



Program Description for Enhanced Personal Health Care

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OVERVIEW

For primary care physicians (PCPs) and other providers, our system has created an untenable situation: not enough time to provide the care they want to deliver, and not enough income to get off the treadmill created by fee-for-service payment arrangements. An overwhelming amount of research tells us that despite being the most costly in the world, the U.S. health care system is lagging behind many other countries and failing to deliver consistent value to the people who use it every day.^{1,2} More Americans have health care coverage now than ever before. This dynamic makes the need for adopting a value-based system and coordinated delivery system more urgent.

We believe our health connects us all; so, we focus on being a valued health partner and delivering quality products and services that give members access to the care they need. With over five million people served by our affiliated companies, we can make a real difference to meet the needs of our diverse population customers.

Amerigroup Community Care is committed to connecting our Medicare Advantage (Medicare) members to patient-centered care. What makes us unique is our approach to supporting delivery system transformation. Amerigroup will offer support through value-based payment and assistance by helping practices transform to patient-centered care.

Though there is growing broad-based support for a patient-centered care model, Amerigroup understands that this shift will not happen instantaneously. Rather, it 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 compensation for important clinical interventions that occur outside of a traditional patient encounter
- 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

The Enhanced Personal Health Care Programs (the Program) is built upon the success of patient-centered medical home (PCMH) programs around the country and fosters 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 PCPs and

¹ The Commonwealth Fund, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*. (June 16, 2014): <http://www.commonwealthfund.org>

² World Health Organization, *World Health Report* (2000): <http://www.who.int/en>

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.

This Program Description gives you important information regarding the operation of the Program, 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. Our intent is to provide you with an easy to understand description of the key elements of the Program. To that end, we have organized this Program Description into sections by topic as outlined in the Table of Contents.

If you have any questions or comments regarding this Program Description, email EnhancedPersonalHealthCare@Anthem.com. Your email request should include your name, provider organization name, tax ID and phone number with area code.

Program communications

In the recruitment packet you received for the Program, you were required to complete a Key Contacts Form. The email address you indicated for your provider organization on the form will be used as the method for communicating with you regarding Program changes, updates and activities. If you have an update to the email address used in the online form, you must send us the update request in writing. NO more than 20 business days after we receive your request, we will begin using your new email address. You will need to keep this information current with us to ensure you are receiving important Program related communications.

Important Information about Program Information, Resources and Tools

The information, resources and tools that Amerigroup provides to you through the Program should not be interpreted as directing or requiring any type of care or treatment decision on your part. 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 any non-Amerigroup resources and tools. We do not advocate the use of any specific product 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. 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 Attributed Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. If Attributed Members have any questions concerning their benefits, they may call the Member Services number listed on the back of their ID card.

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, accountable for substantially improving patient health, by making a significant investment in primary care that allows PCPs to do what they can do best: manage all aspects of their patients' care.
- Provide physicians with tools, resources and meaningful information that promotes (1) access, (2) shared decision-making, (3) proactive health management, (4) coordinated care delivery, (5) adherence to evidence-based guidelines and (6) care planning built around the needs of the individual patient, leading to improved quality and affordability for our customers and their patients.
- Redesign the current payment model to move from volume-based to value-based payment, aligning financial incentives and providing financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach and quality improvement.
- Improve the patient experience by:
 - Facilitating better access to a PCP who will not only care for the whole person but will become each patient's health care champion and help patients navigate through the complex health care system
 - Inviting patients' active participation in their health care through shared decision-making
 - Optimizing patient health

Scope

The Program applies to Amerigroup participating Represented PCPs and/or Represented Physicians, as applicable, who are in good standing, and who have signed or are covered under our Enhanced Personal Health Care Program Letter of Agreement (the Letter of Agreement [LOA]).

For the Program, PCPs are defined by the following specialties who maintain a patient panel:

- General Practice
- Family Practice
- Internal Medicine
- Pediatrics
- Geriatrics

In some cases, advanced nurse practitioners (NP) are considered primary care providers.

Section 2: Roles

The following information describes roles that are necessary within the provider's organization to support the Program.

Roles within your provider organization

Establishing roles within your provider organization to facilitate this process is also essential to forming a collaborative team. The recommended roles that are needed to assist with the provider organization transformation activities are as follows:

- **Provider Champion** – The Provider Champion is a physician, or in some cases an Advanced Practice Registered Nurse, in a leadership position in your provider organization who is the leader of your provider organization'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.
- **Practice Manager** – The Practice Manager is the individual in your provider organization who manages the day-to-day activities in a primary care office.
- **Care Coordinator** – The Care Coordinator is the individual in your provider organization who facilitates care coordination and care plan creation for patients.

Section 3: Care Coordination and Care Plans

Care coordination

This section is designed to help you understand care coordination expectations and additional requirements under the Program.

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as the *“deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.”*³ Proper care coordination should allow for seamless transitions across the health care continuum in an effort to improve outcomes and reduce errors and redundancies.

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.

Care coordination activities should invoke a holistic patient approach which includes:

- 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 records⁴
- Identification and referral of patients to internal Amerigroup programs and community resources

You must ensure that there are personnel supporting care coordination and care management in your provider organization. You are expected to develop and implement processes to ensure that Covered Individuals’ health care needs are coordinated by using a primary contact to effectively organize all aspects of care. Your designated primary contact collaborates with Covered Individuals, Covered Individuals’ caregivers and multiple providers during the coordination process.

³ *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination*, Structured Abstract. Publication No. 04(07)-0051-7, June 2007. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/caregapt.htm>

⁴ http://www.improvingchroniccare.org/downloads/executive_summary_reducing_care_fragmentation_.pdf

To support successful care coordination and care management within the Program, you must:

- Identify high-risk Covered Individuals with the support of Amerigroup reporting to ensure Covered Individuals are receiving appropriate care delivery services
- Facilitate planned interactions with Covered Individuals with the use of up-to-date information provided by Amerigroup to you
- Perform regular outreach to Covered Individuals based on their personal preference, which could include e-mail (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
- Adhere to a team-based approach to care, which drives proactive care delivery

Care plans

This Program Description 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 time frames for reevaluation
- Resources to be utilized, including the appropriate level of care,
- Planning for continuity of care, including transition of care
- Collaborative approaches to be used, including family participation

Care plan format and content

There is not a required template that must be used for the Program when creating a care plan. There are, however, critical assessments and domains that must exist within a care plan, but the care plan format varies based on your charting process and electronic capabilities. Whatever care plan format is used, it should fit into your current workflow, and not require duplicative documentation. Care planning should enhance the Covered Individual's treatment plan, and should provide a broader level of assessment than a standard patient history and physical to efficiently manage care. A sample care plan template and additional care plan information is available via the Provider Toolkit.

The minimum requirements for an initial care plan include:

- Activities that are *individualized* to the needs of the Covered Individual

- Information regarding the family, caregiver and/or patient involvement for specific activities for the purposes of collaboration and coordination of the plan of care
- Short-term and long-term patient-centric goals with interventions that are realistic for the Covered Individual's care
- Patient's self-management plan (also described on the following page), which includes:
 - A shared agenda for physician office visits
 - A list of activities to improve the health of the Covered Individual (developed in collaboration with the Covered Individual)
- Helpful information regarding relevant community programs (if any)
- Applicable resources that should be utilized (e.g., home health care, durable medical equipment, and rehabilitation therapies)
- Time frames for re-evaluation and follow-up
- A transition of care approach (for Covered Individuals discharged from a hospital) which includes:
 - Information on medication self-management
 - A patient-centered record owned and maintained by the Covered Individual
 - A follow-up schedule with primary or specialty care
 - A list of red flags indicative of a worsening condition and instructions for responding to them

Your provider organization team must also perform the following activities in connection with care planning:

- Update the Covered Individual's chart to include care plan goals
- Learn the status of such goals during office visits with Covered Individual
- Ensure the Covered Individual knows his/her role in self-management and what must be done after the visit
- Respond to any questions the Covered Individual may have about his/her treatment or medication plan
- Perform follow-up and monitoring as identified in the care plan

Maintenance of care plans must, at minimum, include the following:

- Detailed notes to indicate progress toward goals
- Updates and additions to scheduling, available resources, and roles and responsibilities
- An assessment of barriers to patients achieving their goals
- Modifications to initial/previous plan to adjust plan to progress level

Care plan assessment domains

Below is a suggested listing of assessment domains or functional areas to guide goal formation and related elements that could further support the identification of goals and interventions.

Domain	Informed choices
Element 1	Life Planning documents (DPOA, Living Will, Healthcare Proxy)
Element 2	Aggressive vs. palliative care – Hospice
Domain	Functional status and safety
Element 1	Personal Safety Plan (child proof/home safety/fall prevention).
Element 2	Level of independence/functional deficits
Element 3	Maximum functional status/functional status goal
Element 4	Cognitive function
Element 5	Support/caregiver resources and involvement
Domain	Condition management
Element 1	Care Gaps
Element 2	Understanding of Self-Management Plan
Element 2	Understanding of Condition Specific Action Plan/Monitoring Plan
Element 3	Understanding of Condition Red Alerts
Element 4	Pain Management
Domain	Medication management
Element 1	Medication reconciliation
Element 2	Polypharmacy
Element 3	Side effects
Element 4	Barriers to adherence
Domain	Prevention/Lifestyle
Element 1	Nutrition/Dietary Plan/BMI
Element 2	Smoking Status
Element 3	Preventive Care/Screenings/Immunizations/Flu Shot
Element 4	Alcohol/Drug Use
Element 5	Depression Screening
Element 6	Play/Stress Management Techniques
Domain	Barriers to care/Impact to Treatment Plan
Element 1	Cultural/language barriers
Element 2	Community Resource Availability
Element 3	Communication Impediments (Hearing/Vision Loss, unable to read, etc.)
Domain	Transitions of care/Access to care
Element 1	Care Transition Plan
Element 2	Participating Provider Network
Element 3	Optimal Site of Service
Element 4	Specialists/Other provider coordination

Identifying the need for care planning

Our goal is for a PCP to perform an annual comprehensive assessment on high-risk attributed patients to allow for early detection and ongoing assessment of their chronic conditions. The annual exam is a fundamental part of medical care and is valuable in promoting prevention practices, recognizing risk factors for disease, identifying medical problems, and establishing the clinician-patient relationship. This assessment can help your care team identify care planning and care coordination opportunities to improve the overall quality of patient care.

We provide access to clinical data to highlight opportunities for management of Attributed Members in an effort to improve patient outcomes. The “Hot Spotter Indicator” (as further described in the Reporting section of this Program Description) includes a listing of high-risk Attributed Members identified by analytic reporting as those who would benefit from development of a care plan.

Attributed Members who appear on the Hot Spotter Indicator will include those who have had an acute inpatient event and, based on predictive modeling algorithms, have been identified as being at high risk for readmission within the next 90 days, as well as Attributed Members who have one of the five core chronic condition diagnoses (as referenced further below).

Although we provide a list of Attributed Members who, through analytic reporting, have been identified as being at high risk and would most benefit by receiving a care plan, you will have additional real-time information from patient assessments that allows you to identify other high-risk Attributed Members.

Attributed Members who may be candidates for care planning may include those who:

- Have been diagnosed with complex medical conditions
- Are receiving treatment from multiple specialists, thereby requiring coordination of care
- Have complex treatment/management plans
- Are impacted by psycho-social concerns (e.g., lack of transportation, live alone, no family support)
- Have multiple chronic conditions or a chronic condition with evidence-based gaps in care (e.g. heart failure and inability to adhere developed treatment plans/medication regime or daily weight monitoring)
- Have a newly diagnosed chronic condition, such as asthma, diabetes, heart failure, COPD, or CAD
- Have co-morbid medical and behavioral health conditions
- Are taking multiple medications for health conditions

Comprehensive assessment

Accurate, uniform and in-depth assessment of high-risk individuals is instrumental in formulating a comprehensive, individualized care coordination plan. High-risk individuals are those who have at least one of the core chronic conditions, have a high readmission risk, a high prospective risk score and some gaps in care. These people would benefit the most by appropriate intervention

and an individualized care plan. Individualized care is the most cost-effective and successful approach to support the needs of the patient. Evidence has shown that it leads to effective and efficient use of health care services and improves the overall quality of patient care. The care team, along with the Attributed Member's family and/or caregiver should collaborate to develop an individualized care plan and review treatment goals at every visit. Incorporating the use of a comprehensive assessment form during each patient visit helps ensure that all of the Attributed Member's needs are addressed, and can help you identify and address chronic conditions that may otherwise go undiagnosed or untreated. The form allows for a thorough patient evaluation so that all the pertinent clinical areas are covered. You can find our comprehensive assessment form template by visiting the Provider Toolkit (as described in Section 4, *Program Requirements and Transformation*). This assessment is similar to the "welcome to Medicare preventive visit" you perform for your Medicare patients.

The advantages of performing a comprehensive patient evaluation include early detection of chronic conditions, gaps in care, and lapses in appropriate preventive services. A comprehensive evaluation will help you formulate the appropriate patient outreach plan. Reminders through mail or a phone call regarding annual screenings are examples of support patients may need from you.

Quality management, with individualized care, enables caregivers to evaluate the progress and determine the need for modification of an Attributed Member's current care plan, thus increasing the likelihood of the Attributed Member receiving the appropriate care. Early detection of conditions and changes in the Attributed Member's health status allows for early intervention, and can prevent the need for significant medical interventions such as hospitalization.

To better understand the health risks and other needs of Attributed Members and their families, provider organizations should perform comprehensive health assessments at least annually, with regular updates thereafter. A written summary of the plan of care should be provided to the patient, family and caregiver at the end of the face-to-face visit.

Comprehensive assessment documentation may include the following:

- Age and gender-appropriate immunizations and screenings
- Familial, social, and cultural characteristics
- Communication needs
- Medical history of Attributed Members and family
- Advanced care planning (not applicable for pediatrics)
- Behaviors affecting health
- Patient and family mental health and/or substance abuse
- Developmental screening using a standardized tool (not applicable for provider organizations with no pediatric patients)
- Depression screening for adults and adolescents using PHQ2, PHQ9 or other nationally recognized tool

Self-management support

Self-management support is a good opportunity for you to educate Covered Individuals on how they can take a greater role and level of responsibility for better health outcomes. “Self-management support is the assistance caregivers give 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.”⁵

You will need to encourage self-management through the following:

- Describing and promoting self-management by emphasizing the Covered Individual’s central role in managing his/her health
- Including family members in this process, at the Covered Individual’s discretion
- Building a relationship with each Covered Individual and family member
- Exploring a Covered Individual’s values, preferences and cultural and personal beliefs to optimize instruction
- Sharing information and communicating in a way that meets the Covered Individual’s and family’s needs and preferences
- Informing and connecting Covered Individuals to community programs to sustain healthy behaviors
- Collaboratively setting goal(s) and developing action plans
- Documenting the patient’s confidence in achieving goals
- Using skill building and problem-solving strategies that help the Covered Individual and family identify and overcome barriers to reaching goals⁶

⁵ Tom Bodenheimer, Helping Patients Manage Their Chronic Conditions, www.chcf.org , 2005

⁶ http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support_a_toolkit_for_clinicians.pdf

Section 4: Program Requirements and Transformation

The following section provides additional information on specific Program requirement and transformation resources for participating providers.

Patient engagement

One of the most important and fundamental requirements of the Enhanced Personal Health Care Program is the commitment to adopting a patient-centered care model. The core attribute of patient-centered care is actively engaging patients and their families in the care process. As discussed in the Introduction section of this Program Description, this means that the patient is the focal point of the health care system, and the patient and the patient's family members are active participants in the process. The first step to engaging your patients in the patient-centered model involves communicating to your patients your commitment to this model of care, what your patients can expect from your provider organization as a result of that commitment and how your patients can actively participate in the process as well.

We want to make the process of communicating this message to your patients as easy as possible. The Provider Toolkit (as described below) makes patient and family letter templates and other supporting information available to you to start a dialog with them. You can find these resources in the Patient-Centeredness subsection of the toolkit. You can also find useful brochures and information intended to help your patients understand your role in patient-centered care and the importance of their active participation as well. Effective and early communication with your patients will not only set the right expectations with your patient relationships, but will ultimately help achieve better health outcomes.

Practice transformation

Practice transformation is a discipline that incorporates quality improvement methodology and practice or organizational-level data to drive change that impacts quality, cost, and patient experience. In order to analyze reports to drive practice improvement, physicians participating in the Program are required to gain access to a series of web based tools and data platforms, including Availity (as referenced below).

Availity – Getting started with population management

As previously described, a core component of the Program is population health management and the sharing of health information. We will give you access to meaningful, actionable information about your patients who are included in the Program. Availity, a secure multi-payer provider portal, is our primary means of delivering that information. A list of the available reports is provided under Section 9 of this Program Description.

How do I get started?

If your organization has not yet registered for Availity, it's easy and free.

1. Go to www.Availity.com and click Register Now
2. Complete the online registration wizard.
Note: In order to expedite the registration process, please have your Primary Controlling Authority (PCA), a person who is authorized to sign on behalf of your organization, complete this registration wizard step.
3. Your designated Primary Access Administrator (PAA) will receive an email from Availity with a temporary password and information on next steps.

Registering for the Enhanced Personal Health Care Program

Registering your organization for access to the Enhanced Personal Health Care Reports is fast and easy and will need to be completed by the Primary Access Administrator for your organization.

1. Go to www.Availity.com and log in
2. Select *Account Administration* from the Availity menu
3. Select *Maintain Organization* – Please note: If the PAA is tied to multiple organizations, select the organization to proceed
4. Select *Enhanced Personal Health Care Enrollment Administration*
5. Verify your organization's information
6. Click Submit
7. You will be redirected to the Enhanced Personal Health Care site and will see Welcome to Enhanced Personal Health Care.
8. Select *Register/Maintain Organization*
9. Select the blue link to *Register Tax ID(s)* for the Program
10. A pop-up window will display the Tax ID(s) that will need to be registered for the Program
11. To register the Tax ID(s) the PAA must check the box and click Save
12. You now have successfully completed the Tax ID Registration; you will notice that after the registration has been completed, the status has changed from Register Tax ID(s) to Edit Tax ID(s) option
13. Log out
14. You should now be viewing the Availity Web Portal
15. Select *Verify Enrollment in Enhanced Personal Health Care*
16. You will then receive a pop up message stating the organization is currently registered
17. Close window

Availity user setup - To register users to access the Enhanced Personal Health Care Reports, complete these steps:

Adding a New User in Availity:

1. Select *Account Administration* from the Availity menu
2. Select *Add user* and proceed with setting up your new user for access
3. Select the check box for *Enhanced Personal Health Care* and click Register

Editing Roles in Availity:

1. Select *Account Administration* from the Availity menu
2. Select *Maintain User* and locate the user's account; click on the name of user
3. In the Roles column, click on *View/Edit*; a list of available roles displays
4. Select the check box for *Enhanced Personal Health Care* and click Save

Please note: If the user is logged into Availity when the PAA is assigning the Enhanced Personal Health Care role, the user will need to log out of Availity and log in again in order for the Enhanced Personal Health Care role assignment to take effect. This also applies to the PAA.

Users can then access the Program by clicking on My Payer Portals on the Availity left navigation bar and then selecting Enhanced Personal Health Care.

Enhanced Personal Health Care site user set up: To register users to access the Enhanced Personal Health Care Reports complete these steps below:

1. The PAA will log into Availity, click My Payer Portal. then Enhanced Personal Health Care
2. Verify Organization and click Submit.
3. Select Maintain User
 - Select the link for “New users available to be registered”
4. The PAA will select the group, the role that is appropriate for user needing access (e.g., to clinical reports, financial reports, or both clinical and financial) and Tax ID(s)
 - **Note:** PAAs must ensure that users are only provisioned access that is required to fulfill their specific business need

If you need further assistance with Availity, contact Availity Client Services at 1-800-282-4548.

Registry

The table below lists the additional requirements expected of Providers, including the expectations around your use of a patient registry. The information below provides you with the details you need to successfully use registry functionality in your practice to support the proactive management of your patient population and optimize the health of each patient.

Identifying the patient population is the backbone of, and essential to, an effective population-based care delivery system. Without identification of the patients included in the population, changes cannot be effectively achieved. It is for this reason that physicians participating in the Program are expected to utilize registry functionality to systematically maintain patient demographic and clinically relevant information based on evidence-based guidelines. To identify patients within the population of focus (as discussed earlier), you need to be able to access data that pertains to this group of patients. Program reports, as referenced in Section 9, and data accessed in our Provider Care Management Solution (PCMS) web tool can be used to identify and manage populations of patients. Active and systematic use of report data can be used to meet this Program requirement.

The tools used to collect and access information about a specific group of patients are often referred to as a registry. Since Program data can be analyzed, sorted and exported through our web-based reporting system, we are pleased to be able to provide you with a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, as well as generate reminders and guidance of the care of patients (both in groups and individually). In addition to Program reports, sample registries will also be available or discussed via the Provider Toolkit. Specific Program resources that can help to inform your implementation of a chronic disease registry include our Practice Essential curriculum.

Provider Toolkit

The Provider Toolkit, found on the Enhanced Personal Health Care website, serves to provide you with research and tools that will support your provider organization in your transformation activities. Information will be available to provide methods for enhancing your provider organization’s performance and quality, organizing your provider organization, establishing 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.

Program requirements

The table below identifies the additional requirements that are applicable to the Provider and Represented PCPs that agree to participate in the Program.

Requirements/Measurements applicable to provider and represented PCPs	
1	Provider and Represented PCPs will provide on-call coverage twenty-four (24) hours a day, seven (7) days a week to respond and provide direction to Covered Individuals regarding their medical needs. This provision specifically requires the Represented PCPs to ensure that he or she, or another PCP with whom the Represented PCP shares after hours call, is available after hours to address the emergent or urgent medical complaints and conditions of Covered Individuals, to inform Covered Individuals about their most cost-effective and medically appropriate treatment options, and to assess whether the best option is self-management, with a timely follow-up appointment, referral to urgent care or referral to an emergency room.
2	All Represented PCPs covered by this LOA must be in good standing with Amerigroup upon entry into the Program and prior to the implementation of the Incentive Program described in Section 8 of this Program Description and, after the Incentive Program is implemented, they must maintain such standing and achieve at least the minimum score on the Program metrics that is established by Amerigroup under the performance assessment program implemented by Amerigroup in conjunction with the Incentive Program and set forth in the Program Description. The quality measures included within the performance assessment program established by Amerigroup for

	the Incentive Program will be based on nationally endorsed quality measures such as those promulgated by the National Quality Forum (NQF) the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) or other recognized sources.
3	In order to demonstrate a commitment to third party validation of the transformation of Provider's practice to a patient centered care model, all Represented PCP practices are encouraged to achieve Level III NCQA Patient Centered Medical Home (PCMH) recognition (or similar recognition from a nationally recognized quality agency if other recognition becomes available) as described in Section 8 the Program Description, if such recognition has not already been achieved. If Represented PCP has or achieves Level III NCQA Patient Centered Medical Home (PCMH) recognition, they will to make best efforts to maintain at least that level of recognition as long as this Attachment remains in effect and Represented PCP practices participates in the Program.
4	Represented PCPs will refer Covered Individuals to the Amerigroup care management team for outreach efforts as more fully described in the Program Description.
5	Represented PCPs shall develop care plans as more fully described in the Program Description, and shall fully support and encourage the aligned care management and disease management activities of Amerigroup or the applicable vendor.
6	Represented PCPs and Provider will create dedicated care coordination and care management functions within the Provider's practice to manage the following responsibilities: (1) develop and manage established patient-centered care plans to assure that care plan Attributed Members are successful with the established care plan; (2) regularly review and recommend appropriate action upon information provided by Amerigroup from time to time regarding the panel of Covered Individuals attributed to each Represented PCP and to assure implementation of recommended actions; (3) coordination of care between specialists, hospitals, nursing home, and case managers; (4) Provider registry management to determine care opportunities; (5) outreach to patients including phone and email to ensure follow-up as allowed under applicable state regulation or state medical licensing requirements; self-management support and counseling; some behavior change management, case management, and disease management; (6) medication management; (7) documentation, data and reports management; (8) care plan follow-up; (9) outreach and care management for patients with chronic disease; and (10) ensure self-management support.
7	Provider, Represented PCPs and their collaboration team staff (as outlined in the Program Description) will make best efforts to participate in practice transformation activities.
8	Represented PCPs and Provider will use their best efforts to comply with nationally-recognized, evidence-based, preventative health and screening guidelines as well as guidelines relative to testing and monitoring as is required to monitor the health status of Covered Individuals with chronic conditions.
9	Represented PCPs and Provider shall use registry functionality to systematically maintain patient demographic and clinically relevant information based on evidence-based guidelines to effectively manage their patient population and support population health management. Provider agrees to proactively identify and outreach

	to patient populations in need of services or care management.
10	Represented PCPs will obtain access to and use the Availity website as part of the management of Attributed Members when these tools are made available by Amerigroup.
11	Whenever clinically appropriate, Represented PCPs will admit and refer Covered Individuals only to inpatient and outpatient Network/Participating Providers, and shall make referrals to, or otherwise utilize Network/Participating anesthesiologists for in-office and ambulatory surgery procedures, and shall use Network/Participating assistants and co-surgeons in all settings.
12	Whenever clinically appropriate, and unless a Covered Individual requests otherwise, Represented PCPs are encouraged to refer all Covered Individuals who require laboratory services, and send all laboratory specimens collected in their offices, to participating freestanding laboratory providers except where the laboratory services required by the Covered Individuals cannot be met by these laboratory providers. A list of participating freestanding laboratory providers, as revised from time to time is available on the Amerigroup website.
13	Whenever clinically appropriate, and unless a Covered Individual requests otherwise, Represented PCPs will encourage all Covered Individuals who need radiology or imaging services to use the services of participating freestanding radiology and imaging providers. A list of participating and imaging providers, as revised from time to time is available on the Amerigroup website.
14	Represented PCPs will prescribe generic medications when medically appropriate.
15	Represented PCPs will use their best efforts to reduce the frequency of unnecessary readmissions, such as by urging all of their Covered Individuals to call them whenever they are admitted to a hospital and immediately after their discharge or by working with hospitals at which they have admitting privileges to ensure such communications occur. Represented PCPs will work cooperatively with Amerigroup to reduce the frequency of unnecessary hospital admissions and readmissions through the care management activities described elsewhere in this table and the Program Description.
16	Represented PCPs will, when clinically appropriate, and unless the Covered Individual requests otherwise, encourage Covered Individuals who require surgeries or infusion services to use the services of office surgery and infusion suites that are Network/Participating Providers consistent with the clinical capabilities of the office location and industry standards.
17	Represented PCPs will support Amerigroup efforts to ensure that all hospital-based providers in the hospitals at which Represented PCPs maintain admitting privileges are Network/Participating Providers.
18	All Represented PCPs covered by this Attachment must be in good standing with Amerigroup upon entry into the Program and prior to the implementation of the Medicare Advantage Incentive Program that is described in Section 8. After the Medicare Advantage Incentive Program is implemented, they must maintain such standing and achieve at least an overall average weighted 4-Star rating on the Program metrics that are established by Amerigroup under the performance assessment program in conjunction with the Medicare Advantage Incentive Program and set forth

	in the Medicare Advantage Measurement Period Handbook. The quality measures included in the performance assessment program, established by Amerigroup for the Medicare Advantage Incentive Program will be based on nationally endorsed quality measures such as those promulgated by the NQF, NCQA and CMS or other recognized sources.
19	Represented PCPs and Provider will create dedicated care coordination and care management functions within the Provider's practice to manage the responsibilities as outlined in this table in order to assist with closing gaps in care provided to Medicare Advantage Attributed Members. Such gaps may be identified by Amerigroup (or an Amerigroup delegate), and sent to Provider for review and handling.
20	Represented PCPs and Provider will support Amerigroup efforts to ensure each Medicare Advantage Attributed Member is assigned the appropriate Hierarchical Condition Category (HCC) code.
21	Represented PCPs and Provider will support Amerigroup efforts to ensure each new Medicare Advantage Attributed Member completes a Health Risk Assessment within sixty (60) days from the time a Covered Individual is identified as a Medicare Advantage Attributed Member for the Provider.
22	Providers will cooperate and provide to [Legal Entity Title] within thirty (30) days of a request, made once annually, medical record documentation in the format requested by [Legal Entity Title] to support an annual HEDIS Medical Record Review project mandated to [Legal Entity Title] by the Centers for Medicare and Medicaid Services (CMS) at no charge to [Legal Entity Title]. Failure to provide requested records within thirty (30) days may result in a suspension of PMPM Payments until the time that all requested records are received, at which time the PMPM Payments will be re-implemented for the start of the next month.

Section 5: Quality Measures and Performance Assessments

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 under the Incentive Program. 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.

Measures

The Program scorecard is comprised of clinical quality measures as identified by CMS that align with the Medicare STARS Program. In addition to serving as a basis for Incentive Program savings 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 Gate can participate in the Incentive Program as described in Section 8, *Incentive Program-Medicare Advantage*.

The clinical quality measures included in the Program scorecard fall into two categories: (1) Standard Measures and (2) Enhanced Measures.

- *Standard Measures* are measures that use data that is readily available, widely used by all Providers, and provide a conclusive answer. These measures' results are derived solely on an evaluation of Claims. An example of a standard measure is Diabetes HbA1c. A review of Claims received for a given member with Diabetes during the Measurement Period will provide a conclusive answer if the test was performed during the timeframe.
- *Enhanced Measures* are measures that require documentation to be submitted on the claim in addition to standard CPT codes, and documented in the medical record. The additional information used to evaluate the measure can be attained by submitting CPTII or V codes on the member's claim that correspond with the members medical record. An example of an enhanced measure is Diabetes: blood sugar controlled. A review of Claims received for a given member with Diabetes during the Measurement Period requires the inclusion of the CPT II code that identifies the members' HbA1c level. The enhanced measures serve as a bonus opportunity to increase your overall shared savings potential, and will not reduce your shared savings potential if not achieved. The use of CPT II codes is further explained in the Medicare Advantage Measurement Period Handbook.

Medicare Advantage Measurement Period Handbook

Amerigroup is committed to providing you with details on quality measures and scoring methodology for the Medicare Advantage Program in advance of the start of each Measurement Period (as defined in Section 8, *Incentive Program- Medicare Advantage*) in the Medicare

Advantage Measurement Period Handbook (“MA Handbook”). As mentioned above, the measures for the Medicare Advantage Attributed Members are selected by Amerigroup based on STARS measures developed by CMS. The MA Handbook will be made available to you as soon as administratively possible after CMS publishes the annual STARS measures and prior to the start of each Measurement Period. The delivery of the Measurement Period Handbook is dependent on CMS development and release of annual STARS measures. The MA Handbook will provide quality indicator definitions and measurement specifications on the Standard and Enhanced Measures as well as detailed information on the scoring methodology. Performance benchmarks will be available on the Scorecard in PCMS at the start of your Measurement Period.

If, upon receipt and review of the MA Handbook, you determine you no longer desire to participate in the Program, you must notify Amerigroup in writing within 30 days after the date the MA Handbook was sent, unless otherwise communicated to you by Amerigroup. If such notice is given, the Letter of Agreement shall terminate, your participation in the Medicare Advantage Program will end on the date communicated to you by Amerigroup, and the MA Handbook will never apply to you. If you do not provide such notice, the Letter of Agreement shall remain in effect, and the MA Handbook shall be deemed to have been accepted by you, and shall become effective and binding on the first day of the Measurement Period.

The provisions of this section entitled “Medicare Advantage Measurement Period Handbook” shall be effective, enforceable and implemented, notwithstanding any conflicting or contrary provision (including provisions relating to amendments or Program termination) contained in the LOA and this Program Description. To the extent that different notices or time-frames other than described above are required by law, then the provisions of law shall supersede the contractual provisions of this section.

Medicare Advantage performance assessment

Performance on the selected Program clinical quality measures will be reported to you throughout the year. The assessment of performance will determine the proportion of shared savings that you earn and will be conducted annually. Performance on the clinical quality measures will be calculated specific to your organization.

The clinical quality scoring will be based on performance relative to quality thresholds as set by Amerigroup. The quality threshold will be based on CMS STAR quality levels four and five, and determined by Amerigroup. Better performance will generate a better score and correspond to a higher percentage of shared savings.

Quality Gate

A minimum threshold of performance on clinical quality measures must be met for you to have the opportunity to earn a portion of the shared savings. The thresholds are set at a four Star level, aligning with the STARS quality program. In order to participate in shared savings, your practice must achieve an overall weighted four star rating in quality performance. Further explanation of the quality measures and the scoring methodology are described in the MA Measurement Period Handbook.

Other Amerigroup Quality Incentive Programs

Unless otherwise indicated, the Program will replace and supersede any other quality incentive programs currently in place with the exception of the Quality-In-Sights®: Hospital Incentive Program (Q-HIP). For services on or after your Program LOA Effective Date, adjustments in fee schedule or payment increases of any type resulting from your participation in any type of quality incentive programs will no longer apply or be paid. Instead, the reimbursement opportunity associated with the Program will be in effect.

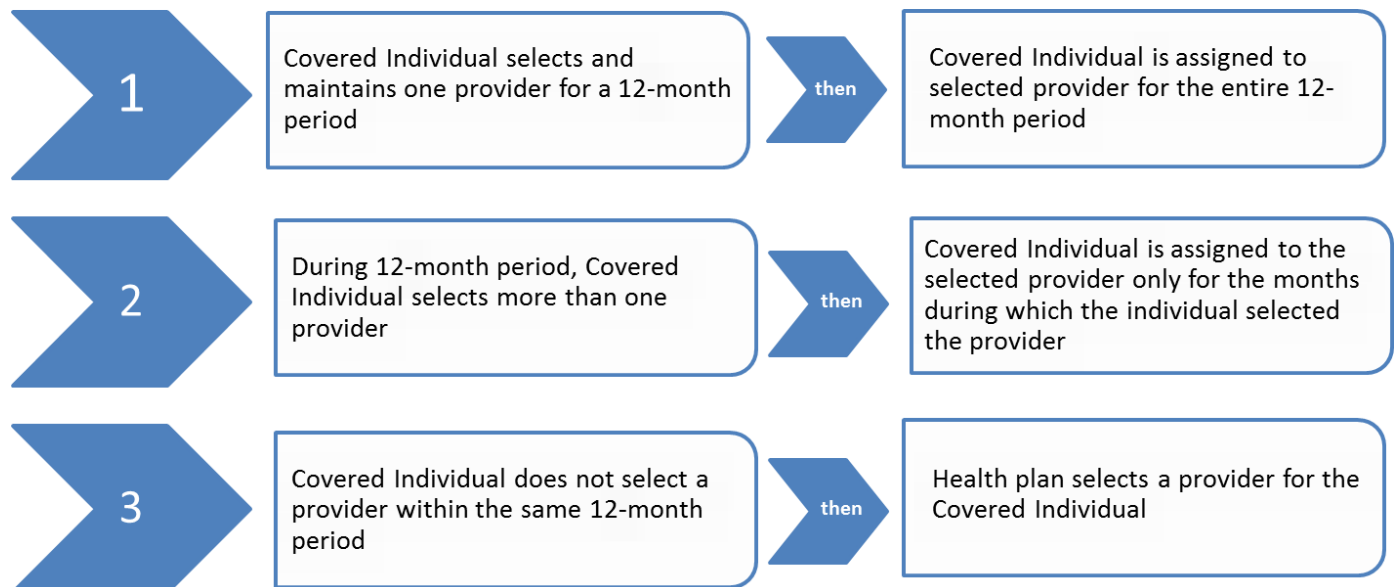
Section 6: Attribution Process

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. 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.

In some cases, 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. Therefore, certain employer groups or Covered Individuals may be excluded from the Program at the sole discretion of Amerigroup. Covered Individuals whose Amerigroup coverage is secondary under applicable laws or coordination of benefit rules or which is provided under a supplemental policy (e.g., Medicare supplement) shall never be Attributed Members. It is our goal to continue to expand the Covered Individuals included in monthly attribution report as operationally feasible and contractually permitted.

Attribution where covered individuals select a PCP

For HMO Products, the following decision framework is generally used to assign Covered Individuals to PCPs. In this scenario, a Covered Individual must have at least 1 active month with the selected PCP:



Section 7: Clinical Coordination Reimbursement

Overview

The Clinical Coordination Reimbursement is a per member per month (PMPM) amount paid to primary care providers for the clinical services they provide outside of a traditional office visit. This includes the clinical activities outlined in Section 3 of this Program Description such as:

- Coordinating patient care
- Preparing care plans
- Maintaining registries
- Providing patients with self-management support
- Performing follow-up with patients regarding care

Note: Depending on local regulatory requirements and/or existing contractual arrangements, the Clinical Coordination Reimbursement does not apply to all participating practices. In addition, when payable, the PMPM amount may vary by market and program.

Payment process

The Clinical Coordination Reimbursement will be paid for applicable Attributed Members as outlined in the Letter of Agreement based on their eligibility and subject to retroactive adjustments, which in most cases will not exceed 3 months. Clinical Coordination Reimbursements are not prorated for partial months; rather, an eligibility snapshot is taken on the 15th day of the month. For Attributed Members added on or before the 15th day of the month, the entire fee is payable regardless of the date added. For Attributed Members added after the 15th day of the month, no payment will be made. Likewise, for Attributed Members deleted on or before the 15th day of the month, no amounts will be payable. The Clinical Coordination Reimbursement will be payable if an Attributed Member is deleted after the 15th day of the month. By way of example, if an Attributed Member becomes eligible on the 14th day of the month, the entire Clinical Coordination Reimbursement will be payable for that Attributed Member. Similarly, if an Attributed Member is deleted on the 14th day of the month, the Clinical Coordination Reimbursement will not be payable for that member for that month.

Retroactivity

On a monthly basis, Amerigroup will confirm that all previously identified Attributed Members remain Covered Individuals and are appropriately designated as Attributed Members. The PMPM payment will apply only to those Attributed Members who are Covered Individuals and who Amerigroup determines were appropriately designated as Attributed Members. Retroactivity for Attributed Member additions, terminations and/or changes will typically be no more than ninety (90) days unless otherwise required by a specific line of business, employer group or other entity that is covered under the terms of this Letter of Agreement or by a provision of law. Such retroactive adjustments will be applied at the Program level.

Per member, per month reimbursement

In the first month of the effective date of the LOA, Amerigroup will begin to administer per member per month (PMPM) payments to your practice for Medicare Advantage Attributed Members. This PMPM payment will be in addition to any other payments made under the Agreement or this Program.

The PMPM payment will reimburse you for practice transformation activities under the Program, including those outlined in the Requirements Table in Section 4 of this Program Description. This PMPM payment amount will be determined by adjusting an initial PMPM base rate of \$3.00 by an average of Hierarchical Condition Code (HCC) risk scores for Provider's Medical Panel (as defined in the Program Description) assigned by CMS to Medicare Advantage Attributed Members based on the diagnosis codes submitted on the Medicare Advantage Attributed Member Claims and verified by CMS on an annual basis. The following steps outline the process that will be used to calculate the PMPM payment amount. Examples accompany these steps for illustrative purposes.

1. The average HCC risk score for the Medical Panel is identified based on the most recent HCC risk scores received by Amerigroup from CMS in the file received from CMS in July of each year, dependent on CMS for delivery. Example: A given Medical Panel includes 30 practices. The average risk score across the 30 practices is 0.90.
2. The average HCC risk score for the Medical Panel is multiplied by the base rate to determine the PMPM payment amount. Example: The average HCC risk score for the Medical Panel of 0.90 is multiplied by the base rate of \$3.00 to determine the PMPM payment amount ($0.90 \times \$3.00 = \2.70) of \$2.70.
3. On a monthly basis, Provider is paid the PMPM payment amount of \$2.70 for each Medicare Advantage Attributed Member. Example: A provider in the Medical Panel has 400 Medicare Advantage Attributed Members, and therefore the monthly payment amount ($\$2.70 \times 400 = \$1,080$) is \$1,080.

Section 8: Incentive Program

Overview

By participating in the Incentive Program, you become accountable for the cost and quality outcomes of your Attributed Members. In order to ensure the statistical validity of calculations under the Program, and to create a learning environment to assist in sharing of best practices, participating physicians will be organized into Medical Panels (defined below) under rules established by Amerigroup. The rules regarding the formation of Medical Panels as well as the role of the Medical Panel in the administration of the Program are described in more detail in this section. The Incentive Program differs based on the line of business. These differences are outlined in the sections below.

Incentive Program

As described in greater detail below, and subject to the Incentive Program terms and details for Medicare Advantage business, Amerigroup will compare the annual Measurement Period Medical Loss Ratio (MPMLR) (as defined below) to a Medical Loss Ratio Target (MLRT) (as defined below) in each MA Measurement Period to determine whether the MPMLR is less than the MLRT (subject to Program details described below). If the MPMLR is less than the MLRT, you may share in a percentage of the savings realized, provided that you meet the Quality Gate (as described in Section 5, Quality Measures & Performance Assessment).

The Medicare Advantage Incentive Program rewards Providers for the quality care they provide to Amerigroup Medicare Advantage Attributed Members and for cost savings due to efficiency improvements. The incentive is primarily based on measures selected by CMS for the Medicare Advantage Star Rating Program. The objectives of the incentive are to improve targeted clinical quality results, promote quality, safe and effective patient care, and increase preventive care services for Medicare Advantage Attributed Members. If the Quality Gate (as defined in the Medicare Advantage Measurement Period Handbook which is referenced in the Program Description) is met, and shared savings are achieved, Provider will receive additional payments as outlined below.

Notwithstanding any provision to the contrary contained in this Program Description or the LOA, any and all payment amounts due under a shared savings only arrangement to Provider or Represented Providers hereunder in connection with the Medicare line of business shall not exceed at the Substantial Financial Risk Limit (as defined in the Program Description).

If all terms have been satisfied for a Measurement Period, Amerigroup will make payment to providers for a portion of any net aggregate savings earned during the Measurement Period associated with Provider's Attributed Members, subject to all other applicable terms and limitations contained in the Program Description.

The Medicare Advantage Incentive Program terms and details are described below.

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.

Annual Determination Period – The two-hundred eighty-five (285) day period of time immediately following the end of the MA Measurement Period, during which Amerigroup will calculate the MPMLR and compare it to the MLRT to determine the amount of any Gross Savings or Gross Loss during the MA Measurement Period.

Attributed Members – Those Covered Individuals who are attributed to the Represented PCPs or Represented Physicians, as applicable, for the purposes of the Enhanced Personal Health Care Program using the Attribution Methodology.

Gross Loss – The dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is greater than the MLRT, as calculated by Amerigroup following an MA Measurement Period.

Gross Savings – The dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is less than the MLRT, and multiplied by the Premium paid to Amerigroup as calculated by Amerigroup following an MA Measurement Period.

Incentive Program – The opportunity for PCPs to increase their revenue as they participate in the Enhanced Personal Health Care Program. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance criteria. A complete description of the Incentive Program is in the Program Description.

Incurred But Not Reported (IBNR) – A reasonable factor applied to the paid medical expenses within MPMLR for the MA Measurement Period to adjust for any Claims that have been incurred but not yet reported. The IBNR factors will be based on Amerigroup historical paid Claims experience, and will be developed by Amerigroup on an actuarially sound basis.

LOA – Abbreviated reference to the Program Letter of Agreement or the Enhanced Personal Health Care Letter of Agreement of the contractual document the Provider signs to participate in the Enhanced Personal Health Care Program. This Letter of Agreement is an amendment to the physician's Provider Agreement with Amerigroup.

Measurement Period Medical Loss Ratio (MPMLR) – The percent calculated by Amerigroup that is based on Total Medical Expense divided by Premium during a MA Measurement Period (see formula below). The MPMLR calculations for shared savings will include the application of an IBNR factor. For purposes of MPMLR calculations, inpatient Claims will be assigned to the MA Measurement Period during which the inpatient admission date occurred, rather than the discharge date. MPMLR is calculated after the MA Measurement Period has ended, and is

compared to the MLRT to determine whether shared savings have been demonstrated under the Program. For Providers opting for Stop Loss, the dollars above the Stop Loss Deductible for Medicare Advantage Attributed Members will be excluded from Total Medical Expense and the Stop-Loss Expense will be added to Total Medical Expense. The MPMLR is calculated using the following equation:

$$MPMLR = \frac{\sum Total\ Medical\ Expense_{Measurement\ Period}}{\sum Premium_{Measurement\ Period}}$$

Medicare Advantage Measurement Period(s) [MA Measurement Period(s)] – The twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Amerigroup and the Provider. The Medicare Advantage Measurement Period(s) for Provider’s participation in the Program is set forth in Medicare Advantage Measurement Period Handbook. The Measurement Period may be shortened in the initial year of the program. If the Measurement Period starts after the first of a given year, that Measurement Period will still commence on 12/31 of that given year, and the subsequent Measurement Period will start on the first day of the following year.

Medical Loss Ratio Target (MLRT) – The MLR target percentages determined by Amerigroup. The MLRT will be identified in the MA Handbook.

Medical Panel – A single provider organization or a grouping of multiple provider organizations by Amerigroup for purposes of calculating statistically meaningful MPMLRs and shared savings. Further details regarding Medical Panels are provided below under Medicare Advantage Medical Panels.

Member Population – The group of Medicare Advantage Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Amerigroup products(s) will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Amerigroup).

Member Months – The number of the Medicare Advantage Member Population’s full attributed months enrolled in the applicable Amerigroup products during a MA Measurement Period.

Net Aggregate Savings – Definition as set forth in section (e) below (under Medicare Advantage Incentive Program Terms and Details).

Premium – The total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Amerigroup for the Member Population under a Amerigroup Health Benefit Plan during a MA Measurement Period less any Part B rebates payable or credited for any Medicare Advantage Attributed Members within the Member Population, less any taxes levied by the Affordable Care Act, less any cost and reinsurance subsidies, and less any other amount otherwise offset against or deducted from amounts payable by CMS to Amerigroup with respect

to the Member Population during such MA Measurement Period, exclusive of any Retroactive Addition Amount or Retroactive Deletion Amount, for such Medicare Advantage Member Population for the same MA Measurement Period.

Paid/Allowed Ratio – The ratio of paid dollars (dollars paid by Amerigroup to providers) to allowed dollars (total dollars paid by Amerigroup plus Cost Shares payable by Covered Individuals) for Covered Services incurred during a Measurement Period, excluding Covered Individuals with certain transplant or high cost Claims amounts.

Quality Gate – The minimum quality standards that Provider must achieve in order to retain any shared savings. It is understood that for purposes of determining whether the Provider passed the Quality Gate for a MA Measurement Period, such determination shall be based on the Medicare scorecard which is measured based on the Medicare Advantage line of business. The Quality Gate for the Program requires a minimum of a four Star level rating for any measures in the Standard and Enhanced Composites.

Quality Targets – Quality performance targets, referenced in Section 5 of the Program Description and the MA Handbook, used to determine the percentage of shared savings under the Incentive Program.

Retroactive Addition Amount – The total of all amounts paid or credited by CMS to Amerigroup for any Medicare Advantage Attributed Members who were retroactively assigned to the Provider during the MA Measurement Period, as applicable.

Retroactive Deletion Amount – The total of all amounts repaid by Amerigroup to CMS or otherwise offset against or deducted from amounts payable by CMS to Amerigroup for any Medicare Advantage Attributed Members whose assignment to the Provider was retroactively deleted during such MA Measurement Period.

Shared Savings Percentage – The percentage of shared savings under the Program to which Provider is determined to be entitled after all other applicable adjustments have been made to the Shared Savings Potential based on the Quality Target scores as shown in the Program Description and the MA Handbook. The Shared Savings Percentage can be the same percent as the Shared Savings Potential if all Quality Targets are fully achieved by Provider under the Program. The Shared Savings Percentage will be less than the Shared Savings Potential if any Quality Targets are not achieved by Provider under the Program.

Shared Savings Potential – The maximum percentage of shared savings under the Shared Saving Program to which Provider may be entitled, as delineated in the MA Handbook. The Shared Savings Potential percent shown in the MA Handbook is subject to the performance adjustments described in this Program Description and in the MA Handbook.

Stop Loss – A methodology that will be incorporated into the Total Medical Expense calculation designed to afford protection to the Provider against the impact under this Agreement of certain high-dollar Claims. For any Arrangement for which Provider is at Substantial Financial Risk, as

such term is defined in 42 CFR 422.208(a), such Stop-Loss methodology shall meet all requirements set forth in 42 CFR 422.208(f). Should the Provider experience a decrease in their attributed membership level throughout the term of this Agreement, the Provider shall remain compliant with the stop-loss deductible levels set forth in 42 CFR 422.208.

Stop-Loss Credit – The Claims amounts in excess of the Stop Loss Deductible.

Stop Loss Deductible – The defined dollar threshold that must be reached, on a per member per year basis, before a Stop-Loss Credit is applied to the calculation of Total Medical Expenses. The Stop Loss Deductible is determined by the Medicare Advantage Member Population attributed to the Provider as follows:

Member Population	Per Member Deductible
1-1,000	\$6,000
1,001-5,000	\$30,000
5,001-8,000	\$40,000
8,001-10,000	\$75,000
10,001-25,000	\$150,000
>25,000	None

Stop Loss Expense – The per member per month amount determined by taking the actual total amount of Claims in excess of the Stop Loss Deductible across all Amerigroup Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period, divided by the total Member Months across all Amerigroup Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period. The Stop-Loss Expense is included as part of the Total Medical Expenses Calculation.

Substantial Financial Risk – Occurs if the percentage of the Shared Savings Percentage that is based upon referral services exceeded the maximum risk percentage threshold specified by CMS in 42 CFR Section 422.208 of the total compensation due to Provider and Represented Providers. This calculation does not include compensation or payment of any kind that is not based upon the use of referral services, such as quality of care furnished, patient satisfaction or committee participation. For purposes of this definition, referral services shall mean any specialty, inpatient, outpatient, or laboratory services that Medicare Advantage Attributed Members receive, but are not furnished directly by Provider or Represented Providers.

Substantial Financial Risk Limit – The total incentive-based payments to the Provider from Amerigroup, inclusive of payments under the Agreement, are limited to no more than 25 percent of the total reimbursement the Provider and Represented Providers receive from Amerigroup for direct services delivered to Amerigroup Medicare Advantage Attributed Members during the applicable MA Measurement Period year.

Total Medical Expenses – The costs incurred by Amerigroup for payment of all Covered Services (including hospital, medical, pharmacy and non-hospital) provided to each Medicare Advantage Attributed member by all providers (participating and non-participating, and including Provider

and its PCPs) furnishing such services to Medicare Advantage Attributed Members, adjusted by the Stop-Loss Expense and Stop-Loss Credit where appropriate. Total Medical Expenses include:

- Claims, capitation and PMPM reimbursement, where applicable, incurred during the MA Measurement Period, paid through a three month Claims run-out period.
- Plus a reasonable amount for IBNR
- Plus the Stop-Loss Expense (if included)
- Minus the Stop-Loss Credits (if included)
- Plus the costs associated with supplemental benefits
- Plus payment made by Amerigroup and/or an Amerigroup vendor for gap closures and/or health risk assessments.

For purposes of MPMLR calculations, inpatient Claims will be assigned to the time period in which the inpatient dates of admission occurred.

Medicare Advantage Incentive Program terms and details

Shared Savings Potential

The Shared Savings Potential as defined above will be communicated to Provider by Amerigroup prior to the start of the MA Measurement Period in the MA Handbook. The Shared Savings Potential percentages are subject to the performance adjustments described in this Incentive Program.

Shared Savings determination

Shared Savings will be calculated by Amerigroup as follows:

- During the Annual Determination Period, Amerigroup will determine the Medicare Advantage Attributed Members' Premium and Total Medical Expense and calculate the MPMLR.
- Amerigroup will compare Medical Panel MPMLR to MLRT. If the Medical Panel's MPMLR is below the MLRT, then Gross Savings will be calculated.
- Each Provider Group's Gross Savings will be calculated by multiplying the difference between the MPMLR and the MLRT by the total of all Premiums paid to Amerigroup for their Medicare Advantage Attributed Members during the MA Measurement Period.
- If Gross Savings are achieved and the Quality Gate is met, then the Shared Savings Percentage is determined based on provider's performance on the Quality Targets, as determined annually by Amerigroup.
- To determine the Net Aggregate Savings, the Shared Savings Percentage is multiplied by the Gross Savings, as demonstrated in the example below in Step 5.
- The Net Aggregate Savings will be limited by the Substantial Financial Risk Limit of 25 percent to determine final Net Aggregate Savings payment amounts.

Shared Savings cannot exceed the Substantial Financial Risk Limit.

For a basic Medicare Advantage Incentive Program calculation example, see the calculation below:

Multi-Provider Panel Shared Savings Payout Example	Group A	Group B	Group C
Number of MA Attributed Members	500	900	300
Target MLR (MLRT)		85%	
MP MLR		83%	
MP MLR - MLRT =		2%	
TOTAL premium for MA membership	\$5,400,000	\$6,480,000	\$3,600,000
Gross Shared Savings per provider group	\$108,000.00	\$129,600	\$72,000.00
Max Shared Savings Potential		50%	
Max shared Savings Payout	\$54,000	\$64,800	\$36,000
% Earned in Quality from Scorecard	45%	35%	40%
Maximum % of Shared Savings Earned	90%	70%	80%
Shared Savings Payout	\$48,600	\$45,360	\$28,800

**Medical Panel Level*

1. In the above example, three Provider Groups are combined into a Medical Panel for the purpose of calculating a statistically meaningful MPMLR.
2. In this example, the Medical Panel's MLRT is set to 85 percent for the initial MA Measurement Period.
3. The Medical Panel's MPMLR is compared to the Medical Panel's MLRT. In the event that the MPMLR is less than the MLRT, the Providers' Gross Savings can be funded.
4. Each Provider Groups' Gross Savings is the result of the MLRT minus the MPMLR, multiplied by the Premiums paid to Amerigroup for the Provider Groups' Medicare Advantage Attributed Members for the MA Measurement Period. In the example above, the MLRT minus the MPMLR is 2 percent. The Providers Gross Savings is for Provider Group A is 2 percent multiplied by the total Premium of \$5,400,000.00 which is equal to \$108,000.00.
5. In the above example each group has the potential to earn 50 percent of the shared savings that are demonstrated in the MA Measurement Period, after meeting the Quality Gate. The actual Shared Savings Percentage is a function of the group's performance on the Quality Targets. In the above example, Provider Group A earns 45 percent of the Gross Savings as a result of their performance on the Quality Targets as shown on the Medicare Advantage scorecard. As a result, Provider Group A earns 45 percent of the Gross Savings of \$108,000.00, which is equal to \$48,600.00.
6. To estimate the impact of the Provider Group's savings payout relative to their Substantial Financial Risk Limit, each group's shared savings payout is divided by its annual paid dollars received from Amerigroup. For Provider Group A, we will use \$450,000 as the annual amount received from Amerigroup and divide it by the \$48,600.00 earned in shared savings to assure that the amount is not greater than 25 percent (the Substantial Financial Risk Limit). In this case, the shared savings is 10.8 percent and does not surpass the 25 percent limit.

Adjustments to MLRT and MPMLR

Medical Loss Ratio Target (MLRT) and Measurement Period Medical Loss Ratio (MPMLR) amounts are calculated based on certain tools and information provided to and available to Amerigroup at specific points in time (e.g., cost experience of Member Population, Premium data, etc.). In the event that any such tools or information are updated, modified or clarified (collectively, the Modifications) in a way that Amerigroup reasonably deems to materially change the calculation of the MLRT or MPMLR, then the parties agree that Amerigroup shall have the right to adjust the MLRT or MPMLR, as applicable, to the extent necessary to account for the Modifications without the need for an amendment to the Agreement. In such an event, Amerigroup will notify you as to the adjusted MLRT and/or MPMLR and the reason for the adjustment. As an example, if new information is discovered (not previously available to Amerigroup) concerning the claims that were used to derive the MLRT, and such new information has a material impact on the MLRT, then an appropriate adjustment may be made to the original MLRT by Amerigroup.

After the initial year in the program, the Medical Panel's MLRT will be evaluated and may be adjusted before the start of each subsequent MA Measurement Period. The final MLRT for each MA Measurement Period will be defined in the MA Handbook.

Upside Shared Savings payment

Assuming all preconditions and terms have been satisfied, on an annual basis, after the end of the relevant MA Measurement Period, Amerigroup shall make any applicable distribution payment to Provider for any Net Aggregate Savings earned during the MA Measurement Period associated with its Medicare Advantage Attributed Members. Based on a Provider's performance, Amerigroup may choose to make interim advance payments to the Provider of its share in Net Aggregate Savings. The Provider must be participating in the Program during the entire MA Measurement Period in order to receive savings amounts under the Incentive Program.

Except as specifically agreed otherwise by the parties, payments for earned Net Aggregate Savings will follow the current payment methods 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 for such savings amounts.

Maximizing your savings goals

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

- Establish a process to review your organization's performance on a regular basis. We will provide you with useful reports that show quality and cost information over time. These reports should be reviewed and discussed on a regular basis to determine how your organization is progressing toward established benchmarks and targets.
- Leverage tools that are available to your organization. Our learning collaborative, and the Provider Toolkit, are just a few ways you can access information on methods for quality improvement.

Medicare Advantage Medical Panels

The Program introduces the concept of the Medical Panel to encourage broad-based provider organization participation across markets while ensuring that patient access needs are met and physician performance assessment is statistically valid. The Medical Panel structure will support collaborative learning and community accountability for quality and affordability. As mentioned earlier in this section, Medical Panels will also serve as the basis for establishing a MPMLR.

Formation of Medical Panels

Medical Panels can be composed of individual physician practice or a group of practices. Prior to the MA Measurement Period start date, Amerigroup will assign Medical Panels for participating practices, and this information will be available on the secure provider website. You will have an opportunity to review your Medical Panel assignment at that time. You will remain in your assigned Medical Panel for the duration of the MA Measurement Period.

General parameters for Medical Panels

Provided below are *general* parameters related to the formation of Medical Panels under the Program.

- A single physician group with more than 1,500 Medicare Advantage Attributed Members will form its own Medical Panel.
- Physician groups with Medicare Advantage Attributed Member populations less than the minimum level set by Amerigroup may form Medical Panels with other participating physician groups. Prior to the start of the MA Measurement Period, assigned Medical Panels will be posted on our provider website. Each Medical Panel that is comprised of multiple practices must meet or exceed the 1,500 minimum number of Medicare Advantage Attributed Members. Amerigroup will make final Medical Panel decisions and the final list will be shown on the provider website.

When multiple physician groups may make up a Medical Panel, quality performance will be evaluated at the physician group level, and MPMLR will be calculated at the Medical Panel level to determine the Shared Savings Percentage achieved. If one provider group represents a Medical Panel, both quality performance and MPMLR will be calculated at the single group level.

Section 9: Reporting

A fundamental building block of the Program is Provider Care Management Solutions (PCMS), Amerigroup web-based reporting platform. Through alerts, dashboards and reports, PCMS supports both population management as well as Program-specific financial performance management. 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. To support performance management, PCMS 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 currently plan to make available to you is below.

Population management

Attributed patients

You will have access to detailed information about your patients who are Attributed Members and have the ability to filter your Attributed Member list by condition type, risk drivers, visit type, care opportunities, associated organization, etc. The available Attributed Member details are listed below.

- Demographic(s)
- Attributed provider
- Attributed organization
- Attributed Member prospective risk score
- Number of care opportunities and corresponding details
- Number of related conditions and condition details
- Number of visits and corresponding details
- Within the Attributed Patient's dashboard, you have the ability to view your high-risk hot spotter Attributed Members, new Attributed Members and Attributed Members with recent inpatient authorizations. An overview of these views is provided below.

Hot spotter chronic conditions and hot spotter readmission views

PCMS gives you the ability to identify Attributed Members who may benefit from a care plan. This drill-down view targets certain high-risk Attributed Members with specific chronic diseases, as well as Attributed Members with a recent inpatient admission who are at high risk for readmission. You will also be able to view targeted risk drivers associated with each Attributed Member's hot spotter status.

New Patient view

All Attributed Members who first appear in PCMS will be displayed in the New Patient view; Attributed Members will remain on this list for a period of 30 days. Here, you will be able to view each Member's attribution date and their associated attribution method.

Inpatient authorization view

You will have the ability to identify Attributed Members who have been recently authorized for an inpatient admission and their risk for readmission; Attributed Members will remain on the list from the time admission is authorized through 30 days post-discharge. Details include:

- Inpatient facility name
- Length of stay
- Admission date
- Discharge date
- Admitting diagnosis
- Readmission risk

Emergency room visits view

This view lists your Attributed Members with emergency room (ER) visits, categorizing frequent fliers and offering information around unnecessary ER avoidance opportunities, with the ability to view each member's admission date, facility name and diagnoses. You will be able to further filter the member list by the following categories:

- Visit frequency
- Visit date range
- Organization

Care opportunities dashboard

This dashboard identifies Attributed Members with care opportunities, that is, active or upcoming (due in 30 or 60 days) gaps in care associated with clinical quality metrics referenced in Section 5, Quality Measures & Performance Assessments. The dashboard summarizes care opportunities at the condition level, and then offers drill-down capabilities into specific measures, with provider and member detail. Selecting a member from this dashboard will provide the following details:

- Open care opportunities as well as completed opportunities
- Last compliance date for each care opportunity
- Clinical due date for each care opportunity
- Status (past due, due in 30 days, due in 60 days, completed) for each care opportunity

Inactive patients

You will have access to detailed information about your inactive Attributed Members, that is, those Attributed Members who used to be attributed to you, but are no longer (e.g., individual changed health plan, individual is attributed to a different Provider). The inactive Attributed Member details available to you are listed below.

- Demographic(s)
- Attributed provider
- Attributed organization
- Months attributed
- Attribution end date
- Attribution end reason

Performance management

Performance summary

This summary provides key metrics reflecting your group's savings performance, scorecard performance, and the resulting estimated shared savings payout. The summary offers the ability to drill into the cost details of your savings performance and the underlying quality and utilization details of your performance scorecard. Of note, the performance information will differ by line of business (e.g., commercial versus Medicare).

Scorecard

View your earned contribution percentage based on your quality performance against Program benchmarks here. You can drill down to measure level performance details, with the ability to differentiate provider performance and also identify specific Attributed Members who are noncompliant and in need of an intervention.

Report registration and questions

If you have questions regarding PCMS, 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 organization name
- Your provider organization's tax identification number (or provider identification number)
- Name, date and details of view(s)
- Description of issue or question

Section 10: Glossary

If there is a conflict between any definition below and the same definition in the Letter of Agreement, then the definition in the Letter of Agreement shall be controlling and shall be applicable to throughout this Program Description.

Glossary Term	Definition	Source
Attributed Members	Those Covered Individuals who are attributed to the Represented PCPs or Represented Physicians, as applicable, for the purposes of the Enhanced Personal Health Care Program using the Attribution Methodology.	Program Description
Attribution Methodology	<p>A process whereby Amerigroup will assign Covered Individuals to the Represented PCPs or Represented Physicians. The process is based on the formal selection of a PCP by the Covered Individual; or</p> <p>Provider agrees and acknowledges that such assignment of a Covered Individual to a PCP or Represented Physician, as applicable, utilizing the Attribution Methodology will not impose any limitations or constraints on the freedom of such Covered Individuals to refer themselves for Health Services except as may otherwise be set forth in the Health Benefit Plan. The Attribution Methodology is described further in Section 5 of this Program Description.</p>	Attachment
Annual Determination Period	The 285-day period of time immediately following the end of the MA Measurement Period, during which Amerigroup will calculate the MPMLR and compare it to the MLRT to determine the amount of any Gross Savings or Gross Loss during the MA Measurement Period.	Program Description (Section 8)
Care Plan	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).	Program Description (Section 3)
Care Plan Assessment Domains	The functional areas we suggest be included in care plans to guide goal formation and related elements that could further support the identification of goals and interventions.	Program Description (Section 3)

Glossary Term	Definition	Source
Clinical Quality Measures	<p>The clinical quality measures included in the Program scorecard fall into two categories: (1) Standard Measures and (2) Enhanced Measures.</p> <p><i>Standard Measures</i> are measures that use data that is readily available, widely used by all Providers, and provide a conclusive answer. These measures' results are derived solely on an evaluation of Claims. An example of a standard measure is Diabetes HbA1c. A review of Claims received for a given member with Diabetes during the Measurement Period will provide a conclusive answer if the test was performed during the timeframe.</p> <p><i>Enhanced Measures</i> are measures that require documentation to be submitted on the claim in addition to standard CPT codes, and documented in the medical record. The additional information used to evaluate the measure can be attained by submitting CPTII or V codes on the member's claim that correspond with the members medical record. An example of an enhanced measure is Diabetes: blood sugar controlled. A review of Claims received for a given member with Diabetes during the Measurement Period requires the inclusion of the CPT II code that identifies the members' HbA1c level. The enhanced measures serve as a bonus opportunity to increase your overall shared savings potential, and will not reduce your shared savings potential if not achieved. The use of CPT II codes is further explained in the MA Handbook.</p>	<p>Program Description (Section 5)</p>
Gross Loss	<p>The dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is greater than the MLRT, as calculated by Amerigroup following an MA Measurement Period.</p>	<p>Program Description (Section 8-Medicare Advantage)</p>
Gross Savings	<p>The dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is less than the MLRT, and multiplied by the Premium paid to Amerigroup as calculated by Amerigroup following an MA Measurement Period.</p>	<p>Program Description (Section 8)</p>

Glossary Term	Definition	Source
Holdback Amount	The percentage of any applicable annual distribution payment based on earned Net Aggregate Savings that may be retained by Amerigroup as security against any future shared loss obligations of Medical Panel during the Measurement Period(s).	Program Description (Section 8)
Incentive Program	The opportunity for PCPs to increase their revenue as they participate in the Enhanced Personal Health Care Program. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance criteria. A complete description of the Incentive Program is in the Program Description.	Program Description (Section 8)
Incurred But Not Reported ("IBNR")	A reasonable factor applied to the paid medical expenses within MPMLR for the MA Measurement Period to adjust for any Claims that have been incurred but not yet reported. The IBNR factors will be based on Amerigroup historical paid Claims experience, and will be developed by Amerigroup on an actuarially sound basis.	Program Description (Section 8-Medicare Advantage)
Measurement Period	The 12-month period during which Medical Cost Performance, and quality will be measured for purposes of calculating shared savings between Amerigroup and the Medical Panel.	Program Description (Section 8)
Measurement Period Medical Loss Ratio ("MPMLR")	The percent calculated by Amerigroup that is based on Total Medical Expense divided by Premium during a MA Measurement Period. The MPMLR calculations for shared savings will include the application of an IBNR factor. For purposes of MPMLR calculations, inpatient Claims will be assigned to the MA Measurement Period during which the inpatient admission date occurred, rather than the discharge date. MPMLR is calculated after the MA Measurement Period has ended, and is compared to the MLRT to determine whether shared savings have been demonstrated under the Program. For Providers opting for Stop Loss, the dollars above the Stop Loss Deductible for Medicare Advantage Attributed Members will be excluded from Total Medical Expense and the Stop-Loss Expense will be added to Total Medical Expense.	Program Description (Section 8-Medicare Advantage)
Medical Loss Ratio Target ("MLRT")	The MLR target percentages determined by Amerigroup. The MLRT will be identified in the MA Handbook.	Program Description (Section 8)

Glossary Term	Definition	Source
Medical Panel	A single provider organization or a grouping of multiple provider organizations by Amerigroup for purposes of calculating statistically meaningful MPMLRs and shared savings. Further details regarding Medical Panels are provided below under “Medicare Advantage Medical Panels”.	Program Description (Section 8)
Medicare Advantage Measurement Period (s) (“MA Measurement Period(s)”)	The 12-month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Amerigroup and the Provider. The Medicare Advantage Measurement Period(s) for Provider’s participation in the Program is set forth in MA Handbook.	Program Description (Section 8)
Member Months-	The number of the Medicare Advantage Member Population’s full attributed months enrolled in the applicable Amerigroup products during a MA Measurement Period.	Program Description (Section 8)
Member Population-	The group of Medicare Advantage Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Amerigroup products(s) will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Amerigroup).	Program Description (Section 8)
Member Risk Months	The Member Population’s average Normalized Risk Score multiplied by their Member Months in the applicable Amerigroup products during a Measurement Period.	Program Description (Section 8)
Net Aggregate Savings	To determine the Net Aggregate Savings, the Shared Savings Percentage is multiplied by the Gross Savings.	Program Description (Section 8)
Paid/Allowed Ratio	The ratio of paid dollars (dollars paid by Amerigroup to providers) to allowed dollars (total dollars paid by Amerigroup plus Cost Shares payable by Covered Individuals) for Covered Services incurred during a Measurement Period, excluding Covered Individuals with certain transplant or high cost Claims amounts.	Program Description (Section 8)

Glossary Term	Definition	Source
Performance Assessments	<p>The annual assessment of performance on the selected Program clinical quality measures to define the proportion of shared savings that the Provider earns. Performance will be calculated for each measure, and then results will be rolled into two categories:</p> <ul style="list-style-type: none"> • Standard Measures • Enhanced Measures 	Program Description (Section 5)
Premium	<p>The total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Amerigroup for the Member Population under a Amerigroup Health Benefit Plan during a MA Measurement Period less any Part B rebates payable or credited for any Medicare Advantage Attributed Members within the Member Population, less any taxes levied by the Affordable Care Act, less any cost and reinsurance subsidies, and less any other amount otherwise offset against or deducted from amounts payable by CMS to Amerigroup with respect to the Member Population during such MA Measurement Period, exclusive of any Retroactive Addition Amount or Retroactive Deletion Amount, for such Medicare Advantage Member Population for the same MA Measurement Period.</p>	Program Description (Section 8)
Primary Care Providers(s) or PCP(s)	<p>Physicians whose primary specialty, as indicated in the Amerigroup provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics.</p>	Attachment
Program	<p>Abbreviated reference to our Enhanced Personal Health Care Program, including the Comprehensive Primary Care initiative.</p>	Attachment
Program Attachment Effective Date	<p>The date the Attachment becomes effective as shown on either (i) the signature page of the Provider Agreement or (ii) the signature page of the Attachment, whichever is applicable.</p>	Attachment

Glossary Term	Definition	Source
Program Description	The description of the Enhanced Personal Health Care Program prepared by Amerigroup, as revised from time to time, that summarizes the clinical programs and other patient-centered practice support offered by Amerigroup to support Represented PCPs and Represented Physicians, as applicable, in creating a patient-centric practice environment and care model for their Covered Individuals as well as Program terms, conditions and requirements. A current copy of the Program Description and periodic updates thereto, is available on the Amerigroup provider website.	Attachment
Program Quality Measures	The defined measures used to establish a minimum level of the Provider’s performance will also serve as the basis for Incentive Program savings calculations. Program Quality Measures are calculated and reported to the Provider on a scorecard comprised of clinical quality measures and utilization measures.	Program Description (Section 5)
Provider Practice Toolkit	The tools and information that will be made available to provider organizations to assist with population health management.	Program Description (Section 4)
Quality Gate	A minimum threshold of performance on clinical quality measures must be met for you to have the opportunity to earn a portion of the shared savings. The thresholds are set at a four and five Star level, aligning with the STARS quality program. In order to participate in shared savings, your practice must achieve an overall four or five star rating in quality performance. Further explanation of the quality measures and the scoring methodology are described in the MA Handbook.	Program Description (Section 8)
Quality Targets	The quality performance targets, contained in Section 5 of the Program Description and the MA Handbook, used to determine the percentage of shared savings under the Incentive Program.	Program Description (Section 8)

Glossary Term	Definition	Source
Represented Primary Care Physician(s) or Represented PCP(s)	All of the physicians in the provider organization whose primary specialty, as indicated in the Amerigroup provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics (collectively, Primary Care Physician(s)) and who participate in the Patient-Centered Care Program by virtue of being covered under the Provider Agreement and Enhanced Personal Health Care Program Attachment.	Attachment
Represented Providers	The physicians in the provider organization who bill under the Organization's tax identification number(s), are board-certified or board eligible, and who participate in the Program by virtue of being covered under the Agreement and this Attachment.	Attachment
Retroactive Additional Amount	The total of all amounts paid or credited by CMS to Amerigroup for any Medicare Advantage Attributed Members who were retroactively assigned to the Provider during the MA Measurement Period, as applicable.	Program Description (Section 8)
Retroactive Deletion Amount	The total of all amounts repaid by Amerigroup to CMS or otherwise offset against or deducted from amounts payable by CMS to Amerigroup for any Medicare Advantage Attributed Members whose assignment to the Provider was retroactively deleted during such MA Measurement Period.	Program Description (Section 8)
Risk Scores	Risk scores are indicators of the health status of an Attributed Member based on the evaluation of diagnosis information pulled from Claims. Amerigroup uses the HCC Risk Scores as established by CMS.	Attachment

Glossary Term	Definition	Source
Shared Savings	The savings the Provider can share in if Program targets are met. We will compare the Medical Panel’s annual Claim cost per Covered Individual in each Measurement Period to each Covered Individual’s cost in a Baseline Period to determine whether the Measurement Period’s Medical Cost Performance (MCP) is less than the Baseline Period’s Medical Cost Target (MCT) subject to Incentive Program details described herein the Medical Loss Ratio Target. In the event that the MCP MP MLR is less than the MCTMLRT, the Provider may share in a percentage of the savings realized, provided that the Provider meets the Quality Gate and other Non-Cost Performance Targets as described in the Quality Measures & Performance Assessment section of this Program Description.	Program Description (Section 8)
Shared Saving Percentage	The percentage of shared savings under the Program to which Provider is determined to be entitled after all other applicable adjustments have been made to the Shared Savings Potential based on the Quality Target scores as shown in the Program Description and the MA Handbook. The Shared Savings Percentage can be the same percent as the Shared Savings Potential if all Quality Targets are fully achieved by Provider under the Program. The Shared Savings Percentage will be less than the Shared Savings Potential if any Quality Targets are not achieved by Provider under the Program.	Program Description (Section 8)
Shared Savings Potential	The maximum percentage of shared savings under the Shared Saving Program to which Provider may be entitled, as delineated in the MA Handbook. The Shared Savings Potential percent shown in the MA Handbook is subject to the performance adjustments described in this Program Description and in the MA Handbook.	Program Description (Section 8)

Glossary Term	Definition	Source
Stop Loss	A methodology that will be incorporated into the Total Medical Expense calculation designed to afford protection to the Provider against the impact under this Agreement of certain high-dollar Claims. For any Arrangement for which Provider is at Substantial Financial Risk, as such term is defined in 42 CFR 422.208(a), such Stop-Loss methodology shall meet all requirements set forth in 42 CFR 422.208(f). Should the Provider experience a decrease in their attributed membership level throughout the term of this Agreement, the Provider shall remain compliant with the stop-loss deductible levels set forth in 42 CFR 422.208.	Program Description (Section 8)
Stop Loss Credit	The Claims amounts in excess of the Stop Loss Deductible.	Program Description (Section 8)
Stop Loss Deductible	The defined dollar threshold that must be reached, on a per member per year basis, before a Stop-Loss Credit is applied to the calculation of Total Medical Expenses. The Stop Loss Deductible is determined by the Medicare Advantage Member Population attributed to the Provider.	Program Description (Section 8)
Stop Loss Expense	The per member per month amount determined by taking the actual total amount of Claims in excess of the Stop Loss Deductible across all Amerigroup Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period, divided by the total Member Months across all Amerigroup Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period. The Stop-Loss Expense is included as part of the Total Medical Expenses Calculation.	Program Description (Section 8)

Glossary Term	Definition	Source
Substantial Financial Risk	This would occur if the percentage of the Shared Savings Percentage that is based upon referral services exceeded the maximum risk percentage threshold specified by CMS in 42 CFR Section 422.208 of the total compensation due to Provider and Represented Providers. This calculation does not include compensation or payment of any kind that is not based upon the use of referral services, such as quality of care furnished, patient satisfaction or committee participation. For purposes of this definition, referral services shall mean any specialty, inpatient, outpatient, or laboratory services that Medicare Advantage Attributed Members receive, but are not furnished directly by Provider or Represented Providers.	Program Description (Section 8)
Substantial Financial Risk Limit	The total incentive-based payments to the Provider from Amerigroup, inclusive of payments under the Agreement, are limited to no more than 25% of the total reimbursement the Provider and Represented Providers receive from Amerigroup for direct services delivered to Amerigroup Medicare Advantage Attributed Members during the applicable MA Measurement Period year.	Program Description (Section 8)
Total Medical Expenses	The costs incurred by Amerigroup for payment of all Covered Services (including hospital, medical, pharmacy and non-hospital) provided to each Medicare Advantage Attributed member by all providers (participating and non-participating, and including Provider and its PCPs) furnishing such services to Medicare Advantage Attributed Members, adjusted by the Stop-Loss Expense and Stop-Loss Credit where appropriate.	Program Description (Section 8)
Upside Shared Savings Potential	The maximum percentage of shared savings under the Incentive Program that you may be entitled to, provided that your provider organization meets the Quality Gate and other Non-Cost Program Targets.	Program Description (Section 8)

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.

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