Patient-Centered Primary Care
Program Description

Also referred to as “Enhanced Personal Health Care”

July 1, 2015
Introduction

For primary care physicians and other providers, our system has created an untenable situation; not enough time to provide the care they want to deliver, and not enough time to get off the treadmill created by fee-for-service payment arrangements. An overwhelming amount of research tells us that despite being the most costly in the world, the U.S. health care system is lagging behind many other countries and failing to deliver consistent value to the people who use it every day. More Americans have health care coverage now, than ever before. This dynamic makes the need for adopting a value-based system and coordinated delivery system more urgent.

At UniCare, we believe that our health connects us all; so, we focus on being a valued health partner and delivering quality products and services that give members access to the care they need. With nearly 67 million people served by our affiliated companies, including 37 million enrolled in our family of health plans, we can make a real difference to meet the needs of our diverse population of customers.

UniCare is committed to connecting our members to patient-centered care. What makes us unique is our approach to supporting delivery-system transformation. UniCare will offer support through value-based payment and assistance by helping practices transform to patient-centered care.

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

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

UniCare has been a leader in support of the patient-centered primary care model through participation of its affiliated health plans in patient-centered medical home (PCMH) programs across the country, covering nearly 1,200 primary care providers and touching more than 130,000 members. The results have been persuasive enough to cement our commitment to patient-centered care. In studies to date, we have observed improvement in compliance with evidence based guidelines and a reduction in avoidable, unnecessary admissions and ER visits, along with measured maintenance or improvements in the quality of health care services.

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Claims are administered by UniCare Life & Health Insurance Company.
Our Patient-Centered Primary Care Program (the “Program”) builds upon the success of our PCMH programs and fosters a collaborative relationship between UniCare (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 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.

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

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

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<thead>
<tr>
<th>Market</th>
<th>Mailbox</th>
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<tbody>
<tr>
<td>Massachusetts</td>
<td><a href="mailto:UniCarePrimaryCareProgram@anthem.com">UniCarePrimaryCareProgram@anthem.com</a></td>
</tr>
</tbody>
</table>

**Program Communications**

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

Section 1: Program Overview ........................................................................................................5  
Section 2: Roles ...............................................................................................................................6  
Section 3: Care Coordination and Care Plans ..............................................................................8  
Section 4: Program Requirements & Transformation .................................................................15  
Section 5: Quality Measures & Performance Assessments ...........................................................22  
Section 6: Attribution Process .......................................................................................................26  
Section 7: Clinical Coordination Reimbursement ......................................................................28  
Section 8: Incentive Program .........................................................................................................29  
Section 9: Reporting ......................................................................................................................38  
Section 10: Appendix ....................................................................................................................40  
Section 11: Glossary .......................................................................................................................43
Section 1: Program Overview

OBJECTIVES
The objectives of the Program are to:

- Support the transition from a fragmented and episodic health care delivery system to a patient-centered system, accountable for substantially improving patient health, by making a significant investment in primary care that allows primary care providers to do what they can do best: manage all aspects of their patients’ care.

- Provide primary care providers with tools, resources and meaningful information that promotes (1) access, (2) shared decision making, (3) proactive health management, (4) coordinated care delivery, (5) adherence to evidence based guidelines and (6) care planning built around the needs of the individual patient, leading to improved quality and affordability for our customers and their patients.

- Redesign the current payment model to move from volume based to value based payment, aligning financial incentives and providing financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach and quality improvement.

- Improve the patient experience by:
  - Facilitating better access to a primary care provider who will not only care for the “whole person” but will become each patient’s health care champion and help patients navigate through the complex health care system,
  - Inviting patients’ active participation in their health care through shared decision-making, and
  - Optimizing their health.

SCOPE
The Program applies to Primary Care Providers who are in good standing, and who have signed or are covered under the accompanying Patient-Centered Primary Care Participation Addendum (the “Addendum”).

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

- general practice
- family practice
- internal medicine
- pediatrics
- geriatrics
- nurse practitioner (NP)
- physician assistants (PA)
Section 2: Roles

We plan to make several Program resources available to support and collaborate with you to achieve successful outcomes and reach Program goals. The following information describes roles we currently intend to develop in order to support the Program. The Community Collaboration Manager contact information will be available via UniCare’s provider portal prior to the Participation Addendum Effective Date or as soon thereafter as practicable. Our intent is to make other roles available following the Participation Addendum Effective Date.

Network Director
The Network Director is responsible for the strategy and implementation of the Patient-Centered Primary Care program. The Network Director is the lead point of contact for provider organizations to address contracting and operational elements of the program.

Community Collaboration Manager
The Community Collaboration Manager supports provider organizations by analyzing market-level data to identify practice support tools and resources. The Community Collaboration Manager creates relevant collaborative learning event content that provides an opportunity for practices to learn from their peers and national experts. The Community Collaboration Manager identifies community resources that can help practices manage population health and create relationships with other providers in the community.

Provider Clinical Liaison
The Provider Clinical Liaison (“PCL”) supports provider organizations’ development of care coordination and care management skills, interpretation of reports, and assistance with identification of patients who can benefit from a care plan. This individual also educates providers and staff around the elements of a care plan and helps create care plans. Additionally, the PCL serves as a subject matter expert on programs and helps provider organizations manage patients with more complex needs by leveraging available UniCare programs. The PCL promotes seamless coordination between the practice and UniCare programs.

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

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

- **Provider Champion** – The Provider Champion is a physician, or in some cases an Advanced Practice Registered Nurse, in a leadership position in your provider organization who is the leader of your provider organization’s patient-centered care approach. This individual has the authority to support and influence transformation to patient-centered care, and supports the needed activities, provides resources and communicates to other physicians about the Program.
- **Practice Manager** – The Practice Manager is the individual in your provider organization who manages the day-to-day activities in a primary care office.
- **Care Coordinator** – The Care Coordinator is the individual in your provider organization who facilitates care coordination and care plan creation for patients.
- **Transformation Team Members** – The Transformation Team Members are those individuals in your provider organization who participate in Program activities focused on improving patient care using recognized quality improvement methodology. Ideally, this group of individuals should include a representative from each area within your office (front office, back office, clinical, billing, etc.).
Section 3: Care Coordination and Care Plans

CARE COORDINATION

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

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as the "deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services." 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.4
- Identification and referral of patients to internal UniCare programs and community resources.

You must ensure that there are personnel supporting care coordination and care management in your provider organization. You are expected to develop and implement processes to ensure that Covered Individuals’ health care needs are coordinated by using a primary contact to effectively organize all aspects of care. Your designated primary contact collaborates 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 UniCare’s 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 UniCare to you.

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

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

**CARE PLANS**

Appendix A of the Patient-Centered Primary Care Participation Addendum identifies care planning expectations for participating physicians under the Program. The information below provides you with the details you need to fully understand and meet these expectations.

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

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

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

**Care Plan Format and Content**

There is not a required template that must be used for the Program when creating a care plan. There are, however, critical assessments and domains that must exist within a care plan, but the care plan format varies based on your charting process and electronic capabilities. Whatever care plan format is used, it should fit into your current workflow, and not require duplicative documentation. Care planning should enhance the Covered Individual’s treatment plan, and should provide a broader level of assessment than a standard patient history and physical to efficiently manage care. A sample care plan template and additional care plan information is available via the Provider Toolkit.

The minimum requirements for an initial care plan include:

- Activities that are *individualized* to the needs of the Covered Individual.
- Information regarding the family, caregiver and/or patient involvement for specific activities for the purposes of collaboration and coordination of the plan of care.
- Short-term and long-term patient-centric goals with interventions that are realistic for the Covered Individual’s care.
- Patient’s self-management plan (also described on the following page), which includes:
  - a shared agenda for physician office visits, and
  - a list of activities to improve the health of the Covered Individual (developed in collaboration with the Covered Individual).
• Helpful information regarding relevant community programs (if any).
• Applicable resources that should be utilized (e.g. home health care, durable medical equipment, and rehabilitation therapies).
• Timeframes for re-evaluation and follow-up.
• A transition of care approach (for Covered Individuals discharged from a hospital) which includes:
  o Information on medication self-management.
  o A patient-centered record owned and maintained by the Covered Individual.
  o A follow-up schedule with primary or specialty care.
  o 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.
• 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.
• Modifications to initial/previous plan to adjust plan to progress level.
**Care Plan Assessment Domains**

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

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

Our goal is for a Primary Care Physician (PCP) to perform an annual comprehensive assessment on high-risk attributed patients to allow for early detection and ongoing assessment of their chronic conditions. The annual exam is a fundamental part of medical care and is valuable in promoting prevention practices, recognizing risk factors for disease, identifying medical problems, and establishing the clinician-patient relationship. This assessment can help your care team identify care planning and care coordination opportunities to improve the overall quality of patient care.

We provide access to clinical data to highlight opportunities for management of Attributed Members in an effort to improve patient outcomes. The “Hot Spotter Indicator” (as further described in Section 9, Reporting) includes a listing of high risk Attributed Members identified by analytic reporting as those who would benefit from development of a care plan.

Attributed Members who appear on the Hot Spotter Indicator will include those who have had an acute inpatient event and, based on predictive modeling algorithms, have been identified as being at high risk for readmission within the next 90 days as well as Attributed Members who have one of the five core chronic condition diagnoses (as referenced further below).

Although we will provide a list of Attributed Members who through analytic reporting have been identified as being at high risk, you will have additional real-time information from patient assessments that allows you to ascertain other high risk Attributed Members. UniCare will collaborate with your provider organization team to identify Attributed Members who have been determined by your organization as candidates to receive a care plan. The Provider Clinical Liaison (“PCL”) will periodically review provider-organization-identified Attributed Members with your care coordinator and/or care managers- in “Clinical Touch Points”, which are clinical review meetings or discussions that provide a recurring forum for collaboration between the PCL and the care coordinator. This time spent together will help to ensure the desired outcomes to optimize coordination of patient-centered care, promote quality interactions, and produce appropriate cost savings in overall medical and pharmacy utilization.

Attributed Members who may be candidates for care planning may 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 psychosocial concerns (e.g., lack of transportation, live alone, no family support).
- Have multiple chronic conditions or a chronic condition with evidence-based gaps in care (e.g. heart failure and inability to adhere developed treatment plans/medication regime or daily weight monitoring).
- Have a newly diagnosed chronic condition, such as asthma, diabetes, heart failure, COPD, or CAD.
- Have co-morbid medical and behavioral health conditions.
- Are taking multiple medications for health conditions.
Comprehensive Assessment

Accurate, uniform and in-depth assessment of high-risk individuals is instrumental in formulating a comprehensive, individualized care coordination plan. High-risk individuals are those who have at least one of the core chronic conditions, have a high readmission risk, a high prospective risk score and some gaps in care. These are the people who would benefit the most by appropriate intervention and an individualized care plan. Individualized care is the most cost-effective and successful approach to support the needs of the patient. Evidence has shown that it leads to effective and efficient use of health care services and improves the overall quality of patient care.

The care team, along with the Attributed Member’s, family and/or caregiver, should collaborate to develop an individualized care plan and review treatment goals at every visit. Incorporating the use of a comprehensive assessment form during each patient visit helps ensure that all of the Attributed Member’s needs are addressed, and can help you identify and address chronic conditions that may otherwise go undiagnosed or untreated. The form allows for a thorough patient evaluation so that all the pertinent clinical areas are covered. You can find our comprehensive assessment form template by visiting the Provider Toolkit (as described in Section 4, Program Requirements and Transformation).

The advantages of performing a comprehensive patient evaluation include early detection of chronic conditions, gaps in care, and lapses in appropriate preventive services. A comprehensive evaluation will help you formulate the appropriate patient outreach plan. Reminders through mail or a phone call regarding annual screenings are examples of support patients may need from you.

Quality management, with individualized care, enables caregivers to evaluate the progress and determine the need for modification of an Attributed Member’s current care plan, thus increasing the likelihood of the Attributed Member receiving the appropriate care. Early detection of conditions and changes in the Attributed Member’s health status allows for early intervention, and can prevent the need for significant medical interventions such as hospitalization.

To better understand the health risks and other needs of Attributed Member’s and their families, provider organizations should perform comprehensive health assessments at least annually, with regular updates thereafter. A written summary of the plan of care should be provided to the patient, family and caregiver at the end of the face-to-face visit.

Comprehensive assessment documentation may include the following:

- Age and gender-appropriate immunizations and screenings
- Familial, social and cultural characteristics
- Communication needs
- Medical history of Attributed Member and family
- Advanced care planning (not applicable for pediatrics)
- Behaviors affecting health
- Patient and family mental health and/or substance abuse
- Developmental screening using a standardized tool (not applicable for provider organizations with no pediatric patients)
- Depression screening for adults and adolescents using PHQ2, PHQ9 or other nationally recognized tool
**Self-Management Support**

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

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

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

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

6 [http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf](http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf)
Section 4: Program Requirements and Transformation

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

PATIENT ENGAGEMENT

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

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

PRACTICE TRANSFORMATION

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

MEMBER MEDICAL HISTORY PLUS (”MMH+”)

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

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

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

You can export the reports to Excel and place them in the Covered Individual’s chart.

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

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

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

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

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

For a demonstration or further information on MMH+, please contact your local provider contract representative.
AVAILITY – Getting Started with Population Management

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

How do I get started?
If your organization is NOT currently registered for the Availity web portal:

1. The designated administrator for your organization should go to www.availity.com.
2. Click “Get Started” under “Register Now for the Availity Web Portal”
3. Complete the online registration wizard.
4. Your designated Primary Access Administrator (“PAA”) will receive an email from Availity with a temporary password and information on next steps.
   Note: In order to expedite the registration process, please have your Primary Controlling Authority (“PCA”), a person who is authorized to sign on behalf of your organization, complete this registration wizard step.

Registering for Patient-Centered Care Programs
Registering your organization for access to the Enhanced Personal Health Care reports is fast and easy and will need to be completed by the Primary Access Administrator for your organization.

1. Go to www.Availity.com and log in
2. Select “Account Administration” in the Availity menu
3. Select “Maintain Organization” – Please note: If the PAA is tied to multiple organizations, select the organization to proceed
4. Select “Provider Online Reporting Enrollment Administration” link
5. Verify your Organization and Payer information
6. Click “Submit”
7. You will be redirected to the Provider Online Reporting site and will see “Welcome to Provider Online Reporting.”
8. Select “Register/Maintain Organization”
9. Select the blue link to “Register Tax ID(s)” for the Program.
10. A pop-up window will display the Tax ID(s) that will need to be registered for the Program.
11. To register the Tax ID(s) the PAA must check the box and click “Save”.
12. You now have successfully completed the Tax ID Registration. You will notice that after the registration has been completed, the status has changed from Register Tax ID(s) to Edit Tax Id(s) option.
13. Click “Logout” to complete the registration process on Availity, which is still running as an active session in the background.
14. Select the link “Verify Enrollment in Provider Online Reporting”
15. You will then receive a pop-up message stating the organization is currently registered.
16. Close Window

Availity User Set Up - To register users to access the Patient-Centered Primary Care Reports, complete these steps:
Adding a New User in Availity:

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

Editing Roles in Availity:

1. Select “Account Administration | Maintain User” from the Availity menu
2. Locate the user’s account. Click on the name of user.
3. In the “Roles” column, click on “View/Edit”. A list of available roles displays.
4. Select the check box for “Provider Online Reporting” and click save.

PLEASE NOTE:

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

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

Register and set up new user in Provider Online Reporting:

1. The PAA will log into Availity, click “My Payer Portal” then “Provider Online Reporting,”
2. Verify Organization and Payer and click “Submit”.
3. Select Maintain User
   a. Select the link for “New users available to be registered”
4. The PAA will select the group, the role that is appropriate for user needing access (i.e. to clinical reports, financial reports, or both clinical and financial), and Tax ID(s).
   a. Note: PAAs must ensure that users are only provisioned access that is required to fulfill their specific business need.

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

Appendix A of the Patient-Centered Primary Care Participation Addendum identifies expectations around your use of a patient registry. The information below provides you with the details you need to successfully utilize registry functionality in your practice to support the proactive management of your patient population and optimize the health of each patient.

Identifying the patient population is the backbone of, and essential to, an effective population-based care delivery system. Without identification of the patients included in the population, changes cannot be effectively achieved. It is for this reason that physicians participating in the Program are expected to utilize registry functionality to systematically maintain patient demographic and clinically relevant information based on evidence-based guidelines. To identify patients within the population of focus (as discussed earlier), you need to be able to access data that pertains to this group of patients. Program reports, as referenced in Section 9, and data accessed in our Provider Care Management Solution (“PCMS”) web tool can be used to identify and manage populations of patients. Active and systematic use of report data can be used to meet this Program requirement.

The tools used to collect and access information about a specific group of patients are often referred to as a registry. Since Program data can be analyzed, sorted and exported through our web-based reporting system, we are pleased to be able to provide you with a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, as well as generate reminders and guidance of the care of patients (both in groups and individually). In addition to Program reports, sample registries will also be available or discussed via the Provider Toolkit. Specific Program resources that can help to inform your implementation of a chronic disease registry include our Practice Essential curriculum. You can also contact your local Patient-Centered Primary Care Team member as directed in your Welcome Packet.

COLLABORATIVE LEARNING EVENTS

Physicians and their care teams participating in the Program should make best efforts to participate in our collaborative learning series such as participation in a live webinar event or listening to educational recordings from our library or taking advantage of a live or virtual training session to tackle the “Triple Aim”. Attendance will be tracked and assessed to determine Program compliance. As a leader in learning, UniCare has developed a transformation education series to help support your organization’s success in improving quality of care, reducing costs, and managing high-risk patients. Collaborative learning events involve a variety of different virtual learning opportunities including monthly webinars, national and pediatric collaborative, local Virtual Office Hours (provide a touch point for providers and care teams who have questions) and forums for sharing best practices. The following team members are invited to attend these educational sessions: Provider Champion, Practice Manager, Care Coordinator, Care Team, or Transformation Team Members.

The collaborative learning series will include discussion of how to reduce unnecessary hospital readmissions and ER visits and how to increase access to care. In addition to pediatric specific events the learning series targets transformation and care coordination topics that specifically focus on Diabetes, Chronic Obstructive Pulmonary Disease (“COPD”), Asthma, Coronary Artery Disease (“CAD”), Congestive Heart Failure (“CHF”) and behavioral health. Finally, our learning series will target special site-of-service and cost-of-care measures, such as laboratory and MRI referrals.
PROVIDER TOOLKIT

The Provider Toolkit, found on the Patient-Centered Primary Care home page, serves to provide you with research and tools that will support your provider organization in your transformation activities. Information will be available to provide methods for enhancing your provider organization’s performance and quality, organizing your provider organization, establishing care coordination and care management processes, and maximizing health information technology, including registry functionality. It will also give you tools for self-management support and motivational interviewing, and offer enhanced access to care for your patients. Finally, in the Provider Toolkit you will find additional information for complimentary access to the American College of Physicians Practice Advisor (“ACP Practice Advisor SM”), which is particularly intended for organizations that have not already achieved Level II or III NCQA PCMH Recognition. Our Contract Advisor, as well as our other local transformation team members, are available to answer additional questions and provide you with more information about the Provider Toolkit and its contents.
ACP Practice Advisor℠ is an online tool offered at no cost to assist practices interested in improving clinical or office operations or in adopting or expanding use of the patient-centered care model. Your local transformation and market team will help you to get set up with Practice Advisor. Please notify your Contract Advisor or Patient-Centered Care Consultant for any questions related to getting started with Practice Advisor.

Module topics include:

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

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

• Background material – quick general information about a topic
• Case study – shows how the information in a module can be applied
• Practice Biopsy – self-assessment questions related to standards set by National Committee for Quality Assurance (“NCQA”), URAC and Joint Commission
• Comprehensive Master Library of articles, books, videos, webinars, downloadable guides and policy templates
Section 5: Quality Measures and Performance Assessments

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

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

COMMERCIAL LINE OF BUSINESS
QUALITY MEASURES & PERFORMANCE ASSESSMENTS

MEASURES – COMMERCIAL BUSINESS

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

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

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

There are currently over 700 clinical quality measures endorsed by the NQF. The above criteria were considered when reviewing which clinical quality measures to use for the Program. At this point in time, measures that require patient surveys or biometric data are not included. We see this as an important area to pursue as the Program evolves in order to increase the types of care that can be measured and to eventually include measures of even greater clinical importance.
Clinical Quality Measures
The clinical quality measures currently included in the Program scorecard and outlined in the Commercial Business Measurement Period Handbook (referenced below) are grouped into two categories: (1) acute and chronic care management and (2) preventive care. These categories may be further broken out into sub composites. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.

Utilization Measures
The utilization measures in the Program scorecard, and outlined in the Commercial Business Measurement period Handbook (referenced below), focus on measures such as appropriate emergency room (“ER”) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and generic dispensing rates for select sets of drug classifications. As with the clinical metrics, administrative data are used to construct the utilization measures.

COMMERCIAL BUSINESS MEASUREMENT PERIOD HANDBOOK
UniCare is committed to providing you with details on quality, utilization and improvement goals and scoring methodology in advance of the start of each Measurement Period (as defined in Section 8, Incentive Program Commercial Business). Approximately 90 days prior to the start of each Measurement Period, UniCare will provide you with a “Commercial Business Measurement Period Handbook” (the “Commercial Handbook”) which, among other things, contains the applicable quality, utilization, improvement and other performance measures for the Measurement Period. It will also provide the scoring methodology for these measures including the tiers of performance thresholds that explain how higher performance equates to higher scores. Performance benchmarks will not be included in the Commercial Handbook, but will be provided to you prior to the start of each Measurement Period.

If, upon receipt and review of the Commercial Handbook, you determine you no longer desire to participate in the Program, you must notify UniCare in writing within 30 days after the date the Commercial Handbook was sent, unless otherwise communicated to you by UniCare. If such notice is given, the Commercial business provisions of the Attachment shall terminate, your participation in the Program will end on the date communicated to you by UniCare, and the Commercial Handbook will never apply to you. If you do not provide such notice, the Attachment shall remain in effect, and the Commercial 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 Measurement Period Handbook” shall be effective, enforceable and implemented, notwithstanding any conflicting or contrary provision (including provisions relating to amendments or Program termination) contained in the Attachment or in the Agreement to which it is attached. To the extent that different notices or time frames than described above are required by law, then the provisions of law shall supersede the contractual provisions of this section.
PERFORMANCE ASSESSMENT-COMMERCIAL BUSINESS

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

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

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

Improvement Scoring Opportunity

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

<table>
<thead>
<tr>
<th>Steps for Performance Improvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Choose a measure.</td>
</tr>
<tr>
<td>2. Determine a baseline.</td>
</tr>
<tr>
<td>4. If performance is not to desired level, develop a performance aim.</td>
</tr>
<tr>
<td>5. Make changes to improve performance.</td>
</tr>
</tbody>
</table>

In addition to assessing performance against thresholds, a subset of the clinical measures will be scored for improvement. The selection of these measures will take into account the make-up of the Medical Panel and current performance on measures. These improvement measures will be assessed at the Provider (as defined in the Attachment) level and will be weighted equally for each measure that has a sufficient denominator size. If no measures are sufficiently large to be statistically valid, no score for this category will be provided.
Scoring on these measures is based upon the performance by the physician group on these measures in a Baseline Period compared to the Measurement Period (as defined in Section 8, Incentive Program Commercial Business).

LINKING PERFORMANCE ASSESSMENT TO SHARED SAVINGS

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

**Quality Gate**

Your organization must achieve a minimum threshold of performance on clinical quality measures to have the opportunity to earn a portion of the shared savings. The quality gate is a threshold defined by UniCare, and is set so that performance on the clinical quality composites must be above a predetermined percentile of the market.

**Proportion of Shared Savings Earned**

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

OTHER UNICARE QUALITY INCENTIVE PROGRAMS

Unless otherwise indicated, the Program will replace and supersede any other quality incentive programs currently in place. For services on or after your Participation Addendum Effective Date, adjustments in fee schedule or payment increases of any type resulting from your participation in any type of quality incentive programs will no longer apply or be paid. Instead, the reimbursement opportunity associated with the Program will be in effect.
Section 6: Attribution Process

Attribution is a process used to assign Covered Individuals to a Primary Care Provider (PCP) based on their historical health care utilization or, in some instances, based on his/her own selection. This process is critical to achieve the objectives of the Program, including transparent and actionable data exchange for the purposes of identifying opportunities for improvement and incenting desired medical outcomes. In this section, as is the case in Section 8, Incentive Program, “Attribution” is the collective term used for assignment of Covered Individuals to a PCP.

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

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

Attribution for Products Where Covered Individuals Select a PCP

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

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

2. During a 12 month period, Covered Individual selected more than one provider
   - Yes: Covered Individual is assigned to a provider for only the months which they selected the provider as his/her provider

3. Covered Individual does not select a provider within the same 12 month period
   - Yes: Health plan selects a provider for the Covered Individual
**Attribution for an Open Access Product**

In an open access product (for example PPO and Indemnity), UniCare generally uses a visit-based approach to attribute Covered Individuals based on historical Claims data. Exceptions to this general rule can be made (but are not required) when an Attributed Member designates a PCP in a recent 12 month period. This Attribution algorithm reviews office based evaluation and management visits, and attribution priority is given to PCP visits. When PCP visits are not available, the Covered Individual may not be attributed. As mentioned previously, Claims-based attribution may be used exclusively in certain circumstances.

Initially, UniCare reviews available historical Claims data incurred during a 24 month period, with 3 months of Claim run-out, to assign Covered Individuals. For this scenario, Covered Individuals must be eligible members for at least 6 months in the entire 24 month period (irrespective of product) and at least 1 month within the most recent 12 month period. Upon initial assignment to a PCP, attribution for an open access product is re-run on a quarterly basis to ensure that the most recent Claims information is utilized for attributing Covered Individuals.
Section 7: Clinical Coordination Reimbursement

OVERVIEW

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

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

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

PAYMENT PROCESS

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

-RETROACTIVITY

On a monthly basis, UniCare 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 UniCare determines were appropriately designated as Attributed Members. Retroactivity for Attributed Member additions, terminations and/or changes will typically be no more than ninety (90) days unless otherwise required by a specific line of business, employer group or other entity that is covered under the terms of this Attachment or by a provision of law. Such retroactive adjustments will be applied at the Program level.
Section 8: Incentive Program

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

INCENTIVE PROGRAM – COMMERCIAL BUSINESS
As described more fully below and subject to the below Incentive Program terms and details, UniCare will calculate any shared savings opportunity by comparing the actual annual Claims cost during a specified 12 month “Measurement Period” for the applicable “Member Population” (the “Medical Cost Performance” (“MCP”)) against the projected costs based on the Claims costs of the applicable Member Population during a “Baseline Period”. In the event that the MCP is less than the “Medical Cost Target” (“MCT”, which is defined below), you may share in a percentage of the savings realized, provided that you meet the Quality Gate and other Non-Cost Performance Targets as described in Section 5, Quality Measures & Performance Assessment Commercial Business). The Incentive Program terms and details are described below.

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

“Baseline Period” means a defined twelve (12) month period preceding the first Measurement Period. Generally, to ensure all Claims have been received and processed by UniCare, there will be a minimum of three (3) months of lag time for Claims run-out between the end of the Baseline Period and the beginning of the Measurement Period plus a two (2) month period to perform calculations. The Baseline Period is the timeframe within which Medical Cost Targets will be set. “Gross Savings” means any amounts by which the MCP is less than the MCT, adjusted by the Paid/Allowed Ratio, as calculated by UniCare, at the end of a Measurement Period for each product requiring a separate product specific calculation. Gross Savings can be in the form of risk adjusted per member per month (PMPM) or a percent of premium paid, depending on the product or line of business.

“Measurement Period” means the twelve (12) month period during which Medical Cost Performance will be measured for purposes of calculating shared savings between UniCare and the Medical Panel.
“Medical Cost Performance” (“MCP”) means the actual cost experience in the defined Member Population during a relevant Measurement Period, expressed in terms of risk-adjusted per member per month (“PMPM”) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost Claims amounts. The formulae for setting the MCP take into account risk-adjusted (“PMPM”) Claims experience within the Attributed Member Population during the Measurement Period, but exclude certain transplant and high-cost Claims amounts. It also accounts for any practice transformation per member per month payments made during the relevant Measurement Period to Provider by UniCare for Attributed Members. As part of the MCP calculation, a risk adjustment is made by UniCare through the Normalized Risk Score for the Measurement Period unless otherwise stated in the Measurement Period Handbook and/or the Attachment. A given Medical Panel may have multiple MCPs, which will aggregate membership separately by product type (e.g., HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through UniCare will be in a separate MCP than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager).

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

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

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

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

“Minimum Risk Corridor” (MRC) means the percentage of MCT that UniCare retains before sharing any savings with the Medical Panel. This percentage is determined by us and is designed to limit savings payouts that are driven by random variation.
“Net Aggregate Savings” shall have the meaning described in section (e) below.

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

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

“Paid/Allowed Ratio” means the ratio of paid dollars (dollars paid by UniCare to providers) to allowed dollars (total dollars paid by UniCare plus Cost Shares payable by Covered Individuals) for Covered Services incurred during a Measurement Period, excluding Covered Individuals with certain transplant or high cost Claims amounts.

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

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

“Upside Shared Savings Percentage” means the percentage of shared savings under the Incentive Program that Provider is determined to be entitled to after (i) it meets the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for Provider and it’s 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 it’s 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 Provider may be entitled to, provided that it meets the Quality Gate and other Non-Cost Program Targets.
INCENTIVE PROGRAM TERMS AND DETAILS – COMMERCIAL BUSINESS

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

Shared Savings Determination
(a) Within one-hundred and eighty (180) days from the end of the relevant Measurement Period, plus the three month Claims run-out period. UniCare will calculate the MCP, compare it with the MCT and make other calculations (e.g. adjust differential based on the Paid/Allowed Ratio, etc.) to determine the amount of any Gross Savings generated during the Measurement Period.

(b) UniCare will then calculate the “Savings Pool” by comparing the Gross Savings to the Minimum Risk Corridor (MRC) (expressed in terms of a PMPM, or percent of premium amount, and adjusted based on the Paid/Allowed Ratio). The Savings Pool is the amount by which the Gross Savings exceeds the MRC. In the event that the Gross Savings is less than the MRC (expressed in terms of a PMPM or percent of premium amount) the Savings Pool is not funded. If, on the other hand, this amount exceeds the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. If the Medical Panel participates in the Program under a number of different UniCare products, there may be multiple MCTs, and the aggregate Savings Pool for a given Line of Business could be the weighted average of each of its product-specific Savings Pools. The weighting, which is based on Measurement Period Member Risk Months, is capped at two times the product-specific Baseline Member Risk Months to limit the impact of large scale membership turnover.

(c) Following application of the MRC calculation described above, the Medical Panel’s aggregate Savings Pool expressed at a risk-adjusted PMPM, will be multiplied by the Member Risk Months within the Medical Panel and allocated accordingly.

(d) Providers in the Medical Panel are evaluated on quality and utilization measures relative to targets to determine the overall Upside Shared Savings Percentage. While many Providers in the Program will be evaluated on their own quality performance relative to targets, some Providers with small membership counts (subject to measure requirements) will be evaluated based on their Medical Panel’s collective performance. Scoring for utilization measures is based on the Medical Panel performance, irrespective of the size of the Provider’s membership count. In the event that a Provider fails to meet the “Quality Gate” requirements of the Incentive Program, it will not be eligible to receive any amount of shared savings payout, regardless of whether other performance targets under the Incentive Program are met.

(e) A Provider’s total allocated Savings Pool(s), described in step (c), will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on your aggregate performance across all products and lines of business.
For a basic example (single commercial product), see the calculation set forth below:

### I. Shared Savings Framework

<table>
<thead>
<tr>
<th>Provider Group Count</th>
<th>3</th>
</tr>
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<tbody>
<tr>
<td>Minimum Risk Corridor (MRC)</td>
<td>1.5%</td>
</tr>
<tr>
<td>Upside Cap</td>
<td>10%</td>
</tr>
<tr>
<td>Upside Shared Savings Potential: Quality</td>
<td>18%</td>
</tr>
<tr>
<td>Upside Shared Savings Potential: Utilization</td>
<td>12%</td>
</tr>
</tbody>
</table>

### II. Panel Savings Pool Calculation (Commercial Example)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Cost Target (MCT)</td>
<td>$300.00</td>
</tr>
<tr>
<td>Inflation Assumption</td>
<td>5%</td>
</tr>
<tr>
<td>Paid/Allowed Ratio</td>
<td>0.95</td>
</tr>
<tr>
<td>Medical Cost Performance (MCP)</td>
<td>$285.00</td>
</tr>
<tr>
<td>Gross PMPM Savings: (MCT-MCP) x Paid/Allowed</td>
<td>$14.25</td>
</tr>
<tr>
<td>Minimum Risk Corridor PMPM: (MRC x MCT) x Paid/Allowed</td>
<td>$4.28</td>
</tr>
<tr>
<td><strong>Savings Pool PMPM</strong></td>
<td><strong>$9.98</strong></td>
</tr>
</tbody>
</table>

1. In the above example, three provider groups are combined into a virtual Medical Panel for purpose of calculating a statistically meaningful Medical Cost Target (“MCT”). Had any group been large enough, it could have formed into its own Medical Panel, with its own MCT and related Savings Pool PMPM.

2. The Medical Panel’s MCT (based on historical risk adjusted PMPM, trended forward based on actuarial medical cost inflation assumptions) is set at $300 PMPM.

3. The Medical Panel’s Gross PMPM Savings – $14.25 – is the result of the MCT minus the MCP, adjusted by the Paid/Allowed Ratio: \([($300-285)] \times .95\). The MCP is $285 because the Medical Panel was able to reduce PMPM costs by 5%, relative to anticipated costs.

4. To limit the impact of random variation, Minimum Risk Corridor (MRC) is set at 1.5%, which means that the first $4.28 of PMPM savings/loss is excluded from the Savings Pool, i.e. MCT ($300) x MRC (1.5%) x Paid/Allowed Ratio (.95).

5. The Savings Pool PMPM – in this example $9.98 PMPM – is the result of the Gross PMPM Savings ($14.25) minus the MRC PMPM ($4.28).

6. The Upside Cap as well as the Shared Savings Potential variables will be referenced below in relationship to the Provider Group savings payouts.
### III. Provider Group Payout Calculation

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

7. Provider groups are allocated savings from their Medical Panel’s Savings Pool based on Member Risk Months. In the above example, Provider Group A is allocated $239,400, which is the product of its 24,000 Member Risk Months multiplied by the $9.98 Savings Pool PMPM.

8. While in the above example each group has the potential to earn 30% of their allocated savings, their actual Shared Savings Percentage is a function of their performance on both quality and utilization measures. In the above example, Provider Group A earns over half of the potential 18% weight relating to quality (i.e. 10%). Since all three groups lack sufficient membership size to calculate statistically meaningful utilization metrics, the utilization metrics are calculated at the panel level; and in the above example, the panel earns the full 12% weight. As a result, Provider Group A earns $52,668, i.e. 22% (10%+12%) of their $239,400 in allocated savings.

9. Before the Provider Group is paid the resulting savings from step #7, a maximum payout allowance is calculated by multiplying the MCT, the Member Risk Months, the Upside Cap and the Paid/Allowed Ratio. In the above example, Provider Group A’s maximum payout would be $684,000, i.e. $300 x 24,000 x 10% x .95.

10. The Provider Groups are paid the lesser of step #8 or step #9. For Provider Group A, since $52,668 is less than $684,000, it is paid $52,668.

11. To estimate the impact of the Provider Group’s savings payout relative to their annual revenue, each group’s shared savings payout is divided by its annual paid dollars received from UniCare. For Provider Group A, $52,668 is divided by $432,000, which is their total PCP PMPM ($14.40) multiplied by member months (30,000).
Adjustments to MCT

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

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

Based on Provider performance, UniCare may choose to make interim advance payments to Provider of its share of Net aggregate savings. If UniCare elects to make such interim payments, the Net Aggregate Savings earned for the interim period of the Measurement Period will be paid to Provider less a percentage amount defined by UniCare, called the “Holdback Amount”. The Holdback Amount will be retained by UniCare as security against any shared loss obligations of Medical Panel during the Measurement Period(s). If Holdback Amount is used, UniCare will remit to Provider the total retained balance of the Net Aggregate savings, less any interim payments associated with Attributed members, no later than two-hundred and ten (210) days after the end of the relevant Measurement Period. If it is determined during the final reconciliation of the Measurement Period that an overpayment was made through an interim payout, the Provider will reimburse Unicare the overpaid amount within two hundred and forty (240) days from the end of the relevant Measurement Period. A Provider must be participating in the Program during the entire Measurement Period in order to receive savings amounts under the Incentive Program.

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

Maximizing Your Savings Goals

We want you to be successful in reaching your shared savings goals. The list below provides some specific things that you can do to improve your chances of achieving these goals:
• Engage your Provider Clinical Liaison for assistance with report interpretation and identifying opportunities for improvements. In addition to utilizing our full suite of transformation and clinical resources, contact your local team members as directed in your Welcome Packet.
• Establish a process to review your organization’s performance on a regular basis. We will provide you with useful reports that show quality, cost and utilization performance over time. These reports should be reviewed and discussed on a regular basis to determine how your organization is progressing toward established benchmarks and targets.
• Leverage tools that are available to your organization. MMH+, our collaborative learning events, virtual office hours, the Provider Toolkit and American College of Physicians Practice Advisor tool are just a few ways you can access information on methods for quality improvement.

MEDICAL PANELS – 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. UniCare will provide a list of all physician practices participating in the Program within each state. The list, available from the Patient-Centered Primary Care web page, will identify the practice names and assigned Medical Panel. UniCare reserves the right to make all final determinations on Medical Panel formation.

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, UniCare 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 UniCare provider portal, you will remain in your assigned Medical Panel for the duration of the Measurement Period. UniCare will make reasonable efforts to consider all preferences submitted in a timely manner; however, we cannot guarantee that all preferences will be accommodated. UniCare 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 UniCare, 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. UniCare will make final Medical Panel decisions, and the final list will be shown on the provider portal.

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

**Limitations for Medicare**

UniCare does not attribute people who are members of a Medicare supplemental plan.
Section 9: Reporting

A fundamental building block of the Program is Provider Care Management Solutions (“PCMS”), UniCare’s web-based reporting platform. Through alerts, dashboards, and reports, PCMS supports both population management as well as Program-specific financial performance management. To support population management the tool will help you stratify your membership based on risk and prevalence of chronic conditions; and offer actionable clinical insights, such as care gap messaging and preemptive flagging of Attributed Members with high risk for readmission. To support performance management, PCMS will help you monitor and improve your performance in the Program’s payment model, connecting the dots for you between the actionable activities that tie to the Program’s financial incentives. Additional detail about the tool and information we currently plan to make available to you is supplied below.

POPULATION MANAGEMENT

Attributed Patients

You will have access to detailed information about your patients who are Attributed Members and have the ability to filter your Attributed Member list by condition type, risk drivers, visit type, care opportunities, associated organization, etc. The available Attributed Member details are listed below.

- Demographic(s)
- Attributed Organization
- Attributed Member prospective risk score
- Number of care opportunities and corresponding details
- Number of related conditions and condition details
- Number of visits and corresponding details
- Within the Attributed Patient’s dashboard, you have the ability to view your high-risk “hot spotter” Attributed Members, new Attributed Members, and Attributed Members with recent inpatient authorizations. An overview of these views is provided below.

Hot Spotter Chronic Conditions and Hot Spotter Readmission Views

PCMS gives you the opportunity to identify Attributed Members who may benefit from a care plan. This drill-down view targets certain high-risk Attributed Members with specific chronic diseases as well as Attributed Members with a recent inpatient admission who are at high risk for re-admission. You will also be able to view targeted risk drivers associated with each Attributed Member’s hot spotter status.

New Patient View

All Attributed Members who first appear in PCMS will be displayed in the ‘New Patient’ view; Attributed Members will remain on this list for a period of 30 days. Here, you will be able to view each Member’s attribution date and their associated attribution method.
Inpatient Authorization View
You have the ability to identify Attributed Members who have been recently authorized for an inpatient admission and their risk for readmission. Attributed Members will remain on the list from the time the admission is authorized through 30 days post-discharge. Detail includes:
- Inpatient Length of stay
- Admission date
- Discharge date
- Admitting diagnosis
- Readmission risk

Emergency Room Visits View
This view lists your Attributed Members with emergency room (“ER”) visits, categorizing “frequent fliers”, and offering information around unnecessary ER avoidance opportunities, with the ability to view each member’s admission date, facility name, and diagnoses. You will be able to further filter the member list by the following categories:
- Visit frequency
- Visit date range
- Organization

Care Opportunities Dashboard
This dashboard identifies Attributed Members with “care opportunities,” i.e. active or potential gaps in care associated with clinical quality metrics referenced in Section 5, Quality Measures & Performance Assessments: The dashboard summarizes care opportunities at the condition level, and then offers drill-down capabilities into specific measures, with provider and member detail. Selecting a member from this dashboard will provide the following details:
- Last compliance date for each care opportunity
- Clinical due date for each care opportunity
- Status (“past due”, “due in 30 days”, “due in 60 days”, “due in calendar year”, “completed”) for each care opportunity

Inactive Patients
You will have access to detailed information about your inactive Attributed Members, i.e. those Attributed Members who used to be attributed to you, but are no longer (e.g. individual changed health plan, individual is attributed to a different Provider). The inactive Attributed Member details available to you are listed below.
- Demographic(s)
- Attributed provider
- Attributed organization
- Months attributed
- Attribution end date
- Attribution end reason
PERFORMANCE MANAGEMENT

Performance Summary
This summary provides key metrics reflecting your group’s savings performance, scorecard performance, and the resulting estimated shared savings payout. The summary offers the ability to drill into the cost details of your savings performance and the underlying quality and utilization details of your performance scorecard. Of note, the performance information will differ by line of business (i.e. Commercial vs. Medicare).

Scorecard
View your earned contribution percentage based on your quality performance against Program benchmarks here. You can drill-down to measure level performance details, with the ability to differentiate provider performance and also identify specific Attributed Members who are noncompliant and in need of an intervention.

Medical Cost: Medical Cost Target (“MCT”) and Medical Cost Performance (“MCP”)
Note: The Medical Cost Target and Medical Cost Performance reports apply only to Commercial business.

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

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

REPORT REGISTRATION AND QUESTIONS

Your local provider Contract Advisor can work with you as needed to complete the registration process in Availity to access PCMS. If you have questions regarding your PCMS, please forward an e-mail to UniCarePrimaryCareProgram@anthem.com. In your message, please include the following information:

- Your name
- Your phone number
- Your provider organization name
- Your provider organization’s tax identification number (or provider identification number)
- Name, date and details of view(s)
- Description of issue or question
Section 10: Appendix

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

MMH+ Access Form

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

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

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

Practice Name_________________________________________________________

Practice TIN___________________________________________

Practice e-mail____________________________________________

Person who will fill out access form for MMH+_____________________________________

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

Phone number of person filling out the form_____________________________________


Section 11: Glossary

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

<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addendum</td>
<td>Abbreviated reference to the Patient-Centered Primary Care Participation Addendum, the contractual document the Provider signs to participate in the Patient-Centered Primary Care Program. This addendum is an amendment to the primary care provider’s Provider Agreement with UniCare.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Attributed Members</td>
<td>Those Covered Individuals who are attributed to the Represented Primary Care Providers for the purposes of the Patient-Centered Primary Care Program using the Attribution Methodology.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Attribution Methodology</td>
<td>A process whereby UniCare will assign Covered Individuals to the Represented Primary Care Providers in one of the following manners: i) based on the formal selection of a Primary Care Provider by the Covered Individual; or ii) based on the formal assignment of a Primary Care Provider to the Covered Individual by UniCare; or iii) based on a Covered Individual’s prior utilization of evaluation and management services. Provider agrees and acknowledges that such assignment of a Covered Individual to a Primary Care Provider utilizing the Attribution Methodology will not impose any limitations or constraints on the freedom of such Covered Individuals to refer themselves for Health Services except as may otherwise be set forth in the Health Benefit Plan. The Attribution Methodology is described further in Section 5 of this Program Description.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Baseline Period</td>
<td>A defined twelve (12) month period preceding the first Measurement Period. To ensure all Claims have been received and processed by UniCare, there will be a minimum of three (3) months of lag time for Claims run-out between the end of the Baseline Period and the beginning of the Measurement Period plus a two (2) month period to perform calculations. The Baseline Period is the timeframe within which Medical Cost Targets will be set.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Care Plan</td>
<td>A detailed approach to care that is customized to an individual patient’s needs. Often, care plans are needed in circumstances where patients can benefit from personalized physician instruction and feedback regarding management of their condition(s).</td>
<td>Program Description (Section 3)</td>
</tr>
<tr>
<td>Care Plan Assessment Domains</td>
<td>The functional areas we suggest be included in care plans to guide goal formation and related elements that could further support the identification of goals and interventions.</td>
<td>Program Description (Section 3)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Clinical Quality Measures – Commercial Business</td>
<td>The clinical quality measures currently included in the Program scorecard and outlined in the Commercial Handbook are grouped into two categories, (1) acute and chronic care management and (2) preventive care. These categories may be further broken out into subcategories. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td>Gross Savings – Commercial Business</td>
<td>Any amounts by which the Medical Cost Performance (MCP) is less than the Medical Cost Target (MCT), adjusted by the Paid/Allowed Ratio, as calculated by UniCare, at the end of a Measurement Period for each product requiring a separate product specific calculation. Gross Savings can be in the form of risk adjusted per member per month (PMPM) or a percent of premium paid, depending on the product or line of business.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Holdback Amount</td>
<td>The percentage of any applicable annual distribution payment based on earned Net Aggregate Savings that may be retained by UniCare as security against any future shared loss obligations of Medical Panel during the Measurement Period(s).</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Incentive Program</td>
<td>The opportunity for PCPs to increase their revenue as they participate in the Patient-Centered Primary Care Program. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance criteria. A complete description of the Incentive Program is in the Program Description.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Measurement Period</td>
<td>The twelve (12) month period during which Medical Cost Performance will be measured for purposes of calculating shared savings between UniCare and the Medical Panel.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Medical Cost Performance (MCP)</td>
<td>The actual cost experience in the defined Member Population during a relevant Measurement Period, expressed in terms of risk adjusted per member per month (“PMPM”) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost Claims amounts. As part of the MCT calculation, a risk adjustment is made by Unicare through the Normalized Risk Score for the Baseline Period, unless otherwise stated in the Measurement Period Handbook and/or the Attachment. The MCT calculation also accounts for any practice transformation per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period. The formulae for setting the MCP take into account risk-adjusted (“PMPM”) Claims experience within the Attributed Member Population during the Measurement Period, but exclude certain transplant and high-cost Claims amounts. 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 UniCare will be in a separate MCP than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Medical Cost Target (&quot;MCT&quot;)</td>
<td>The historic cost experience in the defined Member Population during the Baseline Period, trended forward and expressed in terms of risk adjusted per member per month (PMPM) or percent of premium paid, as applicable, but excluding certain Covered Individuals with transplant or high cost Claims amounts. It also accounts for any practice transformation per-member per-month payments made during the relevant Measurement Period to Provider by UniCare for Attributed Members. As part of the MCP calculation, a risk adjustment is made by UniCare through the Normalized Risk Score for the Measurement Period unless otherwise stated in the Measurement Period Handbook and/or the Attachment. The formulae for setting the MCT take into account risk adjusted Per Member/Per Month (&quot;PMPM&quot;) Claims experience within the Attributed Member Population during the Baseline Period, but exclude certain transplant and high cost Claims amounts. MCT sets the baseline for shared savings/loss calculations under the Incentive Program. A given Medical Panel may have multiple MCTs, which will aggregate membership separately by product type (e.g. HMO, PPO, etc.) and pharmacy benefits (e.g., PPO members with pharmacy benefits through UniCare) will be in a separate MCT than PPO members who receive pharmacy benefits through a third party Pharmacy Benefits Manager.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Medical Panel – Commercial Business</td>
<td>A single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful Medical Cost Targets (&quot;MCTs&quot;), shared savings, and utilization performance targets. Medical panels shall be formed either by the providers themselves or by UniCare.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Member Months – Commercial Business</td>
<td>The number of the Member Population’s full months enrolled in the applicable UniCare products during a Measurement Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Member Population</td>
<td>The group of Attributed Members assigned to the Medical Panel as applicable; and whose costs under the relevant UniCare products(s) will be used to calculate (MCTs) and (MCPs) pursuant to the Program (subject to criteria established by UniCare).</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Member Risk Months</td>
<td>The Member Population’s average Normalized Risk Score multiplied by their Member Months in the applicable UniCare products during a Measurement Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Minimum Risk Corridor (&quot;MRC&quot;)</td>
<td>The percentage of Medical Cost Target (MCT) that UniCare retains before sharing any savings with the Medical Panel. This percentage is determined by UniCare and is designed to limit savings payouts that are driven by random variation.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>MMH+ (Member Medical History-Plus)</td>
<td>The UniCare system the Provider will use to access Covered Individual-based personal health information to clinicians via the internet. To gain access, Providers should submit a completed MMH+ Access Form to the local Contract Advisor.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Net Aggregate Savings – Commercial Business</strong></td>
<td>The total allocated Savings Pool(s) multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Non-Cost Performance Targets</strong></td>
<td>The quality and utilization performance goals tied to shared savings under the Incentive Program. Quality measures are evaluated at the Provider level (subject to membership requirements identified in the Shared Savings Determination section below), whereas utilization measures are evaluated at the Medical Panel level.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Normalized Risk Score</strong></td>
<td>The Medical Panel’s average risk score relative to the state’s average risk score. Risk scores are generated using the DxCG model from Verisk Health, which uses information such as member age, gender and diagnosis information from Covered Individuals’ medical Claims. The approach to risk scores may be adjusted from time to time and changes will be communicated without the need for a formal amendment.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Paid/Allowed Ratio</strong></td>
<td>The ratio of paid dollars (dollars paid by UniCare to providers) to allowed dollars (total dollars paid by UniCare plus Cost Shares payable by Covered Individuals) for Covered Services incurred during a Measurement Period, excluding Covered Individuals with certain transplant or high cost Claims amounts.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Participation Addendum Effective Date</strong></td>
<td>The date the Patient-Centered Primary Care Participation Addendum becomes effective as shown on either (i) the signature page of the Provider Agreement or (ii) the signature page of the Addendum, whichever is applicable.</td>
<td>Addendum</td>
</tr>
<tr>
<td><strong>Patient-Centered Primary Care Participation Addendum</strong></td>
<td>The contractual document the Provider signs to participate in the Patient-Centered Primary Care Program. This addendum is an amendment to the primary care provider's Provider Agreement with UniCare. This term is synonymous with “Addendum.”</td>
<td>Addendum</td>
</tr>
</tbody>
</table>
| **Performance Assessments**                       | The annual assessment of performance on the selected Program clinical quality and utilization measures to define the proportion of shared savings that the Provider earns. Performance will be calculated for each measure, and then results will be rolled into three categorical scores for:  
  - Acute and Chronic Care Management  
  - Preventive Care  
  - Utilization  
The categorical scores will be based on performance relative to different tiers of performance thresholds. | Program Description (Section 5) |
<p>| <strong>Primary Care Provider(s) or PCP(s)</strong>            | Providers whose primary specialty, as indicated in the UniCare provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics. | Addendum                      |
| <strong>Program</strong>                                       | Abbreviated reference to the Patient-Centered Primary Care Program.                                                                                                                                     | Addendum                      |</p>
<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Description</td>
<td>The description of the Patient-Centered Primary Care Program prepared by UniCare, as revised from time to time, that summarizes the clinical programs and other patient-centered practice support offered by UniCare to support Represented Primary Care Providers in creating a patient-centric practice environment and care model for their Covered Individuals as well as Program terms, conditions and requirements. A current copy of the Program Description, and periodic updates thereto, is available on the UniCare provider website.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Program Quality Measures</td>
<td>The defined measures used to establish a minimum level of the Provider’s performance will also serve as the basis for Incentive Program savings calculations. Program Quality Measures are calculated and reported to the Provider on a scorecard comprised of clinical quality measures and utilization measures.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td>Provider Toolkit</td>
<td>The tools and information that will be made available to provider organizations to assist with population health management.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>Quality Gate – Commercial Business</td>
<td>The minimum quality standards that you must achieve in order to retain any shared savings under the Incentive Program. A minimum threshold of performance on clinical quality measures must be achieved to have the opportunity to earn a portion of the shared savings. The quality gate is a threshold defined by UniCare, and is set so that performance on the clinical quality composites must be above a predetermined percentile of the market performance as defined in the Commercial Handbook.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Represented Primary Care Provider(s) or Represented PCP(s)</td>
<td>All of the providers in the provider organization whose primary specialty, as indicated in the UniCare provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics (collectively, Primary Care Provider(s)) and who participate in the Patient-Centered Primary Care Program by virtue of being covered under the Provider Agreement and Patient-Centered Primary Care Participation Addendum.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Risk Scores</td>
<td>Risk scores are indicators of the health status of an Attributed Member based on the evaluation of diagnosis information pulled from Claims. UniCare uses industry standard methods to determine risk scores.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Savings Pool</td>
<td>The Minimum Risk Corridor (MRC) is applied by comparing the Gross Savings to the MRC to determine the Member Population’s “Savings Pool”. If the Gross Savings is less than the MRC, the Savings Pool is not funded. If the Gross Savings exceed the MRC, the Savings Pool is funded based on the amounts in excess of the MRC. The total allocated Savings Pool(s) will be multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap, to determine final Net Aggregate Savings payment amounts. While there could be multiple Saving Pool(s) due to different products and/or lines of business, there will be just one Upside Shared Savings Percentage based on the aggregate performance across all products and lines of business.</td>
<td>Program Description (Section 8)</td>
</tr>
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<td>Glossary Term</td>
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<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Shared Savings</td>
<td>The savings the Provider can share in if Program targets are met. We will compare the Medical Panel’s annual Claim cost per Covered Individual in each Measurement Period to each Covered Individual’s cost in a Baseline Period to determine whether the Measurement Period’s Medical Cost Performance (“MCP”) is less than the Baseline Period’s Medical Cost Target (“MCT”) subject to Incentive Program details described herein. In the event that the MCP is less than the MCT, the Provider may share in a percentage of the savings realized, provided that the Provider meets the Quality Gate and other Non-Cost Performance Targets as described in the Quality Measures &amp; Performance Assessment section of this Program Description.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Upside Cap</td>
<td>The maximum limit on Incentive Program shared savings that you can earn through the Incentive Program. Like the Gross Savings, the Upside Cap is adjusted by the Paid/Allowed Ratio.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Upside Shared Savings Percentage</td>
<td>The percentage of shared savings under the Incentive Program that Provider is determined to be entitled to after (i) you meet the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for you and your Medical Panel. The Upside Shared Savings Percentage can be the same percentage as the Upside Shared Savings Potential if all Non-Cost Performance Targets are fully achieved by you and your Medical Panel under the Program. The Upside Shared Savings Percentage will be less than the Upside Shared Savings Potential if all Non-Cost Performance Targets are not achieved, and zero if the Quality Gate is not met.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Upside Shared Savings Potential</td>
<td>The maximum percentage of shared savings under the Incentive Program that you may be entitled to, provided that your provider organization meets the Quality Gate and other Non-Cost Program Targets.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Utilization Measures</td>
<td>The utilization measures in the Program scorecard and outlined in the Commercial Handbook focus on measures such as appropriate emergency room (“ER”) utilization, management of ambulatory-sensitive care conditions as measured by hospital admissions, and generic dispensing rates for select sets of drug classifications. As with the clinical metrics, administrative data are used to construct the utilization measures.</td>
<td>Program Description (Section 5)</td>
</tr>
</tbody>
</table>