



# Program Description for Enhanced Personal Health Care

*Known nationally as Blue Distinction Total Care*

*Modified 01/01/16*

# Introduction

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Our health care system has created an untenable situation for many providers: not enough time to offer the comprehensive, patient-centered care they want to deliver, and a payment model that rewards volume of visits or procedures rather than compensating them for time spent on prevention, holistic care and care planning. 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.<sup>1,2</sup> The fact that more Americans have health care coverage now than ever before makes the need for adopting a value-based system and coordinated delivery system more urgent.

At Anthem Blue Cross, we are working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. Nearly 71 million people are served by our affiliated companies, including more than 38 million enrolled with us and our affiliated health plans.

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

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

- A redesign of current payment models to align financial incentives and provide compensation for important clinical interventions that occur outside of traditional patient encounters;
- Support for risk-stratified care management;
- The sharing of meaningful information regarding patients that goes beyond the information captured in the physicians' medical record; and
- 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.

Anthem Blue Cross designed Enhanced Personal Health Care based on years of experience. Anthem Blue Cross has been a leader in its support for the patient-centered care model through its participation in patient-centered medical home ("PCMH") programs across the country. The results were persuasive enough to cement our commitment to patient-centered care. In our studies to date, we have observed improvement in compliance with evidence-based guidelines and a reduction in

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<sup>1</sup> 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>

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

avoidable, unnecessary admissions and emergency room visits along with maintenance or improvement in the quality of health care services.

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

The Program includes our own Anthem Blue Cross-specific Enhanced Personal Health Care Program for Primary Care, and includes the Comprehensive Primary Care ("CPC") initiative (collectively, the "Program"). CPC is an effort by the Centers for Medicare and Medicaid Services ("CMS") to align multiple payers around select physician practices in specific geographic areas for the purpose of transforming payment and practice redesign. The Anthem Blue Cross markets with participating physicians in the CPC initiative are Colorado (statewide), New York (Mid-Hudson and Capital District region), and Ohio (including the Cincinnati/Dayton region and four northern counties in Kentucky). Further details about the applicability of the Program can be found in Section 1, under "Scope."

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

We are providing this Program Description to give 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. Towards that end, we have organized this Program Description into sections by topic as outlined in the Table of Contents.

Instances where CPC varies from the Anthem Blue Cross-specific Enhanced Personal Health Care Program are identified at the end of each section within this Program Description as "special terms." For physicians participating in CPC, to the extent that CPC special terms identified in this Program Description conflict with any other provision, the CPC special terms control. We have also included a Glossary of frequently used terms. Though all of these terms are defined when they are first used in either the Attachment or this Program Description, you may refer to the Glossary as a quick reference guide.

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

Market	Mailbox
California	<a href="mailto:CAEPHC@anthem.com">CAEPHC@anthem.com</a>
Colorado	<a href="mailto:COPrimaryCareProgram@anthem.com">COPrimaryCareProgram@anthem.com</a>
Connecticut	<a href="mailto:CT_PrimaryCareProgram@anthem.com">CT_PrimaryCareProgram@anthem.com</a>
Georgia	<a href="mailto:GA_PrimaryCareProgram@bcbsga.com">GA_PrimaryCareProgram@bcbsga.com</a>
Indiana	<a href="mailto:IN_PrimaryCareProgram@anthem.com">IN_PrimaryCareProgram@anthem.com</a>
Kentucky	<a href="mailto:KY_PrimaryCareProgram@anthem.com">KY_PrimaryCareProgram@anthem.com</a>
Maine	<a href="mailto:ME_PrimaryCareProgram@anthem.com">ME_PrimaryCareProgram@anthem.com</a>
Missouri	<a href="mailto:MO_PrimaryCareProgram@anthem.com">MO_PrimaryCareProgram@anthem.com</a>
Nevada	<a href="mailto:NV_PrimaryCareProgram@anthem.com">NV_PrimaryCareProgram@anthem.com</a>
New Hampshire	<a href="mailto:NHPrimaryCareProgram@anthem.com">NHPrimaryCareProgram@anthem.com</a>
New York	<a href="mailto:NYPrimaryCareProgram@empireblue.com">NYPrimaryCareProgram@empireblue.com</a>
Ohio	<a href="mailto:OHPrimaryCareProgram@anthem.com">OHPrimaryCareProgram@anthem.com</a>
Virginia	<a href="mailto:VAPrimaryCareProgram@anthem.com">VAPrimaryCareProgram@anthem.com</a>
Wisconsin	<a href="mailto:WI_PrimaryCareProgram@anthem.com">WI_PrimaryCareProgram@anthem.com</a>

### Program Communications

In the recruitment packet you received for the Program, you were required to complete a Key Contacts Form. Communications regarding program changes, updates, and activities will be sent to the e-mail address you listed for your provider organization. If you have an update to the e-mail address used in the online form, you must send us the update request in writing. Twenty (20) business days after we receive your request, we will begin using your new e-mail address. You will need to keep this information current with us to ensure you are receiving important Program-related communications.

***Important Note About Program Information, Resources and Tools***

- The information, resources, and tools that Anthem Blue Cross provides to you through the Enhanced Personal Health Care Program are intended for general educational purposes only, and should not be interpreted as directing, requiring, or recommending any type of care or treatment decision for Anthem Blue Cross members or any other patient. Anthem Blue Cross cannot guarantee that the information provided is absolutely accurate, current or exhaustive since the field of health is constantly changing.
- The information contained in presentations that Anthem Blue Cross makes available to you is compiled largely from publicly available sources and does not represent the opinions of Anthem Blue Cross or its personnel delivering the presentations.
- If [Legal Entity Title provides links to or examples of information, resources or tools not owned, controlled or developed by [Legal Entity Title) this does not constitute or imply an endorsement by Anthem Blue Cross. Additionally, we do not guarantee the quality or accuracy of the information presented in, or derived from, any non-health plan resources and tools.
- We do not advocate the use of any specific product or activity identified in this educational material, and you may choose to use items not represented in the materials provided to you. Trade names of commonly used medications and products are provided for ease of education but are not intended as particular endorsement.
- None of the information, resources or tools provided is intended to be required for use in your practice or infer any kind of obligation on you in exchange for any value you may receive from the program. Physicians and other health professionals must rely on their own expertise in evaluating information, tools, or resources to be used in their practice. The information, tools, and resources provided for your consideration are never a substitute for your professional judgment.
- With respect to the issue of coverage, each Anthem Blue Cross Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. If Members have any questions concerning their benefits, they may call the Member Services number listed on the back of their ID card.

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# Section 1: Program Overview

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## 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 primary care physicians to do what they can do best: manage all aspects of their patients' care.
- Provide physicians with tools, resources and meaningful information that promote (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 primary care physician who will not only care for the "whole person" but also 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, and
  - ✓ Optimizing their health.

## SCOPE

The Program applies to Provider and Anthem Blue Cross participating Represented Primary Care Physicians and/or Represented Physicians, as applicable, who are in good standing, and who have signed or are covered under our Enhanced Personal Health Care Attachment for Primary Care that includes the Medical Cost Target and/or Medical Loss Ratio payment models and/or Medicare Advantage, the Enhanced Personal Health Care Attachment for Freestanding Patient-Centered Care, the Enhanced Personal Health Care Agreement for Freestanding Patient-Centered Care, the Comprehensive Primary Care Attachment, or any agreement that incorporates an Enhanced Personal Health Care Attachment (collectively, the "Attachment").

## Section 2: Roles

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We are making several Program resources available to support and collaborate with you to achieve successful outcomes and reach Program goals. The following information describes roles developed to support the Program. The names of these support staff members and their contact information will be available via Anthem Blue Cross's provider portal prior to the Program Attachment Effective Date or as soon thereafter as practicable. Some roles may vary by state, and the level of interaction with the support team may vary by organization.

### **Network Director for Payment Innovation Programs**

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

### **Contract Advisor**

The Contract Advisor provides support for contract amendments, practice operations, implementation and ongoing maintenance of the Program. This team member organizes local meetings and collaborative learning events for the provider organizations.

### **Care Consultant Senior**

The Care Consultant is a quality improvement trained specialist who focuses on work flows and process improvement. This team member uses reports to help focus on interventions that improve population health outcomes by maximizing available practice resources, establishing quality improvement structures, and linking practices to relevant community resources. The Care Consultant works collaboratively with providers and care teams to establish data driven transformation action plans that impact shared savings and quality measures. In addition, the Care Consultant hosts collaborative learning events that allow practices to learn from their peers and national experts, and creates and hosts tailored learning opportunities for continuing education credit.

### **Provider Clinical Liaison**

The Provider Clinical Liaison ("PCL") supports provider organizations' development of care coordination and care management skills, interpretation of reports, and assistance with identification of patients who can benefit from a care plan. This individual also educates providers and staff around the elements of a care plan and care plan creation. Additionally, the PCL serves as a subject matter expert on the health plan's disease management, case management and behavioral health programs. The PCL helps practices manage Attributed Members who have more complex needs by leveraging available health plan programs. The PCL promotes seamless coordination between the Primary Care Provider's care plan for his or her patients and the health plan-sponsored programs that support the PCP's care plan.

## **Referral Specialist**

The Referral Specialist works closely with the PCL and is responsible for processing referrals that practices submit to health plan sponsored programs. The Referral Specialist provides support to the PCL with initial introduction of program requirements along with care planning and care coordination program curriculum. This curriculum includes non-clinical topics such as promoting the use of program tools (reports, toolkit, MMH+) and referrals into appropriate programs.

## **Pharmacist**

The Pharmacist serves as a member of the Anthem Blue Cross clinical team, and is a subject matter expert for pharmaceutical care management issues. The Pharmacist works collaboratively with the PCL to help identify pharmacy care management opportunities. The Pharmacist serves as a resource regarding formulary or certain medication questions (e.g. barriers to medication adherence).

## **Program Advisory Council**

Program Advisory Council ("PAC") members are participating providers who are leaders in the community and are knowledgeable and enthusiastic about patient-centered care. PAC members provide valuable feedback to Anthem Blue Cross regarding Program design and execution. PAC members are asked to consider and offer their opinions about the Program, from its foundational structure to individual communication materials. Their advice and insight helps ensure that Program tools and support are meaningful and useful to participating providers.

## ROLES WITHIN YOUR PROVIDER ORGANIZATION

The roles listed on the previous pages were established to help your provider organization be successful in establishing and maintaining a patient-centered care approach. 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.

### Transformation Team Members

The Transformation Team Members are those individuals in your provider organization who participate in Program activities focused on improving patient care using recognized quality improvement methodology. Ideally this group of individuals should include a representative from each area within your office (front office, back office, clinical, billing, etc.).

### **Comprehensive Primary Care (CPC) Initiative Special Terms**

The roles identified in this section will not apply to the CPC Initiative. The responsibilities addressed by the clinical roles identified above will be assumed by the participating practices. CMS will also facilitate discussions with participating payers and practices to evaluate the CPC Initiative elements and develop and refine community-based approaches to care. [Legal Entity Title] will be a collaborative partner with the CPC community in the markets that have been selected by CMS.

## Section 3: Care Coordination and Care Plans

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### CARE COORDINATION

This section is designed to help you understand care coordination expectations and 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.”*<sup>3</sup> 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 records.<sup>4</sup>
- Identification and referral of patients into appropriate programs and community resources.

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

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

- Identify high-risk Covered Individuals with the support of Anthem Blue Cross reporting to ensure Covered Individuals are receiving appropriate care delivery services,

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<sup>3</sup> *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/caregaptp.htm>

<sup>4</sup> [http://www.improvingchroniccare.org/downloads/executive\\_summary\\_reducing\\_care\\_fragmentation\\_.pdf](http://www.improvingchroniccare.org/downloads/executive_summary_reducing_care_fragmentation_.pdf)

- Facilitate planned interactions with Covered Individuals with the use of up-to-date information provided by Anthem Blue Cross 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, and
- Adhere to a team-based approach to care, which drives proactive care delivery.

## CARE PLANS

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

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

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

- Prioritized goals for a patient's health status,
- Established timeframes for reevaluation,
- Resources to be utilized, including the appropriate level of care,
- Planning for continuity of care, including transition of care, and
- Collaborative approaches to be used, including family participation.

### *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. The care plan format will vary 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 online 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,
- The patient's self-management plan (also described on the following page), which includes:
  - A shared agenda for physician office visits, and
  - 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 reevaluation and follow-up, and
- 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, and
  - 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, and
- 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, and
- 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 Durable Power of Attorney (DPOA, Living Will, Health Care 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/ Body Mass Index (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 Primary Care Physician (“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 Chronic Conditions and Readmission Hot Spotter views (as further described in the Reporting section of this Program Description) include 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 Chronic Conditions and Readmission Hot Spotter views 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 core chronic conditions (as referenced further below).

Although we provide a list of Attributed Members who, through analytic reporting, have been identified as being at high risk, you will have additional real-time information from patient assessments that allows you to identify other high-risk Attributed Members. Anthem Blue Cross will collaborate with your provider organization team as Anthem Blue Cross determines appropriate to identify Attributed Members who have been determined by your organization as candidates to receive a care plan.

The Provider Clinical Liaison (“PCL”) may periodically review provider organization-identified Attributed Members with your care coordinator and/or care managers in “Clinical Touch Points,” which are clinical review meetings or discussions that provide a recurring forum for collaboration between the PCL and the care coordinator. The PCL may request to extend the ‘Clinical Touch Points’ to include your organization’s clinical management team. These meetings provide a venue to discuss trends, opportunities and desired outcomes related to high risk members, chronic condition management, population health processes, clinical programs/interventions and patient engagement/education. This time spent together will help to ensure the desired outcomes to optimize coordination of patient-centered care, promote quality interactions, and produce appropriate cost savings in overall medical and pharmacy utilization.

Attributed Members who may be candidates for care planning 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, chronic obstructive pulmonary disease (“COPD”), coronary artery disease (“CAD”), migraine, hypertension, or morbid obesity,
- Have comorbid medical and behavioral health conditions,

- Have a behavioral health diagnosis (depression, schizophrenia, dementia, bipolar) which will amplify the patient's risk score,
- Have specific risk drivers and/or high care gaps risk score, or
- 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/or some gaps in care. These are the people who 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, early identification of potential gaps in care, and addressing or avoiding 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 Personal Health Quest Two (“PHQ2”), Personal Health Quest Nine (“PHQ9”) or other nationally recognized tool

### ***Self-Management Support***

Self-management support means educating Attributed Members so that they may take a greater role and level of responsibility for improving their own health outcomes. Self-management support is the assistance caregivers offer to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership. The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.”<sup>5</sup>

You should encourage self-management through the following:

- Describing and promoting self-management by emphasizing the Attributed Member’s central role in managing his/her health,
- Including family members in this process, at the Attributed Member’s discretion,
- Building a relationship with each Attributed Member and family member,
- Exploring a Attributed Member’s values, preferences and cultural and personal beliefs to optimize instruction,
- Sharing information and communicating in a way that meets the Attributed Member’s and family’s needs and preferences,
- Informing and connecting Attributed Members to community programs to sustain healthy behaviors,
- Collaboratively setting goal(s) and developing action plans,
- Documenting the patient’s confidence in achieving goals, and
- Using skill building and problem-solving strategies that help the Attributed Member and family identify and overcome barriers to reaching goals.<sup>6</sup>

### **Comprehensive Primary Care (CPC) Initiative Special Terms**

There are no significant differences between the Enhanced Personal Health Care and CPC for this section.

<sup>5</sup> Tom Bodenheimer, Helping Patients Manage Their Chronic Conditions, [www.chcf.org](http://www.chcf.org) , 2005

<sup>6</sup> [http://www.improvingchroniccare.org/downloads/partnering\\_in\\_selfmanagement\\_support\\_a\\_toolkit\\_for\\_clinicians.pdf](http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support_a_toolkit_for_clinicians.pdf)

## Section 4: Program Requirements and Transformation

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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, (nationally known as Blue Distinction Total Care), is the commitment to adopting a patient-centered care model. Actively engaging patients and their families in the care process is the core attribute of patient-centered care. 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 that the patient and the patient's family are active participants in reaching their optimum health. The first step to engaging your patients in the patient-centered model is to communicate your commitment to this model of care and tell your patients what to expect from your provider organization as a result of that commitment— and how they can actively participate in their own care.

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" sub-section 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 and use a series of web based tools and data platforms, including MMH+, Patient360 and Availity (as referenced below).

### **MEMBER MEDICAL HISTORY PLUS ("MMH+")**

Physicians with Attributed Members enrolled in Anthem Blue Cross's commercial products ("commercial Attributed Member") participating in the Program are required to gain access to and utilize Anthem Blue Cross's MMH+ system. This section will help you understand the benefits of this system and how you can gain access and utilize this tool in a manner that will help you manage the health of your patients.

Member Medical History Plus or MMH+ is a web-based tool that combines our rich claims-based data with lab results from our contracted reference lab partners to create a longitudinal record that gives physicians visibility to the health care services received by their patients, whether received within or outside their provider organization or whether prescribed by them, another physician or received by the patient on self-referral. Having access to more complete information (e.g., specialty visits, prescription medications, etc.)

than what may be contained in the medical record maintained by you or your provider organization is instrumental for care coordination and management. It will enable you to develop data-informed comprehensive care plans for your patients.

From MMH+, users can learn the following information about a Covered Individual:

- Physicians seen by the Covered Individual
- Covered Individual demographics
- Eligibility history
- Diagnoses the Covered Individual has had
- Procedures performed on the Covered Individual
- Medications filled by the Covered Individual
- Care Alerts
- Lab results for the Covered Individual (if performed at certain national labs)
- Utilization management and case management for services provided to the Covered Individual

Users can export the reports to Excel and place them in the Covered Individual's chart.

**MMH+ is easy to use.** No special hardware is needed. No software has to be installed. Only a computer with internet connection is needed to use the system.

**MMH+ is secure.** It meets all HIPAA security requirements. It provides two levels of access. Initially, certain sensitive information (e.g. reproductive-related, mental health- related) is not displayed. However, in emergency situations, you can activate a "break glass" option to see the complete report.

**MMH+ is free.** There is no charge for you to use MMH+.

**MMH+ is fast.** On average it takes only a few seconds to retrieve a Covered Individual's record. With defaults of 1 and 2 years and custom date ranges, MMH+ can provide up to 6 years of history.

As noted above, under the terms of the Program, you are required to access and utilize MMH+ to manage your Attributed Member population. To gain access, you will need to complete the MMH+ Access Request Process form. The MMH+ Access Request Process Form is included in our Program recruitment packet and must be returned, along with other specified materials, in order to begin your participation in the Program. For your convenience, an additional copy of the MMH+ Access Request Process Form is included in *Section 10: Appendix* of this Program Description.

For a demonstration or further information on MMH+, please contact your Contract Advisor or local provider contract representative.

**NOTE:** BlueCard membership information will not be available in MMH+.

## **PATIENT360**

Physicians with Medicare Advantage Attributed Members participating in the Program are required to access and utilize Anthem Blue Cross's Patient360 system. This section will help you understand the benefits of this system and how to access and utilize this tool in a manner that will help you manage the health of your patients.

Patient360 is a real-time dashboard that gives you a robust picture of a patient's health and treatment history and is designed to facilitate care coordination. It allows you to quickly retrieve detailed records about your Anthem Blue Cross Medicare Advantage Members through our provider self-service website using Patient360.

With this tool you will be able to drill down to specific patient details including:

- Demographic information
- Care summaries
- Claims details
- Authorization details
- Pharmacy information
- Care management activities

With this level of detail at your fingertips, you'll be able to:

- Immediately retrieve a complete medical history for new patients
- Spot utilization and pharmacy patterns
- Avoid service duplication
- Identify care gaps and trends
- Coordinate care more effectively
- Reduce the number of communications needed with case managers

There is no additional registration or sign up needed for Provider 360. To access:

1. Log into Availity
2. Navigate to *"My Payer Portals"*
3. Select *"Anthem Blue Cross Medicare Advantage Provider Self Service"*
4. Select *"Member Information"* to go to the Patient360 home page.

## **AVAILITY – Getting Started With Population Management**

Population health management and the sharing of health information are core components of the Program. 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 is NOT currently registered for the Availity web portal:

1. The designated administrator for your organization should go to [www.availity.com](http://www.availity.com).
2. Click *"Get Started"* under *"Register Now for the Availity Web Portal"*
3. Complete the online registration wizard.
4. Your designated Primary Access Administrator ("PAA") will receive an email from Availity with a temporary password and information on next steps.

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.

## 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](http://www.Availity.com) and log in
2. Select "Account Administration" in the Availity menu
3. Select "Maintain Organization" Please note: If the PAA is tied to multiple organizations, select the organization to proceed.
4. Select "Provider Online Reporting Enrollment Administration" link
5. Verify your Organization and Payer information
6. Click "Submit"
7. You will be redirected to the Provider Online Reporting site and will see "Welcome to Provider Online Reporting."
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. Click "Logout" to complete the registration process on Availity, which is still running as an active session in the background.
14. Select the link "Verify Enrollment in Provider Online Reporting"
15. You will then receive a pop-up message stating the organization is currently registered.
16. Close Window

**Availity User Set Up** - To register users to access the Enhanced Personal Health Care Reports, complete these steps:

### Adding a New User in Availity:

1. Select "Account Administration | Add User" from the Availity menu and complete the required fields for access.
2. Click the "Provider Online Reporting" check box under Roles, click "next", and then click "Submit". A temporary password and User ID will be provided to the PAA.

### Editing Roles in Availity:

1. Select "Account Administration | Maintain User" from the Availity menu
2. 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 "Provider Online Reporting" and click save.

## PLEASE NOTE:

After assigning user roles in Provider Online Reporting, users –including the PAA –must log out and log back in to Availity to see the updated role assignment

Users can access the Provider Online Reporting application from the left navigation menu in Availity: My Payer Portal > Provider Online Reporting.

Register and set up new user in Provider Online Reporting:

1. The PAA will log into Availity, click "*My Payer Portal*" then "*Provider Online Reporting*,"
2. Verify Organization and Payer and click "*Submit*".
3. Select *Maintain User*  
Select "*New users available to be registered*"
4. The PAA may select the group, the role that is appropriate for the user needing access (i.e. 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, please contact Availity Client Services at 1-800-282-4548.

## **PATIENT REGISTRY**

Program requirements identify expectations around your use of a patient registry. The information below provides you with the details you need to successfully utilize 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 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 meets 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 PCMS, 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. You can also contact your local Enhanced Personal Health Care Team member as directed in your Welcome Packet.

## COLLABORATIVE LEARNING EVENTS

To help ensure Program success, a culture of learning is deemed essential for participants. To meet this Program component, participants shall provide an email contact for learning event pre-registration with the expectation that at least one participant from the organization participate in scheduled events. The email contact provided shall be a designated person in the practice who helps to champion a culture of learning. Learning events include the following:

- A National Transformation webinar series that features state of the art transformation topics delivered by national experts.
- Practice Essentials, a virtual curriculum designed to help primary care practices take the first steps toward practice transformation and move along the medical home continuum. Through this comprehensive, customizable curriculum, we guide practices step-by-step through quality improvement methodology to achieve sustainable change and improve patient satisfaction, clinical outcomes and value.
- *Achieving the Triple Aim* Intervention bundles. This continuing education series promotes small, straightforward sets of evidence-based practices (generally three to five) that, when performed collectively and reliably, have been proven to improve patient outcomes. Note: CEU/CME credit is available.
- A pediatric-focused learning series that features transformation topics delivered by national pediatric experts.

All sessions are recorded in order to offer viewing at a time that is convenient for learners.

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

## PROVIDER TOOLKIT

The Provider Toolkit, found on the Enhanced Personal Health Care webpage, serves to provide you with research and tools that will support your organization during transformation activities. These resources are available to help enhance your organization's performance, quality, operations and establishment of care coordination and care management processes, as well as maximizing health information technology, including registry functionality. The Provider Toolkit offers resources that address self-management support, motivational interviewing, and enhanced access to care for your patients. In addition you will find information for complimentary access to the American College of Physicians' Practice Advisor (ACP Practice Advisor®). Our Care Consultants, as well as our other local transformation team members, are available to answer additional questions and provide you with more information about the Provider Toolkit and its contents.

## PRACTICE ADVISOR

ACP Practice Advisor is an online tool offered at no cost to assist practices interested in improving clinical or office operations or in adopting or expanding use of the patient-centered care model. Your local transformation and market team will help you to get set up with Practice Advisor. Please notify your Contract Advisor or Care Consultant for any questions related to getting started with Practice Advisor.

Practice Advisor module topics include:

- Building the Foundation
- Specialty Practice Recognition
- Improving Clinical Care
- Managing your Practice
- Maintenance of Certification from the American Board of Internal Medicine (ABIM)

Each module is organized in the following categories to help practices enhance patient care and office efficiency:

- Background material – quick general information about a topic
- Case study – shows how the information in a module can be applied
- Practice Biopsy – self assessment questions related to standards set by National Committee for Quality Assurance (“NCQA”), URAC and Joint Commission
- Comprehensive Master Library of articles, books, videos, webinars, downloadable guides and policy templates

**Comprehensive Primary Care (CPC) Initiative Special Terms**

The Provider Practice Toolkit for the Enhanced Personal Health Care Program will be available for use under the CPC Initiative; however, it will not be CPC-specific.

## Section 5: Quality Measures and Performance Assessments

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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.

Quality measures and performance assessments differ, in some cases, based on lines of business. The different measures and assessments for Attributed Member populations in the Commercial and Medicare Advantage lines of business are described separately below:

### *COMMERCIAL LINE OF BUSINESS*

#### **QUALITY MEASURES & PERFORMANCE ASSESSMENTS**

**\*\*All terms and provisions in this and all Commercial business-designated subsections shall refer only to Commercial business Medical Cost Target Model and not to Medicare Advantage business. \*\***

#### **MEASURES - COMMERCIAL BUSINESS MEDICAL COST TARGET INCENTIVE MODEL**

The Performance Scorecard is comprised of clinical quality measures and utilization measures. 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. Given the importance of measurement to the Program, it is critical to select meaningful measures.

We use the following measurement criteria, consistent with the National Quality Forum ("NQF"), to select Program measures. We select measures that are:

- **Measureable and reportable** in order to maintain focus on priority areas where the evidence is highest that measurement can have a positive impact on health care quality.
- **Useable and relevant** to ensure that Providers can understand the results and find the results compelling to support quality improvement.
- **Scientifically acceptable** so that the measure, when implemented, will produce consistent (reliable) and credible (valid) results about the quality of care.
- **Feasible to collect** using data that is readily available for measurement and retrievable without undue burden.

There are currently over 700 clinical quality measures endorsed by the NQF. The above criteria were considered when reviewing which clinical quality measures to use for the Program. At this point in time, measures that require patient surveys or biometric data are not included. We see this as an important area to pursue as the Program evolves in order to increase the types of care that can be measured and to eventually include measures of even greater clinical importance.

In some instances, pharmacy information may not be available for certain membership. Membership that is lacking pharmacy detail will be excluded from the measures that require pharmacy information. Once pharmacy information becomes available to Anthem Blue Cross, the data will be phased into the measures.

### ***Clinical Quality Measures***

The clinical quality measures currently included in the Performance Scorecard and outlined in the Commercial Business Medical Cost Target Measurement Period Handbook (referenced below) are grouped into two categories: (1) Acute and Chronic Care Management and (2) Preventive Care. These categories may be further broken out into sub-composites. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.

### ***Utilization Measures***

The utilization measures in the Performance Scorecard and outlined in the Commercial Business Medical Cost Target Measurement Period Handbook (referenced below) focus on measures such as appropriate emergency room ("ER") utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and generic dispensing rates for select sets of drug classifications. As with the clinical metrics, administrative data are used to construct the utilization measures.

## **COMMERCIAL BUSINESS MEDICAL COST TARGET MEASUREMENT PERIOD HANDBOOKS**

Anthem Blue Cross is committed to providing you with details on quality, utilization and improvement goals and scoring methodology in advance of the start of each Measurement Period (as defined in Section 8, *Incentive Program-Commercial Business Medical Cost Target Model*) Approximately 90 days prior to the start of each Measurement Period, Anthem Blue Cross will provide you with a "Commercial Business Measurement Period Handbook" ("Medical Cost Target Measurement Period Handbook" (MCT Measurement Period Handbook) specific to the program(s) in which you are participating) which, among other things, will contain the applicable quality, utilization, improvement and other performance measures for the Measurement Period. It will also provide the scoring methodology for these measures, including the tiers of performance thresholds that explain how higher performance equates to higher scores. Performance benchmarks will not be included in the MCT Measurement Period Handbook but will be provided to you prior to the start of each Measurement Period or as soon thereafter practicable.

If, upon receipt and review of the MCT Measurement Period Handbook, you determine you no longer desire to participate in the Program, you must notify Anthem Blue Cross in writing within 30 days after the date the MCT Measurement Period Handbook was sent unless otherwise communicated to you by Anthem Blue Cross. If such notice is given, the Commercial Business provisions of the applicable program Attachment shall terminate, your participation in the Program will end on the date communicated to you by Anthem Blue Cross, and the MCT Measurement Period Handbook will never apply to you. If you do not provide such notice, the Attachment shall remain in effect, and the MCT Measurement Period 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 "Commercial Business Medical Cost Target" shall be effective, enforceable and implemented, notwithstanding any conflicting or contrary provision (including provisions relating to amendments or Program termination) contained in the Attachment or in the Agreement to which it

is attached. To the extent that different notices or time-frames than described above are required by law, then the provisions of law shall supersede the contractual provisions of this section.

## PERFORMANCE ASSESSMENT - COMMERCIALBUSINESS MEDICAL COST TARGET

Performance on the selected Program clinical quality and utilization measures will be reported to you periodically throughout the year. The assessment of performance to define the proportion of shared savings that you earn will be conducted annually, and may also be conducted more frequently if interim payments (as outlined in Section 8, *Incentive Program-Commercial Business Medical Cost Target*) apply.

Performance on the clinical quality measures will be calculated specific to your organization, and scoring will occur at the Medical Panel-level (as defined in Section 8, *Incentive Program-Commercial Business Medical Cost Target and Section 8*) only in cases where the number of related cases is so small that it is not statistically or clinically meaningful. The utilization measures will always be reported at a Medical Panel-level to achieve sufficient denominator sizes for meaningful measurement.

The clinical quality and utilization scoring will be based on performance relative to market performance thresholds. These market thresholds are set based on the distribution of the performance across Anthem Blue Cross's network. If there is insufficient volume to generate robust market thresholds, then larger geographies such as regional or national may be leveraged to establish the performance thresholds. Better performance will generate a better score and correspond to a higher percentage of shared savings.

### *Improvement Scoring Opportunity*

Performance improvement is a core component of patient-centered transformation. Performance improvement begins with established measures as well as quality improvement processes. The steps for effective performance improvement are listed below.

#### **Steps for Performance Improvement:**

- 1) Choose a measure.
- 2) Determine a baseline.
- 3) Evaluate performance.
- 4) If performance is not to desired level, develop a performance aim.
- 5) Make changes to improve performance.
- 6) Monitor performance over time.

In addition to assessing performance against thresholds, a subset of the clinical measures will be scored for improvement. The selection of these measures will take into account the current performance on measures. These improvement measures will be assessed at the Provider (as defined in the Attachment) level and will be weighted equally for each measure that has a sufficient denominator size. If no measures are sufficiently large to be statistically valid, no score for this category will be provided.

Scoring on these measures is based upon the performance by the physician group on these measures in a Baseline Period compared to the Measurement Period (as defined in Section 8, *Incentive Program-Commercial Business Medical Cost Target Model*).

## **LINKING PERFORMANCE ASSESSMENT TO SHARED SAVINGS**

The opportunity to share in savings that are accrued due to enhanced care management and delivery of care is a key characteristic of the Program. After any savings are determined, the proportion of shared savings that you can earn is determined by level of performance on a "Performance Scorecard" comprised of clinical and utilization measures. The Performance Scorecard serves two functions: (1) quality gate, and (2) overall determinant of proportion of shared savings you earn.

### ***Quality Gate***

Your organization must achieve a minimum threshold of performance on clinical quality measures to have the opportunity to earn a portion of the shared savings. The quality gate is a threshold defined by Anthem Blue Cross, and is set so that performance on the clinical quality composites must be above a predetermined percentile of the market performance as defined in the MCT Measurement Period Handbook.

### ***Proportion of Shared Savings Earned***

After the quality gate is satisfied, the proportion of shared savings you receive depends on scores on the clinical sub-composite scores, the utilization score, and the improvement score that are defined above. The better the performance, the greater the proportion of shared savings earned.

## **OTHER Anthem Blue Cross QUALITY INCENTIVE PROGRAMS**

Unless otherwise indicated, the Program(s) 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 Attachment 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.

## **MEDICARE ADVANTAGE LINE OF BUSINESS QUALITY MEASURES & PERFORMANCE ASSESSMENTS**

**\*\*All terms and provisions in this and other Medicare Advantage subsections shall refer only to Medicare Advantage business and not to Commercial Business Medical Cost Target Model.\*\***

## **MEASURES - MEDICARE ADVANTAGE**

The Performance Scorecard is comprised of clinical quality measures as identified by the Centers for Medicare and Medicaid Services ("CMS") that align with the Medicare Stars Program. 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 Performance 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***

Anthem Blue Cross 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 Anthem Blue Cross 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 MA Handbook is delivered later than the Commercial Handbook because the MA Handbook's delivery is dependent on CMS's 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 not be included in the MA Handbook, but will be provided to you prior to the start of each Measurement Period or as soon thereafter practicable.

If, upon receipt and review of the MA Handbook, you determine you no longer desire to participate in the Program, you must notify Anthem Blue Cross in writing within 30 days after the date the MA Handbook was sent, unless otherwise communicated to you by Anthem Blue Cross. If such notice is given, the Attachment shall terminate, your participation in the Medicare Advantage Program will end on the date communicated to you by Anthem Blue Cross, and the MA Handbook will never apply to you. If you do not provide such notice, the Attachment 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 Attachment or in the Agreement

to which it is attached. 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. Assessments may also be conducted more frequently if interim payments (as outlined in Section 8, *Incentive Program*) apply. 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 Anthem Blue Cross. The quality threshold will be based on CMS Star quality levels four and five, and determined by Anthem Blue Cross. 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 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.

## **OTHER Anthem Blue Cross 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 Attachment 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.

### ***Comprehensive Primary Care (CPC) Initiative Special Terms***

Community-driven metrics and measures were developed in support of the CPC Initiative. These community-driven metrics and measures are used when assessing performance under the Incentive Program, which is further outlined in Section 8 of this Program Description.

## Section 6: Attribution Process

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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.

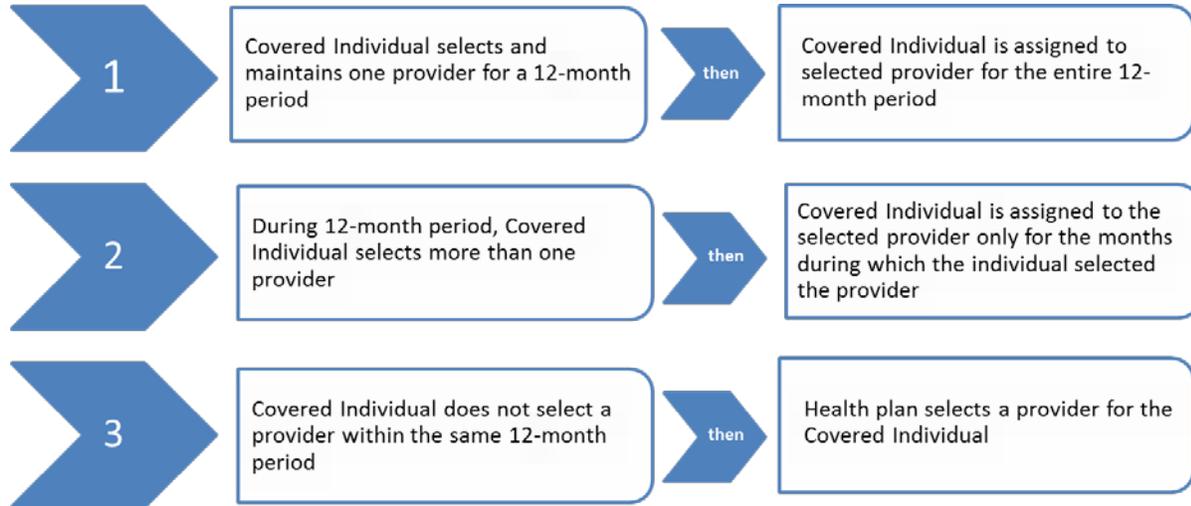
Depending on the product, Anthem Blue Cross will use an Attribution algorithm that is simple, logical and reasonable to enable the most appropriate assignment of Covered Individuals to participating providers. Based on this algorithm, Anthem Blue Cross offers providers a list of patients who have been assigned to them. Provided below is an overview of the Program's Attribution algorithm for: (1) a product where Covered Individuals select a PCP, and (2) an open access product.

The Attribution process for open access products may be used exclusively for certain Covered Individuals, and is generally based on historical Claims data, except in certain (but not all) cases where PCPs are specified by the Covered Individual. Due to certain contract restrictions, customer requirements, Program specific product limitations, and technological limitations, etc., it will not be possible to include all Covered Individuals as Attributed Members in the Program. For example, if an employer group prohibited us from including their employees in the Program, these Covered Individuals would not be Attributed Members. Also, there are Programs that focus on specific product inclusion and therefore members of other products wouldn't be included as Attributed Members. Therefore, certain lines of business, employer groups or Covered Individuals may be excluded from the Program at Anthem Blue Cross's sole discretion. Covered Individuals whose Anthem Blue Cross coverage is secondary under applicable laws or coordination of benefit rules or whose coverage is provided under a supplemental policy (e.g., Medicare supplement) shall never be Attributed Members. It is Anthem Blue Cross's goal to continue to expand the Covered Individuals included in monthly attribution report as operationally feasible and contractually permitted.

BlueCard members who are attributed to you at the start of your Measurement Period and used to calculate your MCT will be the only BlueCard membership that will be attributed to you throughout your entire Measurement Period. For example, on October 1, 2016, if you have 200 BlueCard members attributed to a physician in your practice, those 200 BlueCard members will be the only BlueCard members included in the program for that Measurement Period, and no additional BlueCard members would be attributed to that physician until the start of the next Measurement Period. The only exception to this would be the instance whereby a BlueCard member is already attributed to one practice, and that practice's Measurement Period started on or before your practice's Measurement Period, and the member then moves to your practice during the Measurement Period. In this instance, if this member is then attributed to your practice, this member would also be included in your current Measurement Period

### *Attribution for Products Where Covered Individuals Select a PCP*

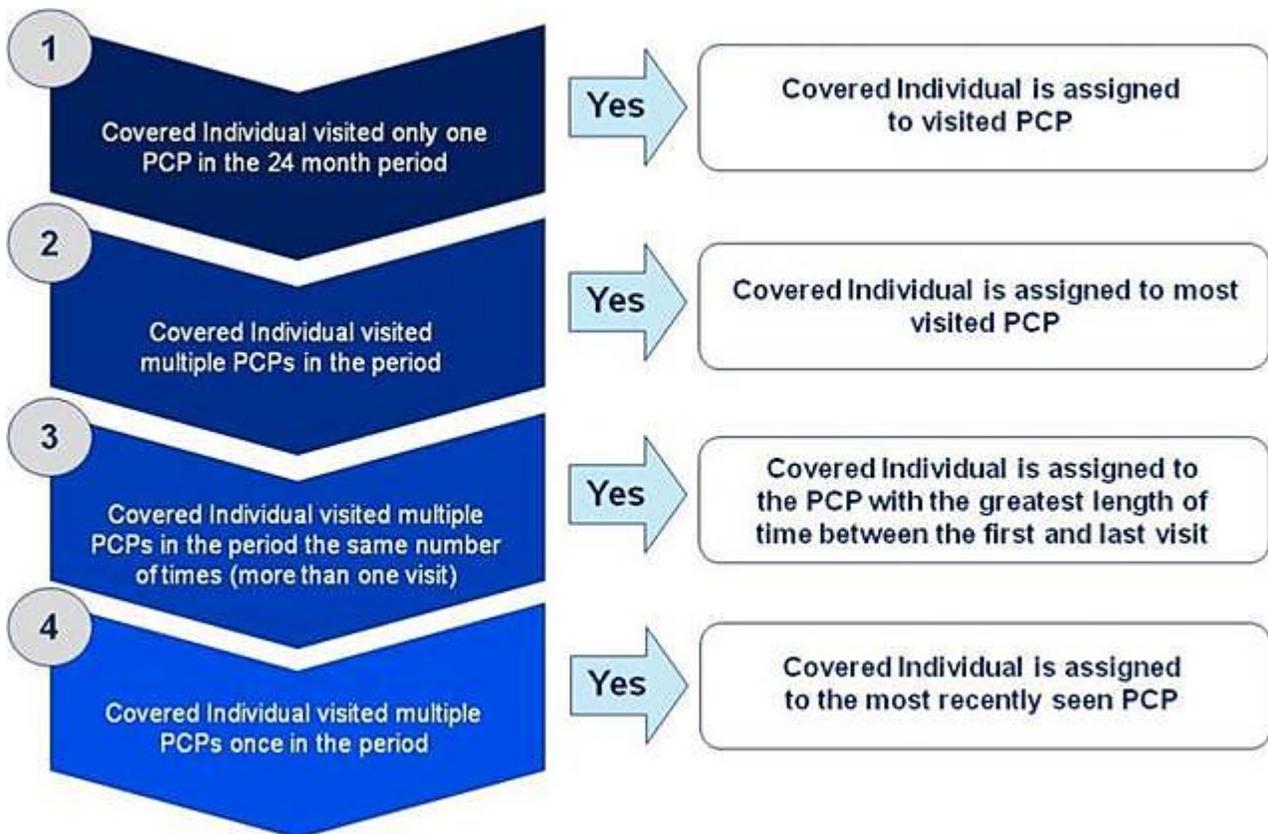
In these products (for example, HMO), the following decision framework is generally used to assign Covered Individuals to PCPs. In this scenario, a Covered Individual must have at least 1 active month with the selected PCP:



## Visit-based Attribution

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

Initially, Anthem Blue Cross reviews available historical Claims data incurred during a 24 month period, with 3 months of Claim run-out, to assign Covered Individuals. For this scenario, Covered Individuals must be eligible members for at least 6 months in the entire 24 month period (irrespective of product) and at least one month within the most recent 12-month period. Upon initial assignment to a provider, attribution for an open access product is re-run on a quarterly basis to ensure that the most recent Claims information is utilized for attributing Covered Individuals.



### ***Distinctions between Attribution for Clinical Coordination Payments and Incentive Program Payments***

It is important to note that there are some differences between the Attribution Methodology used for clinical coordination payments and the Attribution Methodology used for Incentive Program payments. For example, reimbursement for clinical coordination payments (see Section 7) is based on current Attributed Membership in a given month. Reimbursement for Incentive Program payments (see Section 8) is based on Member Months for Attributed Membership during the associated Measurement Period. Further, an Attributed Member who has Member Months attributed to him/her in the Baseline Period may not have Member Months attributed to him/her in the Measurement Period if, for example, the Attributed Member changed PCPs or visit patterns during the Measurement Period.

There are also times when the total Member Months for an Attributed Member during a completed Measurement Period may be higher than the sum of Member Months attributed to that same individual in monthly attribution reports. For example, when a Covered Individual is attributed to a physician during a Measurement Period using visit-based attribution, that Covered Individual may be attributed to a physician for the full Measurement Period as long as he/she had medical coverage in those months, even if the member was not included in the monthly attribution reports for those months.

As a final example, when a physician with Attributed Members leaves a practice, if his/her Attributed Members stay with the practice, and the Attributed Members do not select a different PCP or have record of visiting another provider in the practice, then those Attributed Members will remain attributed to the practice for purposes of clinical coordination payments, but will not be counted as an Attributed Member for the incentive program payment calculations.

#### ***Comprehensive Primary Care (CPC) Initiative Special Terms***

There are no significant differences between the Enhanced Personal Health Care and CPC for this section.

## Section 7: Clinical Coordination Reimbursement

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### 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 by program and by provider.

### PAYMENT PROCESS

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

### RETROACTIVITY

On a monthly basis, Anthem Blue Cross 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 Anthem Blue Cross 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 Attachment or by a provision of law. Such retroactive adjustments will be applied at the Program level.

## Section 8: Incentive Program

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### 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 Anthem Blue Cross. 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 - COMMERCIAL BUSINESS MEDICAL COST TARGET MODEL*

**\*\*All terms and provisions in this and all Commercial Business- Medical Cost Target Model designated subsections shall refer only to Medical Cost Target Model and not to Medicare Advantage.\*\***

As described more fully below, and subject to the below Incentive Program terms and details, Anthem Blue Cross will calculate any shared savings opportunity by comparing the actual annual Claims cost during a specified 12 month "Measurement Period" for the applicable "Member Population" (the "Medical Cost Performance" ("MCP")) against the projected costs based on the Claims costs of the applicable Member Population during a prior 12 month period of time used to establish a "Medical Cost Target" ("MCT"), which is defined below. In the event that the MCP is less than the MCT, you may share in a percentage of the savings realized, provided that you meet the Quality Gate and other Non-Cost Performance Targets (as described in Section 5, *Quality Measures & Performance Assessment-Medical Cost Target Model*).

The 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.

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

"Gross Savings" means any amounts by which the MCP is less than the MCT, adjusted by the Paid/Allowed Ratio, as calculated by Anthem Blue Cross, at the end of a Measurement Period for each product requiring a separate product specific calculation. Gross Savings can be in the form of risk-adjusted per member per month (PMPM), depending on the product or line of business.

"Measurement Period" means the twelve (12) month period during which Medical Cost Performance, and quality and utilization performance, will be measured for purposes of calculating shared savings between Anthem Blue Cross and the Medical Panel.

"Medical Cost Performance" ("MCP") means the actual cost experience in the defined Member Population during a relevant Measurement Period, expressed in terms of risk-adjusted per member per month ("PMPM"), but excluding certain Covered Individuals with transplant or high cost Claims amounts. The formulae for setting the MCP take into account risk-adjusted ("PMPM") Claims experience within the Attributed Member Population during the Measurement Period, but exclude certain transplant and high cost Claims amounts. It also accounts for any clinical coordination per member per month payments made during the relevant Measurement Period to Provider by Anthem Blue Cross for Attributed Members. As part of the MCP calculation, a risk adjustment is made by Anthem Blue Cross through the Normalized Risk Score for the Measurement Period unless otherwise stated in the Measurement Period Handbook and/or the Attachment. A given Medical Panel may have multiple MCPs, which will aggregate membership separately by product type (e.g., HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through Anthem Blue Cross will be in a separate MCP than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager).

"Medical Cost Target" ("MCT") means the historic cost experience in the defined Member Population during the Baseline Period, trended forward and expressed in terms of risk-adjusted per member per month ("PMPM") but excluding certain Covered Individuals with transplant or high cost Claims amounts. The formulae for setting the MCT take into account risk-adjusted ("PMPM") Claims experience within the Attributed Member Population during the Baseline Period, but exclude certain transplant and high cost Claims amounts. As part of the MCT calculation, a risk adjustment is made by Anthem Blue Cross through the Normalized Risk Score for the Baseline Period, unless otherwise stated in the Measurement Period Handbook and/or the Attachment. The MCT calculation also accounts for any clinical coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period. The MCT is the baseline for shared savings/loss calculations under the Incentive Program. A given Medical Panel may have multiple MCTs, which will aggregate membership separately by product type (e.g., HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through Anthem Blue Cross will be in a separate MCT than PPO members who receive pharmacy benefits through a third-party Pharmacy Benefits Manager).

"Medical Panel" means a single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful MCTs, shared savings, and utilization performance targets. Medical panels shall be formed either by the providers themselves or by Anthem Blue Cross. Further details regarding medical panels are provided at the end of this section.

"Member Population" means the group of Attributed Members assigned to the Medical Panel or Program, as applicable; and whose costs under the relevant Anthem Blue Cross products(s) will be used to calculate MCTs and MCPs pursuant to the Program (subject to criteria established by Anthem Blue Cross).

"Member Months" means the number of the Member Population's full months enrolled in the applicable Anthem Blue Cross products during a Measurement Period.

"Member Risk Months" means the Member Population's average Normalized Risk Score multiplied by their Member Months in the applicable Anthem Blue Cross products during a Measurement Period.

"Minimum Risk Corridor" ("MRC") means the percentage of MCT that Anthem Blue Cross retains before sharing any savings with the Medical Panel. This percentage is determined by Anthem Blue Cross to limit savings payouts that are driven by random variation.

"Net Aggregate Savings" shall have the meaning described in section (e) below.

"Non-Cost Performance Targets" means quality and utilization performance goals tied to shared savings under the Incentive Program. Quality measures are evaluated at the Provider level (subject to membership requirements identified in the Shared Savings Determination section below), whereas utilization measures are evaluated at the Medical Panel level.

"Normalized Risk Score" means the either the Provider's or Medical Panel's average risk score relative to the state's average risk score (excluding BlueCard from state average risk). Risk scores are generated using the DxCG model from Verisk Health, which uses information such as member age, gender and diagnosis information from Covered Individuals' medical Claims. The approach and underlying elements used to calculate risk scores may be adjusted from time to time and changes will be communicated without the need for a formal amendment.

"Paid/Allowed Ratio" means the ratio of paid dollars (dollars paid by Anthem Blue Cross to providers) to allowed dollars (total dollars paid by Anthem Blue Cross 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" means the minimum quality standards that Providers must achieve in order to retain any shared savings under the Incentive Program.

"Upside Cap" means the maximum limit on Incentive Program shared savings that you can earn through the Incentive Program. Like the Gross Savings, the Upside Cap is adjusted by the Paid/Allowed Ratio.

"Upside Shared Savings Percentage" means the percentage of shared savings under the Incentive Program that a Provider is determined to be entitled to after (i) it meets the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for Provider and its Medical Panel. The Upside Shared Savings Percentage can be the same percentage as the Upside Shared Savings Potential if all Non-Cost Performance Targets are fully achieved by Provider and its Medical Panel under the Program. The Upside Shared Savings Percentage will be less than the Upside Shared Savings Potential if all Non-Cost Performance Targets are not achieved, and zero if the Quality Gate is not met.

"Upside Shared Savings Potential" means the maximum percentage of shared savings under the Incentive Program that a Provider may be entitled to, provided that it meets the Quality Gate and other Non-Cost Program Targets.

## INCENTIVE PROGRAM TERMS AND DETAILS - MEDICAL COST TARGET MODEL

### *Upside Shared Savings Potential*

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

### *Shared Savings Determination*

- (a) Within one-hundred and eighty (180) days from the end of the relevant Measurement Period, plus the three-month Claims run-out period, Anthem Blue Cross will calculate the MCP, compare it with the MCT and make other calculations (e.g. adjust differential based on the Paid/Allowed Ratio, etc.) to determine the amount of any Gross Savings generated during the Measurement Period.
- (b) Anthem Blue Cross will then calculate the "Savings Pool" by comparing the Gross Savings to the Minimum Risk Corridor (MRC) (expressed in terms of a PMPM, or percent of premium amount, and adjusted based on the Paid/Allowed Ratio). The Savings Pool is the amount by which the Gross Savings exceeds the MRC. In the event that the Gross Savings is less than the MRC (expressed in terms of a PMPM), the Savings Pool is not funded. If, on the other hand, this amount exceeds the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. If the Medical Panel participates in the Program under a number of different Anthem Blue Cross products, there may be multiple MCTs, and the aggregate Savings Pool for a given Line of Business could be the weighted average of each of its product-specific Savings Pools.
- (c) Following application of the MRC calculation described above, the Medical Panel's aggregate Savings Pool, expressed at a risk-adjusted PMPM, will be multiplied by the Member Risk Months for each Provider within the Medical Panel and allocated accordingly. The weighting, which is based on Measurement Period Member Risk Months, is capped at two times the product-specific Baseline Member Risk Months to limit the impact of large scale membership changes.
- (d) Providers in the Medical Panel are evaluated on quality and utilization measures relative to targets to determine the overall Upside Shared Savings Percentage. While many Providers in the Program will be evaluated on their own quality performance relative to targets, some Providers with small membership counts (subject to measure requirements) will be evaluated based on their Medical Panel's collective performance. Scoring for utilization measures is based on the Medical Panel performance, irrespective of the size of the Provider's membership count. In the event that a Provider fails to meet the "Quality Gate" requirements of the Incentive Program, it will not be eligible to receive any amount of shared savings payout, regardless of whether other performance targets under the Incentive Program are met.
- (e) A Provider's total allocated Savings Pool(s), described in step (c), will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on your aggregate performance across all products and lines of business.

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

<b>I. Shared Savings Framework</b>	
Provider Group Count	3
Minimum Risk Corridor (MRC)	1.5%
Upside Cap	10%
Upside Shared Savings Potential: Quality	18%
Upside Shared Savings Potential: Utilization	12%

<b>II. Panel Savings Pool Calculation (Commercial Example)</b>	
Medical Cost Target (MCT)	\$ 300.00
Trend	5%
Paid/Allowed Ratio	0.95
Medical Cost Performance (MCP)	\$ 285.00
Gross PMPM Savings: (MCT-MCP) x Paid/Allowed	\$ 14.25
Minimum Risk Corridor PMPM: (MRC x MCT) x Paid/Allowed	\$ 4.28
<b>Savings Pool PMPM</b>	<b>\$ 9.98</b>

1. In the above example, three provider groups are combined into a virtual Medical Panel for purpose of calculating a statistically meaningful Medical Cost Target (“MCT”). Had any group been large enough, it could have formed into its own Medical Panel, with its own MCT and related Savings Pool PMPM.
2. The Medical Panel’s MCT (based on historical risk-adjusted PMPM, trended forward based on actuarial medical cost inflation assumptions) is set at \$300 PMPM.
3. The Medical Panel’s Gross PMPM Savings – \$14.25 – is the result of the MCT minus the MCP, adjusted by the Paid/Allowed Ratio:  $[(\$300 - \$285)] \times .95$ . The MCP is \$285 because the Medical Panel was able to reduce PMPM costs by 5%, relative to anticipated costs.
4. To limit the impact of random variation, Minimum Risk Corridor (“MRC”) is set at 1.5%, which means that the first \$4.28 of PMPM savings/loss is excluded from the Savings Pool, i.e.  $MCT (\$300) \times MRC (1.5\%) \times \text{Paid/Allowed Ratio } (.95)$ .
5. The Savings Pool PMPM – in this example \$9.98 PMPM – is the result of the Gross PMPM Savings (\$14.25) minus the MRC PMPM (\$4.28).
6. The Upside Cap as well as the Shared Savings Potential variables will be referenced below in relationship to the provider group savings payouts.

<b>III. Provider Group Payout Calculation</b>				
	<b>Provider Group A</b>	<b>Provider Group B</b>	<b>Provider Group C</b>	<b>Panel Total</b>
Avg PCP PMPM	\$ 14.40	\$ 21.60	\$ 18.00	\$ 18.54
Members	2,500	4,000	3,500	10,000
Members Months	30,000	48,000	42,000	120,000
Provider's Group Normalized Risk Score	0.80	1.20	1.00	1.03
Member Risk Months	24,000	57,600	42,000	123,600
<b>Savings Pool Allocation</b>	<b>\$ 239,400</b>	<b>\$ 574,560</b>	<b>\$ 418,950</b>	<b>\$ 1,232,910</b>
Upside Shared Saving (Actual) Percentage				
Quality Percentage	10%	5%	18%	10%
Utilization Percentage		<-----12%----->		
<b>Shared Savings Percentage: Total</b>	<b>22%</b>	<b>17%</b>	<b>30%</b>	<b>22%</b>
Net Aggregate Savings (pre-cap)	\$ 52,668	\$ 97,675	\$ 125,685	\$ 276,028
Upside Cap	\$ 684,000	\$ 1,641,600	1,197,000	
<b>Net Aggregate Savings (post-cap)</b>	<b>\$ 52,668</b>	<b>\$ 97,675</b>	<b>\$ 125,685</b>	<b>\$ 276,028</b>
PCP Baseline Revenue	\$ 432,000	\$ 1,036,800	\$ 756,000	\$ 2,224,800
PCP Shared Savings Revenue Increase	12.19%	9.42%	16.63%	12.41%

7. Provider groups are allocated savings from their Medical Panel's Savings Pool based on Member Risk Months. In the above example, Provider Group A is allocated \$239,400, which is the product of its 24,000 Member Risk Months multiplied by the \$9.98 Savings Pool PMPM.
8. While in the above example each group has the potential to earn 30% of their allocated savings, their actual Shared Savings Percentage is a function of their performance on both quality and utilization measures. In the above example, Provider Group A earns over half of the potential 18% weight relating to quality (i.e. 10%). Since all three groups lack sufficient membership size to calculate statistically meaningful utilization metrics, the utilization metrics are calculated at the panel level; and in the above example, the panel earns the full 12% weight. As a result, Provider Group A earns \$52,668, i.e. 22% (10%+12%) of their \$239,400 in allocated savings.
9. Before the provider group is paid the resulting savings from step #7, a maximum payout allowance is calculated by multiplying the MCT, the Member Risk Months, the Upside Cap and the Paid/Allowed Ratio. In the above example, Provider Group A's maximum payout would be \$684,000, i.e. \$300 x 24,000 x 10% x .95.
10. The provider groups are paid the lesser of step #8 or step #9. For Provider Group A, since \$52,668 is less than \$684,000, it is paid \$52,668.
11. To estimate the impact of the provider group's savings payout relative to their annual revenue, each group's shared savings payout is divided by its annual paid dollars received from Anthem Blue Cross. For Provider Group A, \$52,668 is divided by \$432,000, which is their total PCP PMPM (\$14.40) multiplied by member months (30,000).

## Adjustments to MCT/MCP

Medical Cost Target (“MCT”) and Medical Cost Performance (“MCP”) amounts are calculated based on certain tools and information provided to and available to Anthem at specific points in time (e.g., cost experience of Member Population, risk adjustment tools and data, etc.). In the event that any such tools or information are updated, modified or clarified (collectively, the “Modifications”) in a way that Anthem reasonably deems to materially change the calculation of the MCT or MCP, then the parties agree that Anthem shall have the right to adjust the MCT and/or MCP, as applicable, to the extent necessary to account for the Modifications without the need for an amendment to the Agreement. In such an event, Anthem will notify you as to the adjusted MCT and/or MCP and the reason for the adjustment. For example, if risk score groupers are updated after the MCT has been established, but before the MCP can be calculated, or diagnosis coding changes occur, such as the transition from ICD-9 to ICD-10 inadvertently impact risk calculations, then an appropriate adjustment may be applied to the MCT by Anthem to account for such grouper or coding updates. As an additional example, if new information is discovered (not previously available to Anthem) concerning the Claims that were used to derive the MCT, and such new information has a material impact on the MCT, then an appropriate adjustment may be made to the original MCT by Anthem.

## Exclusions from the calculation of risk scores, MCT, MCP, and other shared savings [loss]:

We exclude Attributed Members with certain high-cost Claims amounts and organ transplants during either the Baseline Period used to determine the Medical Cost Targets or the Measurement Period for Medical Cost Performance calculations for Enhanced Personal Health Care providers. The members (and all Claims associated with them) that are excluded meet either of the following criteria:”

- Allowed claims that have exceeded the \$250K amount for an Attributed Member over the associated period.
- Inpatient transplant claims with the below diagnosis related group (DRG) codes.

Diagnosis-Related Group	DRG Code
Heart transplant or implant of heart assist system w MCC	001
Heart transplant or implant of heart assist system w/o MCC	002
Liver transplant w MCC or intestinal transplant	005
Liver transplant w/o MCC	006
Lung transplant	007
Simultaneous pancreas/kidney transplant	008
Pancreas transplant	010
Allogeneic Bone Marrow Transplant	014
Autologous Bone Marrow Transplant W CC/MCC	016
Autologous Bone Marrow Transplant W/O CC/MCC	017
Kidney transplant	652

## Upside Shared Savings Payment

Assuming all preconditions and terms have been satisfied, on an annual basis, but not later than two-hundred and ten (210) days after the end of the relevant Measurement Period, Anthem Blue Cross shall make any applicable distribution payment to the Provider for any Net Aggregate Savings earned during the Measurement Period associated with its Attributed Members. Based on Provider performance, Anthem Blue Cross may choose to make interim advance payments to the Provider of its share in Net Aggregate Savings.

If Anthem Blue Cross elects to make such interim payments, the Net Aggregate Savings earned for the interim period of the Measurement Period will be paid to the Provider less a percentage amount defined as the "Holdback Amount." The Holdback Amount will be retained by Anthem Blue Cross as security against any future shared loss obligations of the Provider during the Measurement Period(s). If a Holdback Amount is used, Anthem Blue Cross will remit to the Provider the total retained balance of the Net Aggregate Savings, less any interim payments associated with its Attributed Members, no later than two-hundred and ten (210) days after the end of the relevant Measurement Period.

If it is determined during the final reconciliation of the Measurement Period that an overpayment was made through an interim payout, the Provider will reimburse Anthem Blue Cross the overpaid amount within two hundred and forty (240) days from the end of the relevant Measurement Period.

A Provider must be participating in the Program during the entire 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 the Provider has in place with Anthem Blue Cross under the Agreement. For example, if Claim payments are currently remitted at the physician group level, [Legal Entity Title 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:

- Engage your Care Consultant and Provider Clinical Liaison for assistance with report interpretation and identifying opportunities for improvements. In addition to utilizing our full suite of transformation and clinical resources, contact your local team members as directed in your Welcome Packet.
- Establish a process to review your organization's performance on a regular basis. We will provide you with useful reports that show quality, cost and utilization performance 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. PCMS, MMH+, our collaborative learning events, virtual office hours, the Provider Toolkit, and ACP Practice Advisor® tool are just a few ways to access information and drive quality improvement.

## MEDICAL PANELS - COMMERCIAL BUSINESS MEDICAL COST TARGET MODEL

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 Savings Pools, which contribute to the amount a provider organization receives under the Incentive Program.

### *Formation of Medical Panels*

Medical Panels can be composed of an individual physician practice or a group of practices. Anthem Blue Cross will provide a list of all physician practices participating in the Program within each state and assigned Medical Panel. You are required to access the Anthem Blue Cross provider portal to identify your assigned Medical Panel.

During a period of time prior to the start date of the Measurement Period, you may have the opportunity to submit your preference for your Medical Panel to us. If such opportunity is available, our provider portal will include a form for submission of Medical Panel preferences, as well as a list of practices that have been selected for participation in the Program.

Prior to the Measurement Period start date, Anthem Blue Cross will assign Medical Panels for participating practices, and this information will be available on the secure provider portal. You will have an opportunity to review your Medical Panel assignment at that time.

If you are satisfied with your assigned Medical Panel, or you do not submit your preference to us within the timeline indicated on the Anthem Blue Cross provider portal, you will remain in your assigned Medical Panel for the duration of the Measurement Period. Anthem Blue Cross will make reasonable efforts to consider all preferences submitted in a timely manner; however, we cannot guarantee that all preferences will be accommodated. Anthem Blue Cross reserves the right to make all final determinations on Medical Panel formation.

### *General Parameters for Medical Panels*

Provided below are general parameters related to the formation of Medical Panels under the Program. Specifically, the qualifying thresholds related to Attributed Member populations covered by the Medical Panel will vary to address market-specific variations and needs. The thresholds below are for an example market.

- A single physician group with more than 7,500 commercial Attributed Members will form its own Medical Panel.
- Physician groups with Attributed Member populations less than 7,500, but more than the minimum level set by Anthem Blue Cross, may form Medical Panels with other participating physician groups. Prior to the start of the Measurement Period, assigned Medical Panels will be posted on our provider portal. Each Medical Panel that is comprised of multiple practices must exceed the 7,500 minimum number of Attributed Members. If a physician group would like to change the assigned Medical Panel to another Medical Panel, a form may be available prior to the Measurement Period to identify this preference. Practices will have a window of time to submit such preferences. After this preference

time period is complete. Anthem Blue Cross will make final Medical Panel decisions, and the final list will be shown on the provider portal.

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

## INCENTIVE PROGRAM – MEDICARE ADVANTAGE BUSINESS

***\*\*All terms and provisions in the Medicare Advantage-designated subsections shall refer only to Medicare Advantage business and not to Commercial Business Medical Cost Target or to those participating in the CPC Program. \*\****

As described in greater detail below, and subject to the Incentive Program terms and details for Medicare Advantage business, Anthem Blue Cross 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 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" means the two-hundred eighty-five (285) day period of time immediately following the end of the MA Measurement Period, during which Anthem Blue Cross 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.

"Gross Loss" means the dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is greater than the MLRT, and multiplied by the Premium paid to [Legal Entity Title] as calculated by Anthem Blue Cross following an MA Measurement Period.

"Gross Savings" means 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 Anthem Blue Cross as calculated by Anthem Blue Cross following an MA Measurement Period.

"Incurred But Not Reported ("IBNR")" means 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 Anthem Blue Cross historical paid Claims experience, and will be developed by Anthem Blue Cross on an actuarially sound basis.

“Medicare Advantage Measurement Period(s) (“MA Measurement Period(s)”)” means the twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Anthem Blue Cross 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. *If a Provider starts a Measurement Period on a quarter that begins on 4/1 or 7/1 of a given year, the initial Measurement Period will still conclude on 12/31 of that year. In those cases, the Provider’s initial Measurement Period will be a shortened Measurement Period and the subsequent Measurement Period will begin on 1/1 of the following year.*

“Measurement Period Medical Loss Ratio (“MPMLR”)” means the percent calculated by Anthem Blue Cross 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:

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

“Medical Loss Ratio Target (“MLRT”)” means the MLR target percentages determined by Anthem Blue Cross. The MLRT will be identified in the MA Handbook.

“Medical Panel” means a single provider organization or a grouping of multiple provider organizations by Anthem Blue Cross 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” means the group of Medicare Advantage Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Anthem Blue Cross products(s) will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Anthem Blue Cross).

“Member Months” means the number of the Medicare Advantage Member Population’s full attributed months enrolled in the applicable Anthem Blue Cross products during a MA Measurement Period.

“Net Aggregate Savings” has the meaning as set forth in section (e) below (under “Medicare Advantage Incentive Program Terms and Details”).

“Premium” means the total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Anthem Blue Cross for the Member Population under an Anthem Blue Cross 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 Anthem Blue Cross 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.

“Quality Gate” means 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 number of points to achieve a weighted average four Star level.

“Quality Targets” means 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” means the total of all amounts paid or credited by CMS to Anthem Blue Cross for any Medicare Advantage Attributed Members who were retroactively assigned to the Provider during the MA Measurement Period, as applicable.

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

“Shared Savings Percentage” means 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” means 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” is 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” means the Claims amounts in excess of the Stop Loss Deductible.

“Stop Loss Deductible” means 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” means the per member per month amount determined by taking the actual total amount of Claims in excess of the Stop Loss Deductible across all Anthem Blue Cross Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period, divided by the total Member Months across all Anthem Blue Cross 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” 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.

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

“Total Medical Expenses” means the costs incurred by Anthem Blue Cross 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 Anthem Blue Cross and/or Anthem Blue Cross's 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 Anthem Blue Cross 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 Anthem Blue Cross as follows:

- a) During the Annual Determination Period, Anthem Blue Cross will determine the Medicare Advantage Attributed Members' Premium and Total Medical Expense and calculate the MPMLR.
- b) Anthem Blue Cross will compare Medical Panel MPMLR to MLRT. If the Medical Panel's MPMLR is below the MLRT, then Gross Savings will be calculated.
- c) 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 Anthem Blue Cross for their Medicare Advantage Attributed Members during the MA Measurement Period.
- d) 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 Anthem Blue Cross.
- e) 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.
- f) The Net Aggregate Savings will be limited by the Substantial Financial Risk Limit of 25% 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 set forth below:***

<i>Multi-Provider Panel Shared Savings Payout Example</i>	<i>Provider Group A</i>	<i>Provider Group B</i>	<i>Provider Group C</i>
<b>Number of MA Attributed Members</b>	500	900	300
<b>MLRT*</b>		85%	
<b>MP MLR*</b>		83%	
<b>MP MLR - MLRT = % of premium to share*</b>		2%	
<b>TOTAL Premium paid to Anthem Blue Cross</b>	\$5,400,000	\$6,480,000	\$3,600,000
<b>Gross Savings</b>	<b>\$108,000</b>	<b>\$129,600</b>	<b>\$72,000</b>
<b>Shared Savings Potential</b>		50%	
<b>Shared Savings Percentage(actual)</b>	<b>45%</b>	<b>35%</b>	<b>40%</b>
<b>Net Aggregate Savings</b>	<b>\$48,600</b>	<b>\$45,360</b>	<b>\$28,800</b>

\*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% 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 Anthem Blue Cross for the Provider Groups' Medicare Advantage Attributed Members for the MA Measurement Period. In the example above, the MLRT minus the MPMLR is 2%. The Providers Gross Savings is for Provider Group A is 2% 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% 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% 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% 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 Anthem Blue Cross. For Provider Group A, we will use \$450,000 as the annual amount received from Anthem Blue Cross and divide it by the \$48,600.00 earned in shared savings to assure that the amount is not greater than 25% (the Substantial Financial Risk Limit). In this case, the shared savings is 10.8%, and does not surpass the 25% 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 Anthem Blue Cross 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 Anthem Blue Cross reasonably deems to materially change the calculation of the MLRT or MPMLR, then the parties agree that Anthem Blue Cross 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, Anthem Blue Cross 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 Anthem Blue Cross) 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 Anthem Blue Cross.

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 Annual Determination Period, Anthem Blue Cross 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, Anthem Blue Cross may choose to make interim advance payments to the Provider of its share in Net Aggregate Savings. If such interim advanced payments are in excess of the final Net Aggregate Savings earned for the Measurement Period, Provider will reimburse Anthem Blue Cross for the difference within three hundred and fifteen (315) days from the end of the relevant Measurement Period. The Provider must be participating in the Program through the end of the 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 Anthem Blue Cross under the Agreement. For example, if claim payments are currently remitted at the physician group level, Anthem Blue Cross 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:

- Engage your Care Consultant and Provider Clinical Liaison for assistance with report interpretation and identifying opportunities for improvements. In addition to utilizing our full suite of transformation and clinical resources, contact your local team members as directed in your Welcome Packet.
- Establish a process to review your organization's performance on a regular basis. We will provide you with useful reports that show quality, cost, and utilization performance 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. PCMS, P360 our learning collaboratives, the Provider Toolkit, and American College of Physicians Practice Advisor (American College of Physicians Practice Advisor) tool 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, Anthem Blue Cross will assign Medical Panels for participating practices, and this information will be available on the secure provider portal. 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 Anthem Blue Cross 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 portal. Each Medical Panel that is comprised of multiple practices must meet or exceed the 1,500 minimum number of Medicare Advantage Attributed Members. Anthem Blue Cross will make final Medical Panel decisions, and the final list will be shown on the provider portal.

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.

### *Comprehensive Primary Care (CPC) Initiative Special Terms*

The Incentive Program under CPC will closely align with the Commercial Business Incentive Program for the Enhanced Personal Health Care Program. The key differences are as follows:

- As mentioned in Section 5, the quality measures for CPC may be different than those used under the Enhanced Personal Health Care Program in that there will be community-based quality metrics and measures developed under CPC. The Quality Gate for CPC will utilize these community-based metrics and measures.
- The opportunity to submit Medical Panel preferences may not be available under the CPC Initiative because all practices participating in the CPC Initiative may need to be combined to form a Medical Panel. If this is the case, the list of physician practices identified above may not be available via the [Legal Entity Title] provider portal. This will be determined prior to the start date of the Measurement Period.

## Section 9: Reporting

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A fundamental building block of the Program is Provider Care Management Solutions (“PCMS”), Anthem Blue Cross’s 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 supplied 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 Patients 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,” i.e. 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,” “due in calendar year,” or “completed”) for each care opportunity

## Inactive Patients

You will have access to detailed information about your inactive Attributed Members, i.e. 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 (i.e. Commercial vs. Medicare).

### **Performance 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 may be in need of an intervention.

### **Medical Cost: Medical Cost Target (“MCT”) and Medical Cost Performance (“MCP”)**

*Note: The Medical Cost Target and Medical Cost Performance reports apply only to Commercial business.*

The Medical Cost Target report provides the detailed calculations behind the Program’s product-specific Medical Cost Targets.

The Medical Cost Performance report allows you to compare medical costs incurred during the Measurement Period (known as “Medical Cost Performance”) to the Medical Cost Targets, with detailed calculations estimating possible shared savings payouts.

## ***REPORT REGISTRATION AND QUESTIONS***

Your local provider Contract Advisor can work with you as needed to complete the registration process in Availity to access PCMS. 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
- Name, date and details of view(s)
- Description of issue or question

### ***Comprehensive Primary Care (CPC) Initiative Special Terms***

The above reports will be available to physician practices that are participating in the CPC Initiative As identified under Section 5 of this Program Description, community-based quality metrics and measures were developed in support of the CPC Initiative.

**MMH+ Access Request Form** – See form on the following page or access the form on the Enhanced Personal Health Care webpage.

**Comprehensive Primary Care (CPC) Initiative Special Terms**

There are no significant differences between the Enhanced Personal Health Care Program and CPC for this section.

Anthem Blue Cross

**MMH+ Access Form**

Anthem Blue Cross's MMH+ system provides Covered Individual-based personal health information to clinicians via the internet. MMH+ provides a picture of the services patients may have received outside of the primary care practice. This information provides a better history of utilization which can help the primary care team to develop data-informed comprehensive care plans with their patients.

**Please fill out the information below and send the completed form to your local Contract Advisor. An access form will be sent to you to complete this process.**

Once received, complete the MMH+ Access Form for all individuals in your provider organization who should have access to clinical information regarding Anthem Blue Cross Covered Individuals via MMH+.

Practice Name \_\_\_\_\_

Practice TIN \_\_\_\_\_

Practice e-mail \_\_\_\_\_

Person who will fill out access form for MMH+ \_\_\_\_\_

E-mail of person who will be filling out the form \_\_\_\_\_

Phone number of person filling out the form \_\_\_\_\_

## Section 11: Glossary

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

Glossary Term	Definition	Source
<b>Attachment</b>	Abbreviated reference to the Program Attachment or the Enhanced Personal Health Care Attachment of the contractual document the Provider signs to participate in the Enhanced Personal Health Care Program. This attachment is an amendment to the physician's Provider Agreement with Anthem Blue Cross.	Attachment
<b>Attributed Members</b>	Those Covered Individuals who are attributed to the Represented Primary Care Physicians or Represented Physicians, as applicable, for the purposes of the Enhanced Personal Health Care Program using the Attribution Methodology.	Attachment
<b>Attribution Methodology</b>	<p>A process whereby Anthem Blue Cross will assign Covered Individuals to the Represented Primary Care Physicians or Represented Physicians, as applicable, in one of the following manners:</p> <ul style="list-style-type: none"> <li>i) based on the formal selection of a Primary Care Physician by the Covered Individual; or</li> <li>ii) based on the formal assignment of a Primary Care Physician or Represented Physician, as applicable, to the Covered Individual by Anthem Blue Cross; or</li> <li>iii) based on a Covered Individual's prior utilization of evaluation and management services.</li> </ul> <p>Provider agrees and acknowledges that such assignment of a Covered Individual to a Primary Care Physician 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
<b>Annual Determination Period –Medicare Advantage</b>	The two-hundred eighty-five (285) day period of time immediately following the end of the MA Measurement Period, during which Anthem Blue Cross 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-Medicare Advantage)

Glossary Term	Definition	Source
<b>Baseline Period</b>	A defined twelve (12) month period preceding the first Measurement Period. To ensure all Claims have been received and processed by Anthem Blue Cross, there will be a minimum of three (3) months of lag time for Claims run-out between the end of the Baseline Period and the beginning of the Measurement Period plus a two (2) month period to perform calculations. The Baseline Period is the timeframe which is used to set Medical Cost Targets.	Program Description (Section 8)
<b>BlueCard</b>	The national program sponsored by the Blue Cross Blue Shield Association that enables members of one Blue Cross and/or Blue Shield (BCBS) Plan to obtain healthcare services while in another Blue Cross and/or Blue Shield Plan's service area	Attachment
<b>Care Plan</b>	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)
<b>Care Plan Assessment Domains</b>	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)
<b>Clinical Quality Measures-Commercial Business</b>	The clinical quality measures currently included in the Program scorecard and outlined in the Commercial Handbook are grouped into two categories: (1) acute and chronic care management and (2) preventive care. These categories may be further broken out into sub-composites. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.	Program Description (Section 5)

Glossary Term	Definition	Source
<b>Clinical Quality Measures-Medicare Advantage Business</b>	<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>	Program Description (Section 5-Medicare Advantage)
<b>Gross Loss</b>	The dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is greater than the MLRT, as calculated by Anthem Blue Cross following an MA Measurement Period.	Program Description (Section 8-Medicare Advantage)
<b>Gross Savings --Medical Cost Target Model</b>	Any amounts by which the Medical Cost Performance ("MCP") is less than the Medical Cost Target ("MCT"), adjusted by the Paid/Allowed Ratio, as calculated by Anthem Blue Cross, at the end of a Measurement Period for each product requiring a separate product specific calculation. Gross Savings can be in the form of risk adjusted per member per month ("PMPM") or a percent of premium paid, depending on the product or line of business.	Program Description (Section 8 Medical Cost Target Model)
<b>Gross Savings-Medicare Advantage Business</b>	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 Anthem Blue Cross as calculated by Anthem Blue Cross following an MA Measurement Period.	Program Description (Section 8-Medicare Advantage)

Glossary Term	Definition	Source
<b>Holdback Amount</b>	The percentage of any applicable annual distribution payment based on earned Net Aggregate Savings that may be retained by Anthem Blue Cross as security against any future shared loss obligations of Medical Panel during the Measurement Period(s).	Program Description (Section 8)
<b>Incentive Program</b>	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)
<b>Incurred But Not Reported ("IBNR")</b>	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 Anthem Blue Cross historical paid Claims experience, and will be developed by Anthem Blue Cross on an actuarially sound basis.	Program Description (Section 8-Medicare Advantage)
<b>Measurement Period – Medical Cost Target Model</b>	The twelve (12) month period during which Medical Cost Performance, and quality and utilization performance, will be measured for purposes of calculating shared savings between Anthem Blue Cross and the Medical Panel.	Program Description (Section 8-Medical Cost Target Model)
<b>Measurement Period Medical Loss Ratio ("MPMLR")-Medicare Advantage</b>	The percent calculated by Anthem Blue Cross 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)

Glossary Term	Definition	Source
<b>Medical Cost Performance (“MCP”)</b>	<p>The actual cost experience in the defined Member Population during a relevant Measurement Period, expressed in terms of risk-adjusted per member per month (“PMPM”) but excluding certain Covered Individuals with transplant or high-cost claims amounts. The formulae for setting the MCP take into account risk-adjusted (“PMPM”) Claims experience within the Attributed Member Population during the Measurement Period, but exclude certain transplant and high-cost Claims amounts. It also accounts for any clinical coordination per-member per-month payments made during the relevant Measurement Period to Provider by Anthem Blue Cross for Attributed Members. As part of the MCP calculation, a risk adjustment is made by Anthem Blue Cross through the Normalized Risk Score for the Measurement Period unless otherwise stated in the Measurement Period Handbook and/or the Attachment. A given Medical Panel may have multiple MCPs, which will aggregate membership separately by product type (e.g., HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through Anthem Blue Cross) will be in a separate MCP than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager).</p>	Program Description (Section 8)
<b>Medical Cost Target (“MCT”)</b>	<p>The historic cost experience in the defined Member Population during the Baseline Period, trended forward and expressed in terms of risk-adjusted per member per month (PMPM) but excluding certain Covered Individuals with transplant or high-cost Claims amounts. The formulae for setting the MCT take into account risk-adjusted (“PMPM”) Claims experience within the Attributed Member Population during the Baseline Period, but exclude certain transplant and high-cost Claims amounts. As part of the MCT calculation, a risk adjustment is made by Anthem Blue Cross through the Normalized Risk Score for the Baseline Period, unless otherwise stated in the Measurement Period Handbook and/or the Attachment. The MCT calculation also accounts for any clinical coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period. MCT sets the baseline for shared savings/loss calculations under the Incentive Program. A given Medical Panel may have multiple MCTs, which will aggregate membership separately by product type (e.g., HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through Anthem Blue Cross) will be in a separate MCT than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager).</p>	Program Description (Section 8)

<b>Glossary Term</b>	<b>Definition</b>	<b>Source</b>
<b>Medical Loss Ratio Target ("MLRT")- Medicare Advantage</b>	The MLR target percentages determined by Anthem Blue Cross. The MLRT will be identified in the MA Handbook.	Program Description (Section 8- Medicare Advantage)
<b>Medical Panel –Medical Cost Target Model</b>	A single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful Medical Cost Targets ("MCTs"), shared savings, and utilization performance targets. Medical panels shall be formed either by the providers themselves or by Anthem Blue Cross.	Program Description (Section 8- Medical Cost Target Model)
<b>Medical Panel-Medicare Advantage Business</b>	A single provider organization or a grouping of multiple provider organizations by Anthem Blue Cross 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)
<b>Medicare Advantage Measurement Period (s) ("MA Measurement Period(s)")</b>	The twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Anthem Blue Cross 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- Medicare Advantage)
<b>Member Months –Medical Cost Target Model</b>	The number of the Member Population's full months enrolled in the applicable Anthem Blue Cross products during a Measurement Period.	Program Description (Section 8- Medical Cost Target Model )
<b>Member Months- Medicare Advantage Business</b>	The number of the Medicare Advantage Member Population's full attributed months enrolled in the applicable Anthem Blue Cross products during a MA Measurement Period.	Program Description (Section 8- Medicare Advantage)
<b>Member Population- Medical Cost Target Model</b>	The group of Attributed Members assigned to the Medical Panel or Program, as applicable; and whose costs under the relevant Anthem Blue Cross products(s) will be used to calculate MCTs and MCPs pursuant to the Program (subject to criteria established by Anthem Blue Cross).	Program Description (Section 8- Medical Cost Target Model )
<b>Member Population- Medicare Advantage Business</b>	The group of Medicare Advantage Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Anthem Blue Cross products(s) will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Anthem Blue Cross).	Program Description (Section 8- Medicare Advantage)
<b>Member Risk Months</b>	The Member Population's average Normalized Risk Score multiplied by their Member Months in the applicable Anthem Blue Cross products during a Measurement Period.	Program Description (Section 8)

Glossary Term	Definition	Source
<b>Minimum Risk Corridor ("MRC") Medical Cost Target Model</b>	The percentage of Medical Cost Target ("MCT") that Anthem Blue Cross retains before sharing any savings with the Medical Panel. This percentage is determined by Anthem Blue Cross and is designed to limit savings payouts that are driven by random variation.	Program Description (Section 8-Medical Cost Target Model)
<b>Member Medical History Plus ("MMH+")</b>	The Anthem Blue Cross system the Provider will use to access Covered Individual-based personal health information to clinicians via the internet. To gain access, Providers should submit a completed MMH+ Access Form to the local Contract Advisor.	Program Description (Section 4)
<b>Net Aggregate Savings-Medical Cost Target Model</b>	The total allocated Savings Pool(s) multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap.	Program Description (Section 8-Medical Cost Target Model)
<b>Net Aggregate Savings-Medicare Advantage Business</b>	To determine the Net Aggregate Savings, the Shared Savings Percentage is multiplied by the Gross Savings.	Program Description (Section 8-Medicare Advantage)
<b>Non-Cost Performance Targets</b>	The quality and utilization performance goals tied to shared savings under the Incentive Program. Quality measures are evaluated at the Provider level (subject to membership requirements identified in the Shared Savings Determination section below), whereas utilization measures are evaluated at the Medical Panel level.	Program Description (Section 8)
<b>Normalized Risk Score</b>	Means either the Provider's or Medical Panel's average risk score relative to the state's average risk score (excluding Blue Card from state average risk). Risk scores are generated using the DC model from Verisk Health, which uses information such as member age, gender and diagnosis information from Covered Individuals' medical Claims. The approach and underlying elements used to calculate risk scores may be adjusted from time to time and changes will be communicated without the need for a formal amendment.	Program Description (Section 8)
<b>Paid/Allowed Ratio</b>	The ratio of paid dollars (dollars paid by Anthem Blue Cross to providers) to allowed dollars (total dollars paid by Anthem Blue Cross 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
<b>Performance Assessments</b>	<p>The annual assessment of performance on the selected Program clinical quality and utilization 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 three categorical scores for:</p> <ul style="list-style-type: none"> <li>▪ Acute and Chronic Care Management</li> <li>▪ Preventive Care</li> <li>▪ Utilization</li> </ul> <p>The categorical scores will be based on performance relative to different tiers of performance thresholds.</p>	Program Description (Section 5)
<b>Premium-Medicare Advantage</b>	<p>The total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Anthem Blue Cross for the Member Population under an Anthem Blue Cross 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 Anthem Blue Cross 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-Medicare Advantage)
<b>Primary Care Physician(s) or PCP(s)</b>	<p>Physicians whose primary specialty, as indicated in the Anthem Blue Cross provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics.</p>	Attachment
<b>Program</b>	<p>Abbreviated reference to our Enhanced Personal Health Care Program, including the Comprehensive Primary Care initiative.</p>	Attachment
<b>Program Attachment Effective Date</b>	<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
<b>Program Description</b>	<p>The description of the Enhanced Personal Health Care Program prepared by Anthem Blue Cross, as revised from time to time, that summarizes the clinical programs and other patient-centered practice support offered by Anthem Blue Cross to support Represented Primary Care Physicians 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 Anthem Blue Cross provider website.</p>	Attachment

<b>Glossary Term</b>	<b>Definition</b>	<b>Source</b>
<b>Program Quality Measures</b>	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)
<b>Provider Practice Toolkit</b>	The tools and information that will be made available to provider organizations to assist with population health management.	Program Description (Section 4)
<b>Quality Gate-Medical Cost Target Model</b>	A minimum threshold of performance on clinical quality measures must be achieved to have the opportunity to earn a portion of the shared savings. The quality gate is a threshold defined by Anthem Blue Cross, and is set so that performance on the clinical quality composites must be above a predetermined percentile of the market performance as defined in the Commercial Handbook.	Program Description (Section 8-Medical Cost Target Model)
<b>Quality Gate-Medicare Advantage Business</b>	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-Medicare Advantage)
<b>Quality Targets-Medicare Advantage</b>	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-Medicare Advantage)
<b>Represented Primary Care Physician(s) or Represented PCP(s)</b>	All of the physicians in the provider organization whose primary specialty, as indicated in the Anthem Blue Cross 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
<b>Represented Providers</b>	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
<b>Retroactive Additional Amount</b>	The total of all amounts paid or credited by CMS to Anthem Blue Cross for any Medicare Advantage Attributed Members who were retroactively assigned to the Provider during the MA Measurement Period, as applicable.	Program Description (Section 8-Medicare Advantage)

Glossary Term	Definition	Source
<b>Retroactive Deletion Amount</b>	The total of all amounts repaid by Anthem Blue Cross to CMS or otherwise offset against or deducted from amounts payable by CMS to Anthem Blue Cross for any Medicare Advantage Attributed Members whose assignment to the Provider was retroactively deleted during such MA Measurement Period.	Program Description (Section 8-Medicare Advantage)
<b>Risk Scores</b>	Risk scores are indicators of the health status of an Attributed Member based on the evaluation of diagnosis information pulled from Claims. Anthem Blue Cross uses industry standard methods to determine risk scores.	Attachment
<b>Savings Pool</b>	The Minimum Risk Corridor (MRC) is applied by comparing the Gross Savings to the MRC to determine the Member Population's "Savings Pool". If the Gross Savings is less than the MRC, the Savings Pool is not funded. If the Gross Savings exceed the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. The total allocated Savings Pool(s) will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on the aggregate performance across all products and lines of business.	Program Description (Section 8)
<b>Shared Savings</b>	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. In the event that the MCP is less than the MCT, 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)
<b>Shared Saving Percentage</b>	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-Medicare Advantage)

Glossary Term	Definition	Source
<b>Shared Savings Potential</b>	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-Medicare Advantage)
<b>Stop Loss</b>	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-Medicare Advantage)
<b>Stop Loss Credit</b>	The Claims amounts in excess of the Stop Loss Deductible.	Program Description (Section 8-Medicare Advantage)
<b>Stop Loss Deductible</b>	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-Medicare Advantage)
<b>Stop Loss Expense</b>	The per member per month amount determined by taking the actual total amount of Claims in excess of the Stop Loss Deductible across all Anthem Blue Cross Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period, divided by the total Member Months across all Anthem Blue Cross 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-Medicare Advantage)

Glossary Term	Definition	Source
<b>Substantial Financial Risk</b>	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-Medicare Advantage)
<b>Substantial Financial Risk Limit</b>	The total incentive-based payments to the Provider from Anthem Blue Cross, inclusive of payments under the Agreement, are limited to no more than 25% of the total reimbursement the Provider and Represented Providers receive from Anthem Blue Cross for direct services delivered to Anthem Blue Cross Medicare Advantage Attributed Members during the applicable MA Measurement Period year.	Program Description (Section 8-Medicare Advantage)
<b>Total Medical Expenses-Medicare Advantage</b>	The costs incurred by Anthem Blue Cross 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-Medicare Advantage)
<b>Upside Cap –Medical Cost Target Model</b>	The maximum limit on Incentive Program shared savings that you can earn through the Incentive Program. Like the Gross Savings, the Upside Cap is adjusted by the Paid/Allowed Ratio.	Program Description (Section 8-Medical Cost Target Model)
<b>Upside Shared Savings Percentage-Medical Cost Target Model</b>	The percentage of shared savings under the Incentive Program that Provider is determined to be entitled to after (i) you meet the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for you and your Medical Panel. The Upside Shared Savings Percentage can be the same percentage as the Upside Shared Savings Potential if all Non-Cost Performance Targets are fully achieved by you and your Medical Panel under the Program. The Upside Shared Savings Percentage will be less than the Upside Shared Savings Potential if all Non-Cost Performance Targets are not achieved, and zero if the Quality Gate is not met.	Program Description (Section 8-Medical Cost Target Model)

Glossary Term	Definition	Source
<b>Upside Shared Savings Potential –Medical Cost Target Model</b>	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- Medical Cost Target Model)
<b>Utilization Measures</b>	The utilization measures in the Program scorecard and outlined in the Commercial Handbook focus on measures such as appropriate emergency room (“ER”) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and generic dispensing rates for select sets of drug classifications. As with the clinical metrics, administrative data are used to construct the utilization measures.	Program Description (Section 5)

**Comprehensive Primary Care (CPC) Initiative Special Terms**

There are no significant differences between the Enhanced Personal Health Care Program and CPC for this section.