EXHIBIT A
PROTOCOLS FOR PRIMARY CARE PHYSICIANS

1. DEFINITIONS

NOTE: *Additional definitions relevant to PCP participation are set forth in: (i) the Agreement; (ii) the PIF that is normally sent with the Agreement; and (iii) the Provider Manual.*

"Adult Preventive Health Services" shall mean primary, secondary, and tertiary preventive measures provided to individuals in a clinical setting. Primary preventive measures are those provided to individuals to prevent the onset of a targeted condition (e.g. routine immunization of healthy individuals). Secondary preventive measures are those that identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease but in whom the condition has not become clinically apparent. Tertiary preventive measures are those that are part of the treatment and management strategy of persons with clinical illnesses that can prevent sequelae.

"Clinic" shall mean County's FQHC Clinics, which provide Covered Services to Authority Members.

"Clinic Physician" shall mean any physician who provides the services of a PCP for Clinic and meets the qualifications of a PCP as specified in §2 of this Exhibit A.

"Community Clinic" shall mean that organization representing PCPs that is licensed as a community clinic and has executed an Agreement with Authority to provide the services of a PCP, as specified in §§ 2 and 3 of the Agreement.

"Medical Specialty Group" shall mean one of the following: (i) family practice / general medicine/ Clinic/Community Clinic; (ii) internal medicine; (iii) OB/GYN; or (iv) pediatrics. The Medical Specialty Group will be determined by specialty unless Authority determines that: (i) the specialty does not substantially relate to practice as a result of: California Medical Board certification requirements or eligibility; (ii) patient mix age; (iii) patient age range; or (iv) DHS Medi-Cal certification data. Authority may subsequently make an assignment to a different Peer Pool as defined in Attachment A-3. Medical Specialty Groups consisting of Physicians with a variety of medical specialties will be included in the family practice / general practice / Clinic/Community Clinic Medical Specialty Group (Peer Pool F1) unless otherwise noted on the PIF.

"Primary Care Group" shall mean that organization representing PCPs that has executed an Agreement with Authority to provide the services of a PCP, as specified in the Agreement or this Exhibit A. Each Primary Care Group is assigned a provider number for all physicians located in one office site. A Clinic is not a Primary Care Group.

"Primary Care Group Physician" shall mean a physician who provides the services and meets the qualifications of a PCP for the Primary Care Group.

2. COUNTY's PCP PARTICIPATION

Any physician duly licensed in the State may elect to serve Members as County's PCP if that physician meets the qualifications set by the Board of Directors and the appropriate Committees of Authority as outlined in the Provider Credentialing Policy in the Provider Manual, and has been credentialed or recredentialed by Authority; and

2.1 Is employed by or contracts with County to provide professional services; and

2.2 Will accept a minimum of fifty (50) SBHI Members unless accepted by Authority; and

2.3 County has received certification as a CHDP Program provider in order to be assigned SBHI Members under nineteen (19) years of age; and

2.4 County has completed the PIF, including indicating names of employed or contracted PCP's the maximum capacity at each site, Peer Pool Designation , age ranges, access, regular office hours and any extended office hours, and/or additional information as requested.

3. PHYSICIAN/PATIENT RELATIONSHIP

3.1 Member Designation

Each Member who is to be Case Managed shall receive a Contracted Provider List (CPL) and be given the opportunity to choose the PCP through whom the Member will seek all Covered Services. The CPL contains the location of County's Clinics. Members are permitted to select a Clinic site but are not permitted to select a specific Clinic PCP. County has listed its Clinic locations on the PIF that is included with the Agreement. If County has accepted "auto assignment" to obtain Members who do not select their PCP, it will be so noted on the PIF.

3.2 Change of Primary Care Physician by Member

Members may change their choice of PCP in accordance with procedures established by Authority.

3.3 Limitation of Members

Authority will prevent Members from choosing any PCP or Clinic site in excess of the stated Physician Patient Load Limitation set forth on the PIF.

3.4 Responsibility of Physician to Exercise Choice

County's Physicians or the Member's Attending Physician may, on occasion, be faced with an Emergency Medical Condition in which: (i) the Member is unconscious or unable to give reasonable consideration to methods of treatment; and (ii) it appears that the Member is in immediate need of Medically Necessary services and has no reasonable opportunity to obtain such Medically Necessary services from any other source. In any such case, unless said Physicians have prior knowledge of the Member's wishes, e.g. Durable Power of Attorney, "Living Will", Advance Directives, etc., said Physicians shall be entitled to pursue the procedures or courses of treatment which, in his or her professional judgment, are dictated.

3.5 Unsatisfactory Relationships Between Members and Primary Care Physicians

The physician/patient relationship is a personal relationship and circumstances may arise under which relations between Members and their PCP become unsatisfactory. In such cases, County may request that the Member be reassigned to a PCP with whom a satisfactory physician-patient relationship may be developed. Authority will follow procedures set forth in the Primary Care Provider Request for Member Re-assignment policy set forth in the Provider Manual when reassigning Members under these circumstances. If Authority is unable to make such arrangements, County will continue to provide Covered Service to the Member according to the County's best professional judgment until Authority is able to process the change but not to exceed two (2) months after County's request is received by the Authority.

3.6 Member Non-compliance with Medical Treatment

A Member, for conscientious or other reasons, may refuse to follow or undergo one or more procedures or courses of recommended treatment. In cases where the Provider is of the opinion that no professionally acceptable alternatives to such recommended procedures or courses of treatment exist ("alternative care"), County shall consult with the Medical Director or a consultant designated for that purpose by the Medical Director. In all cases in which alternative care exists, and which is acceptable to all parties County shall arrange such services for the Member. In cases where no alternative care exists that is acceptable to all parties, and provided the alternative care is a covered benefit, the Member may be reassigned to a different PCP in order to receive Covered Services that are Medically Necessary and appropriate.

4. MANAGEMENT OF CARE

4.1 Care Management

With the exception of Emergency Services, Self Referral Services, Authority Referrals and services that do not require RAFs, County's PCPs will: (i) determine Medically Necessary and appropriate care; (ii) prescribe Covered Services for Members that at that time are determined to be Medically Necessary services for the prevention or control of disease, illness, or disability; and (iii) manage the Members and provide authorized care in accordance with sound professional principles and with proper attention to the need for containment of costs.

County agrees to abide by the Case Management Protocols set forth in the Provider Manual.

4.2 Notification of Health Insurance Other Than Medicare

The Authority is under a contractual obligation to the State to recover for any Covered Service for which a Member is also covered under any other public or private health insurance. These potential recoveries have already been subtracted from the Capitation rate that State pays Authority. If County discovers that a Member has other health insurance coverage, it shall inform Authority of this potential recovery situation. The requirements concerning notification in the current EDS manual may apply. See also Other Health Coverage in the Provider Manual.

4.3 Withholding of Care

When a Member changes PCPs, either by the Member's or PCP's choice, and it is subsequently suspected and determined after the Medical Director's review that Medically Necessary services were withheld or delayed by the previous PCP, the Medical Director shall inform the PCP or County, if appropriate, of such findings and allow for further discussion. If the parties conclude that such Medically Necessary services are currently necessary to maintain the health and welfare of the Member, the Medical Director will inform Authority staff of the outcome. Authority may adjust the Utilization Pool of the PCP Incentive Program. The PCP Incentive Program is summarized in Attachment A-3 of this Exhibit and is set forth in full in the Provider Manual.

4.4 Recommended Preventive Health Services

In addition to the Medi-Cal Covered Services set forth in §2.3 of the Agreement, Authority recommends that Clinics perform the services set forth in the Authority's "Recommended Preventive Health Guidelines for Adults" in the Provider Manual. See Preventive Health Services for SBHI Members in Section 5.6 of this Exhibit A.

4.5 Supervision of Non-Physician Medical Providers

Clinic is expected to case manage SBHI Members and render all necessary Primary Care Services. If County employs County Health Professionals County is responsible for verifying the license and qualifications of such County Health Professionals under its supervision. Standardized procedures must be developed and maintained by County, and signed by both the supervising Physician and the County Health Professional. These include, without limitation, the provisions and requirements set forth in Business and Professions Code, §2725, and Title 16, CCR, §1480 and those set forth in §3.1.6 of the Agreement.

5. PAYMENTS AND INCENTIVES FOR CASE MANAGED MEMBERS

5.1 Guaranteed Payment for Class I Members and Acceptance of Guaranteed Payment

Authority shall pay to County a monthly sum called the "Guaranteed Payment". This sum shall be eighty percent (80%) of the portion of the full Capitation rate allocated to Primary Care Services and adjusted by eligibility category, as specified in §1-C of Attachment A-2, and will be paid to County by the fifteenth (15^{th}) day of each month, excepting Saturdays, Sundays and holidays. This full Capitation rate allocated to Primary Care Services may be increased, but not decreased, unilaterally by Authority to be applicable to services rendered during a specified period. The Guaranteed Payment will be calculated according to the total number of eligible Class I Members (adjusted for eligibility category, and age and sex if appropriate) assigned to Clinics for the calendar month. County shall receive notice each month of those Members who are entitled to receive Covered Services from or through its Clinics and for whom County has been paid the Guaranteed Payment. County is expected to authorize all Covered Services and cause its Clinics to render all necessary Primary Care Services (as specified in Attachment A-1) to Class I Members in exchange for the monthly Guaranteed Payment. County does not receive fee-for-service reimbursement for the capitated services.

County must notify Authority in writing within 120 Days after receiving the Guaranteed Payment of any Members assigned to its Clinics that should have been assigned Special Class status. Failure to timely do so will result in calculating the expenses and utilization of any such Member towards the Incentive Payment calculation.

5.2 Reporting of Primary Care Services

County agrees to submit Encounters, according to the guidelines set forth in Exhibit C of the Agreement, for all capitated Primary Care Services listed in Attachment A-1 that its Clinics render to Class l Members. Failure to submit Encounters may result in a delay of County's receipt of the monthly Guaranteed Payment. Any service, including said Encounters, not reported on an Explanation of Benefits (EOB) before the final PCP Incentive calculations are completed will not be used in the PCP Incentive calculations. Additional information regarding Encounters is set forth in Exhibit C and in the Provider Manual. See also subsection 5.9, Administrative Data Reporting of this Exhibit A.

Covered Services not listed in Attachment A-1, (when billed under County's FHC provider numbers) shall be considered Non Case Managed Services, as set forth in subsection 4.2.3 of the Agreement. County shall complete and submit monthly an Encounter for said services rendered to Class l Members.

5.3 Payment for Non Case Managed Services

5.3.1 Authority will process Encounters that County has submitted for authorized Medi-Cal and for Authority only benefits that are not listed in Attachment A-1 and that are rendered to Class l Members on the Case Management list. In order to be counted as a valid Encounter, County must meet the criteria set forth in Exhibit C to the Agreement. Encounters that County submits for these Services shall be tracked in order for total dollars paid for each Case Managed Member to be included in each Clinic's Incentive Payment calculation.

5.3.2 County shall submit Encounters to Authority for Covered Services on the HCFA 1500 or UB-92 or in an electronic format using industry standards as specified by DHS and/or HIPAA as agreed by the parties, or via the Internet. Authority will accept Encounters from County up to one (1) year from the date of service in order for the services to be included in the Incentive Payment calculation. A reduction in determining the fee-for-service equivalent rate, if there is no valid exception code indicated at the time of submission, is normally made after six (6) months from the end of the month of date-of-service and further reductions are applied after nine (9) months.

5.3.3 If Authority assumes responsibility for the payment of Claims for CHDP services, County's Encounters for said services will be processed for calculating the Incentive Payment at the rates set by the State.

5.4 Primary Care Physician Incentive Program

The Primary Care Physician Incentive Program ("PCP Incentive Program") has been established by the Authority to reward SBHI PCPs and Clinics who meet established utilization and quality criteria. Funding for this Program is obtained from the Authority's voluntary contribution from its reserve funds and from 20% of the withhold from the Guaranteed Payment. Two payments are made within six (6) months of the close of each Fiscal Year of Authority for the previous Fiscal Year services. The PCP Incentive Program is not considered "compensation", and changes to this program do require Notice of the changes but do not require written acceptance of the changes by Provider. In its sole and absolute discretion, Authority reserves the right to change or eliminate any or all of the PCP Incentive Program at any time.

To determine the PCP Incentive Program amount payable to County, Authority will prepare an accounting of Covered Services rendered to the Class l Members, and provide monthly reports to County. Utilization of Covered Services will be tracked according to Authority's established Utilization Criteria while quality of Covered Services will be tracked according to Authority's established Quality Criteria. A summary of the SBHI PCP Incentive Program is set forth in Attachment A-3. The PCP Incentive Program is set forth in full in the Provider Manual.

5.5 Special Class Members

5.5.1 Payment For Special Class Members

When a person is identified as a Special Class Member, and while that person remains a Special Class Member, the full Capitation amount for that individual will be placed into an account of the Authority from which all Claims for that Member will be paid. Claims paid for identified Special Class Members will not be used in calculating any expenses in the PCP Incentive Program.

5.5.2 Special Class Members are subject to Case Management by the Authority's UM Unit in consultation with the Attending Physician and, as necessary, with the Medical Director. Providers (but not County) who are authorized to render Covered Services to Special Class Members shall be paid State Medi-Cal allowable rates or at Authority

rates in effect at the time of service. County instead will submit Encounters for Special Class Members.

5.6 Preventive Health Services for Class I and Special Class Members

The following Preventive Health Care Services are not Medi-Cal benefits, but are Authority only benefits, and County does not receive PCP capitation for these services. When said services are rendered to Authority's Members, County should submit Encounters to Authority in order for the services to be included in the Incentive Payment calculation.

Procedure Code	Description
99385	Initial Preventive Medicine; 18 – 39 years
99386	Initial Preventive Medicine; 40 – 64 years
99387	Initial Preventive Medicine; 65 years & up
99395	Periodic Preventive Medicine; 18 – 39 years
99396	Periodic Preventive Medicine; 40 – 64 years
99397	Periodic Preventive Medicine; 65 years & up

5.7 Payment for CHDP Program

For 18 to 21 year old Members who are eligible for a screening exam under CHDP, CHDP Providers must separately bill the State CHDP Program for the Initial or Periodic Preventive Medicine service. Non-CHDP Providers and CHDP Providers whose Claims already have been denied by the State CHDP Program may bill Authority, however these services will be calculated as Non Case Managed Services.

In the event that Authority assumes administrative responsibility for the CHDP Program during the term of the Agreement, County shall submit Encounters for CHDP services to Authority as set forth in the Provider Manual.

5.8 Reimbursement for Selected Procedures

Authority shall count as Encounters and establish the fee-for-service equivalent rates for the following selected procedures. County shall not be required to submit additional paperwork or invoices in order to process these services as Encounters:

- Code Z7610 miscellaneous drugs and supplies $ 8.12
- Code 90799 unlisted diagnostic or therapeutic injection $15.83

5.9 Administrative Data Reporting

5.9.1 As indicated above in this Exhibit A, County shall report as Encounters the services rendered in County's Clinics that are covered under Capitation. County, using the current Medi-Cal accepted Claim form, or entering Encounters through Authority's web site to report such services, must include, at a minimum, the data elements set forth in the current EDS manual issued by the State, and the data elements set forth in Exhibit C to the Agreement.

5.9.2 County is required to cooperate with Authority's quality improvement activities, including submission of complete and accurate data and supporting Encounters. County must correct and resubmit data that is unacceptable within six (6) months after the request for additional data on Encounters.

5.9.3 In addition to supplying required data to Authority, within the above-described six (6) months, County must allow for the inspection and audit of such data at the Clinic offices upon seven (7) Days advance written notice.

5.9.4 Authority will monitor County's timely submission of Encounters to Authority in accordance with the relevant provisions of the current EDS manual.

5.9.5 County shall allow Authority to publish reports obtained from the compilation of such required data for quality improvement purposes. Confidentiality of Clinics' and Members' identities shall be maintained in such publications.

5.10 Failure to Provide Data

Failure to provide Encounter Data in accordance with Medi-Cal Claims requirements for timeliness, completeness and accuracy, or to provide additional information required by the Agreement, may result in corrective action as provided for by Authority's Practitioner Corrective Action Policy.

ATTACHMENT A-1

Services Included in Guaranteed Payment/Encounter Procedures

CPT-4 Codes (2005)	***Description***
MEDICAL SERVICES - OFFICE	
New Patient	
99201	Office Visit, New, Level 1
99202	Office Visit, New, Level 2
99203	Office Visit, New, Level 3
99204	Office Visit, New, Level 4
99205	Office Visit, New, Level 5
Established Patient	
99211	Office Visit, Established, Level 1
99212	Office Visit, Established, Level 2
99213	Office Visit, Established, Level 3
99214	Office Visit, Established, Level 4
99215	Office Visit, Established, Level 5
SURGICAL PROCEDURES	
10060	Drainage and Incision of Skin Abscess, simple or single
11100	Biopsy of Skin, Subcutaneous Tissue, single lesion
11101	Biopsy Each Separate and Additional Lesion
11740	Evacuation of Sublingual Hematoma
12001	Repair Simple of Superficial Wound to 2.5 Cm - Extremities
12011	Repair Simple of Superficial Wound to 2.5 CM - Face, etc.
16000	Initial Treatment First Degree Burn
16020	Dressing / Debridement -w/o Anesthesia - Small
69210	Removal Impacted Cerumen - one/both Ears
LABORATORY SERVICES	
81000	Urinalysis by dip stick or tablet reagent, non-automated with microscopy
81002	Urinalysis; non-automated, without microscopy
81005	Urinalysis, qualitative or semi-quantitative
81015	Urinalysis, qualitative or semi-quantitative, microscopic only
82273	Test for blood, other source.

ATTACHMENT A-2
PAYMENT ADDENDUM

SECTION 1-C
*FULL CAPITATION RATES
CLASS 1 SBHI MEMBERS FOR COUNTY
JANUARY 1, 2006

(1) Aged and Blind; no adjustment for age and sex	***Aged***	***Blind***
1. PUBLIC ASSISTANCE	$7.55	$22.22
2. MEDICALLY NEEDY	$8.64	$57.57

	Male	***Female***
(**2) Disabled**		
Ages:		
Less than 1	$17.07	$17.07
1-4	17.07	17.07
5-14	14.64	12.20
15-19	14.64	12.20
20-44	10.00	19.65
45-64	13.79	20.81
65+	1.84	1.84
(3) Family		
Ages:		
Less than 1	18.73	18.51
1-4	11.13	10.62
5-14	5.82	7.72
15-19	5.82	7.72
20-44	9.22	14.12
45+	14.49	17.94
(**4) Medically Needy: Disabled**		
Ages:		
Less than 1	35.81	39.63
1-4	35.81	39.63
5-14	25.57	39.63
15-19	25.57	39.63
20-44	24.30	38.36
45-64	29.14	38.36
65+	6.14	6.65

***The County is paid 80% of this amount monthly (the "Guaranteed Payment"). Attachment A-1of the Agreement specifies services covered by this payment.**

SECTION 1-C
*FULL CAPITATION RATES
CLASS 1 SBHI MEMBERS FOR COUNTY
JANUARY 1, 2006

	Male	***Female***
(5) Medically Needy: Family		
Ages:		
Less than 1	$24.24	$23.41
1-4	17.72	18.00
5-14	8.76	9.03
15-19	8.76	9.03
20-44	11.03	15.60
45+	14.97	22.90
(6) Medically Indigent Child		
Ages:		
Less than 1	21.81	14.16
1-4	12.42	13.21
5-14	7.97	9.32
15-19	7.97	9.32
20-44	8.45	14.07
45+	17.46	17.46
(7) Refugees		
Ages:		
Less than 1	16.93	16.73
1-4	10.07	9.61
5-14	5.26	6.96
15-19	5.26	6.96
20-44	8.33	12.78
45+	13.11	16.22
(**8) BCCTP**		
Ages:		
Less than 1	35.81	39.63
1-4	35.81	39.63
5-14	25.57	39.63
15-19	25.57	39.63
20-44	24.30	38.36
45-64	29.14	38.36
65+	6.14	6.65

***The County is paid 80% of this amount monthly (the "Guaranteed Payment"). Attachment A-1 of the Agreement specifies services covered by this payment.**

ATTACHMENT A-3

SUMMARY OF THE SBHI PCP INCENTIVE PROGRAM FOR COUNTY

The Primary Care Physician Incentive Program ("PCP Incentive Program") was established voluntarily by the Authority to reward SBHI PCPs and Clinics who meet established utilization and quality criteria. This PCP Incentive Program utilizes a model in which the financial incentives are primarily based on the utilization and quality performance relative to peers who share the same provider type, and incorporates criteria more indicative of quality of care. Authority, in its sole and absolute discretion and only if it is financially feasible, may elect to pay Incentive Payments to some Providers based on specific criteria, which Authority may amend, or delete in its sole and absolute discretion. No Provider shall be entitled to any such Incentive Payment. Incentive Payment shall **not** be deemed to be: (i) compensation for Covered Services under the Agreement; or (ii) a program in which any change requires an amendment to the Agreement.

This Attachment A-3 is a summary of the PCP Incentive Program to provide County with pertinent information about additional funds available when specified utilization and quality measures are met. The PCP Incentive Program is set forth in full in the Provider Manual.

1. FUNDING OF THE PCP INCENTIVE PROGRAM

The total funds used for the PCP Incentive Program are based in part upon the Authority's historical payout under past trust account methodology. The funds are divided into two pools, one related to utilization and one related to quality, as more particularly defined in §5.3 hereof. Each pool is based upon a percentage of the monthly guaranteed Capitation rates for Class l (or Case Managed) Members.

The funding for the Quality Pool is only from the Authority. The Total Incentive Payments for all PCPs will be approximately 57% of the total of the Guaranteed Payments paid to all PCPs during that Fiscal Year. Of the approximately 57%, approximately 45% will fund the Utilization Pool and approximately 55% will fund the Quality Pool.

2. DEFINITIONS

"Chart Quality" shall mean Authority's review of a specified number of medical records chosen by Authority for individual PCPs, Clinics, Community Clinics and Primary Care Groups. Primary Care Groups are those receiving one Case Management report for multiple physicians and are not a Clinic.

"Encounter" shall mean (i) Covered Services rendered to Members Case Managed by County; (ii) Covered Services rendered to Members not Case Managed by County; (iii) non capitated Covered Services rendered to County's Case Managed Members; and (iv) County Physician Specialist Covered Services when provided in County FQHC Clinics. PCP capitated services are identified by select procedure codes included in Attachment A-1 of the Agreement. County submits Encounter information on a Claim form, indicating the capitated service(s) provided by inserting the appropriate procedure code(s) as set forth in Exhibit C to this Agreement. Encounters with more than one County Health Professional and multiple Encounters with the same County Health Professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first Encounter, suffers an illness or injury requiring additional diagnosis or treatment. Encounters are for tracking of Covered Services for the purpose of Incentive Payment calculation only and County

receives no fee-for-service reimbursement for these services. Encounters will also be submitted for Covered Services provided by County Physician Specialists and rendered in County's Clinics.

"Increased Access" shall mean maintaining an average number of Members per month, or increasing the Clinic's caseload each Fiscal Year, and meeting the minimum ages for Members as described in "Peer Pool" and in the PCP Incentive Program in the Provider Manual.

"Office Hours" shall mean the actual hours each week when Clinic PCPs are routinely available to see Class 1 Members.

"Peer Pool" shall mean the particular pool to which County is assigned by the Authority in order to perform benchmark comparisons within the PCP Incentive Program. The assignment is based on the specialty designation as well as the age ranges that it serves. The Peer Pools are as follows:
Peer Pool F1: CHDP certified family practice/general practice/Clinic/Community Clinic physician who accept Members, 3 years and older;
Peer Pool M2: internal medicine and non CHDP certified family practice/general practice/Clinic/Community Clinic physicians who accept adult Members age 19 and older;
Peer Pool P4: CHDP certified pediatricians who accept Member children from newborn to, at a minimum, age 12.

"Preventive Health Services" shall mean those Covered Services that are provider-type specific and relate to preventing illnesses from occurring. Preventive Health Services are applicable to the Providers as indicated in this Attachment A-3. The procedure codes that quantify the Preventive Health Services are described in the PCP Incentive Program in the Provider Manual.

"Utilization Expenses" shall mean all expenditures for Class I Members, which include:

- "Physician and Outpatient Hospital Expenses" (including but not limited to specialist physicians, home health, durable medical equipment, and outpatient hospital services)
- "Inpatient Hospital Expenses" (including but not limited to an acute care or rehabilitative care setting)
- "Pharmacy Expenses" (including but not limited to prescription pharmaceuticals and prescribed over-the-counter pharmaceuticals).

3. ALLOCATION OF POOLS

3.1 Utilization Pool

The Utilization Pool is funded by: (i) the twenty percent of the Capitation that is not paid monthly to County (the Clinic's withhold); and (ii) contributions by Authority. For each Clinic, the Utilization Pool is allocated into sub-categories by multiplying the total dollar amount in the Pool by the following percentages:

- Physician /Outpatient Expenses 35%
- Inpatient Hospital Expenses 33%
- Pharmacy Expenses 32%

These percentages are an approximation of historical allocations to these expense categories.

3.2 Quality Pool

The Quality Pool is funded solely by the Authority. For each Clinic, the Quality Pool is allocated into the "quality-based" sub-categories by multiplying the total dollar amount in the Pool by the following percentages:

- Chart Quality 30%
- Encounters 20%
- Increased Access 10%
- Office Hours 10%
- Preventive Services 30%

3.3 Reports

County is sent a monthly report ("Schedule 1") which explains the calculation of funding during the Fiscal Year of Authority to date for both the Utilization and Quality Pools and for some measures indicates how each Clinic's individual values and performance scores compare to others who share a common membership assignment, i.e. a Peer Pool. How each Clinic fared based on Fiscal Year-to-date Claims data in both the utilization and quality criteria categories results in the "Total Incentive Payment for the Fiscal Year" reflected in the Schedule 1 reports. Additional Schedule reports are available which provide details of each Clinics' performance.

4. QUALITY MEASURES

4.1 Chart Quality

Chart Quality refers to the Authority's annual review of medical records. For each Clinic, each chart is scored according to professional standards adopted by Authority following input and recommendations made by an Authority's committee. The number of charts reviewed and the required scores for passing are annually established by the Authority. Each Clinic is compared to a fixed score that is not based on the performance of others in the Peer Pool.

4.2 Encounter Data

As one of the PCP Incentive Program measures, comprehensive Encounter data (derived from Claims submitted by County for Covered Services included in the Capitation payment) is important to the Authority for a variety of reasons including tracking utilization, complying with State, federal and regulatory agency requirements and adjusting Capitation. Each Clinic is compared to similar Providers as to the average number of Encounters received in the same timeframe, but the figure is adjusted for the particular case mix to assure a fair comparison. A lower number of Encounters than average may be the result of fewer Member Encounters, or the lack of submission of Encounters.

4.3 Increased Access

The Authority's quality incentive measure, called "Increased Access" was added to encourage increased availability of PCPs or Clinics to Members in order to allow for the most optimal PCP-patient assignment. The measure requires Clinics accept: (a) eight hundred (800) Members per month for each full-time PCP throughout the Fiscal Year in specified age ranges; or (b) at a level of access that requires Clinics to accept a minimum of twenty-five (25) Members into their practice during each Fiscal Year, and maintain the age criterion for at least ten (10) months each Fiscal Year. The Clinic will receive 100% of the Increased Access funds in the Quality Pool if level (a) is maintained, or a percent of the Pool in level (b) based on the Clinic's caseload increase. The Clinic

is compared to fixed values that are not based on the performance of other PCPs and Clinics in the Peer Pool.

4.4 Clinics Office Hours

The intent of this measure is to reward those Clinics who increase their availability for Authority Members to be seen on a walk-in or appointment basis. In addition, County will qualify if an arrangement with another PCP is made that offers Members access equal to the standard criteria for this measure. The Office Hours used for reporting purposes are those reported by the County on the PIF. This criterion rewards Clinics offering a minimum of thirty (30) hours of availability per week, with the maximum payout occurring for those with availability of forty-five (45) hours per week or more.

Office Hours include both the Clinic's regular office hours, as well as office hours over and above those the Clinic offered by the backup Physician(s), referred to as extended Office Hours. The Clinic is compared to fixed values that are not based on the performance of others in the Peer Pool.

4.5 Preventive Health Services Measure Criteria

The Preventive Health Services measure criteria is a set of quality criteria designed to be Provider specific, to allow further comparison of Covered Services delivered by Providers that serve comparable populations, and that are designed to prevent Member illness. This measure is structured as follows:

4.5.1 Family Practice/General Practice/Clinics/Community Clinics who offer initial and periodic Preventive Medicine evaluations as set forth in 5.6 of Exhibit A, and submit Encounters for well infants, well child, well adolescent visits and Adult Preventive Health Service evaluations may receive payment for this incentive measure. Such visits shall include: a comprehensive history & examination, counseling/anticipatory guidance/risk factor reduction interventions and ordering of appropriate laboratory/diagnostic procedures, as defined in the most recent American Medical Association Current Procedural Terminology (CPT) manual. Each Clinic is compared to similar Providers as to the average number of Preventive Medicine evaluations received in the same timeframe, but the figure is adjusted for each Clinic's particular case mix to assure a fair comparison.

4.5.2 Internists who offer Initial and Periodic Preventive Medicine Evaluations and submit Encounters with CPT codes 99381-99387, or 99391-99397 with appropriate diagnostic code(s) may receive payment for this incentive measure. Such visits shall include: a comprehensive history & examination, counseling/anticipatory guidance/risk factor reduction interventions and ordering appropriate laboratory/diagnostic procedures, as defined in the most recent American Medical Association CPT Manual. Each Clinic is compared to similar Providers as to the average number of Preventive Medicine evaluations received in the same timeframe, but the figure is adjusted for the particular case mix to assure a fair comparison.

4.5.3 OB/GYN Physicians no longer participate as Primary Care Physicians and their preventive services no longer constitute a portion of the PCP Incentive Program.

4.5.4 Pediatricians who provide timely childhood immunizations (DTP, IPV, Hib, HepB, MMR, and VZV) to two year olds in accordance with the Centers for Disease Control and Prevention Recommended Childhood Immunization Schedule and

submit Encounters may receive payment for this incentive measure. Immunizations may be administered by the Clinics for their Case Managed Members for which the Clinics will receive credit. The Authority will also obtain immunization information from the CHDP Program. The immunizations which are administered individually or as combination vaccines (as set forth in the Provider Manual) must be administered during the required time frames. Each Clinic is compared to a fixed score that is not based on the performance of others in the Peer Pool.

5. PAYMENT THRESHOLDS AND FORMULAS

5.1 Utilization Expenses and Capitation

The Authority calculates the PCPs' total Utilization Expenses based on the actual dollars paid, and the fee-for-service equivalent amount if Covered Services were rendered by a capitated Referral Physician for Covered Services during the specified time period. Covered Services not included in the said calculation include: (i) all of the capitated services; (ii) any service not reported on an EOB before the final PCP Incentive Program calculations are completed; and (iii) Utilization Expenses (total of Physician and Outpatient Hospital Expenses, Inpatient Hospital Expenses and Pharmacy Expenses) which total more than $15,000 rendered per Member, per Clinic, per Fiscal Year.

5.2 Establishment of Total Actual Values & Average Values Adjusted for Case Mix

The total actual Utilization Expenses and the number of Encounters and Preventive Health Services are called the Actual Values and are used as a basis to establish the Performance Score for the three Utilization criteria subcategories and the Quality criteria sub-categories Encounters and Preventive Health Services. If a PCP is part of a Medical Specialty Group, these actual values are averaged out, and the separate totals for each aid category or sub-category for the three components of the Utilization Pool, together with the Encounters and Preventive Health Services components of the Quality Pool, are totaled to produce the "Average Values Adjusted for Case Mix".

5.3 Calculation of Performance Scores

The performance scores are calculated by dividing the total Actual Values by the Average Values Adjusted for the Case Mix to determine the resulting percentage score. For example, if Dr. John Doe's actual Physician/Outpatient Hospital Expenses total $32,946.41 (Actual Value) and the Average Values Adjusted for Case Mix total $24,432.26 for the same time period, then Dr. Doe's performance score for this criteria would be 134.85%. Performance scores for Inpatient Hospital, Pharmacy, Encounters and Preventive Health Services criteria will be calculated using the same methodology.

5.4 Variables Used In Calculating Earned Percent Of Pool

	% Of Pool Earned		Clinic's Performance	
	Min %	Max %	Start Pay	Max Pay
Utilization Pool Criteria Expenses:				
Physician/Outpatient	20%	120%	110%	75%
Inpatient Hospital	20%	120%	110%	50%
Pharmacy	20%	120%	110%	75%

Quality Pool Criteria				
Encounters	20%	100%	90%	125%
Office Hours	20%	100%	30 hours	45 hrs
Chart Quality	20%	100%	80%	100%
Preventive Health Services	20%	100%	90%	125%
Immunization Timeliness	20%	100%	90%	100%

5.5 Incentive Payments

The Incentive Payment for each Utilization Pool and Quality Pool sub-category is determined by multiplying the sub-category Pool amount by the corresponding earned percent of Pool values.

6. INCENTIVE PAYMENTS

The total Incentive Payment for each Clinic for the Fiscal Year is equal to the sum of the Utilization Pool and Quality Pool sub-category Incentive Payments. If County qualifies for a total Incentive Payment, such payment shall be made in two installments within six (6) months of the close of that Fiscal Year. The initial payout of 25% of the estimated total Incentive Payment will be made in July following the close of the previous Fiscal Year, with the remaining Incentive Payment to be paid in December of that Fiscal Year.

7. CHANGES IN PRACTICE OWNERSHIP AND GROUP MEMBERSHIP

Incentive Payments represent additional payment for performance during each Fiscal Year. When a PCP commences or terminates membership in a Clinic, this change will affect distribution of potential PCP Incentive Program payments. County should send written Notice of the date of the transfer and any relevant terms related to accounts receivable, as soon as possible.