Program Description
For Enhanced Personal Health Care

Known nationally as Blue Distinction Total Care
Introduction

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.\textsuperscript{1,2} The fact that more Americans have health care coverage now than ever before makes the need for adopting a value-based, 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 72 million people are served by our affiliated companies, including more than 39 million enrolled with our affiliated health plans.

Anthem 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 Togetherworks is our name for our strategy of provider collaboration. Anthem Togetherworks brings Anthem and providers together to meet the challenges of a new era in health care — leveraging data, insights and technology to power us toward the common objective of delivering the right care at the right time and in the right place. Enhanced Personal Health Care is the centerpiece program under Anthem Togetherworks.

Anthem 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 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.

\textsuperscript{1}The Commonwealth Fund, \textit{Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally}. (June 16, 2014): \url{http://www.commonwealthfund.org}

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 (also referred to as “we” or “us” in this document) and the contracted Provider (also referred to as “you”, and includes Represented Primary Care Providers, Represented Primary Care Physicians and Represented Physicians, as applicable, in this document). This relationship enables both parties to leverage the other party’s unique assets, whether clinical, administrative, or data, to support coordinated care with a focus on risk stratified care management, wellness and prevention, improved access and shared decision-making with patients and their caregivers.

Where we collaborate with Blues Plans across the country to offer customers access to value-based programs similar to Enhanced Personal Health Care, 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.

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

We have also included 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.

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**Program Communications**

You should have completed a Key Contacts Form in your Program recruitment packet. 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. We will begin using your new e-mail address up to 20 business days after we receive your request. You must 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 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 members or any other patient. Anthem 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 makes available to you is compiled largely from publicly available sources and does not represent the opinions of Anthem or its personnel delivering the presentations.

- If Anthem provides links to or examples of information, resources or tools not owned, controlled or developed by Anthem this does not constitute or imply an endorsement by Anthem. 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 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

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.
- Focus practice attention on opportunities to lower cost of care while improving quality outcomes.

Scope

The Program applies to Provider and Anthem participating Represented Primary Care Providers, Represented Primary Care Physicians and/or Represented Physicians, as applicable, who are in good standing, and who have signed or are covered under our Enhanced Personal Health Care Attachment for Primary Care that includes the Medical Cost Target and/or Medical Loss Ratio payment models and/or Medicare Advantage, Comprehensive Primary Care Plus, the Enhanced Personal Health Care Attachment for Freestanding Patient-Centered Care, the Enhanced Personal Health Care Agreement for Freestanding Patient-Centered Care, or any agreement that incorporates an Enhanced Personal Health Care Attachment (collectively, the “Attachment”).
Section 2: Roles

Roles at Anthem
We make 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’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
The Care Consultant is a quality improvement specialist who is responsible for consulting with provider organizations in an effort to help improve the effectiveness and efficiency of practice activities around quality, cost of care and patient experience. This team member helps practices identify and target high-risk Anthem populations and develop corresponding strategies to optimize outcomes, leverage hot spotter reports and manage gaps in care reporting.

The Care Consultant also supports practice implementation of data-driven population health strategies, recommends care coordination and care management strategies, and identifies action plans for provider organizations to implement in order to improve cost, quality and/or the patient experience. The Care Consultant serves as the subject matter expert with the Anthem care management team regarding patient referrals using Anthem’s automated referral process. The Care Consultant supports providers and care teams as they define workflows that can lead to reliable and systematic processes.

The Care Consultant also creates and hosts learning opportunities to support practice transformation, including events that allow practices to learn from one another and national experts.
Pharmacist
The Pharmacist serves as a member of the Anthem clinical team, and is a subject matter expert for pharmaceutical care management issues. The Pharmacist works collaboratively with the Care Consultant 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 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 in Your Provider Organization
The roles listed above were established to help your provider organization be successful in adopting 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 following roles inside your provider organization are recommended to support your organization’s transformation under the Program.

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 methodologies. Ideally this group of individuals should include a representative from each area within your office (front office, back office, clinical, billing, etc.).
Section 3: Care Coordination and Care Plans

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 that “Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." 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.
- 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 reporting to ensure Covered Individuals are receiving appropriate care delivery services,
Facilitate planned interactions with Covered Individuals with the use of up-to-date information provided by Anthem,

Perform regular outreach to Covered Individuals based on their personal preference, which could include mail, e-mail, text messaging (as allowed under applicable state regulation or state medical licensing requirements) or phone calls,

Provide information on self-management support,

Use population health registry functionality to support care opportunities, and

Adhere to a team-based approach to care, which drives proactive care delivery.

Care 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 (where available).
- Resources that should be utilized (e.g. Anthem clinical programs, 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 list of suggested assessment “domains” or functional areas to guide goal formation and related elements that could further support the identification of goals and interventions.

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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 will collaborate with your provider organization team as Anthem determines appropriate to identify Attributed Members who have been determined by your organization as candidates to receive a care plan.

The Care Consultant may periodically review provider organization-identified Attributed Members with your care coordinator and/or care managers during “Touch Points,” which are discussions that provide a recurring forum for collaboration between the Care Consultant and the care coordinator. The Care Consultant may request to extend the 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 checklist 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 checklist allows for a thorough patient evaluation so that all the pertinent clinical areas are covered. You can find our comprehensive assessment checklist by visiting the Provider Toolkit (as described in Section 4, *Program Requirements and Transformation*). This checklist 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, by phone call, or text messaging 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 enhanced 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 (to the extent permitted by law),
- 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 (2) ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership. The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.\(^5\)

You 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.\(^6\)

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

\(^6\) [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

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

Patient Engagement

The commitment to adopting a patient-centered care model is one of the most important and fundamental requirements of the Enhanced Personal Health Care Program, (nationally known as Blue Distinction Total Care). 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 “Access to Care” 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 patients, but can ultimately help achieve better health outcomes.

Practice Transformation

Practice transformation is a discipline that incorporates quality improvement methodology and practice or organizational-level data to drive change that impacts quality, cost, and patient experience. In order to analyze reports to drive practice improvement, physicians participating in the Program are required to gain access to and use a series of web based tools and data platforms, including Patient 360 and Availity, as referenced below:

Patient 360

Physicians participating in the Program are required to access and utilize Anthem’s Patient 360 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.

Patient 360 is a real-time dashboard that gives you a robust picture of a patient’s health and treatment history to facilitate care coordination. It allows you to quickly retrieve detailed records about your Anthem membership through our provider self-service website using Patient 360.

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

- Member Care Summary Eligibility details
- Claims details
- Authorization details
- Pharmacy information
- Lab information
- Episodic viewer
- Communication details (if applicable)
- Document information (if applicable)
- Care management information

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

Patient360 is now available from Availity Payer Spaces
1. Log into Availity
2. In the navigation bar, click Payer Spaces and then click the payer space.
3. From the Applications tab select the Patient360 app

Note: If the Patient360 app does not display under the Applications tab, contact your Availity Administrator to assign that specific role for access. Patient 360 can be accessed through Availity for any patient details that may not yet be attributed to them.

**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. The Availity Web Portal, a secure multi-payer provider portal, is our primary means of delivering that information. See Section 9 of this Program Description for a list of reports available through Availity.

**How to get started**

If your organization is NOT currently registered for the Availity Web portal, visit www.availity and select “Register” to complete the online application.

**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 Administrator for your organization. Go to www.Availity.com and log in.

**Availity User Set Up**

To register users to access the Enhanced Personal Health Care Program, complete the following steps:

**Adding a New User in the Availity Web Portal:**

Select **Add User** from the My Account Dashboard on the Availity home page or choose **More** in the top navigation bar then **Add User** under **Account Administration**.

1. Enter the user’s information in the fields provided.
2. Choose the **“Provider Online Reporting”** check box under Roles, select “Next”, and then “Submit”. A temporary password and User ID will be viewable to the administrator who can then print the information or email the information to the end user.

**Editing Roles in the Availity Web Portal:**

Select **Maintain User** from the My Account Dashboard on the Availity home page or choose **More** in the top menu bar then **Maintain User** under **Account Administration**.

1. Locate the user’s account. Select the name of user.
2. In the “Roles” column, choose “View/Edit”. A list of available roles displays.
3. Select the check box for “Provider Online Reporting” and then save.

After user setup has been completed on the Availity Web Portal, the administrator must complete the registration set up in the Provider Online Reporting application for the organization and users.

**Registering your Organization:**

1. From the More option, located in the top navigation bar, select “Provider Online Reporting”, located under My Payer Portals.
2. Verify your Organization and Payer Information.
3. Click “I Agree” to be redirected to the Provider Online Reporting application and will see “Welcome to Provider Online Reporting”.
4. Select “Register/Maintain Organization.”
5. Select the blue link to “Register Tax ID(s)” for the Program.
6. To register the Tax ID(s) the administrator must check the box and click “Save.”
7. 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.

**Registering your Users:**

1. Select Maintain User then “New users available to be registered” or you can select Register User.
2. The Administrator may select the group, the role, and users that are appropriate for the users needing access to reports, (i.e. to clinical reports, financial reports, or both clinical and financial), and Tax ID(s).
3. For full registration instructions, please contact your market representative for additional materials on the registration process.

Note: Your Administrator must ensure that users are only granted access that is required to fulfill their specific business needs.
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 use a registry in your practice to support the proactive management of your patient population and optimize the health of each patient.

Identifying your 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 Solutions ("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.

Member Health Information

Maintaining documentation of patient visits and of patients’ diagnoses and chronic conditions helps Anthem fulfill its requirements under the Affordable Care Act ("ACA"). Those requirements relate to the risk adjustment, reinsurance and risk corridor, or “3Rs” provision in the law. In addition to the ACA requirements, Anthem also may be required to produce certain documentation for members enrolled in Medicare Advantage or Medicaid.

Enhanced Personal Health Care providers are expected to partner with Anthem to meet these requirements, and we will periodically monitor providers’ participation. Anthem or its representative may ask you to provide documentation or to schedule a visit for a patient specifically to better meet these requirements.

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 (but are not limited to) the following:

- A National Transformation webinar series that features state of the art practice transformation topics delivered by national experts.
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 practice transformation topics delivered by national pediatric experts.

A Medicare Advantage learning series that features priority topics pertaining to your Medicare population.

Additional series that support practices by providing an education in areas that are crucial to your Program success including risk adjustment, documentation and coding in addition to behavioral health and other areas frequently requested by practices.

All sessions are recorded and added to our extensive recording library in order to offer viewing at a time that is convenient for learners.

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

Provider Toolkit

The Provider Toolkit, found on the Enhanced Personal Health Care 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 critical Medicare topics self-management support, motivational interviewing, and enhanced access to care for your patients. 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.
Section 5: Quality Measures and Performance Assessments

The measurement of quality and performance metrics is a key component of successful performance improvement and patient-centered care programs. Under the Program, quality and performance standards must be achieved in order for you to be eligible to receive additional amounts described under Section 8: 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-Medical Cost Target and Medical Loss Ratio models and Medicare Advantage lines of business are described separately below:

Commercial Line of Business

Quality Measures and Performance Assessments

Note: The section below only pertains to providers who have Enhanced Personal Health Care Attachments that specifically include their participation in our Commercial business Medical Cost Target model and/or Medical Loss Ratio model. All terms and provisions in this and all Commercial business Medical Cost Target model and/or Medical Loss Ratio model designated subsections shall refer only to Commercial business Medical Cost Target model and/or Medical Loss Ratio model and not to the Medicare Advantage business.

Measures - Commercial Business (Medical Cost Target and Medical Loss Ratio Incentive Models)

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.

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 help 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, credible and 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 more than 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, 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 and Medical Loss Ratio Measurement Period Handbooks (referenced below) are grouped into two (2) 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 and Medical Loss Ratio Measurement Period Handbooks (referenced below) focus on measures such as appropriate emergency room (“ER”) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and formulary compliance metric. * As with the clinical metrics, administrative data are used to construct the utilization measures.

* **Note:** Provider organizations in Measurement Periods starting 10/1/17 or prior use the generic dispensing rate metric. Provider organizations in Measurement Periods starting 1/1/18 will use the formulary compliance metric.

**Commercial Business Medical Cost Target And Medical Loss Ratio Measurement Period Handbooks**

Anthem 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 or Medical Loss Ratio Model). Approximately 90 days prior to the start of each Measurement Period, Anthem will provide you with a “Commercial Business Measurement Period Handbook” (“Medical Cost Target Measurement Period Handbook (MCT Measurement Period Handbook) and/or the Medical Loss Ratio Measurement Period Handbook (MLR 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 and/or MLR 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 and/or MLR Measurement Period Handbook, you determine you no longer desire to participate in the Program, you must notify Anthem in writing within 30 days after the date the MCT Measurement Period Handbook and/or MLR Measurement Period Handbook was sent unless otherwise communicated to you by Anthem.

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, and
the MCT Measurement Period Handbook and/or MLR 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 and/or MLR 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 and Medical Loss
Ratio Measurement Period Handbooks” 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 – Commercial Business Medical Cost Target And Medical Loss Ratio
Models

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.

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, Incentive Program Commercial Business Medical Loss Ratio) 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’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 quality 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 level (as defined in the Attachment) 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).

**Linking Performance Assessment To Shared Savings**

The opportunity to share in savings that are achieved 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 (2) functions: (1) quality gate, and (2) overall determinant of proportion of shared savings you earn.

**Quality Gate**

Your provider organization must meet a minimum threshold of performance on the performance scorecard in order for you to share a portion of the savings pool. That threshold, referred to as the Quality Gate, is based on the total score in the performance scorecard, and is defined by Anthem in the MCT Measurement Period Handbook and/or the MLR Measurement Period Handbook.

*Note for Providers in Measurement Periods 10/01/17 and prior 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, 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 and/or MLR Measurement Period Handbook.

**Proportion of Shared Savings Earned**

After the Quality Gate is satisfied, the proportion of shared savings you receive depends on the overall scorecard score defined above. The better the performance, the greater the proportion of shared savings earned.

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

**Other Anthem 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 and Performance Assessments**

**Note:** The section below only pertains to providers who have Enhanced Personal Health Care Attachments that specifically include their participation in Medicare Advantage business. All terms and provisions in this and all Medicare Advantage designated subsections shall refer only to Medicare Advantage and not to the Commercial business Medical Cost Target model and/or the Medical Loss Ratio 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 and may include improvement and utilization measures when administratively possible. 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 can fall into four (4) composites: (1) Standard Measures (2) Enhanced Measures (3) Utilization Measures and (4) Improvement Measures. These composites will be clearly stated in the Measurement Period Handbook made available to you prior to the start on the Measurement Period

- **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 Eye Exam. 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 CPT category II or Z 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 category II code that identifies the members' HbA1c level. The use of CPT category II codes is further explained in the Medicare Advantage Measurement Period Handbook.

- **Utilization Measures** focus on appropriate emergency room (ER) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and readmission rates. As with the clinical metrics, administrative data are used to construct the utilization measures. The readmission rates measure will be informational use only.

- **Quality Improvement Measures** are a subset of the current Standard Measures that will be scored for improvement. These improvement measures will be assessed at your provider organization level.

**Medicare Advantage Measurement Period Handbook**

Anthem 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 quality measures for the Medicare Advantage Attributed Members are selected by Anthem 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 displayed on the Performance Scorecard at the start of each Measurement Period.

If, upon receipt and review of the MA Handbook, you determine you no longer desire to participate in the Program, you must notify Anthem in writing within 30 days after the date the MA Handbook was sent, unless otherwise communicated to you by Anthem. 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, 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. 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. The quality threshold will be based on CMS Star quality levels four (4) and five (5), and determined by Anthem. Better performance will generate a better score and correspond to a higher percentage of shared savings.

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

**Quality Gate**

A minimum threshold of performance on all measures must be met for you to have the opportunity to earn a portion of the shared savings. The thresholds are described in detail in the MA Measurement Period Handbook. In order to participate in shared savings, your practice must achieve the Quality Gate. Further explanation of the measures and the scoring methodology are described in the MA Handbook.

**Other Anthem 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.
Section 6: Attribution Process

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

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

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

Due to certain contract restrictions, customer requirements, Program specific product limitations, and technological limitations, etc., it will not be possible to include all Covered Individuals as Attributed Members in the Program. For example, if an employer group prohibited us from including their employees in the Program, these Covered Individuals would not be Attributed Members. Also, there are Programs that focus on specific product inclusion and therefore members of other products wouldn’t be included as Attributed Members. Therefore, certain lines of business, employer groups or Covered Individuals may be excluded from the Program at Anthem’s sole discretion. Covered Individuals whose Anthem 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’s goal to continue to expand the Covered Individuals included in the Program as operationally feasible and contractually permitted.

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

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

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

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

With regard to the Incentive Program (as described in Section 8), Attributed Members who select a PCP will be identified as follows:

1. Covered Individual selects and maintains one provider for 12-month period → then → Covered Individual is assigned to selected provider for the entire 12-month period

2. During 12-month period, Covered Individual selects more than one provider → then → Covered Individual is assigned to the selected provider only for the months during which the individual selected the provider

3. Covered Individual does not select a provider within the same 12-month period (where product requires PCP selection) → then → Health plan selects a provider for the Covered Individual

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

In an open access product (for example PPO and indemnity), Anthem 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 that a certain provider should be considered his/her PCP. This Attribution algorithm reviews office based evaluation and management visits, and attribution priority is given to PCP visits. When PCP visits (or applicable specialist visits for groups including specialists participating in the Program) are not available, the Covered Individual may not be attributed. As mentioned previously, Claims-based attribution may be used exclusively in certain circumstances.

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

1. Covered Individual visited only one PCP in the 24 month period
   Yes → Covered Individual is assigned to visited PCP

2. Covered Individual visited multiple PCPs in the period
   Yes → Covered Individual is assigned to most visited PCP

3. Covered Individual visited multiple PCPs in the period the same number of times (more than one visit)
   Yes → Covered Individual is assigned to the PCP with the greatest length of time between the first and last visit

4. Covered Individual visited multiple PCPs once in the period
   Yes → Covered Individual is assigned to the most recently seen PCP
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, the Attributed Members for that physician may stay with the practice, as long as the Attributed Members do not select a different PCP or have record of visiting another provider in the practice. In this circumstance, the Attributed Members will remain attributed to the practice for purposes of clinical coordination payments, but will not be counted as an Attributed Member for the incentive program payment calculations.
Section 7: Clinical Coordination Reimbursement

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

- Coordinating patient care
- Preparing care plans
- Maintaining registries
- Providing patients with self-management support
- Performing follow-up with patients regarding care
- Coding for the burden of illness
- Closing gaps in care
- Building infrastructure via people, tools and reporting to manage population health

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 15th day of the month. For Attributed Members added on or before the 15th day of the month, the entire fee is payable regardless of the date added. For Attributed Members added after the 15th day of the month, no payment will be made. Likewise, for Attributed Members deleted on or before the 15th day of the month, no amounts will be payable. The Clinical Coordination Reimbursement will be payable if an Attributed Member is deleted after the 15th day of the month. By way of example, if an Attributed Member becomes eligible on the 14th day of the month, the entire Clinical Coordination Reimbursement will be payable for that Attributed Member. Similarly, if an Attributed Member is deleted on the 14th day of the month, the Clinical Coordination Reimbursement will not be payable for that member for that month. Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such provider in order to promote cost-effective distribution of payments. Such payment will be made to the provider one month after it would otherwise have been paid even if the total amount payable to the provider at that time is still less than $5.

Clinical Coordination Reimbursement payments for Attributed Members whose Claims are processed through the BlueCard program/system will be based on eligible BlueCard Attributed Member counts as determined and updated by Anthem. Reimbursement of PMPM amounts for BlueCard Attributed Members will be issued to Provider no later than the 30th day of each calendar month for BlueCard Attributed Members.
For example, if the Program Attachment Effective Date is July 1st, Anthem will make its PMPM payment for July no later than August 30th. This rule related to the timing of the PMPM payments for BlueCard Attributed Members shall not, however, apply in those instances where Anthem or one of its affiliates are both the “home” and “host” plans for an Attributed Member under the BlueCard rules.

**Note:** California providers’ Clinical Coordination Reimbursement always pays one month in arrears regardless of line of business.

**Retroactivity**

On a monthly basis, Anthem 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 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

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. 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

Note: The section below only pertains to providers who have Enhanced Personal Health Care Attachments that specifically include their participation in our 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 Commercial business Medical Cost Target model and not to the Commercial business Medical Loss Ratio model and/or Medicare Advantage business.

As described more fully below, and subject to the below Incentive Program terms and details, Anthem 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 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, 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 the Medical Cost Baseline and Medical Cost Targets.

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

“Gross Paid Savings” means Gross Allowed Savings (any amount by which the MCP is less than the MCT), adjusted by the Paid/Allowed Ratio, as calculated by Anthem.
“Gross Paid Upside Cap (Upside Cap)” means the maximum limit on Gross Paid Savings that can be generated through the Incentive Program. The Upside Cap is a percentage that includes the MRC value, which is calculated as a percentage of the MCB and is adjusted by the Paid/Allowed Ratio to determine the Upside Cap value expressed as a PMPM. The Upside Cap value expressed as a PMPM is compared to Gross Paid Savings and the lesser of these two values apply to the determination of Net Aggregate Savings.

“Maximum Shared Savings Cap” means the maximum limit on the amount that Anthem must remit to Provider as a result of savings through the Shared Savings Program. The Maximum Shared Savings Cap is determined at the beginning of the Measurement Period.

“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 and the Medical Panel.

Medical Cost Baseline (MCB)” means the untrended cost experience, as determined by Anthem, for the Member Population for each Measurement Period which establishes the baseline benchmark for shared savings calculations under the Program for that Measurement Period. A new MCB is established for each separate Measurement Period. The formula for setting the MCB takes into account risk adjusted per member per month (PMPM) Claims experience within the Member Population during the Baseline Period, but excluding certain Covered Individuals with transplant or high cost claims amounts. The MCB calculation also includes consideration of Anthem product type (e.g. HMO, PPO, etc.). If Provider participates in the Program under a number of different Anthem products, there may be multiple MCBs.

New MCB(s) are established by Anthem for each separate Measurement Period. New MCB(s) will be determined by Anthem, and Anthem will make best effort to make such MCB(s) available to the Provider prior the start of each separate Measurement Period.

“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 formula for setting the MCP takes into account risk-adjusted (“PMPM”) Claims experience within the Attributed Member Population during the Measurement Period, but excludes certain transplant and high cost claims amounts. It also may account for any clinical coordination per member per month payments made during the relevant Measurement Period to Provider by Anthem for Attributed Members. As part of the MCP calculation, a risk adjustment is made by Anthem 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 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 trended cost experience, as determined by Anthem, for the Member Population for each Measurement Period which establishes the benchmark for shared savings calculations under the Program for that Measurement Period. The MCT is established for each separate Measurement Period and provided at the time of reconciliation after the end of the Measurement Period. The MCT is the MCB with a market trend factor determined by Anthem included to account for costs from the Baseline Period to the end of the Measurement Period. The MCT is expressed in terms of a risk-adjusted per member per month (“PMPM”) but excluding certain
Covered Individuals with transplant or high cost claims amounts. The MCT calculation may account for any clinical coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period.

“Medical Panel” means a single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful MCBs, MCTs, shared savings, and utilization performance targets. Medical panels shall be formed either by the providers themselves or by Anthem. 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 products(s) will be used to calculate MCBs, MCTs and MCPs pursuant to the Program (subject to criteria established by Anthem).

“Member Months” means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Anthem product(s) for a Medical Panel during a Measurement Period as determined by Anthem.

“Member Risk Months” means the Member Population’s average Normalized Risk Score multiplied by their Member Months in the applicable Anthem products during a Measurement Period.

“Minimum Risk Corridor” (“MRC”) means the percentage of MCB that Anthem retains before sharing any savings with the Medical Panel. This percentage is determined by Anthem to limit savings payouts that are driven by random variation. Like the Gross Savings and Upside Cap, the MRC is adjusted by the Paid/Allowed Ratio.

“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 Provider’s average risk score relative to the market average risk score. The Normalized Risk Score is calculated as follows:

\[
\text{Normalized Risk Score} = \frac{\text{average Provider risk score}}{\text{average market risk score}}
\]

The market is defined by Anthem and may be inclusive of a region or state. The market average will be calculated using risk scores derived from the claims incurred during the Measurement Period, limited to Covered Individuals with assigned attribution or office based evaluation and management visit claims in the market with at least three (3) months of eligibility. The Average Market Risk Score is calculated as follows:

\[
\text{Average Market Risk Score} = \frac{\text{Sum of Covered Individuals risk scores}}{\text{number of Covered Individuals}}
\]

The average risk score of the Provider’s Attributed Members will be calculated using risk scores derived from the Baseline Period claims for the MCB and the Measurement Period claims for the MCP, weighted by months of eligibility. The Average Provider Risk Score is calculated as follows:

\[
\text{Average Provider Risk Score} = \frac{\text{Sum of Provider’s Attributed Members risk scores}}{\text{number of Provider’s Attributed Members}}
\]

Risk scores are generated using the DxCG model from Verisk Health, which uses diagnosis and demographic information from medical Claims as well as an adjustment allowing for consistency
between pediatric and adult populations. The approach to risk scores may be adjusted from time to time. If such adjustments are material in nature, Anthem will provide notice to Provider. Anthem shall have the option to exclude BlueCard data from the determination of the market average risk score calculation if Anthem determines that such exclusion would result in more accurate or sound calculation results. Anthem will monitor Attributed Members’ risk scores to determine if there are any industry coding changes that inappropriately or disproportionately affect the overall Normalized Risk Score. Anthem has the option to neutralize payment results that are driven by such coding changes and not by changes in Attributed Members’ health risk and will notify Risk Entity if such action is taken.

“Paid/Allowed Ratio” means the ratio of paid dollars (dollars paid by Anthem to providers) to allowed dollars (total dollars paid by Anthem 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 a minimum threshold of performance on the on the Performance Scorecard in order for you to share a portion of the savings pool. The Quality Gate is a threshold defined by Anthem, and is defined in the MCT Measurement Period Handbook.

Note: For Providers in Measurement Periods 10/01/17 and prior “Quality Gate” means a minimum threshold of performance on clinical quality measures that must be achieved to have the opportunity to earn a portion of the shared savings. The Quality Gate is a threshold defined by Anthem, and is Anthem 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.

“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 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 which includes a three-month Claims run-out period, Anthem 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 Paid Savings generated during the Measurement Period.
(b) Anthem compares the Gross Paid Savings to the Upside Cap value expressed as a PMPM. The lesser of these values is used for the remaining calculation steps.

(c) Anthem 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 Paid Savings exceeds the MRC. In the event that the Gross Paid 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 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.

(d) 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.

(e) 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.

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

| I. Shared Savings Framework |
|-----------------------------|---------|
| Provider Group Count        | 3       |
| Minimum Risk Corridor (MRC) | 1.5%    |
| Gross Paid Upside Cap       | 5.5%    |
| Upside Shared Savings Potential: Quality | 18% |
| Upside Shared Savings Potential: Utilization | 12% |
II. Panel Savings Pool Calculation (Commercial Example)

<table>
<thead>
<tr>
<th>Medical Cost Baseline (MCB)</th>
<th>$400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td>5%</td>
</tr>
<tr>
<td>Medical Cost Target (MCT)</td>
<td>$420.00</td>
</tr>
<tr>
<td>Paid/Allowed Ratio</td>
<td>0.95</td>
</tr>
<tr>
<td>Medical Cost Performance (MCP)</td>
<td>$408.00</td>
</tr>
<tr>
<td>Gross Paid PMPM Savings: (MCT-MCP) x Paid/Allowed</td>
<td>$11.40</td>
</tr>
<tr>
<td>Minimum Risk Corridor PMPM: (MRC x MCB) x Paid/Allowed</td>
<td>$5.70</td>
</tr>
</tbody>
</table>

| Savings Pool PMPM | $5.70 |

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 based on market medical costs) is set at $420 PMPM.

3. The Medical Panel's Gross Paid PMPM Savings – $11.40 – is the result of the MCT minus the MCP, adjusted by the Paid/Allowed Ratio: \([420-400] \times 0.95\). The MCP is $408 because the Medical Panel was able to reduce PMPM costs by 3%, relative to anticipated costs.

4. The Medical Panel's Gross Paid PMPM Savings - $11.40 – is compared to the Upside Cap value expressed as a PMPM. The Upside Cap value expressed as a PMPM is calculated by multiplying the Upside Cap of 5.5% by the MCB, and adjusting by the Paid/Allowed Ratio: \([0.055 \times 400 \times 0.95]\). The Gross Paid Savings of $11.40 is not limited by the Upside Cap value expressed as a PMPM of $20.90.

5. To limit the impact of random variation, Minimum Risk Corridor ("MRC") is set at 1.5%, which means that the first $5.70 of PMPM savings is excluded from the Savings Pool, i.e. MCB ($400) x MRC (1.5%) x Paid/Allowed Ratio (.95).

6. The Savings Pool PMPM – in this example $5.70 PMPM – is the result of the Gross Paid PMPM Savings ($11.40) minus the MRC PMPM ($5.70).
### III. Provider Group Payout Calculation

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
<th>Panel Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg PCP PMPM</td>
<td>$14.40</td>
<td>$21.60</td>
<td>$18.00</td>
<td>$18.54</td>
</tr>
<tr>
<td>Members</td>
<td>2,500</td>
<td>4,000</td>
<td>3,500</td>
<td>10,000</td>
</tr>
<tr>
<td>Members Months</td>
<td>30,000</td>
<td>48,000</td>
<td>42,000</td>
<td>120,000</td>
</tr>
<tr>
<td>Provider’s Group Normalized Risk Score</td>
<td>0.80</td>
<td>1.20</td>
<td>1.00</td>
<td>1.03</td>
</tr>
<tr>
<td>Member Risk Months</td>
<td>24,000</td>
<td>57,600</td>
<td>42,000</td>
<td>123,600</td>
</tr>
<tr>
<td><strong>Savings Pool Allocation</strong></td>
<td><strong>$136,800</strong></td>
<td><strong>$328,320</strong></td>
<td><strong>$239,400</strong></td>
<td><strong>$704,520</strong></td>
</tr>
<tr>
<td>Upside Shared Saving (Actual) Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Percentage</td>
<td>10%</td>
<td>5%</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>Utilization Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shared Savings Percentage: Total</strong></td>
<td><strong>22%</strong></td>
<td><strong>17%</strong></td>
<td><strong>30%</strong></td>
<td><strong>22%</strong></td>
</tr>
<tr>
<td>Net Aggregate Savings</td>
<td><strong>$30,096</strong></td>
<td><strong>$55,814</strong></td>
<td><strong>$71,820</strong></td>
<td><strong>$154,994</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
<th>Panel Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Baseline Revenue</td>
<td>$432,000</td>
<td>$1,036,800</td>
<td></td>
<td>$2,224,800</td>
</tr>
<tr>
<td>PCP Shared Savings Revenue Increase</td>
<td>7.0%</td>
<td>5.4%</td>
<td>9.5%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

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 $136,800, which is the product of its 24,000 Member Risk Months multiplied by the $5.70 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 $30,096, i.e. 22% (10%+12%) of their $136,800 in allocated savings.

9. 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. For Provider Group A, $30,096 is divided by $432,000, which is their total PCP PMPM ($14.40) multiplied by member months (30,000).

### Maximum Upside Potential

Providers will have information at the start of their Measurement Period indicating the Maximum Shared Savings Cap. This is the maximum limit on the amount that can be remitted to you as a result of savings through the Program. The Maximum Shared Savings Cap is determined via the Upside Cap expressed as a PMPM, adjusting for the MRC reduction and multiplying by both the Upside Shared Savings Percentage and Member Risk Months.

### Adjustments to MCB/MCT/MCP and Normalized Risk Score

Below are some scenarios that help illustrate when potential adjustments can occur to MCB/MCT/MCP and Normalized Risk Scores.

**Tools and Information**: Medical Cost Baseline (“MCB”), Medical Cost Target (“MCT”) and Medical Cost Performance (“MCP”) amounts are calculated based on certain tools and methods.
information provided to and available to Anthem at specific points in time (e.g., cost experience, risk derived from risk adjustment tools applied to member 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 MCB, MCT and/or MCP, then the parties agree that Anthem shall have the right to adjust the MCB, MCT and/or MCP, as applicable, to the extent necessary to account for the Modifications.

As an example, if new information is discovered (not previously available to Anthem) concerning the Claims that were used to derive the MCB, MCT or MCP, and such new information has a material impact on the MCB, MCT or MCP, then an appropriate adjustment may be made to the MCB, MCT or MCP by Anthem. In such an event, Anthem will notify affected Provider(s) as to the adjusted MCB, MCT and/or MCP and the reason for the adjustment.*

Risk Variation: Anthem tracks and analyzes changes to risk scores generated from the information of participating practices and panels. If an unusual, significant variance in risk is observed which, upon analysis, is determined by to be driven by changes other than Attributed Member health risk, Anthem reserves the right to make adjustments to risk scores accordingly.*

Member Population Shifts: Anthem shall have the option to periodically conduct a review of the Member Population to determine if the Member Population has increased or decreased in excess of ten percent (10%) from the start of the Measurement Period. If such change has occurred, Anthem shall have the option to conduct an impact analysis to determine whether the change has materially impacted MCB components such as Member Population, average risk score, and/or average cost. If Anthem determines the change is material, Anthem reserves the right to issue a revised MCB which shall become effective on the date designated by Anthem*.

* Any such adjustments may be made without an amendment and will be communicated to you in advance of implementation of the change.

Exclusions from the calculation of risk scores, MCB, MCT, MCP, and other shared savings

We exclude Attributed Members with certain high-cost claims amounts and organ transplants during either the Baseline Period used to determine the Medical Cost Baseline, 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 who are excluded meet either of the following criteria:

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

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

**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 shall make any applicable distribution payment to the Provider for any Net Aggregate Savings earned during the Measurement Period associated with its Attributed Members.

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 under the Agreement. For example, if Claim payments are currently remitted at the physician group level, Anthem will pay the Provider for such savings amounts.

Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such provider in order to promote cost-effective distribution of payments. Such payment will be made to the provider one month after it would otherwise have been paid even if the total amount payable to the provider at that time is still less than $5.

**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 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, Patient 360, our collaborative learning events, virtual office hours, and the Provider Toolkit 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 will provide a list of all physician practices participating in the Program within each state and 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 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 provider portal, you will remain in your assigned Medical Panel for the duration of the Measurement Period. Anthem will make reasonable efforts to consider all preferences submitted in a timely manner; however, we cannot guarantee that all preferences will be accommodated. Anthem 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, 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 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 - Commercial Business – Medical Loss Ratio Incentive Plan Model

Note: The section below only pertains to providers who have Enhanced Personal Health Care Attachments that specifically include their participation in our Commercial business Medical Loss Ratio model. All terms and provisions in this and all Commercial business Medical Loss Ratio model designated subsections shall refer only to Commercial business Medical Loss Ratio model and not to the Commercial business Medical Cost Target model and/or Medicare Advantage business.

As described in greater detail below, and subject to the Incentive Program terms and details for the Medical Loss Ratio model, Anthem 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 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 be able to 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 Medical Loss Ratio 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 underlying Agreement to which the Attachment is attached or, if not defined, will be interpreted using the commonly accepted definition of such terms.

“Annual Determination Period” means the three-hundred sixty five (365) day period of time immediately following the end of the Measurement Period, during which Anthem will calculate the MPMLR and compare it to the MLRT and determine the amount of any Net Aggregate Savings generated during the Measurement Period. It is assumed that Anthem will have all applicable modifications to Total Medical Expenses and Premium for use in this calculation, and if not, the Annual Determination Period will be extended until all needed information is received and all calculations completed.

“Cost Share Reduction Program” means the permanent federal cost-sharing benefit program established by the Affordable Care Act (“ACA”) that entitles qualifying individuals, typically those who have purchased silver level benefit plan through the state or federal health care exchange, and who have met certain income qualifications to pay reduced cost share, coinsurance and copays. Plans with eligible enrollees will receive rebate payments from Health and Human Services (HHS) for the eligible enrollees claims.

“Gross Savings” means the Gross Savings Percentage multiplied by the Premium expressed as a PMPM amount.

“Gross Savings Percentage” means the difference between the MPMLR and the MLRT when the MPMLR is less than the MLRT.

“Health and Human Services (HHS)” means the U.S. government’s principal agency responsible for the specifics of the Accountable Care Act and related governmental programs outlined in this document.

“Measurement Period(s)” means each twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Anthem and the Provider. The Measurement Period(s) for Provider’s participation in the Program is set forth in Medical Loss Ratio Measurement Period Handbook.
“Measurement Period Medical Loss Ratio (“MPMLR”)” means the percent calculated by Anthem that is based on Total Medical Expense divided by Premium during a Measurement Period (see formula below). For purposes of MPMLR calculations, inpatient Claims will be assigned to the Measurement Period during which the inpatient admission date occurred, rather than the discharge date. MPMLR is calculated after the Measurement Period has ended and includes six (6) months of Claims run out, and is compared to the MLRT as a step toward determining whether shared savings have been demonstrated under the Program. The basic MPMLR calculation is as follows:

\[
\text{MPMLR} = \frac{\sum \text{Total Medical Expense}_{\text{Measurement Period}}}{\sum \text{Premium}_{\text{Measurement Period}}}
\]

The formula shown above does not reflect the modifications and exclusions referenced in the definitions of “Total Medical Expense” and “Premium”.

“Medical Loss Ratio Rebate Program” (“MLR Rebate Program”) is a provision of the ACA that addresses the amount of refund issued to Attributed Members if the percent of premium spent on claims and other expenses that improve health care quality do not meet federally determined minimums. Refunds allocated to Attributed Members will be a reduction to Premium in the MPMLR calculation.

“Medical Loss Ratio Target (“MLRT”)” means the medical loss ratio target percentages of Premium determined by Anthem. The MLRT will be identified in the Medical Loss Ratio Measurement Period Handbook.

“Medical Panel” means a single provider organization or a grouping of multiple provider organizations by Anthem for purposes of calculating statistically meaningful MPMLRs and shared savings. Further details regarding Medical Panels are provided below under “Medical Panels-Medical Loss Ratio-Commercial Business.”

“Member Months” means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Anthem product(s) for a Medical Panel during a Measurement Period as determined by Anthem.

“Member Population” means the group of Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Anthem product(s) as described in the Attachment will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Anthem).

“Minimum Risk Corridor” (“MRC”) means the percentage of Premium times the MLRT that Anthem retains before sharing any savings with the Medical Panel. This percentage is determined by Anthem and is designed to limit savings payouts that are driven by random variation.

“Net Aggregate Savings” has the meaning as set forth in section (e) under the “Shared Savings Determination” section below (under “Medical Loss Ratio Program Terms and Details”).

“Patient Protection and Affordable Care Act” or “ACA” means the federal program passed by the U.S. Congress on March 21, 2010 with the goals of improving the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government.

“Premium” means the total of all payments for the Member Population’s Health Benefit Plans during a Measurement Period as determined by Anthem less:

- Applicable amounts calculated under the Risk Adjustment Program*
- Applicable amounts calculated under the MLR Rebate Program*
Anthem calculates these amounts using its own internally-developed program that was designed for use primarily by its commercial pricing actuaries, to assess member-level risk and profitability as a tool to inform pricing and strategy decisions. Federal agencies calculate aggregate amounts at a state, market and/or entity level for all plans meeting criteria for inclusion, but do not provide the ability to allocate settlements back to individuals. Anthem’s program allows Anthem to allocate aggregate settlements of these three programs back to individuals. While Anthem believes the member level allocations are appropriate for these purposes, no federal agencies have recognized or authorized Anthem’s approach.

“Quality Gate” means a minimum threshold of performance on the Performance Scorecard in order for you to share a portion of the shared savings. The Quality Gate is a threshold defined by Anthem that is provided in the MLR Measurement Period Handbook.

**Note: For Providers in Measurement Periods 10/01/17 and prior** “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 Measurement Period, such determination shall be based on the scorecard which is measured based on the number of Attributed Members included in this Program.

“Quality Targets” means quality performance targets, referenced in Section 5 of the Program Description and the Medical Loss Ratio Measurement Period Handbook, used to determine the percentage of shared savings under the Incentive Program.

“Risk Adjustment Program” means the actuarial tool, as developed or promulgated by HHS, that is used to adjust for the actuarial risk (age, gender, diagnosis) of individual or small group market enrollees. Risk adjustment will result in payments or charges to revenue to adjust actuarial risk of the Attributed Member population.

“Total Medical Expenses” means the costs, determined by Anthem, that are paid by Anthem during a Measurement Period for all Covered Services (including hospital, medical, pharmacy and non-hospital) provided to the Member Population by all providers (participating and non-participating, and including Provider and its primary care physicians) furnishing such services to the Member Population, as adjusted by the following factors:

- Transplants and high dollar Claims costs as determined by Anthem, if applicable.
- Eligible Covered Individuals out of pocket expenses received by Anthem on behalf of Covered Individuals under the Cost Share Reduction (CSR) Program.
- Any applicable Per Member Per Month clinical coordination payments made by Anthem throughout the Measurement Period, if applicable.

“Upside Cap” means the maximum limit on Incentive Program shared savings that you can earn through the Incentive Program.

“Upside Shared Savings Percentage” means the percentage of shared savings under the Incentive Program that 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
Quality 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 Quality 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 Quality 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 Provider may be entitled to, provided that it meets the Quality Gate.

**Medical Loss Ratio Program Terms and Details**

**Shared Savings Potential**

The Upside Shared Savings Potential as defined above will be communicated to Provider by Anthem prior to the start of the Measurement Period in the Medical Loss Ratio Measurement Period Handbook. The Upside 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 as follows:

a) During the Annual Determination Period, Anthem will determine the Medical Panel’s Member Populations’ Premium and Total Medical Expense and calculate the MPMLR.

b) Anthem will compare Medical Panel’s MPMLR to its MLRT. If the Medical Panel’s MPMLR is below the MLRT, then the Gross Savings Percentage will be calculated.

c) Gross Savings (expressed as a PMPM amount) is calculated for the Medical Panel and then reduced by the Minimum Risk Corridor, resulting in the Total Net Savings (expressed as a PMPM amount).

d) If Provider meets the Quality Gate, then the Upside Shared Savings Percentage is determined based on Provider’s performance on the Quality Targets, as determined annually by Anthem.

e) For each Provider, the Upside Shared Savings Percentage can be applied to the Total Net Savings to determine the net savings by provider group (expressed as a PMPM amount). To determine the payout per provider group, the net savings by provider group is multiplied by each provider’s group Member Months, and these products are totaled to determine the Net Aggregate Savings payable by Anthem to the entire Medical Panel.

f) In no event can the net savings by provider group (expressed as PMPM amount) exceed the amount determined by the application of the Upside Cap.
For a basic Medical Loss Ratio Incentive Program calculation example, see the calculation set forth below. In this example, three provider organizations are combined into a Medical Panel for the purpose of calculating a statistically meaningful MPMLR:

<table>
<thead>
<tr>
<th>Multi-Provider Medical Panel Shared Savings Payout Example</th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>42,000</td>
<td>34,800</td>
<td>27,600</td>
</tr>
<tr>
<td>Premium (expressed as a PMPM amount)</td>
<td></td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>MLRT*</td>
<td></td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>MPMLR*</td>
<td></td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Total Medical Expense</td>
<td></td>
<td>$39,672,000.00</td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td></td>
<td>$52,200,000.00</td>
<td></td>
</tr>
<tr>
<td>Premium (by group)</td>
<td>$21,000,000</td>
<td>$17,400,000</td>
<td>$13,800,000</td>
</tr>
<tr>
<td>Gross Savings Percentage = MLRT – MPMLR</td>
<td></td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Gross Savings (expressed as a PMPM amount)</td>
<td></td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>Minimum Risk Corridor %</td>
<td></td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Minimum Risk Corridor (expressed as a PMPM amount)</td>
<td></td>
<td>$6.00</td>
<td></td>
</tr>
<tr>
<td>Total Net Savings (expressed as a PMPM amount)</td>
<td></td>
<td>$14.00</td>
<td></td>
</tr>
<tr>
<td>Upside Cap %</td>
<td></td>
<td>10%</td>
<td></td>
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<tr>
<td>Upside Cap (expressed as a PMPM amount)</td>
<td></td>
<td>$40.00</td>
<td></td>
</tr>
<tr>
<td>Total Net Savings (by Provider Group)</td>
<td>$588,000</td>
<td>$487,200</td>
<td>$386,400</td>
</tr>
<tr>
<td>Shared Savings Potential</td>
<td></td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Shared Savings Percentage (actual)</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>Net Savings by Provider Group (expressed as a PMPM amount)</td>
<td>$3.50</td>
<td>$4.20</td>
<td>$4.90</td>
</tr>
<tr>
<td>Payout per Provider Group</td>
<td>$147,000</td>
<td>$146,160</td>
<td>$135,240</td>
</tr>
</tbody>
</table>

*Medical Panel Level

Net Aggregate Savings payable to Medical Panel = $428,400
In this example, the Medical Panel’s MLRT is set to 80% for the initial Measurement Period.

1. 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 Percentage is then determined. In the example above the Gross Savings Percentage is 4%.

2. For illustrative purposes, this example assumes the Premium (expressed as a PMPM amount) for the Medical Panel is $500. The Premium (by provider group) is the Premium PMPM amount multiplied by each providers’ Member Months. So, for Provider Group A, the Total Premium (by provider group) is $500 multiplied by 42,000 Member Months equating to a Premium of $21,000,000.

3. To determine Gross Savings (expressed as a PMPM amount), the Gross Savings Percentage, in this example 4%, is multiplied by the Premium, for our example $52,200,000, and divided by the Member Months for the entire Medical Panel. The result is a Gross Savings (expressed as a PMPM amount) of $20.00.

4. The Minimum Risk Corridor is then applied as follows: multiply the MLRT, 80% in the above example, by the Premium (expressed as a PMPM amount) of $500, and that result is multiplied by the Minimum Risk Corridor of 1.5%. The result is a $6.00 Minimum Risk Corridor (expressed as a PMPM amount). This $6.00 is then subtracted from the $20.00 Gross Savings (expressed as a PMPM amount), resulting in a $14.00 Total Net Savings (expressed as a PMPM amount).

5. In the above example, for Provider Group A, the Total Net Savings dollar amount is calculated by multiplying the Total Net Savings (expressed as a PMPM amount) of $14.00 by the Member Months for all their Attributed Members, i.e. 42,000, equating to $588,000.00.

6. In the above example, each provider group has the potential to earn 35% of the shared savings that are demonstrated in the Measurement Period, after meeting the Quality Gate. The actual Upside Shared Savings Percentage is a function of the group’s performance on the Quality Targets. In the above example, Provider Group A earns 25% of the Total Net Savings (expressed as a PMPM amount) as a result of their performance on the Quality Targets. Provider Group A’s net savings by provider group (expressed as a PMPM amount) is the $14.00 Total Net Savings (expressed as a PMPM amount) multiplied by their 25% actual Upside Shared Savings Percentage, resulting in $3.50.

7. The application of the Upside Cap is performed by comparing the Upside Cap to each provider’s Net Savings by Group (expressed as a PMPM amount). The Upside Cap is determined by multiplying the MLRT by the Premium (expressed as a PMPM amount) and multiplying this product by the Upside Cap %. In the example, for Provider Group A the Upside Cap is $40.00 which is well above the net savings by provider group (expressed as a PMPM amount) of $3.50, so the Upside Cap does not limit the Payout.

8. The final step is to determine the Payout for each provider group by multiplying the net savings by provider group (expressed as PMPM) by each provider group’s Member Months. The example above shows a final Payout of $147,000 for Provider A. The Net Aggregate Savings for the Medical Panel is the sum of all the provider groups’ payouts, or $428,400.
Adjustments to MLRT and MPMLR

Tools and Information: 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 at specific points in time (e.g., cost experience of Member Population, Premium data, governmental program information related to ACA, 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 MLRT or MPMLR, then the parties agree that Anthem 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 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) 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.

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 Measurement Period. The final MLRT for each Measurement Period will be defined in the Medical Loss Ratio Measurement Period Handbook.

Member Population Shifts: Anthem shall have the option to periodically conduct a review of the Member Population to determine if the Member Population has increased or decreased in excess of ten percent (10%) from the start of the Measurement Period. If such change has occurred, Anthem shall have the option to conduct an impact analysis to determine whether the change has materially impacted MLRT components such as Member Population, average risk score, and/or average cost. If Anthem determines the change is material, Anthem reserves the right to issue a revised MLRT which shall become effective on the date designated by Anthem.*

* Any such adjustments may be made without an amendment and will be communicated to you in advance of implementation of the change.

Upside Shared Savings Payment

Assuming all preconditions and terms have been satisfied, on an annual basis, after the end of the relevant Measurement Period, Anthem shall make any applicable distribution payment to you for any Net Aggregate Savings earned during the Measurement Period associated with its Attributed Members. The 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 you have in place with Anthem under the Agreement. For example, if claim payments are currently remitted at the physician group level, Anthem will pay the Provider for such savings amounts.

Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such provider in order to promote cost-effective distribution of payments. Such payment will be made to the provider one month after it would otherwise have been paid even if the total amount payable to the provider at that time is still less than $5.

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 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 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, our collaborative learning events, virtual office hours and the Provider Toolkit are just a few ways you can access information on methods for quality improvement.

**Medical Panels – Medical Loss Ratio Model - Commercial Business**

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 individual physician practice or a group of practices. Anthem will provide a list of all physician practices participating in the Program within each state and assigned Medical Panel. Prior to the Measurement Period start date, Anthem 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. Anthem 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, may form Medical Panels with other participating physician groups. Prior to the start of the Measurement Period, assigned Medical Panels will be communicated. Each Medical Panel that is comprised of multiple practices must exceed the 7,500 minimum number of Attributed Members.

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 one provider group represents a Medical Panel, both quality and utilization performance will be calculated at the single-group level.
Incentive Program – Medicare Advantage Business

Note: The section below only pertains to providers who have Enhanced Personal Health Care Attachments that specifically include their participation in our Medicare Advantage business. All terms and provisions in this and all Medicare Advantage designated subsections shall refer only to Medicare Advantage and not to the Commercial business Medical Cost Target model and Medical Loss Ratio model.

As described in greater detail below, and subject to the Incentive Program terms and details for Medicare Advantage business, Anthem 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 (MA) 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 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 Anthem as calculated by Anthem 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 as calculated by Anthem 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 historical paid Claims experience, and will be developed by Anthem 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 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 that is based on Total Medical Expense divided by Premium during a MA Measurement Period (see formula
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. 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 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 products(s) will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Anthem).

“Member Months” means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Anthem product(s) for a Medical Panel during a Measurement Period as determined by Anthem.

“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 for the Member Population under an Anthem 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 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” 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 (4) and five (5) Star level, aligning with the Stars quality program. In order to participate in shared savings, your practice must achieve four (4) or five (5) star rating in quality performance for each individual clinical quality measure. Further explanation of the quality measures and the scoring methodology are described in the MA Handbook.

“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 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 to CMS or otherwise offset against or deducted from amounts payable by CMS to Anthem 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:

<table>
<thead>
<tr>
<th>Member Population</th>
<th>Per Member Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>1,001-5,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>5,001-8,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>8,001-10,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>10,001-25,000</td>
<td>$150,000</td>
</tr>
<tr>
<td>&gt;25,000</td>
<td>None</td>
</tr>
</tbody>
</table>

“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 Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period, divided by the total Member Months across all Anthem 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, 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 for direct services delivered to Anthem Medicare Advantage Attributed Members during the applicable MA Measurement Period year.

“Total Medical Expenses” means the costs incurred by Anthem 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, and Clinical Coordination PMPM Payments, capitation 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 and/or Anthem’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 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 as follows:

a) During the Annual Determination Period, Anthem will determine the Medicare Advantage Attributed Members’ Premium and Total Medical Expense and calculate the MPMLR.
b) Anthem 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 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.

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:

<table>
<thead>
<tr>
<th>Multi-Provider Panel Shared Savings Payout Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of MA Attributed Members</strong></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>MLRT</strong></td>
</tr>
<tr>
<td><strong>MP MLR</strong></td>
</tr>
<tr>
<td><strong>MP MLR - MLRT = % of premium to share</strong></td>
</tr>
<tr>
<td><strong>TOTAL Premium paid to Anthem</strong></td>
</tr>
<tr>
<td><strong>Gross Savings</strong></td>
</tr>
<tr>
<td><strong>Shared Savings Potential</strong></td>
</tr>
<tr>
<td><strong>Shared Savings Percentage(actual)</strong></td>
</tr>
<tr>
<td><strong>Net Aggregate Savings</strong></td>
</tr>
</tbody>
</table>

*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 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. For Provider Group A, we will use $450,000 as the annual amount received from Anthem 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**

Tools and Information: 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 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 reasonably deems to materially change the calculation of the MLRT or MPMLR, then the parties agree that Anthem 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 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) 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.

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 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 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 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 under the Agreement. For example, if claim payments are currently remitted at the physician group level, Anthem will pay the Provider for such savings amounts.

Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such provider in order to promote cost-
effective distribution of payments. Such payment will be made to the provider one month after it would otherwise have been paid even if the total amount payable to the provider at that time is still less than $5.

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 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 collaborative learning events and the Provider Toolkit are just a few ways to access information and drive 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 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 may form its own Medical Panel.
- Physician groups with Medicare Advantage Attributed Member populations less than the minimum level set by Anthem 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 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.
Section 9: Reporting

As part of our commitment to sharing actionable data with Enhanced Personal Health Care Providers, reports offering detailed information about your Attributed patient population are available on Provider Care Management Solutions ("PCMS"), Anthem’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, potentially preventable visits (ER) as well as inpatient visits with Ambulatory Sensitive Conditions. 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.

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

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
- Total costs associated with a Attributed Member
- Enrollment in care management or disease management programs

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, day of week and diagnoses. You will be able to further filter the member list by the following categories:

- Visit frequency
- Visit date range
- Organization
- Primary and secondary diagnosis
- Total cost

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

**Pharmacy**

The Pharmacy report provides detailed Cost and Utilization metrics on drugs dispensed through a retail or mail-order pharmacy to identify cost savings opportunities. It offers multiple levels of detail, down to the Script level, in order to identify Cost and Utilization trends that may exist for Therapeutic Classes, Providers or Patients.

Users can filter the Pharmacy report into the following four views:

- Therapeutic Class
- Provider
- Patient
- Scripts

**Cost Performance Detail**

The Cost Performance Detail report shows medical and pharmacy plan benefit costs incurred by a given provider’s attributed members over the course of a specific time period, and how those costs compare to the Medical Cost Target for the period.

Medical Cost Target, Medical Cost Performance and utilization metrics are shown at a summary level and at a detailed service type level, across a group’s attributed membership by:

- Inpatient
- Outpatient
- Professional
- Pharmacy Services

**Inpatient Admissions**

This report provides claims information on patients who have had one or more inpatient admissions for all levels of care, including sub-acute, skilled or rehab in the past rolling 12 months of approved claims. It does not include maternity, newborn, neonatal, ER or observation visits up to 23 hours.

**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 Baseline (“MCB”) and Medical Cost Performance (“MCP”)**

Note: The Medical Cost Baseline and Medical Cost Performance reports apply only to the Commercial business Medical Cost Target Model.

The Medical Cost Baseline report provides the detailed calculations behind the Program’s product-specific Medical Cost Baseline. 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 Baseline, 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
## Section 10: Glossary

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.

<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment</td>
<td>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.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Attributed Members</td>
<td>Means those Covered Individuals who are attributed by Anthem to Represented Primary Care Physicians for Program purposes using the Attribution Methodology and adjusted for retroactive enrollment changes (as applicable). The term “Attributed Members” shall not include any Covered Individuals whom Anthem, in the exercise of its sole discretion, does not include on the attribution reporting tools that are made available to Provider. By way of example, if the monthly attribution report does not include Covered Individuals in certain employer groups, then those Covered Individuals will not be considered Attributed Members for the purposes of the Program. Covered Individuals whose Anthem coverage is secondary under applicable laws or coordination of benefit rules or which is provided under a supplemental policy (e.g., Medicare supplement) shall never be Attributed Members. It is Anthem’s goal to continue to expand the Covered Individuals included in monthly attribution report as operationally feasible and contractually permitted.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Attribution Methodology</td>
<td>Means a process whereby Anthem, in its sole discretion, will assign Covered Individuals to the Represented Primary Care Physicians in one of the following manners:</td>
<td>Attachment</td>
</tr>
<tr>
<td></td>
<td>i. based on the formal selection of a Primary Care Physician by the Covered Individual; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii. based on the formal assignment of a Primary Care Physician to the Covered Individual by Anthem or employer group; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>iii. based on a Covered Individual’s prior utilization of evaluation and management services. Provider agrees and acknowledges that such assignment of a Covered Individual to a Primary Care Physician 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 the Program Description.</td>
<td></td>
</tr>
<tr>
<td>Annual Determination Period-Medical Loss Ratio Model</td>
<td>The three-hundred sixty five (365) day period of time immediately following the end of the Measurement Period, during which Anthem will calculate the MPMLR and compare it to the MLRT and determine the amount of any Net Aggregate Savings generated during the Measurement Period. It is assumed that Anthem will have all applicable modifications to Total Medical Expenses and Premium for use in this calculation, and if not, the Annual Determination Period will be extended until all needed information is received and all calculations completed.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Annual Determination Period –Medicare Advantage</td>
<td>The two-hundred eighty-five (285) day period of time immediately following the end of the MA Measurement Period, during which Anthem 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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Baseline Period</td>
<td>Means a defined twelve (12) month period preceding a Measurement Period. To ensure all Claims have been received and processed by Anthem, 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 the Medical Cost Baseline and Medical Cost Targets.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>BlueCard</td>
<td>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</td>
<td>Attachment</td>
</tr>
<tr>
<td>Care Plan</td>
<td>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).</td>
<td>Program Description (Section 3)</td>
</tr>
<tr>
<td>Care Plan Assessment Domains</td>
<td>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.</td>
<td>Program Description (Section 3)</td>
</tr>
<tr>
<td>Clinical Quality Measures-Commercial Business</td>
<td>The clinical quality measures currently included in the Program Performance 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.</td>
<td>Program Description (Section 5)</td>
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<tr>
<td>Glossary Term</td>
<td>Definition</td>
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</table>
| Clinical Quality Measures-Medicare Advantage Business | The clinical quality measures included in the Program Performance Scorecard fall into two (2) 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 CPT category II or Z 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 category 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 category II codes is further explained in the MA Handbook. | Program Description (Section 5- Medicare Advantage) |
<p>| Cost Share Reduction Program                      | Means the permanent federal cost-sharing benefit program established by the Affordable Care Act (&quot;ACA&quot;) that entitles qualifying individuals - typically those who have purchased silver level benefit plan through the state or federal health care exchange, and who have met certain income qualifications - to pay reduced cost share, coinsurance and copays. Plans with eligible enrollees will receive rebate payments from Health and Human Services (&quot;HHS&quot;) for the eligible enrollee’s claims. | Program Description (Section 8- Medical Loss Ratio Model ) |
| Gross Loss                                         | The dollar amount represented by the difference between the MPMLR and the MLRT, when the MPMLR is greater than the MLRT, as calculated by Anthem following an MA Measurement Period. | Program Description (Section 8- Medicare Advantage) |</p>
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<th>Glossary Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Gross Allowed Savings – Medical Cost Target Model</strong></td>
<td>Any amounts by which the Medical Cost Performance (“MCP”) is less than the Medical Cost Target (“MCT”), as calculated by Anthem, at the end of a Measurement Period for each product requiring a separate product specific calculation. Gross Allowed 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.</td>
<td>Program Description (Section 8 Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Gross Paid Savings – Medical Cost Target Model</strong></td>
<td>Means Gross Allowed Savings (any amount by which the MCP is less than the MCT), adjusted by the Paid/Allowed Ratio, as calculated by Anthem.</td>
<td>Program Description (Section 8 Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Gross Paid Upside Cap (Upside Cap) – Medical Cost Target Model</strong></td>
<td>Means the maximum limit on Gross Paid Savings that can be generated through the Incentive Program. The Upside Cap is a percentage that includes the MRC value, which is calculated as a percentage of the MCB and is adjusted by the Paid/Allowed Ratio to determine the Upside Cap value expressed as a PMPM. The Upside Cap value expressed as a PMPM is compared to Gross Paid Savings and the lesser of these two values apply to the determination of Net Aggregate Savings.</td>
<td>Program Description (Section 8 Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Gross Savings – Medical Loss Ratio Model</strong></td>
<td>The Gross Savings Percentage multiplied by the Premium expressed as a PMPM amount.</td>
<td>Program Description (Section 8 Medical Loss Ratio Model)</td>
</tr>
<tr>
<td><strong>Gross Savings – Medicare Advantage Business</strong></td>
<td>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 as calculated by Anthem following an MA Measurement Period.</td>
<td>Program Description (Section 8 Medicare Advantage)</td>
</tr>
<tr>
<td><strong>Gross Savings Percentage – Medical Loss Ratio Model</strong></td>
<td>The difference between the MPMLR and the MLRT when the MPMLR is less than the MLRT.</td>
<td>Program Description (Section 8 Medical Loss Ratio Model)</td>
</tr>
<tr>
<td><strong>Health and Human Services (“HHS”)</strong></td>
<td>The U.S. government’s principal agency responsible for the specifics of the Accountable Care Act and related governmental programs outlined in this document.</td>
<td>Program Description (Section 8 Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Glossary Term</td>
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<tr>
<td>Holdback Amount</td>
<td>The percentage of any applicable annual distribution payment based on earned Net Aggregate Savings that may be retained by Anthem as security against any future shared loss obligations of Medical Panel during the Measurement Period(s).</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Incentive Program</td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Incurred But Not Reported (&quot;IBNR&quot;)</td>
<td>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 historical paid Claims experience, and will be developed by Anthem on an actuarially sound basis.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Maximum Shared Savings Cap-Medical Cost Target Model</td>
<td>Means the maximum limit on the amount that Anthem must remit to Provider as a result of savings through the Shared Savings Program. The Maximum Shared Savings Cap is determined at the beginning of the Measurement Period.</td>
<td>Program Description (Section 8 Medical Cost Target Model)</td>
</tr>
<tr>
<td>Measurement Period – Medical Cost Target Model</td>
<td>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 and the Medical Panel.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Measurement Period(s) – Medical Loss Ratio Model</td>
<td>Each twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Anthem and the Provider. The Measurement Period(s) for Provider’s participation in the Program is set forth in Medical Loss Ratio Measurement Period Handbook.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Measurement Period Medical Loss Ratio(“MPMLR”)–Medical Loss Ratio Model</td>
<td>The percent calculated by Anthem that is based on Total Medical Expense divided by Premium during a Measurement Period (see formula below). For purposes of MPMLR calculations, inpatient Claims will be assigned to the Measurement Period during which the inpatient admission date occurred, rather than the discharge date. MPMLR is calculated after the Measurement Period has ended and includes six (6) months of claims run out, and is compared to the MLRT as a step toward determining whether shared savings have been demonstrated under the Program.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
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<tr>
<td>Measurement Period Medical Loss Ratio (“MPMLR”)</td>
<td>The percent calculated by Anthem 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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Medical Cost Baseline- (“MCB”)</td>
<td>Means the untrended cost experience, as determined by Anthem, for the Member Population for each Measurement Period which establishes the baseline benchmark for shared savings calculations under the Program for that Measurement Period. A new MCB is established for each separate Measurement Period. The formulae for setting the MCB takes into account risk adjusted per member/per month (PMPM) Claims experience within the Member Population during the Baseline Period, but excluding certain Covered Individuals with transplant or high cost Claims amounts. The MCB calculation also includes consideration of Anthem product type (e.g. HMO, PPO, etc.). If Provider participates in the Program under a number of different Anthem products, there may be multiple MCBs. New MCB(s) are established by Anthem for each separate Measurement Period. New MCB(s) will be determined by Anthem, and Anthem will make best effort to make such MCB(s) available to the Provider prior the start of each separate Measurement Period.</td>
<td>Program Description (Section 8 Medical Cost Target Model)</td>
</tr>
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</tr>
<tr>
<td><strong>Medical Cost Performance (&quot;MCP&quot;)</strong></td>
<td>The actual cost experience in the defined Member Population during a relevant Measurement Period, expressed in terms of risk-adjusted per member per month (&quot;PMPM&quot;) but excluding certain Covered Individuals with transplant or high-cost claims amounts. The formulae for setting the MCP takes into account risk-adjusted (&quot;PMPM&quot;) Claims experience within the Attributed Member Population during the Measurement Period, but exclude certain transplant and high-cost Claims amounts. It also may account for any clinical coordination per-member per-month payments made during the relevant Measurement Period to Provider by Anthem for Attributed Members. As part of the MCP calculation, a risk adjustment is made by Anthem 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) will be in a separate MCP than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager).</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Medical Cost Target (&quot;MCT&quot;)</strong></td>
<td>Means the trended cost experience, as determined by Anthem, for the Member Population for each Measurement Period which establishes the benchmark for shared savings calculations under the Program for that Measurement Period. The MCT is established for each separate Measurement Period and provided at the time of reconciliation after the end of the Measurement Period. The MCT is the MCB with a market trend factor determined by Anthem included to account for costs from the Baseline Period to the end of the Measurement Period. The MCT is expressed in terms of a risk-adjusted per member per month (&quot;PMPM&quot;) but excluding certain Covered Individuals with transplant or high cost Claims amounts. The MCT calculation may account for any clinical coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Medical Loss Ratio Rebate Program (&quot;MLR Rebate Program&quot;)</strong></td>
<td>A provision of the ACA that addresses the amount of refund issued to Attributed Members if the percent of premium spent on claims and other expenses that improve health care quality do not meet federally determined minimums. Refunds allocated to Attributed Members will be a reduction to Premium in the MPMLR calculation.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
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<tr>
<td><strong>Medical Loss Ratio Target (&quot;MLRT&quot;)-Medical Loss Ratio Model</strong></td>
<td>The medical loss ratio target percentages of Premium determined by Anthem. The MLRT will be identified in the Medical Loss Ratio Measurement Period Handbook.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td><strong>Medical Loss Ratio Target (&quot;MLRT&quot;)-Medicare Advantage</strong></td>
<td>The MLR target percentages determined by Anthem. The MLRT will be identified in the MA Handbook.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td><strong>Medical Panel –Medical Cost Target Model</strong></td>
<td>A single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful MCBs, MCTs, shared savings, and utilization performance targets. Medical panels shall be formed either by the providers themselves or by Anthem.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Medical Panel –Medical Loss Ratio Model</strong></td>
<td>A single provider organization or a grouping of multiple provider organizations by Anthem for purposes of calculating statistically meaningful MPMLRs and shared savings. Further details regarding Medical Panels are provided below under “Medical Panels-Medical Loss Ratio-Commercial Business.”</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td><strong>Medical Panel-Medicare Advantage Business</strong></td>
<td>A single provider organization or a grouping of multiple provider organizations by Anthem for purposes of calculating statistically meaningful MPMLRs and shared savings. Further details regarding Medical Panels are provided below under “Medicare Advantage Medical Panels”.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td><strong>Medicare Advantage Measurement Period (s) (&quot;MA Measurement Period(s)&quot;)</strong></td>
<td>The twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Anthem and the Provider. The Medicare Advantage Measurement Period(s) for Provider’s participation in the Program is set forth in MA Handbook.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td><strong>Member Months –Medical Cost Target Model</strong></td>
<td>Means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Anthem product(s) for a Medical Panel during a Measurement Period as determined by Anthem.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Member Months-Medical Loss Ratio Model</strong></td>
<td>Means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Anthem product(s) for a Medical Panel during a Measurement Period as determined by Anthem.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
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</tr>
<tr>
<td>Member Months-Medicare Advantage Business</td>
<td>Means the cumulative number of months Attributed Members in the Member Population are enrolled in the applicable Anthem product(s) for a Medical Panel during a Measurement Period as determined by Anthem.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Member Population-Medical Cost Target Model</td>
<td>The group of Attributed Members assigned to the Medical Panel or Program, as applicable; and whose costs under the relevant Anthem products(s) will be used to calculate MCBs, MCTs and MCPs pursuant to the Program (subject to criteria established by Anthem).</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Member Population-Medical Loss Ratio Model</td>
<td>The group of Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Anthem products(s) as described in the Attachment will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Anthem).</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Member Population-Medicare Advantage Business</td>
<td>The group of Medicare Advantage Attributed Members assigned to Provider or Medical Panel and whose costs under the relevant Anthem products(s) will be used to calculate MPMLRs pursuant to the Program (subject to criteria established by Anthem).</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Member Risk Months</td>
<td>The Member Population’s average Normalized Risk Score multiplied by their Member Months in the applicable Anthem products during a Measurement Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Minimum Risk Corridor (“MRC”) Medical Cost Target Model</td>
<td>The percentage of MCB that Anthem retains before sharing any savings with the Medical Panel. This percentage is determined by Anthem and is designed to limit savings payouts that are driven by random variation. Like the Gross Savings and Upside Cap, the MRC is adjusted by the Paid/Allowed Ratio</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Minimum Risk Corridor (“MRC”) Medical Loss Ratio Model</td>
<td>The percentage of Premium that Anthem retains before sharing any savings with the Medical Panel. This percentage is determined by Anthem and is designed to limit savings payouts that are driven by random variation.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Net Aggregate Savings-Medical Cost Target Model</td>
<td>The total allocated Savings Pool(s) multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
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<td>Glossary Term</td>
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<tr>
<td>Net Aggregate Savings-Medical Loss Ratio Model</td>
<td>The meaning as set forth in section (e) under the “Shared Savings Determination” section below (under “Medical Loss Ratio Program Terms and Details”)</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Net Aggregate Savings-Medicare Advantage Business</td>
<td>To determine the Net Aggregate Savings, the Shared Savings Percentage is multiplied by the Gross Savings.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Non-Cost Performance Targets</td>
<td>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.</td>
<td>Program Description (Section 8)</td>
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<td>Glossary Term</td>
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| Normalized Risk Score | A provider’s average risk score relative to the market average risk score. The Normalized Risk Score is calculated as follows:  
  
  \[
  \text{Normalized Risk Score} = \frac{\text{average Provider risk score}}{\text{average market risk score}}
  \]  
  
  The market is defined by Anthem and may be inclusive of a region or state. The market average will be calculated using risk scores derived from the Claims incurred during the Measurement Period, limited to Covered Individuals with assigned attribution or office based evaluation and management visit claims in the market with at least three (3) months of eligibility. The Average Market Risk Score is calculated as follows:  
  
  \[
  \text{Average Market Risk Score} = \frac{\text{Sum of Covered Individuals risk scores}}{\text{number of Covered Individuals}}
  \]  
  
  The average risk score of the Provider’s Attributed Members will be calculated using risk scores derived from the Baseline Period Claims for the MCB and the Measurement Period Claims for the MCP, weighted by months of eligibility. The Average Provider Risk Score is calculated as follows:  
  
  \[
  \text{Average Provider Risk Score} = \frac{\text{Sum of Provider’s Attributed Members risk scores}}{\text{number of Provider’s Attributed Members}}
  \]  
  
  Risk scores are generated using the DxCG model from Verisk Health, which uses diagnosis and demographic information from medical Claims as well as an adjustment allowing for consistency between pediatric and adult populations. The approach to risk scores may be adjusted from time to time. If such adjustments are material in nature, Anthem will provide notice to Provider.  
  
  Anthem shall have the option to exclude BlueCard data from the determination of the market average risk score calculation if Anthem determines that such exclusion would result in more accurate or sound calculation results.  
  
  Anthem will monitor Attributed Members’ risk scores to determine if there are any industry coding changes that inappropriately or disproportionately affect the overall Normalized Risk Score.  
  
  Anthem has the option to neutralize payment results that are driven by such coding changes and not by changes in Attributed Members’ health risk and will notify Risk Entity if such action is taken.                                                                 | Program Description (Section 8)               |
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<tr>
<td>Paid/Allowed Ratio</td>
<td>The ratio of paid dollars (dollars paid by Anthem to providers) to allowed dollars (total dollars paid by Anthem 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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Patient 360</td>
<td>Real-time dashboard that gives you a robust picture of a patient’s health and treatment history to facilitate care coordination. It allows the provider to quickly retrieve detailed records such as member care summary, claims and authorization details, etc.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>“Patient Protection and Affordable Care Act” or “ACA”</td>
<td>The federal program passed by the U.S. Congress on March 21, 2010 with the goals of improving the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Performance Assessments</td>
<td>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: ▪ Acute and Chronic Care Management ▪ Preventive Care ▪ Utilization  The categorical scores will be based on performance relative to different tiers of performance thresholds.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td>Premium-Medical Loss Ratio Model</td>
<td>The total of all payments for the Member Population’s Health Benefit Plans during a Measurement Period as determined by Anthem less: ▪ Applicable amounts calculated under the Risk Adjustment Program ▪ Applicable amounts calculated under the MLR Rebate Program</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
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</tr>
<tr>
<td>Premium-Medicare Advantage</td>
<td>▪ The total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Anthem for the Member Population under a Anthem 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 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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Primary Care Physician(s) or PCP(s)</td>
<td>Physicians whose primary specialty, as indicated in the Anthem provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program</td>
<td>Abbreviated reference to our Enhanced Personal Health Care Program, including the Comprehensive Primary Care initiative.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program Attachment Effective Date</td>
<td>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.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program Description</td>
<td>The description of the Enhanced Personal Health Care Program prepared by Anthem, as revised from time to time, that summarizes the clinical programs and other patient-centered practice support offered by Anthem 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 provider website.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program Quality Measures</td>
<td>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 Performance Scorecard comprised of clinical quality measures and utilization measures.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td>Provider Practice Toolkit</td>
<td>The tools and information that will be made available to provider organizations to assist with population health management.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Quality Gate-Medical Cost Target Model</td>
<td>A minimum threshold of performance on the Performance Scorecard in order for you to share a portion of the savings pool. The Quality Gate is a threshold defined by Anthem, and is defined in the MCT Measurement Period Handbook. <strong>Note:</strong> For Providers in Measurement Periods 10/01/17 and prior “Quality Gate” means a minimum threshold of performance on clinical quality measures that must be achieved to have the opportunity to earn a portion of the shared savings. The Quality Gate is a threshold defined by Anthem, 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.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Quality Gate-Medical Loss Ratio Model</td>
<td>A minimum threshold of performance on the Performance Scorecard in order for you to share a portion of the shared savings. The Quality Gate is a threshold defined by Anthem that is provided in the MLR Measurement Period Handbook. <strong>Note:</strong> For Providers in Measurement Periods 10/01/17 and prior “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 Measurement Period, such determination shall be based on the scorecard which is measured based on the number of Attributed Members included in this Program</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Quality Gate-Medicare Advantage Business</td>
<td>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 (4) and five (5) Star level, aligning with the Stars quality program. In order to participate in shared savings, your practice must achieve four (4) or five (5) star rating in quality performance for each individual clinical quality measure. Further explanation of the quality measures and the scoring methodology are described in the MA Handbook.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Quality Targets-Medical Loss Ratio Model</td>
<td>The quality performance targets, referenced in Section 5 of the Program Description and the Medical Loss Ratio Measurement Period Handbook, used to determine the percentage of shared savings under the Incentive Program.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Glossary Term</td>
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<td>Quality Targets-Medicare Advantage</td>
<td>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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Represented Primary Care Provider(s) or Represented PCP(s)</td>
<td>Means all of the providers in the Provider’s practice whose primary specialty, as indicated in the [Legal Entity Name] provider files, is internal medicine, family practice/medicine, general practice/medicine or geriatrics (collectively, “Primary Care Physician(s)”) and nurse practitioners who participate in the Program by virtue of being covered under the Agreement and this Attachment.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Represented Providers</td>
<td>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.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Retroactive Additional Amount</td>
<td>The total of all amounts paid or credited by CMS to Anthem for any Medicare Advantage Attributed Members who were retroactively assigned to the Provider during the MA Measurement Period, as applicable.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Retroactive Deletion Amount</td>
<td>The total of all amounts repaid by Anthem to CMS or otherwise offset against or deducted from amounts payable by CMS to Anthem for any Medicare Advantage Attributed Members whose assignment to the Provider was retroactively deleted during such MA Measurement Period.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Risk Adjustment Program</td>
<td>The actuarial tool, as developed or promulgated by HHS, that is used to adjust for the actuarial risk (age, gender, diagnosis) of individual or small group market enrollees. Risk adjustment will result in payments or charges to revenue to adjust actuarial risk of the Attributed Member population</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Savings Pool</td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
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<tr>
<td>Shared Savings</td>
<td>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 &amp; Performance Assessment section of this Program Description.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Shared Saving Percentage</td>
<td>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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Shared Savings Potential</td>
<td>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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Stop Loss</td>
<td>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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Stop Loss Credit</td>
<td>The Claims amounts in excess of the Stop Loss Deductible.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
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<tr>
<td>Stop Loss Deductible</td>
<td>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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Stop Loss Expense</td>
<td>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 Medicare Advantage markets for the calendar year immediately preceding the MA Measurement Period, divided by the total Member Months across all Anthem 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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Substantial Financial Risk</td>
<td>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.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
</tr>
<tr>
<td>Substantial Financial Risk</td>
<td>The total incentive-based payments to the Provider from Anthem, 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 for direct services delivered to Anthem Medicare Advantage Attributed Members during the applicable MA Measurement Period year.</td>
<td>Program Description (Section 8-Medicare Advantage)</td>
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</tbody>
</table>
| **Total Medical Expenses-Medical Loss Ratio Model**    | The costs, determined by Anthem, that are paid by Anthem during a Measurement Period for all Covered Services (including hospital, medical, pharmacy and non-hospital) provided to the Member Population by all providers (participating and non-participating, and including Provider and its primary care physicians) furnishing such services to the Member Population, as reduced by the following factors:  
  - Transplants and high dollar claims costs as determined by Anthem, if applicable.  
  - Eligible Covered Individuals out of pocket expenses received by Anthem on behalf of Covered Individuals under the Cost Share Reduction (CSR) Program.  
Any applicable Per Member Per Month practice transformation payments made by Anthem throughout the Measurement Period, if applicable. | Program Description (Section 8-Medical Loss Ratio Model) |
| **Total Medical Expenses-Medicare Advantage**          | “Total Medical Expenses” means the costs incurred by Anthem 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, and Clinical Coordination PMPM Payments, capitation 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 and/or Anthem’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. | Program Description (Section 8-Medicare Advantage) |
<p>| <strong>Upside Cap –Medical Loss Ratio Model</strong>                | The maximum limit on Incentive Program shared savings that you can earn through the Incentive Program.                                                                                                 | Program Description (Section 8-Medical Loss Ratio Model) |</p>
<table>
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</tr>
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<tbody>
<tr>
<td>Upside Shared Savings Percentage-Medical Cost Target Model</td>
<td>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.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
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<td>Upside Shared Savings Percentage-Medical Loss Ratio Model</td>
<td>The percentage of shared savings under the Incentive Program that 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 Quality 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 Quality Targets are not achieved, and zero if the Quality Gate is not met.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Upside Shared Savings Potential –Medical Cost Target Model</td>
<td>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.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Upside Shared Savings Potential –Medical Loss Ratio Model</td>
<td>The maximum percentage of shared savings under the Incentive Program that Provider may be entitled to, provided that it meets the Quality Gate.</td>
<td>Program Description (Section 8-Medical Loss Ratio Model)</td>
</tr>
<tr>
<td>Utilization Measures</td>
<td>The utilization measures in the Program Performance 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 formulary compliance metric. As with the clinical metrics, administrative data are used to construct the utilization measures.</td>
<td>Program Description (Section 5)</td>
</tr>
</tbody>
</table>

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