

Program Description for Enhanced Personal Health Care*

**formerly referred to as "Patient-Centered Primary Care"*

Modified 1/1/2014

Introduction

In its 2001 seminal report “*Crossing the Quality Chasm: A New Health System for the 21st Century*”, the Institute of Medicine (IOM) described the US health care system as fragmented, poorly designed and most importantly not delivering quality care.¹ Similarly, in its 2007 study “*Mirror, Mirror on the Wall: An International Update On The Comparative Performance Of American Health Care*,” the Commonwealth Fund found that despite having the most costly health system in the world, the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives.² Both the IOM report and the Commonwealth Fund study cited, among other recommendations, the need for a patient-centered, coordinated, approach to health care delivery.

Anthem’s mission is to improve the lives of the people we serve and the health of our communities. While there are many ways to improve the United States health system, Anthem believes that patient-centered primary care forms the foundation and lies at the core. As noted by the World Health Organization in its 2008 Report “*Primary Health Care (Now more than ever)*,” “Primary care brings promotion and prevention, cure and care together in a safe, effective and socially productive way at the interface between the population and the health system.”

Though there is growing broad-based support for a patient-centered care model, Anthem understands that this shift will not just happen. Rather, it requires a concerted effort and active support from all key stakeholders in the delivery system to create an environment conducive for change. This includes:

- 1) a redesign of current payment models to align financial incentives and provide compensation for important clinical interventions that occur outside of a traditional patient encounter;
- 2) support for risk stratified care management;
- 3) the sharing of meaningful information regarding patients that goes beyond the information captured in the physicians’ medical record; and
- 4) providing physicians with the knowledge, information and tools they need to leverage the benefits of new payment models, support services and information exchange to transform the way they deliver care.

As one of the nation’s largest health benefits companies, covering 34 million members, Anthem recognizes the important role we play in creating this environment. In fact, together with our corporate affiliates, 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 covering nearly 1,200 primary care physicians and touching over 130,000 of our members. The results have been

¹ <http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx>

² <http://www.who.int/whr/2008/en/index.html>

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encouraging. In our studies to date we have observed both improvement in compliance with evidence based guidelines and a reduction in avoidable admissions and ER visits.

Our new Enhanced Personal Health Care Programs (the “Program”), build upon the success of our PCMH programs and foster a collaborative relationship between Anthem (also referred to as “we” or “us” in this document) and Provider (also referred to as “you”, and includes Represented Primary Care Physicians and Represented Physicians, as applicable, in this document). This relationship enables both parties to leverage the other parties’ unique assets, whether clinical, administrative, or data, to support coordinated care with a focus on risk stratified care management, wellness and prevention, improved access and shared decision making with patients and their caregivers.

The Program includes our own Anthem-specific Enhanced Personal Health Care Program for Primary Care (formally known as Patient-Centered Primary Care), including the Comprehensive Primary Care (CPC) initiative (collectively, the “Program”). CPC is an effort by the Centers for Medicare and Medicaid Services (“CMS”) to align multiple payers around select physician practices in specific geographic areas for the purpose of transforming payment and practice redesign. The Anthem markets with participating physicians in the CPC initiative are Colorado (statewide), New York (Mid-Hudson and Capital District region), and Ohio (including the Cincinnati/Dayton region and 4 northern counties in Kentucky). Further details about the applicability of the Program can be found in Section 1, under “Scope.”

We are providing this Program Description to give you important information regarding the operation of the Program, including details about the financial benefits of the Program, our obligations to participating physicians to provide reporting and other useful tools, and our expectations for participating physicians under the Program. Our intent is to provide you with an easy to understand description of the key elements of the Program. Towards that end, we have organized this Program Description into sections by topic as outlined in the table of contents.

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

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

<i>Market</i>	<i>Mailbox</i>
<i>California</i>	NetworkRelations@WellPoint.com
<i>Colorado</i>	COPrimaryCareProgram@anthem.com
<i>New Hampshire</i>	NHPPrimaryCareProgram@anthem.com
<i>New York</i>	NYPrimaryCareProgram@empireblue.com
<i>Ohio</i>	OHPrimaryCareProgram@anthem.com
<i>Virginia</i>	VAPrimaryCareProgram@anthem.com
<i>Connecticut</i>	CT_PrimaryCareProgram@anthem.com
<i>Georgia</i>	GA_PrimaryCareProgram@bcbsga.com
<i>Maine</i>	ME_PrimaryCareProgram@anthem.com
<i>Missouri</i>	MO_PrimaryCareProgram@anthem.com
<i>Nevada</i>	NV_PrimaryCareProgram@anthem.com
<i>Wisconsin</i>	WI_PrimaryCareProgram@anthem.com
<i>Indiana</i>	IN_PrimaryCareProgram@anthem.com
<i>Kentucky</i>	KY_PrimaryCareProgram@anthem.com

Program Communications

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

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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 promotes (1) access, (2) shared decision making, (3) proactive health management, (4) coordinated care delivery, (5) adherence to evidence based guidelines and (6) care planning built around the needs of the individual patient, leading to improved quality and affordability for our customers and their patients.
- Redesign the current payment model to move from volume based to value based payment, aligning financial incentives and providing financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach and quality improvement.
- Importantly, improve the patient experience by:
 - ✓ creating better access to a primary care physician who will not only care for their "whole person" but will become their health care champion and help them navigate through the complex health care system,
 - ✓ inviting active participation in their health care through shared decision making, and
 - ✓ optimizing their health.

SCOPE

The Program applies to Anthem participating Represented Primary Care Physicians and/or Represented Physicians, as applicable, who are in good standing, and who have signed our Enhanced Personal Health Care Attachment for Primary Care (previously known as the Patient-Centered Primary Care Attachment), the Enhanced Personal Health Care Attachment for Freestanding Patient-Centered Care (previously known as the Freestanding Patient-Centered Care Attachment), the Comprehensive Primary Care Attachment, or an agreement that incorporates an Enhanced Personal Health Care Attachment (collectively, the "Attachment").

For the Program, Primary Care Physicians are defined by the following specialties who maintain a patient panel:

- general practice
- family practice
- internal medicine
- pediatrics
- geriatrics

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

Comprehensive Primary Care (CPC) Initiative Special Terms

Pediatric practices are not included in the CPC Initiative.

Section 2: Roles

We are making several Program resources available to support and collaborate with you to achieve successful outcomes and reach Program goals. The following information describes roles developed in order to support the Program. The patient-centered care support roles and contact information will be available via Anthem's provider portal prior to the Program Attachment Effective Date or as soon thereafter as practicable. Our intent is to make other roles available following the Program Attachment Effective Date.

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 lead point of contact for provider organizations to address contracting and operational elements for the Program.

Contract Advisor

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

Patient-Centered Care Consultant

The Patient-Centered Care Consultant helps provider organizations access and interpret Program reports, and helps them use those reports to design interventions aimed at improving outcomes. The Patient-Centered Care Consultant works with provider organizations to test and refine workflows that support sustainable transformation, and guides provider organizations as they expand interventions to additional patient populations. This team member also connects provider organizations to Program and community tools and resources.

Community Collaboration Manager

The Community Collaboration Manager supports the Patient-Centered Care Consultant by analyzing reports and data to inform decision-making around provider organization support needs. The Community Collaboration Manager may suggest interventions based on provider organization-level data. This team member also helps create relevant learning collaborative content.

Provider Clinical Liaison

The Provider Clinical Liaison helps provider organizations develop care coordination and care management skills, and helps them interpret clinical reports and identify members who can benefit from a care plan. This member of the team also educates providers and staff around the elements of a care plan and assists in care plan creation. Additionally, the Provider Clinical Liaison serves as a subject matter expert on internal case management, disease management, and behavioral health case management programs and helps organizations manage Attributed Members with more complex needs by leveraging available Anthem programs. The Provider Clinical Liaison promotes seamless coordination between the Primary Care Provider and Anthem programs.

Pharmacist

The Pharmacist serves as a member of the Anthem clinical team as the subject matter expert for pharmaceutical management. The Pharmacist helps identify pharmacy management opportunities and works collaboratively with the Provider Clinical Liaison and primary care provider to guide pharmaceutical clinical strategies. The Pharmacist serves as a resource regarding formulary or medication questions.

Ambassador

Our Ambassadors are carefully selected liaisons who help both their fellow providers succeed and help Anthem serve as a helpful partner to participating providers. In our markets, we look for primary care providers who are motivated to act as enthusiastic and knowledgeable guides and mentors for other participating providers. Ambassadors also bring insights and advice from providers to Anthem program leadership.

Ambassadors advocate for patient-centered primary care by speaking about the benefits of the program, helping identify best methods and practices for success, guiding participating provider organizations to take advantage of all the program offers. They may be asked to speak at symposia, and will attend meetings with other providers in their markets – both in small groups and on a one-on-one basis. They meet regularly with Program leadership to share feedback from other providers as well as their own insights into what is working well or what could help more providers succeed in the Program. Once we identify Ambassadors in a given market, their names are posted on our provider portal.

Program Advisory Council (PAC)

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 WITHIN YOUR PROVIDER ORGANIZATION

The roles listed on the previous pages were established to help your provider organization be successful in establishing and managing toward a patient-centered care approach. Establishing roles within your provider organization to facilitate this process is also essential to forming a collaborative team. The recommended roles that are needed to assist with the provider organization transformation activities are as follows:

- *Provider Champion* – The Provider Champion is a physician, or in some cases an Advanced Practice Registered Nurse, in a leadership position in your provider organization who is the leader of your provider organization’s patient-centered care approach. This individual has the authority to support and influence transformation to patient-centered care, and supports the needed activities, provides resources and communicates to other physicians about the Program.
- *Practice Manager* - The Practice Manager is the individual in your provider organization who manages the day to day activities in a primary care office.
- *Care Coordinator* - The Care Coordinator is the individual in your provider organization who facilitates the care coordination and care plan creation for patients.
- *Transformation Team Members* – The Transformation Team Members are those individuals in your provider organization who participate in Program activities focused on improving patient care using recognized quality improvement methodology. Ideally this group of individuals should include a representative from each area within your office (for example: front office, back office, clinical, billing, etc.).

Comprehensive Primary Care (CPC) Initiative Special Terms

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

Section 3: Care Coordination and Care Plans

CARE COORDINATION

Under the terms of the Attachment, you are required to perform care coordination activities as outlined in Appendix A of the Attachment. This section will provide you with the information you need to fully understand and meet these expectations.

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

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

Care coordination activities include:

- Helping patients choose specialists and obtain medical tests when necessary. The team informs specialists of any necessary accommodations for the patient’s needs.
- Tracking referrals and test results, sharing such information with patients, helping to ensure that patients receive appropriate follow-up care, and helping patients understand results and treatment recommendations.
- Promoting smooth care transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home.
- Developing systems to help prevent errors when multiple clinicians, hospitals, or other providers are caring for the same patient, including medication reconciliation and shared medical records.⁴

You must ensure that there are roles that support care coordination and care management in your provider organization. Additionally, you will need to implement processes to ensure that Covered Individuals’ health care needs are coordinated by using a primary contact to effectively organize all aspects of care. Your designated primary contact will 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 to you,

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

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

- Perform regular outreach to Covered Individuals based on their personal preference, which could include e-mail (as allowed under applicable state regulation or state medical licensing requirements) or phone calls,
- Provide information on self management support,
- Use population health registry functionality to support care opportunities, and
- Adhere to a team-based approach to care, which drives proactive care delivery.

CARE PLANS

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

A care plan is a detailed approach to care that is customized to an individual patient's needs. Often times, 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 single template that must be used for the Program when creating a care plan. There are critical assessments and domains that must exist within a care plan, but 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. A care plan 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 will be available via the Provider Toolkit.

The minimum requirements for an initial care plan include:

- Activities that are *individualized* to the needs of the Covered Individual,
- Information regarding the family, caregiver and/or patient involvement for specific activities for the purposes of collaboration and coordination of the plan of care,
- Short-term and long-term patient-centric goals with interventions that are realistic for the Covered Individual's care,
- Patient's self-management plan (also described on the following page), which includes:
 - a shared agenda for physician office visits, and
 - a list of activities to improve the health of the Covered Individual (developed in collaboration with the Covered Individual),
- Helpful information regarding relevant community programs (if any),
- Applicable resources that should be utilized (e.g. home health care, durable medical equipment, and rehabilitation therapies),

- Timeframes for re-evaluation 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 on how to respond to them.

Your provider organization team must also perform the following activities in connection to the care plan:

- 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 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, and
- Modifications to initial/previous plan to adjust plan to progress level.

Care Plan Assessment Domains

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

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

IDENTIFYING THE NEED FOR A CARE PLAN

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 on-going 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 will provide regular reports to you to highlight opportunities for management of Covered Individuals in an effort to improve patient outcomes. The “Hot Spotter Report” (as further described in the Reporting section of this Program Description) includes a listing of high risk Covered Individuals identified by analytic reporting as those who would benefit from development of a care plan.

Covered Individuals who appear on the Hot Spotter Report 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 Covered Individuals who have chronic condition diagnoses with specific evidence-based care gaps.

Although we will provide a list of Covered Individuals that analytic reporting has identified as being at high risk, you will have additional real-time information from patient assessments that will allow you to ascertain other high risk Covered Individuals. Anthem will collaborate with your provider organization team to identify Covered Individuals who have been determined by your organization as candidates to receive a care plan. The Provider Clinical Liaison will periodically review both the Hot Spotter Report and the provider organization-identified Covered Individuals with your care coordinator and/or care managers.

Covered Individuals who would be candidates for care planning include those with:

- Complex conditions,
- Are receiving treatment from multiple specialists, thereby requiring coordination of care,
- Have complex treatment/management plans,
- Are impacted by psycho-social concerns (e.g. lack of transportation, live alone, no family support),
- Have multiple chronic conditions or a chronic condition with evidence-based gaps in care (e.g. heart failure and inability to adhere developed treatment plans/medication regime or daily weight monitoring),
- Have a newly diagnosed chronic condition, such as asthma, diabetes, heart failure, COPD, or CAD,
- Have co-morbid medical and behavioral health conditions, 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 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 Covered Individual, family and the caregiver should collaborate to develop the individualized care plan and review treatment goals at every visit. Incorporating the use of a comprehensive assessment form during each patient visit helps ensure that all of the Covered Individual's needs are addressed, and can help you identify and address chronic conditions that may otherwise go undiagnosed and/or untreated. The form allows for a thorough patient evaluation so that all the pertinent clinical areas are covered. You can leverage our comprehensive assessment form template by referencing the Provider Toolkit (as described in Section 4, *Program Requirements – Additional Information*). This assessment is similar to the "welcome to Medicare preventive visit" you perform for your Medicare patients.

The advantages of performing a comprehensive patient evaluation include, but are not limited to, early detection of chronic conditions, gaps in care, and lapses in appropriate preventive services. This will help you formulate the appropriate patient outreach plan. Reminders through mail or a phone call regarding annual screenings are examples of levels 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 a Covered Individual's current care plan, thus increasing the likelihood of the Covered Individual receiving the appropriate care. Early detection of conditions and changes in the Covered Individual's health status allows for early intervention, and can prevent the need for significant medical interventions such as hospitalization.

To better understand the health risks and other needs of Covered Individuals 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 Covered Individual and family
- Advanced care planning (not applicable for pediatrics)
- Behaviors affecting health
- Patient and family mental health and/or substance abuse
- Developmental screening using a standardized tool (not applicable for provider organizations with no pediatric patients)
- Depression screening for adults and adolescents using PHQ2, PHQ9 or other nationally recognized tool

Self-Management Support

Self-management support is a good opportunity for you to educate Covered Individuals on how they can take a greater role and level of responsibility for better health outcomes. “Self-management support is the assistance caregivers give to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership.

The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.”⁵

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

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

Comprehensive Primary Care (CPC) Initiative Special Terms

There are no significant differences between the Patient-centered Primary Care Program and CPC for this section.

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

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

Section 4: Program Requirements – Additional Information

The following sections provide additional information on specific Program requirements for participating physicians as referenced in the Attachment.

PATIENT ENGAGEMENT

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

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

MMH+

Physicians participating in the Program are required to gain access to and utilize Anthem's Member Medical History Plus (MMH+) system. This section will help you understand the benefits of this system and how you can gain access and utilize this tool in a manner that will help you manage the health of your patients.

MMH+ is our Member Medical History Plus tool that combines our rich claims-based data with lab results from our contracted reference lab partners to create a longitudinal record that gives physicians visibility to the health care services received by their patients, whether received within or outside their provider organization or whether prescribed by them, another physician or received by the patient on self referral. Having access to more complete information (e.g., specialty visits, prescription medications, etc.) than what may be contained in the medical record maintained by you or your provider organization is instrumental for care coordination and management. It will enable you to develop data informed comprehensive care plans for your patients. The MMH+ is a web-based tool that is available via the internet.

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

- Physicians seen by the Covered Individual
- Covered Individual demographics
- Eligibility history
- Diagnoses the Covered Individual has had
- Procedures performed on the Covered Individual
- Medications filled by the Covered Individual

- Care Alerts
- Lab results for the Covered Individual (if performed at certain national labs)
- Utilization management and case management for services provided to the Covered Individual

You can export the reports to Excel and put them in Covered Individual's chart.

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

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

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

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

As noted above, under the terms of the Program, you are required to access and utilize MMH+ to manage your Attributed Member population. To gain access, you will need to complete the MMH+ Access Request Process form. The MMH+ Access Request Process Form is included in our Program recruitment packet and must be returned, along with other specified materials, in order to begin your participation in the Program. For your convenience, an additional copy of the MMH+ Access Request Process Form is included in *Section 11: Appendix* of this Program Description.

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

LEARNING COLLABORATIVE EVENTS

We will present a series of Learning Collaborative events over the first 12 months of the Program. They were developed to help with your provider organization transformation. We strongly encourage the following staff to attend these sessions so that you can maximize your ability to improve quality of care, reduce costs, manage high risk patients and improve patient experience: Provider Champion, Practice Manager, Care Coordinator and Transformation Team Members.

The Learning Collaborative series will include some of the following themes: Hands-on Session for Care Management, Hands-on Session for Practice Transformation, Care Management and Coordination, Use of Data, Quality Improvement, Patient Engagement, Access to Care in the Medical Home and Behavioral Health.

REGISTRY

Appendix A of the Attachment identifies expectations around your use of a patient registry. The information below provides you with the details you need to successfully utilize registry functionality in your practice to support the proactive management of your patient population to optimize the health of each patient.

Identifying the patient population is the backbone of, and essential to, an effective population-based care delivery system. Without identification of the patients included in the population, changes cannot be effectively achieved. It is for this reason that physicians participating in the Program are expected to utilize registry functionality to systematically maintain patient demographic and clinically relevant information based on evidence-based guidelines. To identify patients within the population of focus (as discussed earlier), you need to be able to access data that pertains to this group of patients. The tools used to collect and access information about a specific group of patients is often referred to as a registry. Simply stated, a registry is 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). Sample registries will also be available or discussed via the Provider Toolkit. Your Patient-Centered Care Consultant will work closely with you to help determine what data points can inform a patient registry as well as assist with workflows to implement registry use.

PROVIDER TOOLKIT

The Provider Toolkit, found in the Enhanced Personal Health Care webpage, serves to provide you with research and tools that will support your provider organization in your transformation activities. Information will be available to provide methods for enhancing your provider organization's performance and quality, organizing your provider organization, establishing care coordination and care management processes, as well as maximizing health information technology, including registry functionality. The Provider Toolkit offers resources that address self management support, motivational interviewing, and enhanced access to care for your patients. Finally, in the Provider Toolkit you will find additional information for complimentary access to the American College of Physicians Practice Advisor (ACP Practice Advisor SM), which is particularly intended for organizations which have not already achieved Level II or III NCQA PCMH Recognition. Our Patient-Centered 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.

PROGRAM INFORMATION FORM

The Program Information Form must be completed for each practice location as part of the contracting process for the Program. This form provides us with important information about your provider organization and/or provider organization sites. The Program Information Form helps us understand how to best collaborate with and support you. Timely completion of the Program Information Form will help us know more about your provider organization team at the practice location as we begin to collaborate with you. Other self-assessment tools will be utilized to support your progress and needs related to patient-centered care.

AVAILITY

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

How do I get started?

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

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

Registering for Patient-Centered Care Programs

- 1.) Your Primary Access Administrator (PAA) will need to go to Maintain Organization to grant your provider organization access to Patient-centered Care Programs.
- 2.) The PAA can then add "*Patient-Centered Care Programs*" access to each user who needs it through Add User or Maintain User.

To access the Patient-Centered Care Reports

- 1.) After logging into Availity, click on My Payer Portals.
- 2.) Click on Patient-centered Care Programs.
- 3.) Verify the organization, and click Submit.
- 4.) Click on Reports Search. You can view or download reports, and view or download a report glossary.

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

Comprehensive Primary Care (CPC) Initiative Special Terms

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

Section 5: Quality Measures & Performance Assessments

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

Performance Improvement

As mentioned, performance improvement is a core component of patient-centered transformation. Providers will utilize their registry functionality to understand their patient population and implement process changes to deliver on evidence based care. 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.

MEASURES

The Program scorecard is comprised of clinical quality measures and utilization measures. In addition to serving as a basis for Incentive Program savings calculations, these measures are used to establish a minimum level of performance expected of you under the Program, and to encourage improvement through sharing of information. Given the importance of measurement to the Program, it is critical to select meaningful measures.

The following measurement criteria, consistent with the National Quality Forum (NQF), were applied to the selection of Program measures:

- **Measureable and reportable** in order to maintain focus on priority areas where the evidence is highest that measurement can have a positive impact on healthcare quality.
- **Useable and relevant** to ensure that Providers can understand the results and find the results compelling to support quality improvement.
- **Scientifically acceptable** so that the measure, when implemented, will produce consistent (reliable) and credible (valid) results about the quality of care.

- **Feasible to collect** using data that is readily available for measurement and retrievable without undue burden.

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

Clinical Quality Measures

The clinical quality measures included in the Program scorecard and outlined in the Measurement Period Handbook (referenced below) are grouped into two categories: (1) acute and chronic care management and (2) preventive care. These categories are then further broken out into six 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 Program scorecard and outlined in the Measurement Period Handbook (referenced below) focus on appropriate emergency room (ER) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and generic dispensing rates for a select set of drug classifications. As with the clinical metrics, administrative data are used to construct the utilization measures.

MEASUREMENT PERIOD HANDBOOK

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*). For Measurement Periods commencing April 1, 2014, and after, and approximately 90 days prior to the start of your Measurement Period, Anthem will provide you with a "Measurement Period Handbook" (the "Handbook") which, among other things, contains the applicable quality, utilization, improvement and other performance measures for the Measurement Period. It will also provide the scoring methodology for these metrics, including the tiers of performance thresholds that explain how higher performance equates to higher scores. Performance benchmarks will not be included in the Handbook, but will be provided to you prior to the start of the Measurement Period.

If, upon receipt and review of the 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 Handbook was sent, unless otherwise communicated to you by Anthem. If such notice is given, the Attachment shall terminate, and your participation in the Program will end on the date communicated to you by Anthem, and the Handbook will never apply to you. If you do not provide such notice, the Attachment shall remain in effect, and the 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 "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 than described above are required by law, then the provisions of law shall supersede the contractual provisions of this section.

PERFORMANCE ASSESSMENT

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

Performance on the clinical quality measures will be calculated specific to your organization, and scoring will occur at the Medical Panel-level (as defined in Section 8, *Incentive Program*) 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 the 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

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

Performance 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*).

NCQA PCMH Recognition

A final scoring category captures whether a group has been recognized by NCQA as having met Level 2 or Level 3 criteria for the NCQA PCMH (Patient-Centered Medical Home) program. This is assessed at the physician group level. Not having this recognition will not penalize a group. In order to receive credit for achieving or maintaining this level of recognition, practices must provide an attestation form to Anthem prior to the completion of Measurement Period. The electronic attestation is located in Availity under the Patient-Centered Reporting. The weighting of other scoring categories are adjusted so that the overall percentage of shared savings remain the same whether or not this recognition is present.

LINKING PERFORMANCE ASSESSMENT TO SHARED SAVINGS

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

Quality Gate

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 quality gate is a threshold defined by Anthem, and is set so that performance on the clinical quality composites must be above the 10th percentile of the market.

Proportion of Shared Savings Earned

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

OTHER Anthem QUALITY INCENTIVE PROGRAMS

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

Comprehensive Primary Care (CPC) Initiative Special Terms

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

Section 6: Attribution Process

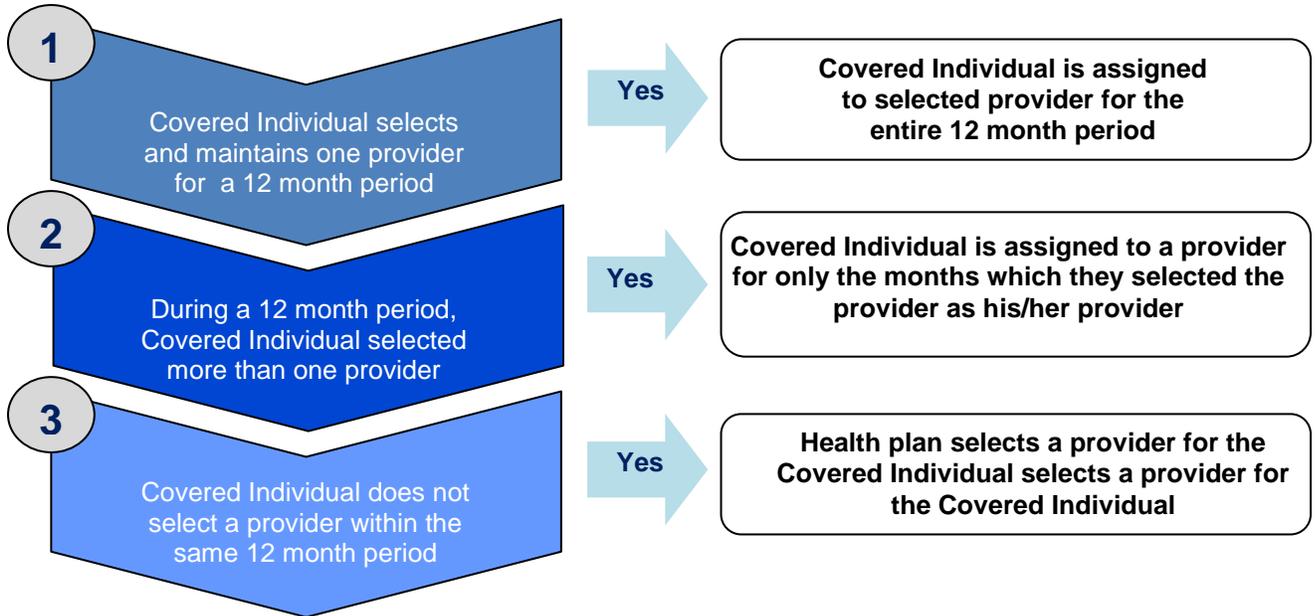
Attribution is a process used to assign Covered Individuals to a provider based on their historical health care utilization, or, where available, his/her own selection. This process is critical to achieve the objectives of the Program, including transparent and actionable data exchange for the purposes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

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

The attribution process for open access products, which uses historical claims data, may be used exclusively for certain Covered Individuals. Due to certain contract restrictions, customer requirements, 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. 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 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.

Attribution for Products Where Covered Individuals Select a PCP

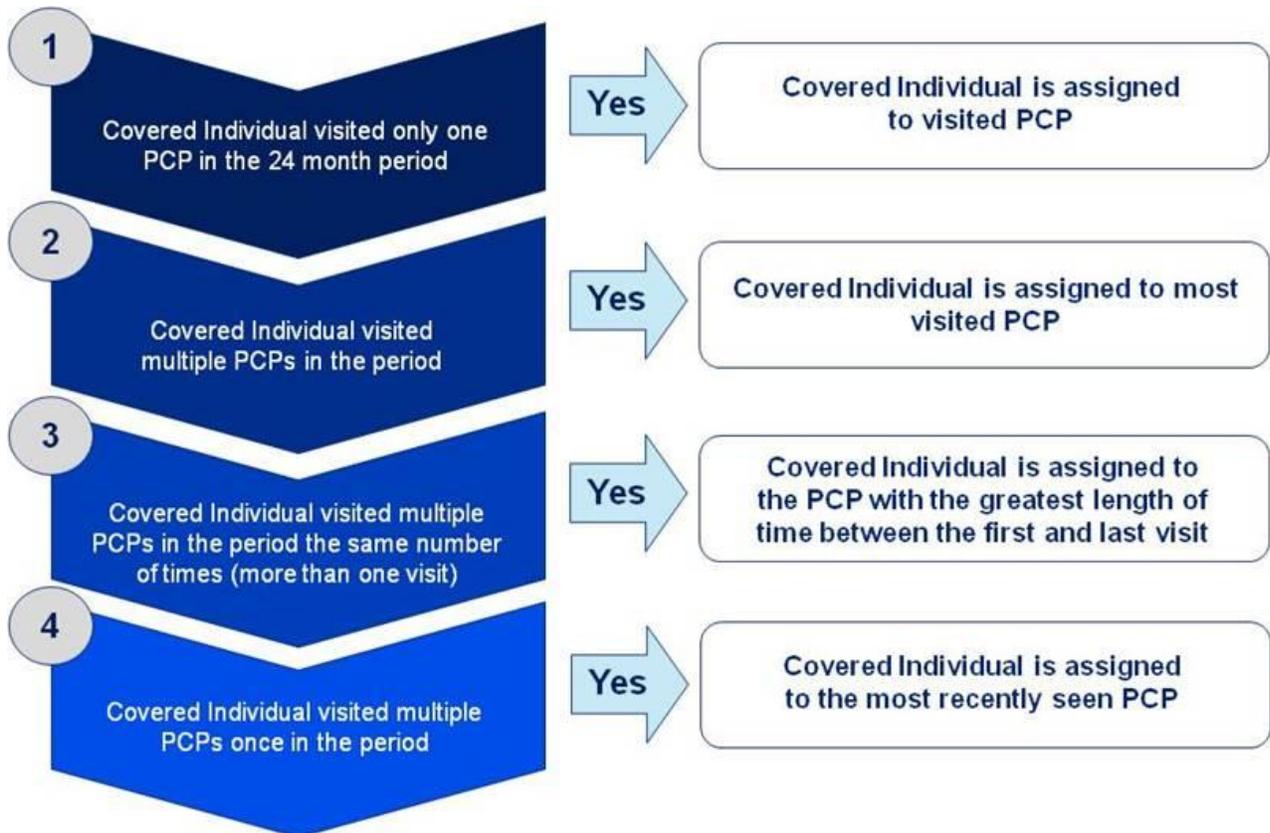
In these products (for example HMO), the following decision framework is used to assign Covered Individuals to PCPs. In this scenario, a Covered Individual must have at least 1 active month with the selected PCP.



Attribution for an Open Access Product

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. 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.

Initially, Anthem reviews available historical Claims data incurred during a 24 month period, with 3 months of Claim run-out, to assign Covered Individuals. For this scenario, Covered Individuals must be eligible members for at least 6 months in the entire 24 month period (irrespective of product) and at least 1 month within the most recent 12 month period. Upon initial assignment to a provider, attribution for an open access product is re-run on a quarterly basis to ensure that the most recent Claims information is utilized for attributing Covered Individuals.



Comprehensive Primary Care (CPC) Initiative Special Terms

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

Section 7: Clinical Coordination Reimbursement

OVERVIEW

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

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

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

PAYMENT PROCESS

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

Retroactivity

On a monthly basis, 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 at the end of this section. A Medical Panel can be comprised of one physician practice or a virtual grouping of separate practices. The makeup of a Medical Panel is based on the number of Attributed Members. Specifically, if one physician practice meets the minimum number of commercial Attributed Members, they will be their own Medical Panel. Smaller practices with less commercial Attributed Members will be combined to ensure that, collectively, they have the minimum number of Attributed Members, as specified by Anthem.

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 projected costs based on the Claims costs of the applicable Member Population during a prior 12 month period of time used to establish a “Medical Cost Target (“MCT”, which is defined below). In the event that the MCP is less than the MCT, you may share in a percentage of the savings realized, provided that you meet the Quality Gate and other Non-Cost Performance Targets (as described in Section 5, *Quality Measures & Performance Assessment*).

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 the first 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 two (2) month period to perform calculations. The Baseline Period is the timeframe which is used to set Medical Cost Targets.

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

“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 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) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost claims amounts. The MCP calculation also includes consideration of Anthem line of business (e.g. Commercial, Medicare Advantage, Medicaid) and product type (e.g. HMO, PPO, etc.). Specifically, if the Medical Panel participates in the Program under a number of different Anthem products, there may be multiple MCPs. Additionally, while some MCPs may be established based on Member Population as represented by a Medical Panel, others (when line of business membership is too low at the Medical Panel level to establish statistically meaningful MCPs) may be based on Member Populations as represented by all Covered Individuals attributed to the Program.

“Medical Cost Target” (MCT) means the historic cost experience in the defined Member Population during the Baseline Period, trended forward and expressed in terms of risk adjusted per member per month (PMPM) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost claims amounts. The formulae for setting the MCT take into account risk adjusted Per Member/Per Month (PMPM) Claims experience within the Attributed Member Population during the Baseline Period, but excluding certain transplant and high cost Claims amounts. MCT sets the baseline for shared savings/loss calculations under the Incentive Program. A given Medical Panel will have multiple MCTs, which will aggregate membership separately by line of business (e.g. Commercial, Medicare Advantage, Medicaid), product type (e.g. HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through Anthem will be in a separate target than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager (PBM)). Additionally, while some MCTs may be established based on Member Population as represented by a Medical Panel, others (when line of business membership is too low at the Medical Panel level to establish statistically meaningful MCTs) may be based on Member Populations as represented by all Covered Individuals attributed to the Program..

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

“Member Months” means the number of the Member Population’s full months enrolled in the applicable Anthem products during a Measurement Period.

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

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

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

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

“Normalized Risk Score” means the Medical Panel’s average risk score relative to the state’s average risk score. Risk scores are generated using the DxCG model from Verisk Health, which uses diagnosis information from Covered Individuals’ medical claims. The approach to risk scores may be adjusted from time to time. If such adjustments are material in nature, we will provide notice to you.

“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 the minimum quality standards that you must achieve in order to retain any shared savings under the Incentive Program.

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

“Upside Shared Savings Percentage” means the percentage of shared savings under the Incentive Program that 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.

“Upside Shared Savings Potential” means 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.

INCENTIVE PROGRAM TERMS AND DETAILS

Upside Shared Savings Potential

The Upside Shared Savings Potential as defined above will be communicated to you 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, 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 Savings generated during the Measurement Period.
- (b) 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 Savings exceeds the MRC. In the event that the Gross Savings is less than the MRC (expressed in terms of a PMPM or percent of premium amount) 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. 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 turnover.
- (c) Following application of the MRC calculation described above, the Savings Pool(s) will be allocated to Providers on a pro rata basis, based on their total Member Risk Months relative to the Member Population represented within the Savings Pool(s).
- (d) Providers in the Medical Panel are evaluated on quality and utilization measures relative to targets to determine the overall Upside Shared Savings Percentage. While many physicians participating 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 you fail to meet the "Quality Gate" requirements of the Incentive Program, you will not be eligible to receive any amount of shared savings payout, regardless of whether other performance targets under the Incentive Program are met.
- (e) Your total allocated Savings Pool(s), described in step (c), will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on your aggregate performance across all products and lines of business.

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

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

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

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

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

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

Adjustments to MCT

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

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 you for any Net Aggregate Savings earned during the Measurement Period associated with your Attributed Members. Based on your performance, we may choose to make interim advance payments to you of your share in Net Aggregate Savings. If we elect to make such interim payments, the Net Aggregate Savings earned for the interim period of the Measurement Period will be paid to you less a percentage amount defined by Anthem called the “Holdback Amount.” The Holdback Amount will be retained by us as security against any future shared loss obligations of Medical Panel during the Measurement Period(s). If a Holdback Amount is used, we will remit to you the total retained balance of the Net Aggregate Savings, less any interim payments associated with your Attributed Members, no later than two-hundred and ten (210) days after the end of the relevant Measurement Period. You 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, we will pay your physician group for such savings amounts.

Maximizing Your Savings Goals

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

- Engage your Patient-Centered Care Consultant and Provider Clinical Liaison for assistance with report interpretation and identifying opportunities for improvements.
- 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 information over time. These reports should be reviewed and discussed on a regular basis to determine how your organization is progressing toward established benchmarks and targets.

- Leverage tools that are available to your organization. MMH+, our learning collaboratives, the Provider Toolkit, and American College of Physicians Practice Advisor (ACP Practice AdvisorSM) tool are just a few ways you can access information on methods for quality improvement.

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 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. The list will identify the practice names and assigned Medical Panel. You are required to access the Anthem provider portal to identify your assigned Medical Panel.

During a period of time prior to the start date of the Measurement Period, you *may* have the opportunity to submit your preference for your Medical Panel to us. If such opportunity is available, our provider portal will include a form for submission of Medical Panel preferences, as well as a list of practices that have been selected for participation in the Program. Prior to the Measurement Period start date, Anthem 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 one provider group represents a Medical Panel, both quality and utilization performance will be calculated at the single group level.

While a single Shared Savings Percentage will be calculated for you, regardless of line of business, the Savings Pool calculations can vary between Commercial, Medicare, and Medicaid membership. For Commercial membership, such financial reconciliations will always take place at the Medical Panel level. For Medicare and Medicaid, however, calculations will only take place at the Medical Panel level if the total Attributed Members exceed minimum thresholds established for these lines of business. If the number of Attributed Members by line of business is below certain thresholds set by Anthem, then the MCTs may be set at the Program level.

Attributed Members – Limitations for Medicare and Medicaid

As indicated in the Attachment, limitations will apply to inclusion of certain Attributed Member populations in the Incentive Program. The paragraph above discusses the possibility for MCTs to be set at the Program level if Attributed Member populations are below certain thresholds set by Anthem. If at the start of or during the Measurement Period, the average monthly Attributed Member population for Medicare and/or Medicaid is below the threshold for the Program level, those Attributed Members associated with that line of business will be removed from the Incentive Program for the relevant Measurement Period. For example, the minimum Attributed Member threshold at the state level for Medicaid business is 10,000 Attributed Members. If a Measurement Period begins, and the Attributed Members for Medicaid business is not at the 10,000 minimum limit for those practices included in the Measurement Period, these members will be removed from the Incentive Program for the associated Measurement Period. Additionally, if the average Attributed Member population for the Medicaid business over the duration of the Measurement Period does not meet the 10,000 minimum threshold for those practices included in the Measurement Period, these members will be removed from the Incentive Program for the associated Measurement Period.

If Anthem chooses to make interim payments, a determination will be made at that time as to whether the limitations described above must be applied for that interim period. A final determination of average Attributed Member populations will be made at the end of the Measurement Period, as applicable.

Current standard threshold limitations at the state level include, but are not limited to:

- Medicare business (3,000 Attributed Members)
- Medicaid business (10,000 Attributed Members)

Comprehensive Primary Care (CPC) Initiative Special Terms

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

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

Section 9: Reporting

A fundamental building block of the Program is the set of reports that we intend to make available to you. These reports will help you meet the expectations under the Program, and will assist you with effective management of your Attributed Member population in order to achieve better health outcomes.

We will make reports available to you primarily via the Availity secure web portal. Your local provider contract representative will work with you to complete the registration process in Availity to access these reports. A brief description on some of the reports that we currently plan to make available to you following the Program Attachment Effective Date are supplied below.

Attribution Report

Details information about your Attributed Members, including information on:

- Demographic(s)
- Attribution method
- Attribution duration
- Primary PCP's visit count
- Total PCP (primary + other) visit counts
- Total specialist count

Attribution Report - Inactive/No Longer Attributed

Includes similar detail to Attribution Report, but focuses on former Attributed Members who are no longer attributed to you (e.g. individual changed health plan, individual is attributed to a different Provider).

Attribution Report Detail

Supplements the Attribution Report, and provides details to further clarify method of attribution, detailing the specific physicians which Attributed Member has visited over the previous 24 months.

Hot Spotter Report

Identifies Attributed Members who may benefit from a care plan. The report generally targets certain Attributed Members with a recent inpatient admission as well as Attributed Members with chronic diseases. Detail includes:

- Demographics
- Primary risk drivers (determinants of Attributed Member selection on report)
- Prospective risk score
- Summary of gaps in care
- Diagnostic groupings
- Recent information on admissions and emergency room visits
- Cost summary (dollars related to inpatient, outpatient, medical, and Rx)

Inpatient Authorization Report

Identifies all Attributed Members who have been authorized for an inpatient admission; Attributed Members remain on the report from the time the admission was authorized through 7 days post-discharge. Detail includes:

- Demographics
- Predictive information on likelihood for readmission
- Admission detail (hospital name, admission date, admitting diagnosis, etc)

Care Opportunity View Report

Identifies Attributed Members with “care opportunities,” i.e. active or potential gaps in care associated with clinical quality metrics referenced in Section 5, *Quality Measures & Performance Assessments*. Detail includes:

- Demographics
- Next clinical due date associated with measure
- Urgency around potential opportunity/gap in care

Emergency Room View Report

Identifies Attributed Members with emergency room (ER) volume, categorizing “frequent fliers” and offering information around ER avoidance opportunities. Detail includes:

- Demographics
- ER visit details (hospital name, day of week and date of visit, primary diagnosis, etc)
- Potentially avoidable visits identified

Performance Scorecard

Summary of your performance on performance metrics referenced in Section 5, *Quality Measures & Performance Assessments*. Detail includes:

- Historic measure rate during baseline period
- Rolling measure rate
- Rolling measure numerator and denominator

If you have questions regarding your reports, please forward an e-mail to the mailbox indicated for your state under the *Introduction* section of this Program Description. In your message, please include the following information:

- Your name
- Your phone number
- Your provider organization name
- Your provider organization’s tax identification number (or provider identification number)
- Name of report(s)
- Date of report(s)
- Description of issue or question

Comprehensive Primary Care (CPC) Initiative Special Terms

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

Section 10: Blue Distinction Total Care

The Blue Distinction Total Care (“BD Total Care”) provisions described in this Section 10 are effective as of the Program Attachment Effective Date or October 1, 2013, whichever is later (the “BD Total Care Effective Date”), and contain the terms and conditions for designation and participation for your organization in the **Blue Distinction Total Care** program, which is administered by Blue Cross and Blue Shield Association (“BCBSA”) and Anthem.

BD Total Care is a national designation program that delivers a network solution for patient-centered, value-based care. BD Total Care designates providers participating in local value-based, patient-centered care delivery programs, such as our Patient-Centered Care Program that meet set criteria. BD Total Care enables all Blue members, both local and out-of-area, to identify and access local patient-centered care delivery models that manage to both quality and cost.

PROVISIONS:

1. As a participant of our Patient-Centered Care Program (including the CPC Program) your provider organization meets the criteria of the BD Total Care program. As a participant in one of our Patient-Centered Care programs you acknowledge this national designation and consent to be designated as a Blue Distinction Total Care Provider in provider directories, website listings, and in marketing and other materials as further described below.
2. As a participant of the BD Total Care Program, you are not required to use the BD Total Care name or logo; but if you choose to do so, then you must follow the Blue Distinction Total Care Guidelines shown below. This Section 10 does not convey to you any right to use the **Blue Cross** and/or **Blue Shield** names or service marks, except to the limited extent provided in the attached Blue Distinction Total Care Guidelines shown below.
3. These BD Total Care Provisions and your provider organization’s designation as a Blue Distinction Total Care Provider will begin on the BD Total Care Effective Date (set forth above) or October 1, 2013, whichever is later, and will remain in effect until December 31, 2014 (the “BD Total Care Initial Term”). Thereafter, the BD Total Care Provisions and your provider organization’s designation as a Blue Distinction Total Care Provider will renew automatically for consecutive terms of one (1) year each (individually, a “BD Total Care Renewal Term,” and collectively with the BD Total Care Initial Term, the “BD Total Care Term”); provided, that your provider organization continues to participate in one of our Patient-Centered Care Programs.
4. Your participation in the BD Total Care program will end if Anthem or you terminate your participation in one of our Patient-Centered Care Programs.
5. Your provider organization’s participation in BD Total Care does not alter, amend, or replace any other agreement that may exist between your provider organization and Anthem.
6. These BD Total Care Provisions in this Section 10 contain the entire agreement between the Anthem and your provider organization with respect to your participation in BD Total Care, and, assuming Anthem determines that your provider organization does meet the BD Total Care program criteria, will supersede any prior oral or written agreements pertaining to the subject matter of these BD Total Care Provisions.

BLUE DISTINCTION TOTAL CARE GUIDELINES

If you become a Blue Distinction Total Care (BD Total Care) provider, you are not required to use the BD Total Care name or logo; but if you choose to do so, then you must follow these guidelines:

BD Total Care Designation Information. All communications concerning BD Total Care status must include the name of Anthem, as described below (together, the “BD Total Care Designation Information”). If your provider organization was designated by two or more Blue Cross and/or Blue Shield Plans for BD Total Care, it is preferable, though not required, for your provider organization’s Blue Distinction communications to mention each designating Plan unless the communication’s content or distribution is limited to one of the designating Plans.

Use of BD Total Care Designation Information. The BD Total Care Designation may be used as long as your provider organization is designated as a Blue Distinction Total Care Provider and the BD Total Care Provisions are in effect, and if you do use the BD Total Care Designation, then you must feature the BD Total Care Designation Information in signage, advertising, web sites, press releases and other communications as follows:

Signage:

- ***BD Total Care Templates.*** A BD Total Care provider may display signage (banners, plaques, billboards and certificates) using any of the templates provided by Anthem for the duration of your provider organization’s participation in the BD Total Care Program. Non-templated signage that refers to the BD Total Care Program or designation must be approved in advance by Anthem.
- ***Use Limited to Site-Specific Designated Location.*** BD Total Care signage may be used/displayed only at your provider organization’s office that received the BD Total Care designation. BD Total Care signage cannot be used at affiliated hospitals/facilities, unless those facilities also have a site-specific BD Total Care provider designation.

Communications, Advertising and Web Sites:

- ***BD Total Care Templates.*** All communications and signage (including signage, advertising, web sites, press releases and other communications) concerning any BD Total Care Program or using BD Total Care Designation Information and/or BD Total Care Icons must use applicable templates provided to you by Anthem, which contain messaging that has been pre-approved by Anthem. Variations from BD Total Care templates must be approved in advance by Anthem.
- ***BD Total Care Icons.*** Approved art files for various “BD Total Care Icons” are available from Anthem upon request.
- ***Web Content.*** The content of each web page that displays the BD Total Care Designation Information or BD Total Care Icon, or uses the “Blue Distinction” name, must be approved by Anthem in advance of its use. BD Total Care Icons may be displayed on the BD Total Care’s web site (subject to these Guidelines), but each web page on which the BD Total Care Icon is displayed must include the name of the designating Plan, and must be approved in advance by Anthem.
- ***BD Total Care Disclaimer.*** The following legal disclaimer (the “BD Total Care Disclaimer”) must be used on all communications (e.g., advertising, web sites, press releases and other

communications) involving BD Total Care's, except "Signage" (limited to banners, plaques, billboards and certificates) and television or radio:

Disclaimer: "Designation as a Blue Distinction® Total Care Provider means this Provider has met the established national criteria and been designated by the local Plan. To find out which services are covered under your policy at any facilities, please call your local Blue Cross and/or Blue Shield Plan; and call your provider before making an appointment, to verify the most current information on its Network participation and Blue Distinction Total Care status. Neither Blue Cross and Blue Shield Association nor any of its Licensees are responsible for any damages, losses, or non-covered charges that may result from using Blue Distinction or other provider finder information or receiving care from a Blue Distinction or other provider."

An abbreviated BD Total Care Disclaimer may be used for television or radio communications, along with other requirements consistent with BCBS Brand Regulations:

Disclaimer: "To learn more about Blue Distinction® Total Care, please visit www.bcbs.com or contact your local Blue Plan."

Press Releases

All press releases concerning any BD Total Care Provider or using BD Total Care Designation Information and/or BD Total Care Icons must be approved by Anthem in advance of their release.

Miscellaneous

- ***Relative Size of Blue Names/Symbols and Your Practice's Names/Symbols.*** Whenever they appear together in the same communications vehicle:
 - the names and symbols for your provider organization and/or any professional society may appear more prominently than those of the BD Total Care designation and Anthem;
 - provided, however, that the names and symbols of the BD Total Care designation(s) and Anthem must appear no less prominently than those of any other health insurer or any organization other than your provider organization or any professional society.
- ***Use on Variable Media Prohibited.*** BD Total Care Designation Information and/or BD Total Care Icons may not be used on any form of stationery, letterhead, templates, forms or other materials whose contents or application may vary.
- ***Appeal and Termination of BD Total Care Designation.*** When loss of BD Total Care designation is under formal appeal, BD Total Care signage and advertising may be used until the appeal process is complete. Upon termination or loss of BD Total Care designation, all use of BD Total Care Designation Information, the BD Total Care Icon, the "Blue Distinction" name, and all BD Total Care signage, advertising and web site references must be removed, and must cease, immediately.

Section 11: Appendix

MMH+ Access Request Form – See form on the following page or access the form on the Patient-Centered Primary Care webpage.

Comprehensive Primary Care (CPC) Initiative Special Terms

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

Anthem

MMH+ Access Form

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

Please fill out the information below and send the completed form to your local provider contract representative. An access form will be sent to you to complete this process.

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

Practice Name _____

Practice TIN _____

Practice e-mail _____

Person who will fill out access form for MMH+ _____

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

Phone number of person filling out the form _____

Section 12: Glossary

Glossary Term	Definition	Source
Attachment	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.	Attachment
Attributed Members	Those Covered Individuals who are attributed to the Represented Primary Care Physicians or Represented Physicians, as applicable, for the purposes of the Enhanced Personal Health Care Program using the Attribution Methodology.	Attachment
Attribution Methodology	<p>A process whereby Anthem will assign Covered Individuals to the Represented Primary Care Physicians or Represented Physicians, as applicable, in one of the following manners:</p> <ul style="list-style-type: none"> i) based on the formal selection of a Primary Care Physician by the Covered Individual; or ii) based on the formal assignment of a Primary Care Physician or Represented Physician, as applicable, to the Covered Individual by [Legal Entity Title]; or iii) based on a Covered Individual's prior utilization of evaluation and management services. <p>Provider agrees and acknowledges that such assignment of a Covered Individual to a Primary Care Physician or Represented Physician, as applicable, utilizing the Attribution Methodology will not impose any limitations or constraints on the freedom of such Covered Individuals to refer themselves for Health Services except as may otherwise be set forth in the Health Benefit Plan. The Attribution Methodology is described further in Section 5 of this Program Description.</p>	Attachment
Baseline Period	A defined twelve (12) month period preceding the first Measurement Period. Generally, to ensure all Claims have been received and processed by Anthem, there will be a minimum of three (3) months of lag time for Claims run-out between the end of the Baseline Period and the beginning of the Measurement Period plus a two (2) month period to perform calculations. The Baseline Period is the timeframe which is used to set Medical Cost Targets.	Program Description (Section 8)
Care Plan	A detailed approach to care that is customized to an individual patient's needs. Often times, care plans are needed in circumstances where patients can benefit from personalized physician instruction and feedback regarding management of their condition(s).	Program Description (Section 3)
Care Plan Assessment Domains	The functional areas we suggest be included in care plans to guide goal formation and related elements that could further support the identification of goals and interventions.	Program Description (Section 3)

Glossary Term	Definition	Source
Clinical Quality Measures	One of the categories by which the Providers' performance in the Enhanced Personal Health Care Program will be measured. The clinical quality measures are grouped into two categories, acute and chronic care management and preventive care. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.	Program Description (Section 5)
Gross Savings	Any amounts by which the Medical Cost Performance (MCP) is less than the Medical Cost Target (MCT), adjusted by the Paid/Allowed Ratio, as calculated by Anthem, at the end of a Measurement Period for each product requiring a separate product specific calculation. Gross Savings can be in the form of risk adjusted per member per month (PMPM) or a percent of premium paid, depending on the product or line of business.	Program Description (Section 8)
Holdback Amount	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).	Program Description (Section 8)
Incentive Program	The opportunity for PCPs to increase their revenue as they participate in the Enhanced Personal Health Care Program. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance criteria. A complete description of the Incentive Program is in the Program Description.	Program Description (Section 8)
Measurement Period	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.	Program Description (Section 8)
Medical Cost Performance (MCP)	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) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost claims amounts. The MCP calculation also includes consideration of Anthem line of business (e.g. Commercial, Medicare Advantage, Medicaid) and product type (e.g. HMO, PPO, etc.). Specifically, if the Medical Panel participates in the Program under a number of different Anthem products, there may be Multiple MCPs. Additionally, while some MCPs may be established based on Member Population as represented by a Medical Panel, others (when line of business membership is too low at the Medical Panel level to establish statistically meaningful MCPs) may be based on Member Populations as represented by all Covered Individuals attributed to the Program.	Program Description (Section 8)

Glossary Term	Definition	Source
Medical Cost Target (MCT)	The historic cost experience in the defined Member Population during the Baseline Period, trended forward and expressed in terms of risk adjusted per member per month (PMPM) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost claims amounts. The formulae for setting the MCT take into account risk adjusted Per Member/Per Month (PMPM) Claims experience within the Attributed Member Population during the Baseline Period, but excluding certain transplant and high cost Claims amounts. MCT sets the baseline for shared savings/loss calculations under the Incentive Program. A given Medical Panel will have multiple MCTs, which will aggregate membership separately by line of business (e.g. Commercial, Medicare Advantage, Medicaid), product type (e.g. HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through Anthem will be in a separate target than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager (PBM). Additionally, while some MCTs may be established based on Member Population as represented by a Medical Panel, others (when line of business membership is too low at the Medical Panel level to establish statistically meaningful MCTs) may be based on Member Populations as represented by all Covered Individuals attributed to the Program.	Program Description (Section 8)
Medical Panel	A single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful Medical Cost Targets (MCTs), shared savings, and utilization performance targets. Medical panels shall be formed either by the providers themselves or by Anthem.	Program Description (Section 8)
Member Months	The number of the Member Population's full months enrolled in the applicable Anthem products during a Measurement Period.	Program Description (Section 8)
Member Population	The group of Attributed Members assigned to Provider, Medical Panel, County, Region, or State, as applicable; and whose costs under the relevant Anthem products(s) will be used to calculate Medical Cost Targets (MCTs) and Medical Cost Performance (MCPs) pursuant to the Program (subject to criteria established by Anthem)].	Program Description (Section 8)
Member Risk Months	The Member Population's average Normalized Risk Score multiplied by their Member Months in the applicable Anthem products during a Measurement Period.	Program Description (Section 8)
Minimum Risk Corridor (MRC)	The percentage of Medical Cost Target (MCT) 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.	Program Description (Section 8)
MMH+ (Member Medical Health Plus)	The Anthem system the Provider will use to access Covered Individual-based personal health information to clinicians via the internet. To gain access, Providers should submit a completed MMH+ Access Form to the local provider contract representative.	Program Description (Section 4)

Glossary Term	Definition	Source
Net Aggregate Savings	The total allocated Savings Pool(s) multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap.	Program Description (Section 8)
Non-Cost Performance Targets	The quality and utilization performance goals tied to shared savings under the Incentive Program. Quality measures are evaluated at the Provider level (subject to membership requirements identified in the Shared Savings Determination section below), whereas utilization measures are evaluated at the Medical Panel level.	Program Description (Section 8)
Normalized Risk Score	The Medical Panel's average risk score relative to the state's average risk score. Risk scores are generated using the DxCG model from Verisk Health, which uses diagnosis information from Covered Individuals' medical claims. The approach to risk scores may be adjusted from time to time.	Program Description (Section 8)
Paid/Allowed Ratio	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.	Program Description (Section 8)
Performance Assessments	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: <ul style="list-style-type: none"> ▪ Acute and Chronic Care Management ▪ Preventive Care ▪ Utilization The categorical scores will be based on performance relative to different tiers of performance thresholds.	Program Description (Section 5)
Primary Care Physician(s) or PCP(s)	Physicians whose primary specialty, as indicated in the Anthem provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics.	Attachment
Program	Abbreviated reference to our Enhanced Personal Health Care Program, including the Comprehensive Primary Care initiative.	Attachment
Program Attachment Effective Date	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.	Attachment
Program Description	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.	Attachment

Glossary Term	Definition	Source
Program Quality Measures	The defined measures used to establish a minimum level of the Provider's performance will also serve as the basis for Incentive Program savings calculations. Program Quality Measures are calculated and reported to the Provider on a scorecard comprised of clinical quality measures and utilization measures.	Program Description (Section 5)
Provider Practice Toolkit	The tools and information that will be made available to provider organizations to assist with population health management.	Program Description (Section 4)
Quality Gate	The minimum quality standards that you must achieve in order to retain any shared savings under the Incentive Program.	Program Description (Section 8)
Represented Primary Care Physician(s) or Represented PCP(s)	All of the physicians in the provider organization whose primary specialty, as indicated in the Anthem provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics (collectively, Primary Care Physician(s)) and who participate in the Patient-Centered Care Program by virtue of being covered under the Provider Agreement and Enhanced Personal Health Care Program Attachment.	Attachment
Represented Providers	Represented Provider(s)" means the physicians in the provider organization who bill under the Organization's tax identification number(s), are board-certified or board eligible, and who participate in the Program by virtue of being covered under the Agreement and this Attachment.	Attachment
Risk Scores	Risk scores are indicators of the health status of an Attributed Member based on the evaluation of diagnosis information pulled from claims. Anthem uses industry standard methods to determine risk scores.	Attachment
Savings Pool	The Minimum Risk Corridor (MRC) is applied by comparing the Gross Savings to the MRC to determine the Member Population's "Savings Pool". If the Gross Savings is less than the MRC, the Savings Pool is not funded. If the Gross Savings exceed the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. The total allocated Savings Pool(s) will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on the aggregate performance across all products and lines of business.	Program Description (Section 8)

Glossary Term	Definition	Source
Shared Savings	The savings the Provider can share in if Program targets are met. We will compare the Medical Panel's annual Claim cost per Covered Individual in each Measurement Period to each Covered Individual's cost in a Baseline Period to determine whether the Measurement Period's Medical Cost Performance ("MCP") is less than the Baseline Period's Medical Cost Target ("MCT") subject to Incentive Program details described herein. In the event that the MCP is less than the MCT, the Provider may share in a percentage of the savings realized, provided that the Provider meets the Quality Gate and other Non-Cost Performance Targets as described in the Quality Measures & Performance Assessment section of this Program Description.	Program Description (Section 8)
Upside Cap	The maximum limit on Incentive Program shared savings that you can earn through the Incentive Program. Like the Gross Savings, the Upside Cap is adjusted by the Paid/Allowed Ratio.	Program Description (Section 8)
Upside Shared Savings Percentage	The percentage of shared savings under the Incentive Program that Provider is determined to be entitled to after (i) you meet the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for you and your Medical Panel. The Upside Shared Savings Percentage can be the same percentage as the Upside Shared Savings Potential if all Non-Cost Performance Targets are fully achieved by you and your Medical Panel under the Program. The Upside Shared Savings Percentage will be less than the Upside Shared Savings Potential if all Non-Cost Performance Targets are not achieved, and zero if the Quality Gate is not met.	Program Description (Section 8)
Upside Shared Savings Potential	The maximum percentage of shared savings under the Incentive Program that you may be entitled to, provided that your provider organization meets the Quality Gate and other Non-Cost Program Targets.	Program Description (Section 8)
Utilization Measures	One of the categories by which the Providers' performance in the Enhanced Personal Health Care Program will be measured. The utilization measures focus on appropriate emergency room (ER) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and generic dispensing rates for a select set of drug classifications. As with the clinical metrics, administrative data are used to construct the utilization measures.	Program Description (Section 5)

Comprehensive Primary Care (CPC) Initiative Special Terms

There are no significant differences between the Enhanced Personal Health Care Program formally referred to as Patient Centered Primary Care and CPC for this section.