

# Program Description For Enhanced Personal Health Care

Known nationally as Blue Distinction Total Care

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

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- None of the information, resources or tools provided is intended to be required for use in your practice or infer any kind of obligation on you in exchange for any value you may receive from the Program. Physicians and other health professionals must rely on their own expertise in evaluating information, tools, or resources to be used in their practice. The information, tools, and resources provided for your consideration are never a substitute for your professional judgment.
- With respect to the issue of coverage, each Anthem Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. If Members have any questions concerning their benefits, they may call the Member Services number listed on the back of their ID card.

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## Section 1: Program Overview

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

As you read through this Program Description, you will see the terms “Covered Individual,” “Attributed Member” and “patient” used. A “Covered Individual” refers to people who are covered under a Anthem’s Health Plan. “Attributed Member” is defined in the Program contractual documents and essentially means a Covered Individual who is attributed to you for Program purposes. The term “patient” is used to refer generically to your patients that may or may not be a Covered Individual or an Attributed Member.

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

This Program Description serves as a reference regarding the operation of the Program and to further describe all Parties’ rights and obligations, including details about the financial benefits of the Program, our commitment to participating physicians to provide reporting and other useful tools, and our expectations for participating physicians under the Program.

### Program Communications

You should have completed a Key Contacts Form in your Program Recruitment Packet. Communications regarding Program changes, updates, and activities will be sent to the e-mail address you listed for your provider organization. If you have an update to the e-mail address used in the online form, you must send us the update request in writing. We will begin using your new e-mail address up to 20 business days after we receive your request. You must keep this information current with us to ensure you are receiving important Program-related communications.

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

Market	Mailbox
California	<a href="mailto:CAEPHC@Anthem.com">CAEPHC@Anthem.com</a>
Colorado	<a href="mailto:COEPHC@Anthem.com">COEPHC@Anthem.com</a>
Connecticut	<a href="mailto:CTEPHC@Anthem.com">CTEPHC@Anthem.com</a>
Georgia	<a href="mailto:GAEPHC@Anthem.com">GAEPHC@Anthem.com</a>
Indiana	<a href="mailto:INEPHC@Anthem.com">INEPHC@Anthem.com</a>
Kentucky	<a href="mailto:KYEPHC@Anthem.com">KYEPHC@Anthem.com</a>
Maine	<a href="mailto:MEEPHC@Anthem.com">MEEPHC@Anthem.com</a>
Missouri	<a href="mailto:MOEPHC@Anthem.com">MOEPHC@Anthem.com</a>
Nevada	<a href="mailto:NVEPHC@Anthem.com">NVEPHC@Anthem.com</a>
New Hampshire	<a href="mailto:NHEPHC@Anthem.com">NHEPHC@Anthem.com</a>
New York	<a href="mailto:NYEPHC@Anthem.com">NYEPHC@Anthem.com</a>
Ohio	<a href="mailto:OHEPHC@Anthem.com">OHEPHC@Anthem.com</a>
Virginia	<a href="mailto:VAEPHC@Anthem.com">VAEPHC@Anthem.com</a>
Wisconsin	<a href="mailto:WIEPHC@Anthem.com">WIEPHC@Anthem.com</a>

## Program 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 providers to do what they can do best: manage all aspects of their patients' care.
- Provide physicians with tools, resources and meaningful information that promote:
  - access,
  - shared decision-making,
  - proactive health management,
  - coordinated care delivery,
  - adherence to evidence-based guidelines
  - care planning built around the needs of the individual patient, leading to improved quality and affordability for our customers and their patients.
- Redesign the current payment model to move from volume-based to value-based payment, aligning financial incentives and providing financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach and quality improvement.
- Improve the patient experience by:
  - Facilitating better access to Represented Primary Care Providers who will not only care for the "whole person" but also will become each patient's health care champion and help patients navigate through the complex health care system,
  - Inviting patients' active participation in their health care through shared decision-making, and optimizing their health.
- Focus practice attention on opportunities to lower cost of care while improving quality outcomes.

## Scope

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

## Section 2: Practice Support

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### Support offered by Anthem

Program resources are available to support and collaborate with you to achieve successful outcomes and reach Program goals. Resources include support for strategy, contracting, quality improvement, care management, population health management and consulting to help improve the quality, cost and patient experience within your practice.

### Support Needed in Your Provider Organization

Establishing a foundation of support within your provider organization is essential to forming a collaborative team. The following roles inside your provider organization are recommended to support your organization's transformation under the Program.

#### Provider Champion

The Provider Champion is a physician, or in some cases an Advanced Practice Registered Nurse in a leadership position in your provider organization who is the leader of your provider organization's patient-centered care approach. This individual has the authority to support and influence transformation to patient-centered care, and supports the needed activities, provides resources and communicates to other physicians about the Program.

#### Practice Manager

The Practice Manager is the individual in your provider organization who manages the day-to-day activities in a primary care office.

#### Care Coordinator

The Care Coordinator is the individual in your provider organization who facilitates care coordination and care plan creation for patients.

## Transformation Team Members

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

## Section 3: Care Coordination and Care Plans

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### Care Coordination

This section is designed to help you understand care coordination expectations and requirements under the Program.

The Agency for Healthcare Research and Quality (AHRQ) defines that “Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”<sup>1</sup> Proper care coordination should allow for seamless transitions across the health care continuum in an effort to improve outcomes and reduce errors and redundancies.

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

Care coordination activities should invoke a holistic patient approach, which includes:

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

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<sup>1</sup> Care Coordination. (2014) Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD.  
<https://www.ahrq.gov/ncepcr/care/coordination.html>

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

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

- Identify high-risk Covered Individuals with the support of Anthem reporting to ensure Covered Individuals are receiving appropriate care delivery services,
- Facilitate planned interactions with Covered Individuals with the use of up-to-date information provided by Anthem,
- Perform regular outreach to Covered Individuals based on their personal preference, which could include mail, e-mail, text messaging (as allowed under applicable state regulation or state medical licensing requirements) or phone calls,
- Provide information on self-management support,
- Use population health registry functionality to support care opportunities, and
- Adhere to a team-based approach to care, which drives proactive care delivery.

## Care Plans

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

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

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

## *Care Plan Format and Content*

Whichever care plan format is used, it should fit into your current workflow, and not require duplicative documentation. Care planning should enhance the Covered Individual's treatment plan, and should provide a broader level of assessment than a standard patient history and physical to efficiently manage care. A sample care plan template and additional care plan information is available in the online Provider Toolkit described in Section 4, *Program Requirements and Transformation*.

The minimum requirements for an initial care plan include:

- Activities that are individualized to the needs of the Covered Individual,
- Information regarding family, caregiver and/or patient involvement for specific activities for the purposes of collaboration and coordination of the plan of care,
- Short-term and long-term patient-centric goals with interventions that are realistic for the Covered Individual's care,
- The patient's self-management plan (also described on the following page), includes:
  - A shared agenda for physician office visits, and
  - A list of activities to improve the health of the Covered Individual (developed in collaboration with the Covered Individual),



- Helpful information regarding relevant community programs where available.
- Resources that should be utilized (e.g., Anthem clinical programs, home health care, durable medical equipment, and rehabilitation therapies),
- Time frames for reevaluation and follow-up, and
- A transition of care approach (for Covered Individuals discharged from a hospital) includes:
  - Information on medication self-management,
  - A patient-centered record owned and maintained by the Covered Individual,
  - A follow-up schedule with primary or specialty care, and
  - A list of “red flags” indicative of a worsening condition and instructions for responding to them.

Your provider organization team must also perform the following activities in connection with care planning:

- Update the Covered Individual's chart to include care plan goals,
- Learn the status of such goals during office visits with Covered Individual,
- Ensure the Covered Individual knows his/her role in self-management and what must be done after the visit,
- Respond to any questions the Covered Individual may have about his/her treatment or medication plan, and
- Perform follow-up and monitoring as identified in the care plan.

Maintenance of care plans must, at minimum, include the following:

- Detailed notes to indicate progress toward goals,
- Updates and additions to scheduling, available resources, and roles and responsibilities,
- An assessment of barriers to patients achieving their goals, and
- Modifications to initial/previous plan to adjust the plan to progress level.

## Identifying the Need for Care Planning

Our goal is for a Represented Primary Care Provider to perform an annual comprehensive assessment on high-risk attributed patients to allow for early detection and ongoing assessment of their chronic conditions. The annual exam is a fundamental part of medical care and is valuable in promoting prevention and wellness recognizing risk factors for disease, identifying medical problems, and establishing the clinician-patient relationship.

Although we provide a list of Attributed Members (as defined in Section 6: Attribution) who, through analytic reporting, have been identified as being at high risk, you will have additional real-time information from patient assessments and the medical record that allows you to identify other high-risk Attributed Members.

Attributed Members who may be candidates for care planning include those who:

- Have been diagnosed with complex medical conditions,
- Are receiving treatment from multiple specialists, thereby requiring coordination of care,
- Have complex treatment/management plans,
- Are impacted by social determinants of health (e.g., social isolation, food insecurity),
- Have multiple chronic conditions or a chronic condition with evidence-based gaps in care (e.g., heart failure and inability to adhere developed treatment plans/medication regime or daily weight monitoring),
- Have a newly diagnosed chronic condition, such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), migraine, hypertension, or morbid obesity,
- Have comorbid medical and behavioral health conditions,

- Have a behavioral health diagnosis (e.g., depression, schizophrenia, dementia, bipolar) which will amplify the patient's risk score,
- Have specific risk drivers and/or high care gaps risk score, or
- Are taking multiple medications for health conditions.

### ***Comprehensive Assessment***

Accurate, uniform and in-depth assessment of high-risk individuals is instrumental in formulating a comprehensive, individualized care coordination plan. High-risk individuals are those who have at least one of the core chronic conditions, high ER and Inpatient utilization, complex medication regimen, multiple specialists, have a high readmission risk, a high prospective risk score and/or some gaps in care. These are the people who would benefit the most by appropriate intervention and an individualized care plan. Individualized care is the most cost-effective and successful approach to support the needs of the patient. Evidence has shown that it leads to effective and efficient use of health care services and improves the overall quality of patient care. Incorporating the use of a comprehensive assessment checklist during each patient visit helps ensure that all of the Attributed Member's needs are addressed, and can help you identify and address chronic conditions that may otherwise go undiagnosed or untreated. The checklist allows for a thorough patient evaluation so that all the pertinent clinical areas are covered.

A comprehensive evaluation will help you formulate the appropriate patient outreach plan. Reminders through mail, by phone call, text messaging and/or patient portals regarding annual screenings are examples of support patients may need from you.

Early detection of conditions and changes in the Attributed Member's health status allows for early intervention, and can prevent the need for significant medical interventions such as hospitalization.

Comprehensive assessment documentation may include the following:

- Age and gender-appropriate immunizations and screenings,
- Familial, social, and cultural characteristics,
- Communication needs,
- Medical history of Attributed Members and family,
- Advanced care planning (not applicable for pediatrics),
- Behaviors affecting health,
- Patient and family mental health and/or substance abuse (to the extent permitted by law),
- Developmental screening using a standardized tool (not applicable for provider organizations with no pediatric patients),
- Depression screening for adults and adolescents using Personal Health Quest Two ("PHQ2"), Personal Health Quest Nine ("PHQ9") or other nationally recognized tool.

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

Self-management support means educating Attributed Members so that they may take a greater role and level of responsibility for improving their own health outcomes. Self-management support is the assistance caregivers offer to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two (2) ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership. The purpose of self-

management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.<sup>2</sup>

You should encourage self-management through the following:

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

## Section 4: Program Requirements and Transformation

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

### Patient Engagement

The commitment to adopting a patient-centered care model is one of the most important and fundamental requirements of the Enhanced Personal Health Care Program, (nationally known as Blue Distinction Total Care). Actively engaging patients and their families in the care process is the core attribute of patient-centered care. You can engage your patients in the patient-centered care model by communicating your commitment to this model of care and sharing with your patients what to expect from your provider organization as a result of that commitment— and how they can actively participate in their own care.

### Practice Transformation

Practice transformation is a discipline that incorporates quality improvement methodology and practice along with organizational-level data to drive change that impacts quality, cost, and patient experience. In order to analyze reports to drive practice improvement, physicians participating in the Program are required to gain access to and use a series of web based tools and data platforms, including Patient360 and Availity, as referenced below:

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<sup>2</sup> Tom Bodenheimer, *Helping Patients Manage Their Chronic Conditions*, [www.chcf.org](http://www.chcf.org) , 2005

## Patient360

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

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

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

- Member Care Summary Eligibility details
- Claims details (as described in Section 5, *Quality Measures and Performance Assessments* and in Section 6, *Attribution Process* of this document)
- Authorization details
- Pharmacy information
- Lab information
- Episodic viewer
- Care management information

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

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

The Patient360 application is available from Availity Payer Spaces

1. Log in to [www.availity.com](http://www.availity.com).
2. Select Payer Spaces in the top menu bar.
3. Select the payer tile that corresponds to your market.
4. Select Applications.
5. Select Patient360

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

You can also access the Patient360 via the web-based reporting tool:

1. Access via a hyperlink by selecting the patient icon to the left of the member's name
2. The user's credentials and patient context will automatically pass to Patient360 if a profile is available for the member

## Availity – Getting Started With Population Management

Population health management and the sharing of health information are core components of the Program. We will give you access to meaningful, actionable information about your patients who are included in the Program.

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

### How to get started

If your organization is not currently registered for the Availity Portal, go to [www.availity.com](http://www.availity.com) and select Register to complete the online application.

#### Your Administrator will need to take the following steps to assign access to Provider Online Reporting (POR):

1. Assign the user role of Provider Online Reporting to your Availity access.
2. Select **Payer Spaces** in the navigation bar and then choose the payer tile that corresponds to the market.
3. Accept the User Agreement (once every 365 days).
4. On the *Applications* tab, select **Provider Online Reporting**.
5. Choose the organization and select **Submit**.
6. In the Provider Online Reporting application, register the tax ID by selecting **Register/Maintain Organization**.
7. Last, register users to the Program by selecting **Register Users** and completing the required fields.

#### Access Enhanced Personal Health Care reports:

1. After logging in to Availity, select **Payer Spaces** in the navigation bar and then choose the payer tile that corresponds to the market.
2. Accept the User Agreement (once every 365 days).
3. On the *Applications* tab, select **Provider Online Reporting**.
4. Choose the organization and select **Submit**.
5. Select **Report Search**, choose your Program, and then select the link to launch the reporting application.

For additional information on editing roles, registering your organization and registering users, ask your Market Representative for our **Availity and POR Registration Deck** and **Availity and POR Registration Job Aid**.

### Patient Registry

Program requirements identify expectations around your use of a patient registry. The information below provides you with the details you need to successfully use a registry in your practice to support the proactive management of your patient population and optimize the health of each patient.

Registries are organized systems that can be used to identify and track, schedule visits, labs, educational sessions, as well as generate reminders and guidance of the care of patients (both in groups and individually).

Identifying your patient population is essential to an effective population-based care delivery system. Without identification of the patients included in the population, changes cannot be effectively achieved. It is for this reason that physicians participating in the Program are expected to utilize registry functionality to systematically maintain patient demographic and clinically relevant information based on evidence-based guidelines.

To identify patients within the population of focus, you need to be able to access data that pertains to particular groups of patients. Program reports, as referenced in Section 9, and data accessed in our web-based reporting application can be used to identify and manage populations of patients. Active and systematic use of report data meets this Program requirement.

Since Program data can be analyzed, sorted and exported through the web-based reporting application, we are pleased to be able to provide you with a mechanism for keeping all pertinent information about a specific group of patients at your fingertips.

## **Member Health Information**

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

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

## **Practice Transformation Resources**

To help ensure Program success, several resources are available to practices. First, considering that a culture of learning is deemed essential for participants, Collaborative Learning events are offered all year long in a national webinar series that educates on critical topics. Presentations are delivered by national experts and a full color digital catalog is provided to allow for online registration and attendance.

These national learning events support practices by providing an education in areas that are crucial to Program success. All sessions are recorded and added to our extensive recording library for 24/7/365 viewing. To fulfill this Program component, practices shall provide at least one participant from the organization to participate in scheduled events. Program participation in learning events is tracked to ensure that each participating Provider adopts a culture of learning.

The Provider Toolkit, found on the Enhanced Personal Health Care webpage, serves to provide you with tools that support your organization during practice transformation activities. These resources are available to help enhance your organization's performance, quality, operations and population health management. Our Care Consultants, as well as our other local transformation team members, are available to answer additional questions and provide you with more information about the resources offered within the Program.

## Section 5: Quality Measures and Performance Assessments

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The measurement of quality and performance metrics is a key component of successful improvement and patient-centered care programs. Under the Program, quality and performance standards must be achieved in order for you to be eligible to receive additional amounts described under *Section 8: Incentive Program*. The scoring measures, methodology, calculations and other related parameters and criteria associated with quality measures and performance assessments may be updated from time to time.

Quality measures and performance assessments differ, in some cases, based on lines of business. The different measures and assessments for Attributed Member Populations in the Commercial-Medical Cost Target and Medical Loss Ratio models are described separately below:

### Commercial Line of Business

#### Quality Measures and Performance Assessments

**Note:** The section below only pertains to Providers who have Enhanced Personal Health Care Attachments that specifically include their participation in our **Commercial business Medical Cost Target model and/or Medical Loss Ratio model**. All terms and provisions in this and all Commercial business Medical Cost Target model and/or Medical Loss Ratio model designated subsections shall refer only to Commercial business Medical Cost Target model and/or Medical Loss Ratio model.

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

The Performance Scorecard is comprised of performance measures. In addition to serving as a basis for Incentive Program savings calculations, these measures are used to establish a minimum level of performance expected of you under the Program, and to encourage improvement through sharing of information.

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

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

The above criteria were considered when reviewing which 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.

## **Commercial Business Medical Cost Target and Medical Loss Ratio Measurement Period Handbooks**

Anthem is committed to providing you with performance details and scoring methodology for the Program. Approximately 90 days prior to the start of each Measurement Period, Anthem will provide you with a "Commercial Business Measurement Period Handbook" (the "Handbook") specific to the Program(s) in which you are participating which, among other things, will contain the applicable performance measures for the Measurement Period.

It will also provide the scoring methodology for these measures, including the tiers of performance thresholds that explain how higher performance equates to higher scores. Performance benchmarks will not be included in the Handbook, but will be provided to you prior to the start of each Measurement Period or as soon thereafter practicable.

If, upon receipt and review of the Handbook, you determine you no longer desire to participate in the Program, you must notify Anthem in writing within 30 days after the date the Handbook was sent unless otherwise communicated to you by Anthem.

If such notice is given, the Commercial Business provisions of the applicable Program Attachment shall terminate, your participation in the Program will end on the date communicated to you by Anthem, and the Handbook will never apply to you. If you do not provide such notice, the Attachment shall remain in effect, and the Handbook shall be deemed to have been accepted by you, and shall become effective and binding on the first day of the Measurement Period.

The provisions of this section entitled "Commercial Business Medical Cost Target and Medical Loss Ratio Measurement Period Handbooks" shall be effective, enforceable and implemented, notwithstanding any conflicting or contrary provision (including provisions relating to amendments or Program termination) contained in the Attachment or in the Agreement to which it is attached. To the extent that different notices or time-frames than described above are required by law, then the provisions of law shall supersede the contractual provisions of this section.

### ***Linking Performance Assessment to Shared Savings***

A key characteristic of the Program is the opportunity to share in savings that are achieved due to enhanced care management and delivery of care. After any savings are determined, the proportion of shared savings that you can earn is determined by level of performance on a "Performance Scorecard" comprised of clinical and utilization measures. The Performance Scorecard serves two functions: (1) Quality Gate (as defined in Section 8, *Incentive Program*), and (2) overall determinant of proportion of shared savings you earn.

### ***Quality Gate***

Your provider organization must meet a minimum threshold of performance on the performance scorecard in order for you to share a portion of the Savings Pool. That threshold, referred to as the Quality Gate (as defined in Section 8, *Incentive Program*), is based on the total score in the performance scorecard, and is defined by Anthem in the applicable Handbook.



### *Proportion of Shared Savings Earned*

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

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

### **Other Anthem Quality Incentive Programs**

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

## **Section 6: Attribution Process**

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

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

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

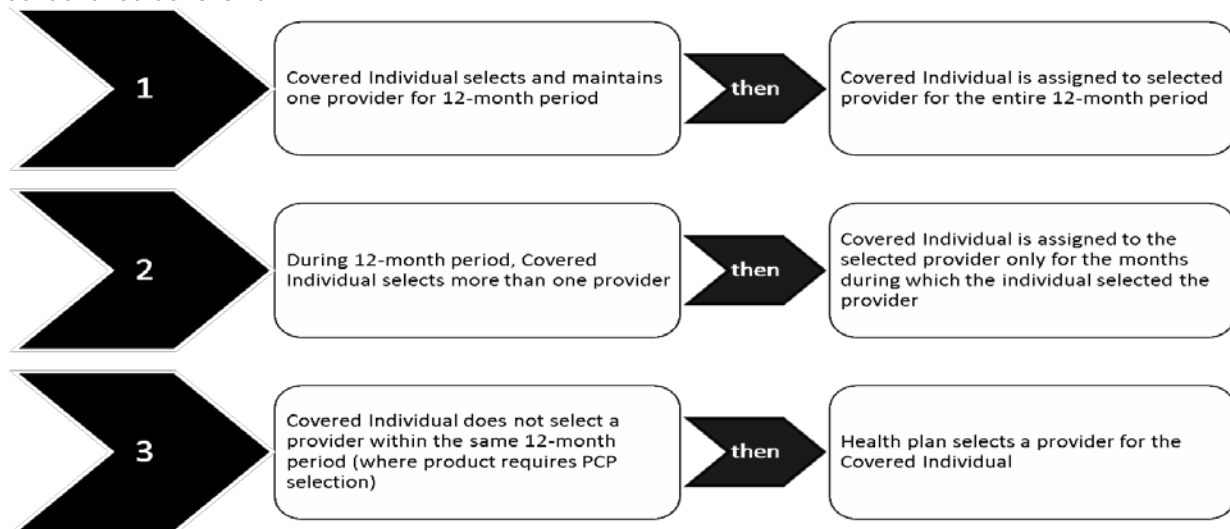
Due to certain contract restrictions, customer requirements, Program specific product limitations, and technological limitations, etc., it will not be possible to include all Covered Individuals as Attributed Members in the Program. For example, if an employer group prohibited us from including their employees in the Program, these Covered Individuals would not be Attributed Members. Also, there are Programs that focus on specific product inclusion and therefore members of other products wouldn't be included as Attributed Members.

Therefore, certain lines of business, employer groups or Covered Individuals may be excluded from the Program at Anthem's sole discretion. Covered Individuals whose Anthem coverage is secondary under applicable laws or coordination of benefit rules or whose coverage is provided under a supplemental policy (e.g., Medicare supplement) shall never be Attributed Members. It is Anthem's goal to continue to expand the Covered Individuals included in the Program as operationally feasible and contractually permitted.

### Attribution with PCP selection

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

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

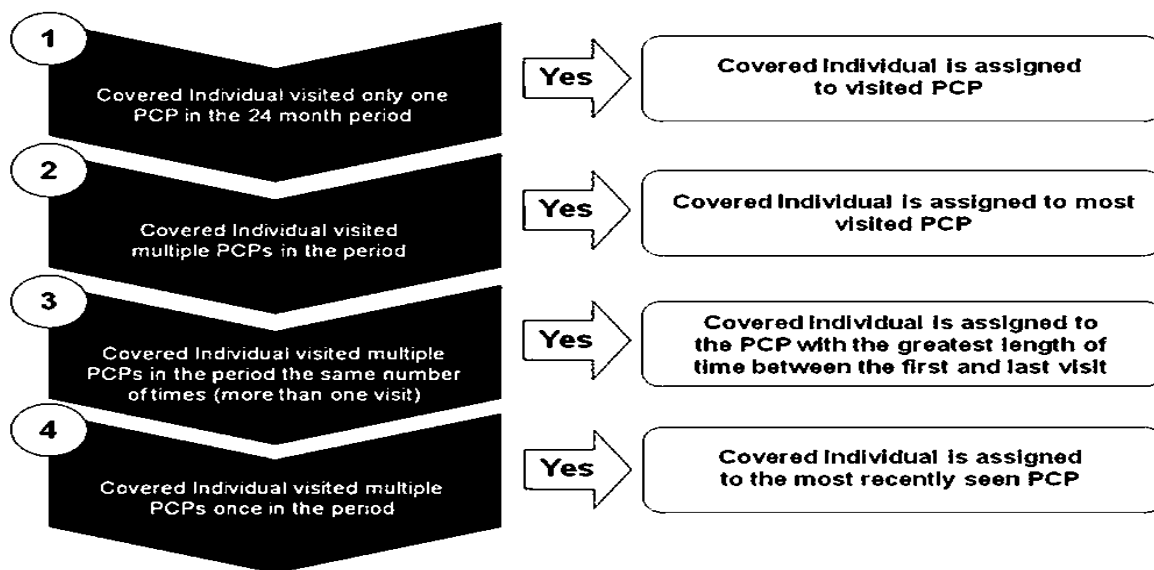


**Note:** If visit-based Attribution is used exclusively for a Covered Individual, the method on the following page will apply.

### Visit-based Attribution

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

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



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

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

### Member Months Clarifications:

#### Measurement Periods 1/1/19 and prior:

There are times when the total Member Months for an Attributed Member during a completed Measurement Period may be higher than the sum of Member Months attributed to that same individual in monthly attribution reports. For example, when a Covered Individual is attributed to a physician during a Measurement Period using visit-based attribution, that Covered Individual may be attributed to a physician for the full Measurement Period as long as he/she had medical coverage in those months, even if the member was not included in the monthly attribution reports for those months. There are also times, when a physician with Attributed Members leaves a practice, the Attributed Members for that physician may stay with the practice, as long as the Attributed Members do not select a different PCP or have record of visiting another provider in the practice. In this circumstance, the Attributed Members will remain attributed to the practice for purposes of Clinical Coordination payments, but will not be counted as an Attributed Member for the Incentive payment calculations.

#### Measurement Periods 4/1/19 and forward:

Monthly "snapshot" Member Months are used for the purpose of generating the Member Risk Months (as defined in Section 8, *Incentive Program-Commercial Business Medical Cost Target Model*) used in calculating shared savings/loss amounts. Starting with the 4/1/19 Measurement Period and forward, Member Months will be determined by identifying the Attributed Member Population in the given month

of the period. If a member is an Attributed Member to Provider during that month, the Attributed Member will count toward the Member Month count for that month. This Member Month count will be the same count as is used for the Clinical Coordination PMPM Payments (some variance may occur as the Member Month process captures full retroactivity). The Baseline Period Member Months will be treated similarly to above approach used in the associated Measurement Period. This Member Month attribution methodology will be used for the duration of the Program Term unless otherwise agreed to by the Parties.

## Section 7: Clinical Coordination Reimbursement

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### Overview

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

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

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

### Payment Process

The Clinical Coordination Reimbursement will be paid for applicable Attributed Members as outlined in the Attachment based on their eligibility and subject to retroactive adjustments, which in most cases will not exceed three months. Clinical Coordination Reimbursements are not prorated for partial months; rather, an eligibility snapshot is taken on the 15th day of the month. For Attributed Members added on or before the 15th day of the month, the entire fee is payable regardless of the date added. For Attributed Members added after the 15th day of the month, no payment will be made. Likewise, for Attributed Members deleted on or before the 15th day of the month, no amounts will be payable. The Clinical Coordination Reimbursement will be payable if an Attributed Member is deleted after the 15th day of the month. By way of example, if an Attributed Member becomes eligible on the 14th day of the month, the entire Clinical Coordination Reimbursement will be payable for that Attributed Member. Similarly, if an Attributed Member is deleted on the 14th day of the month, the Clinical Coordination Reimbursement will not be payable for that member for that month. Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a Provider that is less than \$5 for a period of one month beyond the point when it would otherwise have been paid to such Provider in order to promote cost-effective distribution of payments. Such payment will be made to the Provider one month after it would otherwise have been paid even if the total amount payable to the Provider at that time is still less than \$5.

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

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

### Retroactivity

On a monthly basis, Anthem will confirm that all previously identified Attributed Members remain Covered Individuals and are appropriately designated as Attributed Members. The PMPM payment will apply only to those Attributed Members who are Covered Individuals and who Anthem determines were appropriately designated as Attributed Members. Retroactivity for Attributed Member additions, terminations and/or changes will typically be no more than ninety (90) days unless otherwise required by a specific line of business, employer group or other entity that is covered under the terms of this Attachment or by a provision of law. Such retroactive adjustments will be applied at the Program level.

## Section 8: Incentive Program

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### Overview

By participating in the Incentive Program, you become accountable for the cost and quality outcomes of your Attributed Members. In order to ensure the statistical validity of calculations under the Program, and to create a learning environment to assist in sharing of best practices, participating physicians will be organized into “Medical Panels” (defined below) under rules established by Anthem. 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 detail in this section. The Incentive Program differs based on the line of business. These differences are outlined in the sections below.

### Incentive Program - Commercial Business Medical Cost Target Model

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

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”)

as defined below) against the Claims costs of the applicable Member Population (as defined below) during a prior 12 month period of time used to establish a "Medical Cost Target ("MCT"), which is defined below.

In the event that the MCP is less than the MCT, you may share in a percentage of the savings realized, provided that you meet the Quality Gate and other Non-Cost Performance Targets (as described in Section 5, *Quality Measures & Performance Assessment-Medical Cost Target Model*).

The Incentive Program terms and details are described below.

### **Definitions**

All capitalized terms will have the meanings given to such terms as shown below or in the Provider Agreement or, if not defined, will be interpreted using the commonly accepted definition of such terms.

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

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

"Gross Paid PMPM Savings" means the product level Gross Allowed PMPM Savings multiplied by the Paid/Allowed Ratio (as defined below).

"Gross Paid Upside Cap" or the "Upside Cap" means the maximum limit on the combined Gross Paid PMPM Savings Provider can earn under the Incentive Program. The Upside Cap is a percentage of the MCB, and is adjusted by the Paid/Allowed Ratio to determine the Upside Cap value expressed as a PMPM. The Upside Cap value expressed as a PMPM is compared to combined Gross Paid PMPM Savings amount and the lesser of these values apply to the determination of Net Aggregate Savings (as defined below). The Upside Cap, when expressed as a PMPM, may change if there are Attributed Member shifts across Anthem designated regions and products during the Measurement Period. This can occur because the Member Months per region and by product will be weighted and applied to the MCB.

"Maximum Shared Savings Cap" means the estimated maximum dollar amount the Medical Panel could earn for a given Measurement Period. The Maximum Shared Savings Cap assumes the Upside Shared Savings Potential is achieved. The Maximum Shared Savings Cap is a dollar amount that is calculated by subtracting the MRC PMPM from the Gross Paid Upside Cap PMPM, multiplying the result by the Member Risk Months, and then multiplying by the Upside Shared Savings Potential. The Maximum Shared Savings Cap is illustrated on the MCB report provided at the start of the Measurement Period.

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

"Medical Cost Baseline (MCB)" means the untrended cost experience, as determined by Anthem, for the Member Population for each Measurement Period which establishes the baseline benchmark for shared savings calculations under the Program for that Measurement Period. A new MCB is established for each separate Measurement Period. The formula for setting the MCB takes into account risk adjusted per member/per month (PMPM) Claims experience within the Member Population during the Baseline Period, but excludes certain transplant Claims and accounts for the High Cost Adjustment (as described further below within this Section 8: Incentive Payment). It also may account for any Clinical Coordination Per Member Per Month payments made during the relevant Baseline Period to Provider by Anthem for Attributed Members. The MCB calculation also includes consideration of Anthem product type (e.g. HMO, PPO, etc.). If Provider participates in the Program under a number of different Anthem products, there may be multiple MCBs.

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

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

"Medical Cost Target (MCT)" means the trended cost experience, as determined by Anthem, for the Member Population for each Measurement Period which establishes the benchmark for shared savings calculations under the Program for that Measurement Period. The MCT is established for each separate Measurement Period and provided at the time of reconciliation after the end of the Measurement Period. The MCT is the MCB with a market trend factor determined by Anthem included to account for costs from the Baseline Period to the end of the Measurement Period. The MCT is expressed in terms of a risk-adjusted per member per month ("PMPM") but excludes certain transplant and high cost Claims amounts. The MCT calculation may account for any Clinical Coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period.

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

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

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

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

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

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

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

"Normalized Risk Score" means Provider's average risk score relative to the market average risk score. The Normalized Risk Score is calculated as follows:

Normalized Risk Score = Provider average risk score/ market average risk score

The market is defined by Anthem and may be inclusive of a region or state. The market average will be calculated using risk scores derived from the Claims incurred during the Measurement Period, limited to Covered Individuals with assigned attribution or office based evaluation and management visit Claims in the market with at least three (3) months of eligibility. If exclusions apply to the average Provider risk score (for example removal of transplant cases as outlined in the MCB, MCT and MCP definitions), these exclusions may also apply to the market average risk score calculation as determined by Anthem. The market average risk score is calculated as follows:

market average risk score = sum of Covered Individuals risk scores for a defined market / Number of Covered Individuals in a defined market

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

Provider average risk score = Sum of Provider's Attributed Members risk scores/Number of Provider's Attributed Members.

Risk scores are based on a diagnosis based cost model, which uses diagnosis and demographic information from medical Claims as well as an adjustment allowing for consistency between pediatric and adult populations. The approach to determining risk scores may be adjusted by Anthem from time to time. If such adjustments are material in nature, Anthem will provide notice to Provider. Anthem



shall have the option to exclude BlueCard data from the determination of the market average risk score calculation if Anthem determines that such exclusion would result in more accurate or sound calculation results. Anthem will monitor Attributed Members' risk scores to determine if there are any industry coding changes that inappropriately or disproportionately affect the overall Normalized Risk Score. Anthem has the option to neutralize payment results that are driven by such coding changes and not by changes in Attributed Members' health risk and will notify Provider if such action is taken.

"Paid/Allowed Ratio" means the ratio of paid dollars (dollars paid by Anthem to Providers) to allowed dollars (total dollars paid by Anthem plus Cost Shares payable by Covered Individuals) for Covered Services incurred during a Measurement Period, excluding certain transplant and high cost Claims amounts.

"Quality Gate" means a minimum threshold of performance on the on the Performance Scorecard in order for you to share a portion of the Savings Pool. The Quality Gate is a threshold defined by Anthem, and is defined in the MCT Measurement Period Handbook.

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

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

### ***Incentive Program Terms And Details - Medical Cost Target Model***

#### ***Upside Shared Savings Potential***

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

#### ***Shared Savings Determination***

- (a) Within one-hundred and eighty (180) days from the end of the relevant Measurement Period which includes a three-month Claims run-out period, Anthem will calculate the MCP, compare it with the MCT and make other calculations (e.g. adjust differential based on the Paid/Allowed Ratio, etc.) to determine the amount of any Gross Paid PMPM Savings generated during the Measurement Period.
- (b) Anthem compares the Gross Paid PMPM Savings to the Upside Cap value expressed as a PMPM. The lesser of these values is used for the remaining calculation steps. .
- (c) Anthem will then calculate the "Savings Pool" by comparing the Gross Paid PMPM Savings to the Minimum Risk Corridor (MRC) (expressed in terms of a PMPM, and adjusted based on the Paid/Allowed

Ratio). The Savings Pool is the amount by which the Gross Paid PMPM Savings exceeds the MRC. In the event that the Gross Paid PMPM Savings is less than the MRC (expressed in terms of a PMPM), the Savings Pool is not funded. If, on the other hand, this amount exceeds the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. If the Medical Panel participates in the Program under a number of different Anthem products, there may be multiple MCTs, and the aggregate Savings Pool for a given Line of Business could be the weighted average of each of its product-specific Savings Pools.

- (d) Following application of the MRC calculation described above, the Medical Panel's aggregate Savings Pool, expressed at a risk-adjusted PMPM, will be multiplied by the Member Risk Months for each Provider within the Medical Panel and allocated accordingly. The weighting, which is based on Measurement Period Member Risk Months, is capped at two times the product-specific Baseline Member Risk Months to limit the impact of large scale membership changes.
- (e) Providers in the Medical Panel are evaluated on quality and utilization measures relative to targets to determine the overall Upside Shared Savings Percentage. While many Providers in the Program will be evaluated on their own quality performance relative to targets, some Providers with small membership counts (subject to measure requirements) will be evaluated based on their Medical Panel's collective performance. Scoring for utilization measures is based on the Medical Panel performance, irrespective of the size of the Provider's membership count. In the event that a Provider fails to meet the "Quality Gate" requirements of the Incentive Program, it will not be eligible to receive any amount of shared savings payout, regardless of whether other performance targets under the Incentive Program are met.

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

<b>I. Shared Savings Framework</b>	
Provider Group Count	3
Minimum Risk Corridor (MRC)	1.5%
Gross Paid Upside Cap	5.5%
Upside Shared Savings Potential: Quality	18%
Upside Shared Savings Potential: Utilization	12%

<b>II. Panel Savings Pool Calculation (Commercial Example)</b>	
Medical Cost Baseline (MCB)	\$400.00
Trend	5%
Medical Cost Target (MCT)	\$420.00
Paid/Allowed Ratio	95%
Medical Cost Performance (MCP)	\$408.00
Gross Paid PMPM Savings: (MCT-MCP) x Paid/Allowed	\$11.40
Minimum Risk Corridor PMPM: (MRC x MCB) x Paid/Allowed	\$5.70
<b>Savings Pool PMPM</b>	<b>\$ 5.70</b>

1. In the above example, three Provider groups are combined into a virtual Medical Panel for purpose of calculating a statistically meaningful Medical Cost Target ("MCT"). Had any group been large enough, it could have formed into its own Medical Panel, with its own MCT and related Savings Pool PMPM.
2. The Medical Panel's MCT (based on historical risk-adjusted PMPM, trended based on market medical costs) is set at \$420 PMPM. The MCB of \$400 was increased by the 5% trend to determine the MCT of \$420 PMPM.

3. The Medical Panel's Gross Paid PMPM Savings – \$11.40 – is the result of the MCT minus the MCP, adjusted by the Paid/Allowed Ratio:  $[(\$420 - \$408)] \times .95$ . The MCP is \$408 because the Medical Panel was able to reduce PMPM costs by 3%, relative to anticipated costs.
4. The Medical Panel's Gross Paid PMPM Savings - \$11.40 – is compared to the Upside Cap value expressed as a PMPM. The Upside Cap value expressed as a PMPM is calculated by multiplying the Upside Cap of 5.5% by the MCB, and adjusting by the Paid/Allowed Ratio:  $[.055 \times \$400 \times .95]$ . The Gross Paid Savings of \$11.40 is not limited by the Upside Cap value expressed as a PMPM of \$20.90.
5. To limit the impact of random variation, Minimum Risk Corridor ("MRC") is set at 1.5%, which means that the first \$5.70 of PMPM savings is excluded from the Savings Pool, i.e. MCB (\$400) x MRC (1.5%) x Paid/Allowed Ratio (.95).
6. The Savings Pool PMPM – in this example \$5.70 PMPM – is the result of the Gross Paid PMPM Savings (\$11.40) minus the MRC PMPM (\$5.70).

III. Provider Group Payout Calculation				
	Provider Group A	Provider Group B	Provider Group C	Panel Total
Avg PCP PMPM	\$ 14.40	\$ 21.60	\$ 18.00	\$ 18.54
Members	2,500	4,000	3,500	10,000
Members Months	30,000	48,000	42,000	120,000
Provider's Group Normalized Risk Score	0.80	1.20	1.00	1.03
Member Risk Months	24,000	57,600	42,000	123,600
<b>Savings Pool Allocation</b>	<b>\$ 136,800</b>	<b>\$ 328,320</b>	<b>\$ 239,400</b>	<b>\$ 704,520</b>
Upside Shared Saving (Actual) Percentage				
Quality Percentage	10%	5%	18%	10%
Utilization Percentage		<-----12%----->		
<b>Shared Savings Percentage: Total</b>	<b>22%</b>	<b>17%</b>	<b>30%</b>	<b>22%</b>
Net Aggregate Savings	\$ 30,096	\$ 55,814	\$ 71,820	\$ 154,994
PCP Baseline Revenue	\$ 432,000	\$ 1,036,800	\$ 756,000	\$ 2,224,800
PCP Shared Savings Revenue Increase	7.0%	5.4%	9.5%	7.0%

7. Provider groups are allocated savings from their Medical Panel's Savings Pool based on Member Risk Months. In the above example, Provider Group A is allocated \$136,800, which is the product of its 24,000 Member Risk Months multiplied by the \$5.70 Savings Pool PMPM.
8. While in the above example, each group has the potential to earn 30% of their allocated savings, their actual Shared Savings Percentage is a function of their performance on both quality and utilization measures. In the above example, Provider Group A earns over half of the potential 18% weight relating to quality (i.e. 10%). Since all three groups lack sufficient membership size to calculate statistically meaningful utilization metrics, the utilization metrics are calculated at the panel level; and in the above example, the panel earns the full 12% weight. As a result, Provider Group A earns \$30,096, i.e. 22% (10%+12%) of their \$136,800 in allocated savings.
9. To estimate the impact of the Provider group's savings payout relative to their annual revenue, each group's shared savings payout is divided by its annual paid dollars received from Anthem. For Provider Group A, \$30,096 is divided by \$432,000, which is their total PCP PMPM (\$14.40) multiplied by Member Months (30,000).

### ***Maximum Upside Potential***

Providers will have information at the start of their Measurement Period indicating the Maximum Shared Savings Cap. This is the maximum limit on opportunity for savings in the Program, expressed as a full dollar amount. The Maximum Shared Savings Cap is illustrated on the MCB report and is subject to change during the Measurement Period given potential member month changes.

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

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

Tools and Information: Medical Cost Baseline ("MCB"), Medical Cost Target ("MCT") and Medical Cost Performance ("MCP") amounts are calculated based on certain tools and information provided to and available to Anthem at specific points in time (e.g., cost experience, risk derived from risk adjustment tools applied to member data, etc.). In the event that any such tools or information are updated, modified or clarified (collectively, the "Modifications") in a way that Anthem reasonably deems to materially change the calculation of the MCB, MCT and/or MCP, then the Parties agree that Anthem shall have the right to adjust the MCB, MCT and/or MCP, as applicable, to the extent necessary to account for the Modifications.

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

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

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

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

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

### **High Cost Adjustment.**

*For 1/1/19 Measurement Period and prior:* We exclude Attributed Members with certain high cost Claims amounts during either the Baseline Period used to determine the Medical Cost Baseline, Medical Cost Targets or the Measurement Period for Medical Cost Performance calculations for Enhanced Personal Health Care Providers. The Attributed Members and all Claims associated with them who are excluded meet the following criteria: Allowed Claims that have exceeded the \$250K amount for an Attributed Member over the associated period.\*unless otherwise stated in the Attachment

*For the 4/1/19 Measurement Period and forward:* All Claim cost data for members with allowed Claims cost greater than the High Cost Adjustment value (located in the "Introduction" section of the Provider's Measurement Period Handbook) during a Measurement Period will be limited to the High Cost Adjustment value for the Measurement Period calculation components (e.g. risk scores, MCP, Paid/Allowed Ratio). Similarly, the High Cost Adjustment value will also apply during a Baseline Period for the Baseline Period calculation components (e.g. risk scores, MCB, Paid/Allowed Ratio). When creating the MCB, MCT and MCP reports, the High Cost Adjustment will use the Claim cost experience of Attributed Members when assessing Provider-specific baseline and performance, and will use the Claim cost experience of Covered Individuals with assigned attribution or office based evaluation and management visit Claims in the market with at least three (3) months of eligibility when assessing the market retrospective trend. The High Cost Adjustment may be adjusted by Anthem via notice to Provider prior to the start of a Measurement Period. The high cost threshold amount is established through assessment of total allowed costs at the market level with the top 10% of costs being targeted for exclusion. Rounding is applied to attempt to conservatively assess the dollar threshold most congruous with the intent of the high cost threshold Program feature.

### **Transplant Exclusion.**

All data for Attributed Members with certain transplant Claims (as defined by the table below) during a Measurement Period will be excluded from Measurement Period calculation components (e.g. risk scores, MCP, Paid/Allowed Ratio). When creating the MCB, MCT and MCP reports, the transplant exclusion will use the Claim cost experience of Attributed Members when assessing the Provider-specific baseline and performance, and will use the Claim cost experience of Covered Individuals with assigned attribution or office based evaluation and management visit Claims in the market with at least three (3) months of eligibility when assessing the market retrospective trend.

All data for Attributed Members with certain transplant Claims (as defined by the diagnosis related group (DRG) codes table below) during a Baseline Period will be excluded from Baseline Period calculation components (e.g. risk scores, MCB).

Diagnosis-Related Group	DRG Code
Heart transplant or implant of heart assist system w MCC	001
Heart transplant or implant of heart assist system w/o MCC	002
Liver transplant w MCC or intestinal transplant	005
Liver transplant w/o MCC	006
Lung transplant	007

Diagnosis-Related Group	DRG Code
Simultaneous pancreas/kidney transplant	008
Pancreas transplant	010
Allogeneic Bone Marrow Transplant	014
Autologous Bone Marrow Transplant W CC/MCC	016
Autologous Bone Marrow Transplant W/O CC/MCC	017
Kidney transplant	652

### ***Upside Shared Savings Payment***

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

A Provider must be participating in the Program during the entire Measurement Period in order to receive savings amounts under the Incentive Program.

Except as specifically agreed otherwise by the Parties, payments for earned Net Aggregate Savings will follow the current payment methods the Provider has in place with Anthem under the Agreement. For example, if Claim payments are currently remitted at the physician group level, Anthem will pay the Provider for such savings amounts.

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

### ***Medical Panels - Commercial Business Medical Cost Target Model***

The Program introduces the concept of the Medical Panel to encourage broad-based provider organization participation across markets while ensuring that patient access needs are met and physician performance assessment is statistically valid. The Medical Panel structure will support collaborative learning and community accountability for quality and affordability. As mentioned earlier in this section, Medical Panels will also serve as the basis for establishing Savings Pools, which contribute to the amount a provider organization receives under the Incentive Program.

#### ***Formation of Medical Panels***

Medical Panels can be composed of an individual physician practice or a group of practices. Anthem will provide a list of all physician practices participating in the Program within each state and assigned Medical Panel.

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

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

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

### ***General Parameters for Medical Panels***

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

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

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

### **Incentive Program - Commercial Business – Medical Loss Ratio Incentive Plan Model**

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

As described in greater detail below, and subject to the Incentive Program terms and details for the Medical Loss Ratio model, Anthem will compare the annual Measurement Period Medical Loss Ratio (“MPMLR”) (as defined below) to a Medical Loss Ratio Target (“MLRT”) (as defined below) in each Measurement Period to

determine whether the MPMLR is less than the MLRT (subject to Program details described below). If the MPMLR is less than the MLRT, you may be able to share in a percentage of the savings realized, provided that you meet the Quality Gate (as described in Section 5, *Quality Measures & Performance Assessment*).

The Medical Loss Ratio Program terms and details are described below.

### ***Definitions***

All capitalized terms will have the meanings given to such terms as shown below or in the underlying Agreement to which the Attachment is attached or, if not defined, will be interpreted using the commonly accepted definition of such terms.

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

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

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

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

“Measurement Period(s)” means each twelve (12) month calendar year period(s) during which MPMLR will be measured for purposes of calculating shared savings between Anthem and the Provider. The Measurement Period(s) for Provider’s participation in the Program is set forth in Medical Loss Ratio Measurement Period Handbook.

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

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

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



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

"Medical Loss Ratio Target ("MLRT")" means the Medical Loss Ratio Target percentages of Premium determined by Anthem. The MLRT will be identified in the Medical Loss Ratio Measurement Period Handbook.

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

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

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

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

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

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

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

- Applicable amounts calculated under the Risk Adjustment Program (as defined below)\*
- Applicable amounts calculated under the MLR Rebate Program\*

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

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

“Quality Targets” means quality performance targets used to determine the percentage of shared savings under the Incentive Program.

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

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

- Certain transplants and high cost Claims amounts as determined by Anthem, if applicable.
- Any applicable Per Member Per Month Clinical Coordination payments made by Anthem throughout the Measurement Period, if applicable

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

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

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

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

### ***Medical Loss Ratio Program Terms and Details***

#### ***Shared Savings Potential***

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

### ***Shared Savings Determination***

Shared savings will be calculated by Anthem as follows:

- a) During the Annual Determination Period, Anthem will determine the Medical Panel's Member Populations' Premium and Total Medical Expense and calculate the MPMLR.
- b) Anthem will compare Medical Panel's MPMLR to its MLRT. If the Medical Panel's MPMLR is below the MLRT, then the Gross Savings Percentage will be calculated.
- c) Gross Savings (expressed as a PMPM amount) is calculated for the Medical Panel and then reduced by the Minimum Risk Corridor, resulting in the Total Net Savings (expressed as a PMPM amount).
- d) If Provider meets the Quality Gate, then the Upside Shared Savings Percentage is determined based on Provider's performance on the Quality Targets, as determined annually by Anthem.
- e) For each Provider, the Upside Shared Savings Percentage can be applied to the Total Net Savings to determine the net savings by Provider group (expressed as a PMPM amount). To determine the payout per Provider group, the net savings by Provider group is multiplied by each provider's group Member Months, and these products are totaled to determine the Net Aggregate Savings payable by Anthem to the entire Medical Panel.
- f) In no event can the net savings by Provider group (expressed as PMPM amount) exceed the amount determined by the application of the Upside Cap.

*For a basic Medical Loss Ratio Incentive Program calculation example, see the calculation set forth below.* In this example, three provider organizations are combined into a Medical Panel for the purpose of calculating a statistically meaningful MPMLR:

Multi-Provider Medical Panel Shared Savings Payout Example			
	Provider Group A	Provider Group B	Provider Group C
Member Months	42,000	34,800	27,600
Premium (expressed as a PMPM amount)	\$500		
MLRT*	80%		
MPMLR*	76%		
Total Medical Expense	\$39,672,000.00		
Premium	\$52,200,000.00		
Premium (by group)	\$21,000,000	\$17,400,000	\$13,800,000
Gross Savings Percentage = MLRT – MPMLR	4%		
Gross Savings (expressed as a PMPM amount)	\$20.00		
Minimum Risk Corridor %	1.5%		
Minimum Risk Corridor (expressed as a PMPM amount)	\$6.00		
Total Net Savings (expressed as a PMPM amount)	\$14.00		
Upside Cap %	5%		
Upside Cap (expressed as a PMPM amount)	\$20.00		
Total Net Savings (by Provider Group)	\$588,000	\$487,200	\$386,400
Shared Savings Potential	35%		
Shared Savings Percentage (actual)	25%	30%	35%
Net Savings by Provider Group (expressed as a PMPM amount)	\$3.50	\$4.20	\$4.90
Payout per Provider Group	\$147,000	\$146,160	\$135,240
<b>Net Aggregate Savings payable to Medical Panel = \$428,400</b>			
<i>*Medical Panel Level</i>			

In this example, the Medical Panel's MLRT is set to 80% for the initial Measurement Period.

1. The Medical Panel's MPMLR is compared to the Medical Panel's MLRT. In the event that the MPMLR is less than the MLRT, the Providers' Gross Savings Percentage is then determined. In the example above the Gross Savings Percentage is 4%.

2. For illustrative purposes, this example assumes the Premium (expressed as a PMPM amount) for the Medical Panel is \$500. The Premium (by Provider group) is the Premium PMPM amount multiplied by each providers' Member Months. So, for Provider Group A, the Total Premium (by Provider group) is \$500 multiplied by 42,000 Member Months equating to a Premium of \$21,000,000.
3. To determine Gross Savings (expressed as a PMPM amount), the Gross Savings Percentage, in this example 4%, is multiplied by the Premium, for our example \$52,200,000, and divided by the Member Months for the entire Medical Panel. The result is a Gross Savings (expressed as a PMPM amount) of \$20.00.
4. The Minimum Risk Corridor is then applied as follows: multiply the MLRT, 80% in the above example, by the Premium (expressed as a PMPM amount) of \$500, and that result is multiplied by the Minimum Risk Corridor of 1.5%. The result is a \$6.00 Minimum Risk Corridor (expressed as a PMPM amount). This \$6.00 is then subtracted from the \$20.00 Gross Savings (expressed as a PMPM amount), resulting in a \$14.00 Total Net Savings (expressed as a PMPM amount).
5. In the above example, for Provider Group A, the Total Net Savings dollar amount is calculated by multiplying the Total Net Savings (expressed as a PMPM amount) of \$14.00 by the Member Months for all their Attributed Members, i.e. 42,000, equating to \$588,000.00.
6. In the above example, each Provider group has the potential to earn 35% of the shared savings that are demonstrated in the Measurement Period, after meeting the Quality Gate. The actual Upside Shared Savings Percentage is a function of the group's performance on the Quality Targets. In the above example, Provider Group A earns 25% of the Total Net Savings (expressed as a PMPM amount) as a result of their performance on the Quality Targets. Provider Group A's net savings by Provider group (expressed as a PMPM amount) is the \$14.00 Total Net Savings (expressed as a PMPM amount) multiplied by their 25% actual Upside Shared Savings Percentage, resulting in \$3.50.
7. The application of the Upside Cap is performed by comparing the Upside Cap to each Provider's Net Savings by Group (expressed as a PMPM amount). The Upside Cap is determined by multiplying the MLRT by the Premium (expressed as a PMPM amount) and multiplying this product by the Upside Cap %. In the example, for Provider Group A the Upside Cap is \$20.00 which is well above the net savings by Provider group (expressed as a PMPM amount) of \$3.50, so the Upside Cap does not limit the Payout.
8. The final step is to determine the Payout for each Provider group by multiplying the net savings by provider group (expressed as PMPM) by each Provider group's Member Months. The example above shows a final Payout of \$147,000 for Provider A. The Net Aggregate Savings for the Medical Panel is the sum of all the Provider groups' payouts, or \$428,400.

### ***Adjustments to MLRT and MPMLR***

Tools and Information: Medical Loss Ratio Target (MLRT) and Measurement Period Medical Loss Ratio (MPMLR) amounts are calculated based on certain tools and information provided to and available to Anthem at specific points in time (e.g., cost experience of Member Population, Premium data, governmental program information related to ACA, etc.). In the event that any such tools or information are updated, modified or clarified (collectively, the "Modifications") in a way that Anthem reasonably deems to materially change the calculation of the MLRT or MPMLR, then the Parties agree that Anthem shall have the right to adjust the MLRT or MPMLR, as applicable, to the extent necessary to account for the Modifications without the need for an amendment to the Agreement. In such an event, Anthem will notify you as to the adjusted MLRT and/or MPMLR and the reason for the adjustment. As an example, if new information is discovered (not previously available to Anthem) concerning the Claims that were used to derive the MLRT, and such new information has a material impact on the MLRT, then an appropriate adjustment may be made to the original MLRT by Anthem.

After the initial year in the Program, the Medical Panel's MLRT will be evaluated and may be adjusted before the start of each subsequent Measurement Period. The final MLRT for each Measurement Period will be defined in the Medical Loss Ratio Measurement Period Handbook.

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

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

### ***Upside Shared Savings Payment***

Assuming all preconditions and terms have been satisfied, on an annual basis, after the end of the relevant Measurement Period, Anthem shall make any applicable distribution payment to you for any Net Aggregate Savings earned during the Measurement Period associated with its Attributed Members. The Provider must be participating in the Program during the entire Measurement Period in order to receive savings amounts under the Incentive Program.

Except as specifically agreed otherwise by the Parties, payments for earned Net Aggregate Savings will follow the current payment methods you have in place with Anthem under the Agreement. For example, if Claim payments are currently remitted at the physician group level, Anthem will pay the Provider for such savings amounts.

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

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

The Program introduces the concept of the Medical Panel to encourage broad-based provider organization participation across markets while ensuring that patient access needs are met and physician performance assessment is statistically valid. The Medical Panel structure will support collaborative learning and community accountability for quality and affordability. As mentioned earlier in this section, Medical Panels will also serve as the basis for establishing Savings Pools, which contribute to the amount a provider organization receives under the Incentive Program.

### ***Formation of Medical Panels***

Medical Panels can be composed of individual physician practice or a group of practices. Anthem will provide a list of all physician practices participating in the Program within each state and assigned Medical Panel.

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

### ***General Parameters for Medical Panels***

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


- A single physician group with more than 7,500 commercial Attributed Members will form its own Medical Panel.
- Physician groups with Attributed Member populations less than 7,500, but more than the minimum level set by Anthem, may form Medical Panels with other participating physician groups. Prior to the start of the Measurement Period, assigned Medical Panels will be communicated. Each Medical Panel that is comprised of multiple practices must exceed the 7,500 minimum number of Attributed Members.

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

## **Section 9: Reporting**

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As part of our commitment to sharing actionable data with Enhanced Personal Health Care Providers, reports offering detailed information about your Attributed Member population are available within Anthem's web-based reporting application. Through alerts, dashboards, and reports, the web-based reporting application supports both population management as well as Program-specific financial performance management.

The reports available in the web-based reporting application will help you achieve your goals and stratify your membership based on risk and prevalence of chronic conditions. They offer actionable clinical insights, such as care gap messaging and preemptive flagging of Attributed Members with high risk for readmission and potentially avoidable ER visits. Tools and resources are available to help you utilize and navigate the reports and can easily be accessed from the Quick Links icon () in the top right-hand corner within the application.

Examples of some of the reports within the application:

- **Attributed Members** – Displays detailed information about the members who are attributed with various care opportunity indicators and attribution details.
- **ER Visits** - Lists members with emergency room (ER) visits, categorizing “frequent fliers” and offering information around unnecessary ER visits that potentially can be avoided.
- **Care Opportunity** - Identifies Attributed Members with care opportunities (i.e., situations in which there are active or potential gaps in care associated with recommended evidence-based care and our clinical quality metrics).

- **Cost Opportunity** - Provides insight into selected drivers of medical cost trends through estimated cost savings for various metrics.
- **Performance Scorecard** - Provides key metrics reflecting your group's savings performance, scorecard performance, and the resulting estimated shared savings payout. Offers the ability to drill down to measure-level performance details, with the capability to differentiate Provider performance and also identify specific Attributed Members who may be in need of an intervention.
- **Medical Cost** -
  - The Medical Cost Baseline report provides the detailed calculations behind the Program's product-specific Medical Cost Baseline.
  - The Medical Cost Performance report allows you to compare medical costs incurred during the Measurement Period (known as "Medical Cost Performance") to the Medical Cost Baseline, with detailed calculations estimating possible shared savings payouts.

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

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