC Essentials Performance Payment Model

> Note: The section below only pertains to providers who have Enhanced Personal Health Care Essentials Attachments that specifically include their participation in our Medicare Advantage EPHC Essentials Performance Payment Model. All terms and provisions in this and all Medicare Advantage EPHC Essentials Performance Model designated subsections shall refer only to Medicare Advantage EPHC Essentials Performance Payment Model.

The Medicare EPHC Essentials Performance Payment Model assesses your performance on quality, utilization and cost measures. You will receive a Performance Scorecard that evaluates the following areas:

- Stars Quality Composite
- Annual Wellness Exam
- Persistent Condition Validation Improvement
- Potentially Avoidable Emergency Room
- Episodic Treatment Groups ("ETG®")

Stars Quality Composite

The Performance Scorecard is comprised of clinical quality measures as identified by the Centers for Medicare and Medicaid Services ("CMS") that align with the Medicare Stars Program as well as utilization and cost of care measures. In addition to serving as a basis for EPHC Essentials Performance Payment calculations, these measures are used to establish a minimum level of performance expected of you under the Program, and to encourage improvement through sharing of information. The measures selected encourage efficient, preventive and cost-effective health care practices for the Medicare Advantage Member Population. Eligible Providers who meet the Quality and Incentive Gate can participate in the Incentive Program as described in Section 6, Performance Scorecard and Payment Determination-Medicare Advantage.

The measures included in the Performance Scorecard fall into five (5) categories. The categories are detailed below:

Stars Measures (Included in the Stars Quality Composite)

- Medication adherence measures – Hypertension, Oral Diabetes, Cholesterol
- Screening measures - Breast Cancer, Colorectal Cancer
- Diabetic Measures - Diabetes HbA1c testing, Diabetes Urine Protein Screening

Stars Quality Composite Methodology

Quality category is a composite methodology based on specific Stars measures. Performance on the Stars measures listed above is calculated by Amerigroup for each Provider at a practice level.

The following steps indicates how Stars Quality Composite is scored:

1. Four and Five Stars benchmarks are created for each Stars measure.
2. To determine measures that are be used to score a Provider Group, the measure must have at least 5 Attributed Members in the denominator. Thus, Provider Group may have different Stars measures that are used to calculate their individual score, as all Attributed Members do not qualify for inclusion for every measure (as per each Stars measure specification).
3. A Provider Group must have at least 2 scorable measures (5 Attributed Members in each denominator).
4. After the above criteria are satisfied at the measure level, a Provider Group can be scored if there are at least 30 Attributed Members in their total denominator across all measures. The same Attributed Member may be included in multiple measure denominators.
5. Calculate average Provider Group compliance rate. Provider Group compliance rate is calculated as numerator/denominator for each scorable Stars measure.
6. Calculate the average Stars compliance rate for the same measures for each Provider Group. Stars compliance rate is calculated based on 4 and 5 star level performance for the Stars measures
7. Calculate observed to expected ratio for Stars Composite as (average provider practice compliance rate / average market compliance rate). A value >1 indicates that the Provider Group has higher compliance than their peers. A value <1 indicates that the Provider Group has lower compliance than their peers.

Fig 2: Example of a Medicare Stars Quality Composite calculation – for Medicare Essentials Performance Payment Model

Stars Quality Composite measures (Medicare)	Numerator	Denominator	Scorable Indicator	Practice Compliance Rate	Stars Compliance Rate
Colorectal cancer screening	0	1	N		
Breast cancer screening	5	11	Y	45.45%	79.72%
Medication Adherence – Cholesterol	10	11	Y	90.91%	85.75%
Medication Adherence – Hypertension	9	14	Y	64.29%	76.35%
Medication Adherence – Oral Diabetes	16	19	Y	84.21%	80.31%
Diabetes urine protein screening	14	25	Y	56.00%	68.75%
Diabetes HbA1c testing	190	200	Y	95.00%	76.05%
Total	244	280	Average Rate	72.64%	77.82%
			Scorable Measure Count	6	
			Observed to Expected Ratio	0.93	

Notes: Member counts and market compliance rate are for example purposes only and do not represent actual proposed targets or reflect real performance data. There will be variability by practice and market.
The metrics chosen above were chosen for illustration purposes.

1. Measures with total member count <5 are deemed non-scorable
2. Compliance rate for each measure – numerator/denominator for each measure.
3. Calculate Stars benchmark for the same measures.
4. Calculate the average for provider practice and Stars compliance rate.
5. Calculate the observed to expected ratio (Average Practice compliance rate/ Average Stars compliance rate)

Annual Wellness Exam

Amerigroup Medicare Advantage plans offer coverage for Annual Wellness for individual Medicare Advantage Members. An Annual Wellness will help aid in appropriately diagnosing, monitoring,

assessing, evaluating, and/or treating conditions that may not otherwise be captured, closing gaps in care, and creating a comprehensive care plan to manage possible chronic conditions. When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member.

Calculation:

- Denominator – all Medicare Advantage Members attributed to the Providers practice during a MA Measurement Period.
- Numerator – all Attributed Medicare Advantage Members who have been seen for their annual wellness exam during the same MA Measurement Period.
- Calculate the Providers success rate for Annual Wellness Exams, The success rate is calculated as numerator over denominator.

Persistent Condition Validation Improvement

The Persistent Condition Validation Improvement Performance Measure is calculated as the improvement in the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that persist from year to year.

Coding Accuracy: Provider is responsible for submitting diagnosis codes that are complete, accurate and supported by clinical findings and documentation in the Medicare Advantage Attributed Member's medical records. As such, diagnoses for any of the following situations may be excluded from the calculation of the Provider's Persistent Condition Validation Percentage (PCV %):

- The diagnosis represented by the HCC is no longer applicable due to the fact that the medical condition was cured for the MA Attributed Member; OR
- The diagnosis represented by the HCC is an acute rather than chronic condition; OR
- A diagnosis code represented by the HCC was submitted to Amerigroup in error the year prior to the MA Measurement Period.

Calculation:

1. The Persistent Condition Validation Percentage (PCV %) for the year prior to the MA Measurement Period is calculated. This value serves as a baseline PCV%. The PCV% represents the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that by nature persist from year to year, in this case the calendar year immediately prior to the MA Measurement Period.
2. The Persistent Condition Validation Percentage (PCV %) for the MA Measurement Period is calculated. This value serves as a MA Measurement Period PCV%. The PCV% represents the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that by nature persist from year to year, in this case the MA Measurement Period.
3. The Persistent Condition Validation Improvement is calculated as (MA Measurement Period PCV% - baseline PCV %) / (baseline PCV %).
4. The Persistent Condition Validation Improvement rate is used for scoring purposes, unless the MA Measurement Period PCV% is 90% or greater. If the MA Measurement Period PCV% is 90% or greater, Provider will qualify for the full PMPM for this Performance Measure.

Potentially Avoidable ER Visits

This measure was developed using research that determines ER visits that were potentially avoidable by identifying visits that could have been treatable in an ambulatory care setting. Visits for treatment of conditions, such as the following, are considered potentially avoidable:

- Conjunctivitis
- Sinusitis
- Gastritis
- Urinary tract infection
- Menstrual disorders
- Cellulitis
- Dermatitis
- Sun burn
- Osteoarthrosis
- Joint pain
- Backache
- Cramps
- Constipation
- Urinary tract infection
- Sprains
- Abrasions
- Prenatal
- Gynecological and adult exams
- Health screenings.
- Otitis media
- Bronchitis
- Insomnia
- Malaise and fatigue
- Cough
- Nausea or vomiting alone
- Diarrhea
- Insomnia
- Malaise and fatigue
- Throat pain
- Cough
- Contusions
- First degree burns
- Strep throat
- Vaccinations
- Routine child
- Change of wound dressings
- Radiology and laboratory exams

Calculation: The following numerator and denominator calculations are performed for both age groups:

- Denominator = The total Member Months during the MA Measurement Period
- Numerator = The number of potentially avoidable emergency room visits for the Member Population during the MA Measurement Period.
- The observed rate is computed as (numerator/denominator)*12,000 for each age group.
- The market compliance rate, or expected rate, is calculated by Amerigroup.
- Amerigroup calculates the observed to expected ratio for by dividing the observed rate by the expected rate.

ETG® Cost Efficiency Ratio

The ETG® Cost Efficiency Ratio is measured as an observed to expected ratio, with the "observed value" representing the Allowed Amount cost of episodes of care attributed to Provider and the expected value representing average cost for the same types and severity of episodes for peers within Provider's market* or sub-market, as determined by Amerigroup.

Criteria:

- The analysis aggregates condition-based costs into episodes of care, where all of the costs (professional, institutional inpatient, institutional outpatient, ancillary and pharmacy) reasonably associated with a given chronic or acute condition are grouped together into a total cost of care for that given condition. Optum Symmetry's ETG® grouper is used to aggregate episodic costs for the analysis.
- The ETG® grouper includes risk categories for episodes in which patient risk is significantly related to episode costs. All comparisons are based on the risk-adjusted ETG®s as applicable.

Calculation:

The following steps are performed by Amerigroup to determine ETG® Cost Efficiency Ratio:

1. "Expected" episode costs are calculated by Amerigroup based on network averages within Provider's market or sub-market, as defined by Amerigroup. Norms are calculated separately by medical specialty and by region so that comparisons are always made with Provider's same-specialty peers to recognize the inherent differences in treatment patterns, across specialties even when caring for similar patients. The Provider's specialty is determined at the individual Provider level.
2. A "responsible" provider is assigned by Amerigroup for each episode. Amerigroup assigns Provider all episodes for their Member Population. Total episode costs (including hospital, ancillary and pharmacy costs) are then assigned to that provider.
3. The ETG® Cost Efficiency Ratio is calculated for each Provider, based on a (specialty specific) case mix-adjusted "expected" cost per episode. The "Cost Efficiency Ratio" is the ratio of a Provider's actual average costs for treating each episode type (ETG®) divided by their same-specialty peers' average costs for treating that same ETG®. This ratio is calculated for each ETG® treated by each Provider, and then these ETG®-by-ETG® ratios are averaged, weighted by frequency, to compute Provider's overall ETG Cost Efficiency Ratio. The actual ETG® unit of analysis consists of a base ETG® (condition class and body location) plus a severity indicator. The full ETG® also includes more specific episode information, e.g., complication, comorbidity, and treatment indicators which are not used in the analysis. Information in the complication and comorbidity codes is captured by the severity indicator (or risk adjustment), which takes into account all of the clinical factors that reflect actual clinical differences between patients.
4. Non-specific, routine, and preventive care episodes are excluded by Amerigroup from the analysis. Preventive examination or immunization episodes are excluded to avoid penalizing providers for performing such services. Episodes without Provider involvement (such as pharmacy-only episodes) are also excluded.
5. Final results are aggregated at the Provider Group level using identifiers that uniquely identify providers in each market or sub-market, as defined by Amerigroup. This is necessary in order to compute and apply same-specialty norms for each Provider.

6. The Provider Group must have at least 20 attributed episodes of care as outlined above for the ETG® Cost Efficiency Ratio to be calculated. If Provider does not meet this threshold, the ETG® Cost Efficiency Ratio will not be calculated.
7. To make explicit the underlying variability in the performance scores, a 90% confidence interval is calculated for the ETG® Cost Efficiency Ratio. The upper limit of the 90% confidence interval is used for scoring purposes.

   *In many cases a "market" is an entire state. In certain states where Amerigroup's service area does not include the entire state, a "market" will include that portion of the state within the service area.

Section 6: Performance Scorecard and Incentive Program

Medicare Advantage EPHC Essentials Performance Payment Sum Payment Model

> Note: The section below only pertains to providers who have Enhanced Personal Health Care Essentials Attachments that specifically include their participation in Medicare Advantage EPHC Essentials Performance Payment Model. All terms and provisions in this and all Medicare Advantage EPHC Essentials Performance Payment Model designated subsections shall refer only to Medicare Advantage EPHC Essentials Performance Payment.

Medicare Advantage Performance Assessment

Performance on the selected Stars measures will be reported to you throughout the year. The assessment of performance will determine the EPHC Essentials Performance Payment that you earn and will be conducted annually. Performance on the Stars measures will be calculated specific to your practice. Better performance will generate a better score and correspond to a higher EPHC Essentials Performance Payment.

> Note: Amerigroup uses all Claims and eligibility data available for its Attributed Members to determine their inclusion in and compliance with a metric – even if they were not an Attributed Member for the entire MA Measurement Period. For example, if a member's enrollment history includes a product that is not covered under the Program, but during a MA Measurement Period the member is enrolled in a product that is covered under the Program, then that Attributed Member's full continuous enrollment history and associated Claims will be considered with regard to the Performance Scorecard.

How Targets Are Set for the Performance Scorecard

The Stars measures scoring will have thresholds based on CMS Stars Quality levels and determined by Amerigroup.

Targets for remaining measures are based on market level Amerigroup data where normative benchmarks are identified based on peer level performance for each Performance Scorecard measure. Amerigroup determines Targets based on these benchmark thresholds for each Performance Scorecard measure. If there is insufficient volume to generate robust market thresholds, then larger geographies such as regional or national may be leveraged to establish the performance thresholds.

Targets will be supplied to participating Providers prior to the start of the MA Measurement Period or as soon thereafter as practicable.

Linking Performance Assessment to the EPHC Essentials Performance Payment

The opportunity to earn an EPHC Essentials Performance Payment is achieved through enhanced care management and delivery of care. This is a key characteristic of the Program. The Performance Scorecard serves two (2) functions: (1) Quality and Incentive Gate, and (2) overall determinant of the EPHC Essentials Performance Payment you earn. The High Target, Low Target, Incentive Gate, and Quality Gate and earning opportunity information will be supplied to participating Providers prior to the start of the Measurement Period or as soon thereafter as practicable.

Quality Gate

Your practice must achieve a minimum threshold of performance on Stars measures to have the opportunity to earn an EPHC Essentials Performance Payment in the Program. The Quality Gate is a value defined by

Amerigroup, and is set so that performance on the Stars measures must be above a predetermined threshold as defined in this Program Description.

After the Quality Gate is satisfied, the EPHC Essentials Performance Payment the provider is eligible to receive will vary depending on performance against Performance Scorecard measures. Providers must meet the Quality Gate and the Incentive Gate to receive an EPHC Essentials Performance Payment in the Program. The better the performance, the greater the EPHC Essentials Performance Payment the Provider is eligible to earn.

The Quality Gate will be supplied to participating providers prior to the start of the MA Measurement Period or as soon thereafter as practicable.

Incentive Gate

Your practice must achieve a minimum threshold of performance on the Persistent Condition Validation Improvement rate or the MA Measurement PCV% to have the opportunity to earn a performance incentive in the program. The Incentive Gate is a threshold defined by Amerigroup, and is set so that performance must be above a predetermined threshold as defined in the Program Description.

After the Incentive Gate is satisfied, the EPHC Essentials Performance Payment the Provider is eligible to receive will vary depending on performance on the Performance Scorecard. Providers must meet the Quality Gate and the Incentive Gate to receive an EPHC Essentials Performance Payment in the program. The better the performance, the greater the EPHC Essentials Performance Payment the Provider will earn.

The Incentive Gate will be supplied to participating Providers prior to the start of the MA Measurement Period or as soon thereafter as practicable.

Medicare Business Performance Payment Determination

1. Within one-hundred and eighty (180) days from the end of the relevant MA Measurement Period plus the three-month Claims run-out period, Amerigroup will calculate the EPHC Essentials Performance Payment, and make other calculations.
2. Amerigroup will then calculate the EPHC Essentials Performance Payment.

For a basic example (single Medicare product), see the calculation set forth below:

Fig. 1: Example of a calculation for a Provider Group based on Medicare Performance Scorecard Measures where Stars Measures and Incentive Gate is met.

I. Scorecard Measures	Targets		PMPM Available		Results	Actual Performance
	Low	High	Low	High		
1.Stars Quality Composite	≥ 0.80	≥ 1.05	$0.25	$0.50	0.85	$0.25
2.Annual Wellness Exam	≥ 60%	≥ 85%	$0.25	$0.50	66%	$0.25
3. Persistent Condition Validation Improvement	≥ 7%	≥ 14%	$0.25	$0.50	10%	$0.25
4. Potentially Avoidable ER Visits	≤ 1.01	≤ 0.70	$0.25	$0.50	1.05	$0.00
5. ETG Cost Efficiency Ratio	≤ 0.95	≤ 0.85	$0.50	$1.00	0.85	$1.00
			Max	$3.00	Earned	$1.75

In the example above:

- The Performance Scorecard reflects performance at a Provider Group level.
- The Provider Group met the Low Target for Stars Quality Composite Measure, Annual Wellness Exam measure and Persistent Condition Validation measure.
- The Provider Group met the High Target for ETG® Cost Efficiency Ratio.
- The Provider Group did not meet any of the Targets set for Potentially Avoidable ER Visits measure.
- The Quality Gate is set at 0.80 and the Incentive Gate is set at 7% (Persistent Condition Validation Improvement) or 90% (MA Measurement Period PCV %) in this example. Since the Provider Group has cleared the Quality and Incentive Gate, EPHC Essentials Performance Payment will be generated to calculate the payout.
- The Actual Performance is calculated as the sum of the PMPM earned on each Performance scorecard measure.
- In the above example, the Provider Group has the potential to earn $3.00 PMPM (Potential Performance). Based on Actual Performance, the Provider would earn $1.75 PMPM.
- The EPHC Essentials Performance Payment payout is generated based on Actual Performance multiplied by final aggregated Member Months based on Member Population for the Provider's practice for the MA Measurement Period.
- Based on Figure 1 above, if the Provider had a total of 3,960 Member Months for the MA Measurement Period, ($1.75 PMPM X 3,960) a total of $6,930 would be paid out in EPHC Essentials Performance Payment after the end of the MA Measurement Period.

Fig. 2: Example of a calculation for a Provider Group based on Medicare Advantage Performance Scorecard Measures where Incentive Gate is not met.

II. Scorecard Measures	Targets		PMPM Available		Results	Actual Performance
	Low	High	Low	High		
1.Stars Quality Composite	≥ 0.80	≥ 1.05	$0.25	$0.50	1.10	$0.00
2.Annual Wellness Exam	≥ 60%	≥ 85%	$0.25	$0.50	0.65	$0.00
3. Persistent Condition Validation Improvement	≥ 7%	≥ 14%	$0.25	$0.50	5%	$0.00
4.Potentially Avoidable ER Visits	≤ 1.01	≤ 0.70	$0.25	$0.50	86%	$0.00
5. ETG Cost Efficiency Ratio	≤ 0.95	≤ 0.85	$0.50	$1.00	0.75	$0.00
			Max	$3.00	Earned	$0.00

In the above example,

- Performance Scorecard reflects performance at a Provider Group level.
- The Provider Group met the High Target for Stars Quality Composite Measure and the Potentially Avoidable ER Visits measure and Low Target for Annual Wellness Exam measure and ETG® Cost Efficiency Ratio measure.
- The Provider Group did not meet any of the Targets set for the Persistent Condition Validation measure (for example purposes, the MA Measurement Period PCV% can be assumed to be below 90%).
- The Quality Gate is set at 0.80 and the Incentive Gate is set at 7% (Persistent Condition Validation Improvement) or 90% (MA Measurement Period PCV %) in this example. Since, the Provider Group has not cleared the Incentive Gate, the EPHC Essentials Performance Payment will not be triggered and the Provider Group will not receive a payout in the Program.

Fig: 3 Example of a calculation for a Provider Group based on Medicare Advantage Performance Scorecard Measures where Quality Gate is not met.

III. Scorecard Measures	Targets		PMPM Available		Results	Actual Performance
	Low	High	Low	High		
1.Stars Quality Composite	≥ 0.80	≥ 1.05	$0.25	$0.50	0.60	$0.00
2.Annual Wellness Exam	≥ 60%	≥ 85%	$0.25	$0.50	90%	$0.00
3. Persistent Condition Validation Improvement	≥ 7%	≥ 14%	$0.25	$0.50	16%	$0.00
4.Potentially Avoidable ER Visits	≤ 1.01	≤ 0.70	$0.25	$0.50	0.67	$0.00
5. ETG Cost Efficiency Ratio	≤ 0.95	≤ 0.85	$0.50	$1.00	0.93	$0.00
			Max	$3.00	Earned	$0.00

In the above example,

- Performance Scorecard reflects performance at a Provider Group level.
- The Provider Group met the High Target for Annual Wellness Exam measure, Persistent Condition Validation measure and the Potentially Avoidable ER Visits measure and Low Target for ETG® Cost Efficiency Ratio measure.
- The Provider Group did not meet any of the Targets set for Stars Quality Composite measure.
- The Quality Gate is set at 0.80 and the Incentive Gate is set at 7% (Persistent Condition Validation Improvement) or 90% (MA Measurement Period PCV %) in this example. Since, the Provider Group has not cleared the Quality Gate, the EPHC Essentials Performance Payment will be not triggered and the Provider will not receive a payout in the Program.

EPHC Essentials Performance Payment

Assuming all preconditions and terms have been satisfied, on an annual basis not later than two-hundred and ten (210) days after the end of the relevant MA Measurement Period, Amerigroup shall make the applicable EPHC Essentials Performance Payment to the Provider that was earned during the MA Measurement Period associated with its Attributed Members. Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such provider in order to promote cost-effective distribution of payments. Such payment will be made to the provider one month after it would otherwise have been paid even if the total amount payable to the provider at that time is still less than $5.

A Provider must be participating in the Program during the entire MA Measurement Period in order to receive the EPHC Essentials Performance Payments a under the Program.

Except as specifically agreed otherwise by the parties, payments earned will follow the current payment methods the Provider has in place with Amerigroup under the Agreement. For example, if Claim payments are currently remitted at the physician group level, Amerigroup will pay the Provider.

Maximizing Your Incentive Goal

We want you to be successful in reaching your incentive goals. The list below provides some specific things that you can do to improve your chances of achieving these goals:

- Utilize available Attributed Member reports and identify opportunities for improvements.
- Establish a process to review your practice's performance on a regular basis. We will provide you with useful reports that shows your practice performance over the course of the MA Measurement Period These reports should be reviewed and discussed on a regular basis to determine how your practice is progressing toward established Targets.
- Leverage tools that are available to your practice. Amerigroup's Population Health Platform, our collaborative learning events, virtual office hours, and the Provider Toolkit, are just a few ways to access information and drive quality improvement.

Note: The Potential Performance that you can earn in the Program based on the Performance Scorecard measure for the targets set will be communicated to you prior to the start of the MA Measurement Period.

Appendix: Medicare INDEX

INDEX – Performance Scorecard Measure Specifications

Note: The term "patient(s)," as used throughout the Index, shall mean and refer only to Attributed Member(s). References to "measurement year" below refer to "Measurement Period".

Measure	Description	Numerator/Denominator	Technical Specifications	Measure Citation
Stars Measures-Medication Adherence				
Proportion of Days Covered (PDC): Oral Diabetes	This measure identifies patients with at least two prescriptions for diabetic oral agents in the measurement year who have at least 80% days covered (PDC) since the first prescription of a diabetic agent during the year. "Diabetes medication" means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic drug, a meglitinide drug, or an SGLT2 inhibitor. Plan members who take insulin are not include	Numerator Patients in the denominator with at least 80% days covered for a diabetic Rx since the first prescription for the drug during the Measurement year. Denominator Patients who have at least two prescriptions for an oral diabetic drug during the last 365 days	Numerator >=80% days covered (PDC) for Diabetic Agents (removing overlapping days for Rx) from index event to end of measurement year Denominator ▪ >=2 Rx claims for diabetic agents from end of measurement year -365 to end of measurement year , saving earliest instance as index event (IE); ▪ Rx eligibility from index event to end of measurement year using HEDIS gap method, <=1 gap <=45 days max; ▪ >=18yo ▪ No Rx claims for 'Insulin' from index event to end of measurement year	CMS Part D Specifications 2017
Proportion of Days Covered (PDC): Hypertension (ACE or ARB)	This measure identifies patients with at least two prescriptions for an RAS (Renin-Angiotensin System) antagonists in the measurement year who have at least 80% days covered (PDC) since the first prescription of an RAS (Renin-Angiotensin System) antagonists during the year.	Numerator Patients in the denominator with at least 80% days covered for an RAS (Renin-Angiotensin System) antagonists in since the first prescription for the drug during the Measurement year. Denominator Patients who have at least two prescriptions for an ACE/ARB during the last 365 days	Numerator >=80% days covered (PDC) for (removing overlapping days) from index event to end of measurement year Denominator ▪ >=2 Rx claims for ACE/ ARB from end of measurement year -365 to end of measurement year , saving earliest instance as index event (IE); ▪ Rx eligibility from index event to end of measurement year , using HEDIS gap method, <=1 gap <=45 days max; >=18 yo	CMS Part D Specifications 2017

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Proportion of Days Covered (PDC): Cholesterol (Statins)	This measure identifies patients with at least two prescriptions for a Statin in the measurement year who have at least 80% days covered (PDC) since the first prescription of a Statin during the year.	Numerator Patients in the denominator with at least 80% days covered for a Statin since the first prescription for the drug during the Measurement year. Denominator Patients who have at least two prescriptions for a Statin during the last 365 days	Numerator >=80% days covered (PDC) for Statins (removing overlapping days) from index event to end of measurement year Denominator ▪ >=2 Rx claims for Statins from end of measurement year -365 to end of measurement year , saving earliest instance as index event (IE); ▪ Rx eligibility from index event to end of measurement year using HEDIS gap method, <=1 gap <=45 days max; >=18yo	CMS Part D Specifications 2017
Stars Measures-Screening Measures				
Breast Cancer Screening	The percentage of women 50-74 of age who had a mammogram to screen for breast cancer.	The percentage of women 50-74 of age who had a mammogram to screen for breast cancer.	Numerator At least 1 procedure claim for mammography in the 2 years and 3 months prior to the analysis date Denominator ▪ Female ▪ Age between 52 and 74 years old ▪ AND member eligibility from in the year before the measurement year with no more than 1 gap of no more than 45 days ▪ AND member eligibility in the measurement year with no more than 1 gap of no more than 45 days ▪ AND member eligibility with no gaps on analysis date CONTINUED..	National Committee for Quality Assurance. HEDIS 2017. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2016.

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Breast Cancer Screening (continued)	The percentage of women 50-74 of age who had a mammogram to screen for breast cancer.	The percentage of women 50-74 of age who had a mammogram to screen for breast cancer.	Exclusions Any of the following ▪ At least 1 claim for bilateral mastectomy at any time in the past ▪ At least 2 claims for unilateral mastectomy separated by at least 14 days at any time in the past ▪ At least 1 claim for unilateral mastectomy with bilateral modifier ▪ Identified by the following criteria: At least 18 years old ▪ AND at least 2 claims for breast cancer in any position coming from office visit with activity gap of 30 days ▪ OR have at least 1 claim for breast cancer in any position from a hospital or ER ▪ At least 1 claim for history of bilateral mastectomy at any time in the past ▪ At least 1 claim for unilateral mastectomy with modifier code right modifier at any time in the past and at least 1 claim for unilateral mastectomy with modifier code left modifier at any time in the past ▪ At least 1 claim for absence of left breast at any time in the past ▪ AND at least 1 claim for absence of right breast at any time in the past ▪ At least 1 claim for unilateral mastectomy left at any time in the past ▪ AND at least 1 claim for unilateral mastectomy right at any time in the past Note: The breast cancer exclusion is a deviation from the HEDIS specifications. This has been implemented since the follow up for breast cancer patients is typically performed by oncologists (PCPs are less involved). Sustained member eligibility was defined as 2 years prior to analysis date as opposed to 2 years and 3 months prior to analysis date, as defined by HEDIS. This was done to limit the impact on the denominator count.	National Committee for Quality Assurance. HEDIS 2017. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2016.

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Colorectal Cancer Screening	This measure identifies patients between the ages of 50 and 75 who were up to date on their colorectal cancer screening.	Numerator Patients in the denominator who had a colonoscopy in the last 10 years, a flexible sigmoidoscopy in the last 5 years, or a fecal occult blood test during the measurement year. Denominator Patients between the ages of 50 and 75 with no history of colorectal cancer or total colectomy.	Numerator ANY of the following ▪ At least one claim for colonoscopy in the previous 10 years ▪ At least one claim for flexible sigmoidoscopy in the past 5 years ▪ At least one claim for a fecal occult blood test during the measurement year ▪ CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year. ▪ FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two years prior to the measurement year Denominator ▪ Age between 50 and 75 years on analysis date ▪ AND member eligibility with no gaps on analysis date ▪ AND member eligibility in the year before the measurement year , no more than 1 gap of no more than 45 days ▪ AND member eligibility during the measurement year , , no more than 1 gap of no more than 45 days ▪ AND no claims for colorectal cancer or total colectomy at any time in the past	National Committee for Quality Assurance. HEDIS 2017. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2016.

Stars Measures-Diabetes				
Diabetic Measures				
Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Diabetes: HbA1c Testing	This measure identifies patients with diabetes who have had a HbA1c test over the past year.	Numerator Patients in the denominator who had an HbA1c test during the measurement year. Denominator Patients between the ages of 18 and 75 who have diabetes	Numerator Either one of the following: ▪ At least 1 procedure claim for an HbA1c test during the measurement year ▪ OR at least 1 lab result for an HbA1c test during the measurement year. Denominator ▪ Age between 18 and 75 years as of analysis date ▪ Patients identified by any of the following criteria: • At least 2 claims at least one day apart with a diagnosis of diabetes in any position from an outpatient, observation, acute inpatient ED, or nonacute inpatient setting in the 2 years before the analysis date • At least 1 prescription claim for insulin or oral hypoglycemic medication dispensed in the 2 years before the analysis date - Exclude patients with claims for diabetes exclusions. - Deviation from HEDIS specifications: Added requirement to look for at least 2 diabetes diagnoses from an inpatient setting. ▪ Continuous member eligibility during the measurement year with maximum 1 gap of no more than 45 days. ▪ Member eligibility with no gaps on analysis date.	National Committee for Quality Assurance. HEDIS 2017. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2016.

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Diabetes Urine Protein Screening	This measure identifies diabetic patients with a nephropathy screening test or evidence of nephropathy during the measurement year .	Numerator Patients in the denominator with claims for urine protein tests, nephropathy treatment, ESRD, stage 4 CKD, kidney transplant, ACE inhibitors, ARBs, or an outpatient visit with a nephrologist. Denominator Patients between the ages of 18 and 75 years old who have diabetes.	Denominator ▪ Age between 18 and 75 years as of analysis date ▪ Patients identified by any of the following criteria: • At least 2 claims at least one day apart with a diagnosis of diabetes in any position from an outpatient, observation, acute inpatient ED, or nonacute inpatient setting in the 2 years before the analysis date • At least 1 prescription claim for insulin or oral hypoglycemic medication dispensed in the 2 years before the analysis date • Exclude patients with claims for diabetes exclusions • Continuous member eligibility during the measurement year with maximum 1 gap of no more than 45 days • Member eligibility with no gaps on analysis date Numerator ▪ At least 1 claim for an eye exam as specified by HEDIS in the last 730 days ▪ Exe exams are defined either as • non-specific office visits with an ophthalmologist or optometrist • specific eye care code sets for a diabetic retinal screening • OR At least 1 claim for an eye exam as specified by HEDIS during the Measurement year. Note that HEDIS specifications only count retinal eye exams from the previous year if the results were negative, but due to data limitations this measure was loosened to accept all eye exams from the previous year regardless of result.	National Committee for Quality Assurance. HEDIS 2017. Washington, DC: National Committee for Quality Assurance. Technical Specifications Vol 2, 2016.

Other Stars Measures				
Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Annual Wellness Exam	Medicare Advantage plans offer coverage for Annual Wellness for individual Medicare Advantage Members. An Annual Wellness will help aid in appropriately diagnosing, monitoring, assessing, evaluating, and/or treating conditions that may not otherwise be captured, closing gaps in care, and creating a comprehensive care plan to manage possible chronic conditions. When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member.	Numerator All Attributed Medicare Advantage Members who have been seen for their annual wellness exam during the same MA Measurement year Denominator All Medicare Advantage Members attributed to the Providers practice during a MA Measurement year	Calculate the Providers success rate for Annual Wellness Exams, The success rate is calculated as numerator over denominator.	Internally Developed

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Persistent Condition Validation Improvement	The Persistent Condition Validation Improvement Performance Measure is calculated as the improvement in the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that persist from year to year.	See Technical Specifications column	Calculation: ▪ The Persistent Condition Validation Percentage (PCV %) for the year prior to the MA Measurement year is calculated. This value serves as a baseline PCV%. The PCV% represents the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that by nature persist from year to year, in this case the calendar year immediately prior to the MA Measurement year. ▪ The Persistent Condition Validation Percentage (PCV %) for the MA Measurement year is calculated. This value serves as a MA Measurement year PCV%. The PCV% represents the percentage of Medicare Advantage Member Hierarchical Condition Categories (HCC's) that by nature persist from year to year, in this case the MA Measurement year. ▪ The Persistent Condition Validation Improvement is calculated as (MA Measurement year PCV% - baseline PCV %) / (baseline PCV %). ▪ The Persistent Condition Validation Improvement rate is used for scoring purposes, unless the MA Measurement year PCV% is 90% or greater. If the MA Measurement year PCV% is 90% or greater, Provider will qualify for the full PMPM for this Performance Measure.	Internally Developed

Utilization Measures				
Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Potentially Avoidable Emergency Room Visits	The rate of Potentially Avoidable Emergency Room visits per 1,000 patients.	Numerator The number of potentially avoidable emergency room visits for the Member Population during the Measurement Period. Denominator The total Member Months during the Measurement Period The "observed rate" is computed as (numerator/denominator)*12,000 for each age group. For example, if a Provider Group had 3,000 Member Months associated with Attributed Members younger than 18 years of age and that population observed 3 numerator events during the Measurement Period, the observed rate for that age group would be (3 / 3,000) * 12,000 = 12.00.	Numerator Emergency room visits identified by the presence of UB revenue codes. Potentially avoidable emergency room visits are identified by primary ICD-10 diagnosis codes. Denominator The count of eligible patients for each month of eligibility for the designated time period Exclusions Emergency room visits that resulted in 1) an inpatient admission or 2) a surgical procedure CONTINUED…	

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
Potentially Avoidable Emergency Room Visits (Continued)	The rate of Potentially Avoidable Emergency Room visits per 1,000 patients.	Numerator The number of potentially avoidable emergency room visits for the Member Population during the Measurement Period. Denominator The total Member Months during the Measurement Period The "observed rate" is computed as (numerator/denominator)*12,000 for each age group. For example, if a Provider Group had 3,000 Member Months associated with Attributed Members younger than 18 years of age and that population observed 3 numerator events during the Measurement Period, the observed rate for that age group would be (3 / 3,000) * 12,000 = 12.00.	Calculation: ▪ The market* compliance rate, or "expected rate," for each age group is calculated by Amerigroup. ▪ Amerigroup calculates the observed to expected ratio for each age group by dividing the observed rate by the expected rate for each age group. For example, if the Provider Group observed rate of 12.00 for the younger than 18 years of age population is used and we assume an expected rate of 15.00, the observed to expected ratio for that age group would be 12.00 / 15.00 = 0.80. ▪ The final potentially avoidable ER visits rate is calculated by multiplying the observed to expected ratio value for each age group by the percentage of the Member Population represented by that age group. For example, if Provider had 250 Attributed Members younger than 18 years old and 750 Attributed Members aged 18 years and older, the first age group would be weighted at 25% and the second age group would be weighted at 75%. If the example observed to expected ratio for the younger than 18 years of age from the steps above is used (0.80) and we assume that the observed to expected ratio for the population 18 years and older is 1.10, then the final rate is calculated as follows: (0.80 * 25%) + (1.10 * 75%) = 1.03.	Internally developed. Informed by research conducted by The NYU Center for Health and Public Service Research and the United Hospital Fund of New York

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
ETG Cost Efficiency Ratio	The ETG® Cost Efficiency Ratio is measured as an observed to expected ratio, with the "observed value" representing the Allowed Amount cost of episodes of care attributed to Provider and the expected value representing average cost for the same types and severity of episodes for peers within Provider's market or sub-market, as determined by Amerigroup.	See Technical specifications column	Calculation: The following steps are performed by Amerigroup to determine ETG® Cost Efficiency Ratio: • "Expected" episode costs are calculated by Amerigroup based on network averages within Provider's market or sub-market, as defined by Amerigroup. Norms are calculated separately by medical specialty and by region so that comparisons are always made with Provider's same-specialty peers to recognize the inherent differences in treatment patterns, across specialties even when caring for similar patients. The Provider's specialty is determined at the individual Provider level. • A "responsible" provider is assigned by Amerigroup for each episode. Amerigroup assigns Provider all episodes for their Member Population. Total episode costs (including hospital, ancillary and pharmacy costs) are then assigned to that provider. Non-specific, routine, and preventive care episodes are excluded by Amerigroup from the analysis. Preventive examination or immunization episodes are excluded to avoid penalizing providers for performing such services. Episodes without Provider involvement (such as pharmacy-only episodes) are also excluded. • Final results are aggregated at the Provider Group level using identifiers that uniquely identify providers in each market or sub-market, as defined by Amerigroup. This is necessary in order to compute and apply same-specialty norms for each Provider. CONTINUED…	Internally Developed

Measure	Description	Numerator/ Denominator	Technical Specifications	Measure Citation
ETG Cost Efficiency Ratio (Continued)	The ETG® Cost Efficiency Ratio is measured as an observed to expected ratio, with the "observed value" representing the Allowed Amount cost of episodes of care attributed to Provider and the expected value representing average cost for the same types and severity of episodes for peers within Provider's market or sub-market, as determined by Amerigroup.	See Technical specifications column	(Continued) • The Provider Group must have at least 20 attributed episodes of care as outlined above for the ETG® Cost Efficiency Ratio to be calculated. If Provider does not meet this threshold, the ETG® Cost Efficiency Ratio will not be calculated. • To make explicit the underlying variability in the performance scores, a 90% confidence interval is calculated for the ETG® Cost Efficiency Ratio. The upper limit of the 90% confidence interval is used for scoring purposes.	Internally Developed

- *In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.

- Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.