Patient Centered Primary Care
Program Description

Modified 1/1/2013
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. 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. 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 is its 2008 Report “Primary Health Care (Now more that 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 primary 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 primary care physicians’ medical record; and
4) providing primary care 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 primary care model through its participation in patient center 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

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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.

This new Patient Centered Primary Care Program builds upon the success of our PCMH programs and fosters 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 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 Patient Centered Primary Care Program as well as 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).

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 Patient Centered Primary 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, practice name, tax ID and phone number with area code.

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**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 practice 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 primary care 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,
  - making them active participants in their health care through shared decision making, and
  - optimizing their health.

SCOPE

The Program applies to Anthem participating Primary Care Physicians who are in good standing and who have signed our Provider Agreement and the accompanying Patient Centered Primary Care Attachment (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
- nurse practitioner (NP)

Comprehensive Primary Care (CPC) Initiative Special Terms

Pediatric practices are not included in the CPC Initiative.
Section 2: Roles

We plan to make several Program resources available to support and collaborate with you to achieve successful outcomes and reach Program goals. The following information describes roles we currently intend to develop in order to support the Program. The Patient Centered Care Consultant 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.

Ambassador

The Ambassador is a Primary Care Physician within the market who provides guidance to physicians and solicits feedback from physicians regarding the Program. The Ambassador also provides Anthem with critical advice and support regarding the Program. A list of Ambassadors will be available via the Anthem provider portal once the Ambassadors are available within a given market.

Community Collaboration Manager

The Anthem Community Collaboration Manager will serve as the point of contact for participating physicians and primary care practice staff for orientation, on-going training, and technical support for the Program. The Community Collaboration Managers will outreach to practices regularly to understand progress with Program elements, field questions and concerns, and provide opportunities for Program improvement.

Patient Centered Care Consultant

The Anthem Patient Centered Care Consultant will analyze Program reports for each practice, and meet with practices regarding data to support practice utilization of information to assist with practice transformation activities. The Patient Centered Care Consultant will suggest quality improvement transformation interventions based on practice level data. The Patient Centered Care Consultant will follow up with practices to review the care plan process and identify from practices any Covered Individual that is a candidate for a care plan.

Clinical Care Liaison

The Anthem Clinical Care Liaison serves as the participating practice’s clinical point of contact with Anthem for the Program. This clinician will meet with the practice as needed to support seamless coordination of services between providers and Anthem Care Management. These clinical review calls will support the sharing of information on Anthem’s care management programs as well as the details on individual patient interactions with care management staff, including identified patient health issues and planned interventions. The Clinical Care Liaison will also facilitate ad hoc conversations and referral routing as part of ongoing care coordination.
Pharmacist

The Anthem Pharmacist will collaborate with other Anthem clinical and support staff to assist practices participating in the Program with clinical support for pharmaceutical management. The Pharmacist will participate in clinical review calls, acting as a resource regarding formulary or medication questions. The Pharmacist will provide information and resources to support patient care.

Social Worker

The Anthem Social Worker will collaborate with other Anthem clinical and support staff to assist practices participating in the Program with mental health service support for patient management. The Social Worker will participate in regularly scheduled clinical review calls to facilitate identification of resources and available services as needed.

Program Advisory Council (PAC) Member
The PAC Member is a Primary Care Physician in the community who has agreed to participate in the PAC. During regular meetings, PAC Members will provide valuable feedback to Anthem regarding a variety of topics regarding the Program. Whenever possible, Anthem will use this feedback to make continual improvements in the Program.

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 Patient Centered Primary Care 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 that there are roles that support care coordination and care management in your practice. 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,
- Perform regular outreach to Covered Individuals based on their personal preference, which could include email or phone calls,

• Provide information on self management support,
• Use registry functionality to support care opportunities, and
• Adhere to a team-based approach to care, which drives proactive care delivery.

CARE PLANS

Appendix A of the Patient Centered Primary Care 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 elements 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 Practice Toolkit, which will be accessible on or before the Program Attachment Effective Date.

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:
  o a shared agenda for physician office visits, and
  o 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:
  o Information on medication self-management,
  o A patient-centered record owned and maintained by the Covered Individual,
  o A follow-up schedule with primary or specialty care, and
  o A list of “red flags” indicative of a worsening condition and instructions on how to respond to them.

Your practice 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.

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<td>Element 3</td>
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IDENTIFYING THE NEED FOR A CARE PLAN

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 practice team to identify Covered Individuals who have been determined by the practice as candidates to receive a care plan. The Patient Centered Care Coordinator will review both the Hot Spotter Report and the practice-identified Covered Individuals on a regular basis 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.

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.”

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

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

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

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6 [http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf](http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf)
Section 4: Program Requirements – Additional Information

The following sections provide additional information on specific Program requirements for participating physicians as referenced in Appendix A of the Patient-Centered Primary Care Attachment.

PATIENT ENGAGEMENT

One of the most important and fundamental requirements of the Patient Centered Primary 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 practice 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) will make patient and family letters and other supporting information available to you to start the dialog with them. We’ll also provide 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.

MMHPlus

Physicians participating in the Program are required to gain access to and utilize Anthem’s Member Medical History Plus (MMHPlus) 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.

MMHPlus 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 practice 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 practice is instrumental for care coordination and management. It will enable you to develop data informed comprehensive care plans for your patients. The MMHPlus is a web-based tool that is available via the internet.

From MMHPlus, 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.

**MMHPlus 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.

**MMHPlus 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.

**MMHPlus is free.** There is no charge for you to use MMHPlus.

**MMHPlus 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, MMHPlus can provide up to 6 years of history.

As noted above, under the terms of the Program, you are required to access and utilize MMHPlus to manage your Attributed Member population. To gain access, you will need to complete the MMHPlus Access Request Process form. The MMHPlus 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 MMHPlus Access Request Process Form is included in Section 10: Appendix of this Program Description.

For a demonstration or further information on MMHPlus, please contact your local provider contract representative.

**REGISTRY**

Appendix A of the Patient Centered Primary Care 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). Your Patient Centered Care Consultants will work closely with you to determine the mechanism and workflow for you to implement registry functionality and pull your measures monthly. This process will include review of your current health information technology systems, if applicable. Sample registries will also be available via the Provider Practice Toolkit.
PROVIDER PRACTICE TOOLKIT

The Patient Centered Care Consultants will provide you with research and tools in the Provider Practice Toolkit that will help your practice with your transformation activities. Information will be available to provide methods for enhancing your practice's performance and quality, organizing your practice, establishing care coordination and care management processes, and maximizing health information technology, including registry functionality. It will also give you tools for self management support and motivational interviewing, and offer enhanced access to care for your patients.

Comprehensive Primary Care (CPC) Initiative Special Terms

The Provider Practice Toolkit for the Patient Centered Primary 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.

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 32 clinical quality measures and 3 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 for the Program are grouped into two categories: (1) acute and chronic care management and (2) 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 Plan data.

Acute and Chronic Care Management Measures

1. Appropriate testing for children with pharyngitis
2. Appropriate treatment for children with upper respiratory infection (URI)
3. Appropriate antibiotic treatment for adults with acute bronchitis
4. New episode of depression: effective acute phase treatment
5. New episode of depression: effective continuation phase treatment
6. Acute myocardial infarction (AMI): persistence of beta-blocker treatment after a heart attack
7. CAD: ACE inhibitor/angiotensin receptor blocker (ARB) therapy
8. Complete lipid profile for patients with cardiovascular conditions
9. Heart failure (HF): beta-blocker therapy
10. Proportion of days covered (PDC): for hypertension (ACEI or ARB)
11. Proportion of days covered (PDC): for cholesterol (Statins)
12. Diabetes: eye exam
13. Diabetes: hemoglobin A1c testing
14. Diabetes: lipid profile
15. Diabetes: urine protein screening
16. Proportion of days covered (PDC): oral diabetes
17. Annual monitoring for patients on persistent medications: ACE/ARB
18. Annual monitoring for patients on persistent medications: anticonvulsants
19. Annual monitoring for patients on persistent medications: digoxin
20. Annual monitoring for patients on persistent medications: diuretics
21. Arthritis: disease modifying antirheumatic drug (DMARD) therapy in rheumatoid arthritis
22. Osteoporosis management in women who had a fracture
23. Use of appropriate medications for people with asthma

Preventive Care Measures

1. Breast cancer screening
2. Cervical cancer screening
3. Childhood immunization status: MMR
4. Childhood immunization status: VZV
5. Chlamydia screening in women
6. Glaucoma screening in older adults
7. Adolescent well visits: 12-21 years
8. Well-child visits in the first 15 months of life
9. Well-child visits: 3-11 years
Utilization Measures

Three different utilization measures are included in the Program scorecard. The 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.

Potentially avoidable ER Visits. This measure was developed using research which determines ER visits that were potentially avoidable by identifying visits that would have been treatable in an ambulatory care setting.

Ambulatory Sensitive Care Hospital Admissions. The Agency for Healthcare Research and Quality (AHRQ) developed a Prevention Quality Indicators (PQI) composite measure of 12 potentially avoidable hospitalizations for ambulatory care sensitive conditions; these are as follows:

1. Diabetes short-term complications
2. Diabetes long-term complications
3. Chronic obstructive pulmonary disease or asthma in older adults
4. Hypertension
5. Heart Failure
6. Dehydration
7. Bacterial pneumonia
8. Urinary tract infection
9. Angina without procedure
10. Uncontrolled diabetes
11. Asthma in younger adults
12. Lower-extremity amputation among patients with diabetes

Generic Dispensing Rate. Seven classes of medication will be assessed for the generic dispensing rate:

1. Serotonin-norepinephrine reuptake inhibitors (SNRIs)
2. Amphetamines
4. Nasal steroids
5. Calcium regulators – misc (bone density regulators)
6. Serotonin agonists
7. Non-barbiturate hypnotics
PERFORMANCE ASSESSMENT

Performance on the selected Program clinical quality and utilization measures will be reported to you on a quarterly basis. 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 will be calculated at the physician group level for each measure, and then results will be rolled into three categorical scores for:

- Acute and Chronic Care Management
- Preventive Care
- Utilization

The categorical scores will be based on performance relative to different tiers of performance thresholds. Better performance will generate a better score. For example, meeting or exceeding the regional 50th percentile of performance will score better than meeting or exceeding the regional 30th percentile.

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 make-up of the Medical Panel (as defined in Section 8, Incentive Program) and current performance on measures. That is, there needs to be a good opportunity for the performance rate to improve and you must have a sufficient number of Attributed Members eligible for the measure to assess improvement.

Level of Measurement

It is important that the measures of clinical quality and utilization are meaningful, reliable and valid. To be meaningful, reporting of measures will be available at the individual physician level. This allows individual physicians to view his or her performance relative to peers, and more importantly have information about which Attributed Members appear to not be receiving indicated care services. To assure reliability and validity, the actual annual assessment of performance that determines the level of shared savings will be aggregated to a group level, and if the group size is not sufficient, then performance will be assessed at the Medical Panel level.

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 scorecard comprised of clinical and utilization measures. The 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. We will identify and notify you of the minimum threshold associated with the quality gate prior to the start date of the Incentive Program Measurement Period.
*Proportion of Shared Savings Earned*

After the quality gate is satisfied, the proportion of shared savings you receive depends on scores for the three categorical scores 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.

<table>
<thead>
<tr>
<th>Comprehensive Primary Care (CPC) Initiative Special Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>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. When the community-driven quality metrics and measures are available, they will be included in this Program Description.</td>
</tr>
</tbody>
</table>
Section 6: Attribution Process

Attribution is a process used to assign Covered Individuals to a Primary Care Physician (PCP) 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 PCP.

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 PCPs. Based on this algorithm, a list is provided to PCPs 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. 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.

1. Covered Individual selects and maintains one provider for a 12-month period

   Yes

   Covered Individual is assigned to selected provider for the entire 12 month period

2. During a 12-month period, Covered Individual selected more than one provider

   Yes

   Covered Individual is assigned to a provider for only the months which they selected the provider as his/her provider

3. Covered Individual does not select a provider within the same 12-month period

   Yes

   Health plan selects a provider for the Covered Individual
**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 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 PCP, 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.

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

There are no significant differences between the Patient Centered Primary Care Program and CPC for this section.
Section 7:  Clinical Coordination Fee

OVERVIEW

The Clinical Coordination Fee 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 Fee 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 Fee will be paid for applicable Attributed Members as outlined in the Program Attachment based on their eligibility and subject to retroactive adjustments, which on most cases will not exceed 3 months. Clinical Coordination Fees 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 Fee 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 Fee will be payable for that Attributed Member. Similarly, if an Attributed Member is deleted on the 14th day of the month, the Clinical Coordination Fee will not be payable for that member for that month.
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 “Baseline Period”. In the event that the MCP is less than the “Medical Cost Target” (“MCT”, which is defined below), 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 the Quality Measures & Performance Assessment section of this Program Description.

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 the defined twelve (12) month period preceding the first Measurement Period. The term “Baseline Period” is the timeframe used to calculate the Medical Cost Target for the Medical Panel.

“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 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 certain counties, regions, or states.

“Medical Cost Target” (MCT) means the historic cost experience in the defined Member Population during the Baseline Period, trended forward based on unit cost increase projections 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. MCT sets the baseline for shared savings/loss calculations under the Incentive Program. The MCT 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 MCTs. 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 certain counties, regions, or states.

“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, county, region, or state, 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 practice 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 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:

<table>
<thead>
<tr>
<th>I. Shared Savings Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Group Count</td>
</tr>
<tr>
<td>Minimum Risk Corridor</td>
</tr>
<tr>
<td>Upside Cap</td>
</tr>
<tr>
<td>Upside Shared Savings Potential: Quality</td>
</tr>
<tr>
<td>Upside Shared Savings Potential: Utilization</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Panel Savings Pool Calculation (Commercial Example)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Cost Target (MCT)</td>
</tr>
<tr>
<td>Inflation Assumption</td>
</tr>
<tr>
<td>Paid/Allowed Ratio</td>
</tr>
<tr>
<td>Medical Cost Performance (MCP)</td>
</tr>
<tr>
<td>Gross PMPM Savings: (MCT-MCP) x Paid/Allowed</td>
</tr>
<tr>
<td>Minimum Risk Corridor PMPM: (MRC x MCT) x Paid/Allowed</td>
</tr>
<tr>
<td><strong>Savings Pool PMPM</strong></td>
</tr>
</tbody>
</table>

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: \[\frac{300-285}{0.95}\]. 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) x MRC (1.5%) x 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

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
<th>Panel Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg PCP PMPM</td>
<td>$ 14.40</td>
<td>$ 21.60</td>
<td>$ 18.00</td>
<td>$ 18.54</td>
</tr>
<tr>
<td>Members</td>
<td>2,500</td>
<td>4,000</td>
<td>3,500</td>
<td>10,000</td>
</tr>
<tr>
<td>Members Months</td>
<td>30,000</td>
<td>48,000</td>
<td>42,000</td>
<td>120,000</td>
</tr>
<tr>
<td>Normalized Risk Score</td>
<td>0.80</td>
<td>1.20</td>
<td>1.00</td>
<td>1.03</td>
</tr>
<tr>
<td>Member Risk Months</td>
<td>24,000</td>
<td>57,600</td>
<td>42,000</td>
<td>123,600</td>
</tr>
</tbody>
</table>

#### Savings Pool Allocation

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>$</td>
<td>239,400</td>
<td>574,560</td>
<td>418,950</td>
<td>1,232,910</td>
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</tbody>
</table>

#### Upside Shared Saving (Actual) Percentage

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>10%</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>Utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Shared Savings Percentage: Total

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>22%</td>
<td>17%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>22%</td>
</tr>
</tbody>
</table>

#### Net Aggregate Savings (pre-cap)

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>52,668</td>
<td>97,675</td>
<td>125,685</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ 276,028</td>
</tr>
</tbody>
</table>

#### Upside Cap

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>684,000</td>
<td>1,641,600</td>
<td>1,197,000</td>
</tr>
</tbody>
</table>

#### Net Aggregate Savings (post-cap)

<table>
<thead>
<tr>
<th></th>
<th>Provider Group A</th>
<th>Provider Group B</th>
<th>Provider Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>52,668</td>
<td>97,675</td>
<td>125,685</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ 276,028</td>
</tr>
</tbody>
</table>

|                      | $ 432,000        | $ 1,036,800      | $ 756,000        |
|                      |                  |                  | $ 2,224,800      |

| PCP Baseline Revenue | $ 432,000        | $ 1,036,800      | $ 756,000        |
| 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, unit cost increase projections, 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.

Payments for earned Net Aggregate Savings will follow the current payment methods you have in place with Anthem. For example, if Claim payments are currently remitted at the physician group level, we will pay your physician group for such savings amounts. If Claim payments are currently remitted at the individual physician level, we will pay the individual physician for such savings amounts.

MEDICAL PANELS

The Program introduces the concept of the Medical Panel to encourage broad-based practice 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 practice 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 will 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 county, region or state level.
Attributed Members – Limitations for Medicare and Medicaid

As indicated in the Program 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 county, region or state 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 state 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 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 Patient Centered Primary 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 Patient Centered Primary 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 a secure web portal. 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
- Primary risk drivers (determinants of Attributed Member selection on report)
- 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

Admission View Report
Identifies Attributed Members with inpatient admissions, categorizing such members with high admission volume and offering information around admission avoidance opportunities. Detail includes:
- Demographics
- Inpatient admission details (hospital name, date of admission, attending physician, etc)
- Diagnoses and DRGs
- Elective vs. emergency indicator
- Ambulatory sensitive condition indicator
- Readmission indicator

Rx Reporting
Summarizes pharmacy utilization for drugs with generic options and identifies generic alternatives, where applicable, along with associated savings estimates. Detail includes:
- Prescribing provider
- Therapeutic class roll up
- Drug name and generic alternative
- Prescriptions per 1,000
- Allowed (cost) per 1,000
- Savings estimates associated with generic alternatives, where applicable
**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
- Current care opportunities
- Rolling measure rate
- Rolling measure numerator and denominator

**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: Appendix

MMHPlus 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 Patient Centered Primary Care Program and CPC for this section.
Anthem Blue Cross and Blue Shield

MMHPlus Access Form

Anthem's MMHPlus system provides Covered Individual-based personal health information to clinicians via the internet. MMHPlus 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 MMHPlus Access Form for all individuals in your practice who should have access to clinical information regarding Anthem Covered Individuals via MMHPlus.

Practice Name

Practice TIN

Practice e-mail

Person who will fill out access form for MMHPlus

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

Phone number of person filling out the form
# Section 11: Glossary

<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment</td>
<td>Abbreviated reference to the Patient Centered Primary Care Program Attachment, the contractual document the Provider signs to participate in the Patient Centered Primary Care Program. This attachment is an amendment to the primary care physician's Provider Agreement with Anthem.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Attributed Members</td>
<td>Those Covered Individuals who are attributed to the Represented Primary Care Physicians for the purposes of the Patient Centered Primary Care Program using the Attribution Methodology.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Attribution Methodology</td>
<td>A process whereby Anthem will assign Covered Individuals to the Represented Primary Care Physicians in one of the following manners:</td>
<td>Attachment</td>
</tr>
<tr>
<td></td>
<td>i) based on the formal selection of a Primary Care Physician by the Covered Individual; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii) based on the formal assignment of a Primary Care Physician to the Covered Individual by Anthem; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>iii) based on a Covered Individual’s prior utilization of evaluation and management services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider agrees and acknowledges that such assignment of a Covered Individual to a Primary Care Physician utilizing the Attribution Methodology will not impose any limitations or constraints on the freedom of such Covered Individuals to refer themselves for Health Services except as may otherwise be set forth in the Health Benefit Plan. The Attribution Methodology is described further in the Program Description.</td>
<td></td>
</tr>
<tr>
<td>Baseline Period</td>
<td>The defined twelve (12) month period preceding the first Measurement Period. The term Baseline Period is the timeframe used to calculate the Medical Cost Target (MCT) for the Medical Panel.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Care Plan</td>
<td>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)</td>
<td>Program Description (Section 3)</td>
</tr>
<tr>
<td>Care Plan Assessment Domains</td>
<td>The functional areas we suggest be included in care plans to guide goal formation and related elements that could further support the identification of goals and interventions.</td>
<td>Program Description (Section 3)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
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</tr>
<tr>
<td><strong>Clinical Quality Measures</strong></td>
<td>One of the categories by which the Providers' performance in the Patient Centered Primary 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 Plan data.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td><strong>Gross Savings</strong></td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Holdback Amount</strong></td>
<td>The percentage of any applicable annual distribution payment based on earned Net Aggregate Savings that may be retained by Anthem as security against any future shared loss obligations of Medical Panel during the Measurement Period(s).</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Incentive Program</strong></td>
<td>The opportunity for PCPs to increase their revenue as they participate in the Patient Centered Primary Care Program. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance criteria. A complete description of the Incentive Program is in the Program Description.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Measurement Period</strong></td>
<td>The twelve (12) month period during which Medical Cost Performance will be measured for purposes of calculating shared savings between Anthem and the Medical Panel.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Medical Cost Performance (MCP)</strong></td>
<td>The actual cost experience in the defined Member Population during a relevant Measurement Period, expressed in terms of risk adjusted per member per month (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 certain counties, regions, or states.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
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<tr>
<td>-------------------------------------</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Medical Cost Target (MCT)</strong></td>
<td>The historic cost experience in the defined Member Population during the Baseline Period, trended forward based on unit cost increase projections 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. MCT sets the baseline for shared savings/loss calculations under the Incentive Program. The MCT 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 MCTs. 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 certain counties, regions, or states.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Medical Panel</strong></td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Member Months</strong></td>
<td>The number of the Member Population's full months enrolled in the applicable Anthem products during a Measurement Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Member Population</strong></td>
<td>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).</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Member Risk Months</strong></td>
<td>The Member Population's average Normalized Risk Score multiplied by their Member Months in the applicable Anthem products during a Measurement Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Minimum Risk Corridor (MRC)</strong></td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>MMHPlus (Member Medical Health Plus)</strong></td>
<td>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 MMHPlus Access Form to the local provider contract representative.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
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<tr>
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</tr>
<tr>
<td>Net Aggregate Savings</td>
<td>The total allocated Savings Pool(s) multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Non-Cost Performance Targets</td>
<td>The quality and utilization performance goals tied to shared savings under the Incentive Program. Quality measures are evaluated at the Provider level (subject to membership requirements identified in the Shared Savings Determination section below), whereas utilization measures are evaluated at the Medical Panel level.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Normalized Risk Score</td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Paid/Allowed Ratio</td>
<td>The ratio of paid dollars (dollars paid by Anthem to providers) to allowed dollars (total dollars paid by Anthem plus Cost Shares payable by Covered Individuals) for Covered Services incurred during a Measurement Period, excluding Covered Individuals with certain transplant or high cost claims amounts.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Patient Centered Primary Care Program Attachment</td>
<td>The contractual document the Provider signs to participate in the Patient Centered Primary Care Program. This attachment is an amendment to the primary care physician’s Provider Agreement with Anthem. This term is synonymous with “Attachment”.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Performance Assessments</td>
<td>The annual assessment of performance on the selected Program clinical quality and utilization measures to define the proportion of shared savings that the Provider earns. Performance will be calculated for each measure, and then results will be rolled into three categorical scores for: Acute and Chronic Care Management Preventive Care Utilization The categorical scores will be based on performance relative to different tiers of performance thresholds.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td>Primary Care Physician(s) or PCP(s)</td>
<td>Physicians whose primary specialty, as indicated in the Anthem provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program</td>
<td>Abbreviated reference to the Patient Centered Primary Care Program.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Program Attachment Effective Date</td>
<td>The date the Patient Centered Primary Care Program Attachment becomes effective as shown on either (i) the signature page of the Provider Agreement or (ii) the signature page of the Attachment, whichever is applicable.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program Description</td>
<td>The description of the Patient Centered Primary 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 in creating a patient-centric practice environment and care model for their Covered Individuals as well as Program terms, conditions and requirements. A current copy of the Program Description, and periodic updates thereto, is available on the Anthem provider website.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Program Quality Measures</td>
<td>The defined measures used to establish a minimum level of the Provider’s performance will also serve as the basis for Incentive Program savings calculations. Program Quality Measures are calculated and reported to the Provider on a scorecard comprised of 32 clinical quality measures and 3 utilization measures.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td>Provider Practice Toolkit</td>
<td>The tools and information that will be made available to practices to assist with population health management.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>Quality Gate</td>
<td>The minimum quality standards that you must achieve in order to retain any shared savings under the Incentive Program.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Represented Primary Care Physician(s) or Represented PCP(s)</td>
<td>All of the physicians in the Provider’s practice 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 Primary Care Program by virtue of being covered under the Provider Agreement and Patient Centered Primary Care Program Attachment.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Risk Scores</td>
<td>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.</td>
<td>Attachment</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
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</tr>
<tr>
<td>Savings Pool</td>
<td>The Minimum Risk Corridor (MRC) is applied by comparing the Gross Savings to the MRC to determine the Member Population’s “Savings Pool”. If the Gross Savings is less than the MRC, the Savings Pool is not funded. If the Gross Savings exceed the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. The total allocated Savings Pool(s) will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on the aggregate performance across all products and lines of business.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>The savings the Provider can share in if Program targets are met. We will compare the Medical Panel's annual Claim cost per Covered Individual in each Measurement Period to each Covered Individual's cost in a Baseline Period to determine whether the Measurement Period’s Medical Cost Performance (“MCP”) is less than the Baseline Period’s Medical Cost Target (“MCT”) subject to Incentive Program details described herein. In the event that the MCP is less than the MCT, the Provider may share in a percentage of the savings realized, provided that the Provider meets the Quality Gate and other Non-Cost Performance Targets as described in the Quality Measures &amp; Performance Assessment section of this Program Description.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Upside Cap</td>
<td>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.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Upside Shared Savings Percentage</td>
<td>The percentage of shared savings under the Incentive Program that Provider is determined to be entitled to after (i) you meet the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for you and your Medical Panel. The Upside Shared Savings Percentage can be the same percentage as the Upside Shared Savings Potential if all Non-Cost Performance Targets are fully achieved by you and your Medical Panel under the Program. The Upside Shared Savings Percentage will be less than the Upside Shared Savings Potential if all Non-Cost Performance Targets are not achieved, and zero if the Quality Gate is not met.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Upside Shared Savings Potential</td>
<td>The maximum percentage of shared savings under the Incentive Program that you may be entitled to, provided that your practice meets the Quality Gate and other Non-Cost Program Targets.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
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<tr>
<td>Utilization Measures</td>
<td>One of the categories by which the Providers' performance in the Patient Centered Primary 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.</td>
<td>Program Description (Section 5)</td>
</tr>
</tbody>
</table>

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

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