Program Description for Patient-Centered Primary Care

Modified January 1, 2017
Introduction

Our health care system has created an untenable situation for many providers: not enough time to offer the comprehensive, patient-centered care they want to deliver, and a payment model that rewards volume of visits or procedures rather than compensating them for time spent on prevention, holistic care and care planning. An overwhelming amount of research tells us that despite being the most costly in the world, the U.S. health care system is lagging behind many other countries and failing to deliver consistent value to the people who use it every day.\textsuperscript{1, 2} The fact that more Americans have health care coverage now than ever before makes the need for adopting a value-based system and coordinated delivery system more urgent.

At UniCare, we are working to transform health care with trusted and caring solutions. Our health plan companies deliver quality products and services that give their members access to the care they need. Nearly 72 million people are served by our affiliated companies, including more than 39 million enrolled with us and our affiliated health plans.

UniCare is committed to collaborating with providers to adopt value-based payment and patient-centered care across the health care delivery system, and we offer practices comprehensive support as they take on this challenge with us.

UniCare understands that creating a high-functioning health care system requires a concerted effort and active support from all key stakeholders in the delivery system to create an environment conducive for change. This includes:

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

UniCare designed Patient-Centered Primary Care based on years of experience. UniCare has been a leader in its support for the patient-centered care model through its participation in patient-centered medical home ("PCMH") programs across the country. The results were persuasive enough to cement our commitment to patient-centered care. In our studies to date, we have observed improvement in

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

compliance with evidence-based guidelines and a reduction in avoidable, unnecessary admissions and emergency room visits along with maintenance or improvement in the quality of health care services.

Our Patient-Centered Primary Care Program (the “Program”), is designed to build upon the success of early patient-centered programs and foster 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, Represented Primary Care Physicians and Represented Physicians, as applicable, in this document). This relationship enables both parties to leverage the other party’s unique assets , whether clinical, administrative, or data , to support coordinated care with a focus on risk-stratified care management, wellness and prevention, improved access and shared decision-making with patients and their caregivers.

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

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

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<tr>
<td>Massachusetts</td>
<td><a href="mailto:UniCarePrimaryCareProgram@anthem.com">UniCarePrimaryCareProgram@anthem.com</a></td>
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**Program Communications**

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

- The information, resources, and tools that UniCare provides to you through the Patient-Centered Primary Care Program are intended for general educational purposes only, and should not be interpreted as directing, requiring, or recommending any type of care or treatment decision for UniCare members or any other patient. UniCare cannot guarantee that the information provided is absolutely accurate, current or exhaustive since the field of health is constantly changing.

- The information contained in presentations that UniCare makes available to you is compiled largely from publicly available sources and does not represent the opinions of UniCare or its personnel delivering the presentations.

- If UniCare provides links to or examples of information, resources or tools not owned, controlled or developed by UniCare this does not constitute or imply an endorsement by UniCare. Additionally, we do not guarantee the quality or accuracy of the information presented in, or derived from, any non-health plan resources and tools.

- We do not advocate the use of any specific product or activity identified in this educational material, and you may choose to use items not represented in the materials provided to you. Trade names of commonly used medications and products are provided for ease of education but are not intended as particular endorsement.

- None of the information, resources or tools provided is intended to be required for use in your practice or infer any kind of obligation on you in exchange for any value you may receive from the program. Physicians and other health professionals must rely on their own expertise in evaluating information, tools, or resources to be used in their practice. The information, tools, and resources provided for your consideration are never a substitute for your professional judgment.

- With respect to the issue of coverage, each UniCare Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. If Members have any questions concerning their benefits, they may call the Member Services number listed on the back of their ID card.
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Section 1: Program Overview

OBJECTIVES

The objectives of the Program are to:

- Support the transition from a fragmented and episodic health care delivery system to a patient-centered system, accountable for substantially improving patient health, by making a significant investment in primary care that allows primary care physicians to do what they can do best: manage all aspects of their patients’ care.
- Provide physicians with tools, resources and meaningful information that promote (1) access, (2) shared decision-making, (3) proactive health management, (4) coordinated care delivery, (5) adherence to evidence-based guidelines and (6) care planning built around the needs of the individual patient, leading to improved quality and affordability for our customers and their patients.
- Redesign the current payment model to move from volume-based to value-based payment, aligning financial incentives and providing financial support for activities and resources that focus on care coordination, individual patient care planning, patient outreach and quality improvement.
- Improve the patient experience by:
  - Facilitating better access to a primary care physician who will not only care for the “whole person” but also will become each patient’s health care champion and help patients navigate through the complex health care system,
  - Inviting patients’ active participation in their health care through shared decision-making, and optimizing their health.
- Focus practice attention on opportunities to lower cost of care while improving quality outcomes.

SCOPE

The Program applies to Provider and UniCare participating Represented Primary Care Providers, Represented Primary Care Physicians and/or Represented Physicians, as applicable, who are in good standing, and who have signed or are covered under our Patient-Centered Primary Care Addendum that includes the Medical Cost Target and/or Medical Loss Ratio payment models.
Section 2: Roles

We make several Program resources available to support and collaborate with you to achieve successful outcomes and reach Program goals. The following information describes roles developed to support the Program. The names of these support staff members and their contact information will be available via UniCare’s provider portal prior to the Program Addendum Effective Date or as soon thereafter as practicable. Some roles may vary by state, and the level of interaction with the support team may vary by organization.

Network Director for Payment Innovation Programs

The Network Director for Payment Innovation Programs (“Network Director”) is responsible for the strategy and implementation of the Program. The Network Director is the point of contact for provider organizations to address overall contracting performance and operational elements for the Program.

Contract Advisor

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

Provider Clinical Liaison

The Provider Clinical Liaison (PCL) is a quality improvement specialist who is responsible for consulting with provider organizations in an effort to help improve the effectiveness and efficiency of practice activities around quality, cost of care and patient experience. This team member helps practices identify and target high-risk UniCare populations and develop corresponding strategies to optimize outcomes, leverage hot spotter reports and manage gaps in care reporting. The PCL also supports practice implementation of data-driven population health strategies, recommends care coordination and care management strategies, and identifies action plans for provider organizations to implement in order to improve cost, quality and/or the patient experience. The PCL serves as the subject matter expert with the UniCare care management team regarding patient referrals using UniCare’s automated referral process. The PCL supports providers and care teams as they define workflows that can lead to reliable and systematic processes.

The Provider Clinical Liaison also creates and hosts learning opportunities to support practice transformation including events that allow practices to learn from one another and national experts.
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 following roles inside your provider organization are recommended to support your organization’s transformation under the Program.

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

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

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

Transformation Team Members
The Transformation Team Members are those individuals in your provider organization who participate in Program activities focused on improving patient care using recognized quality improvement methodologies. Ideally this group of individuals should include a representative from each area within your office (front office, back office, clinical, billing, etc.).
Section 3: Care Coordination and Care Plans

CARE COORDINATION

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

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

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

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

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

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

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

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

CARE PLANS

The 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 time frames for reevaluation,
• Resources to be utilized, including the appropriate level of care,
• Planning for continuity of care, including transition of care, and
• Collaborative approaches to be used, including family participation.

Care Plan Format and Content

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

The minimum requirements for an initial care plan include:
• Activities that are individualized to the needs of the Covered Individual,
• Information regarding the family, caregiver and/or patient involvement for specific activities for the purposes of collaboration and coordination of the plan of care,
• Short-term and long-term patient-centric goals with interventions that are realistic for the Covered Individual’s care,
• The patient’s self-management plan (also described on the following page), which includes:
  o A shared agenda for physician office visits, and
o A list of activities to improve the health of the Covered Individual (developed in collaboration with the Covered Individual),
• Helpful information regarding relevant community programs where available.
• Resources that should be utilized (e.g. UniCare clinical programs, home health care, durable medical equipment, and rehabilitation therapies),
• Time frames for reevaluation and follow-up, and
• A transition of care approach (for Covered Individuals discharged from a hospital) which includes:
  o Information on medication self-management,
  o A patient-centered record owned and maintained by the Covered Individual,
  o A follow-up schedule with primary or specialty care, and
  o A list of “red flags” indicative of a worsening condition and instructions for responding to them.

Your provider organization team must also perform the following activities in connection with care planning:
• Update the Covered Individual’s chart to include care plan goals,
• Learn the status of such goals during office visits with Covered Individual,
• Ensure the Covered Individual knows his/her role in self-management and what must be done after the visit,
• Respond to any questions the Covered Individual may have about his/her treatment or medication plan, and
• Perform follow-up and monitoring as identified in the care plan.

Maintenance of care plans must, at minimum, include the following:
• Detailed notes to indicate progress toward goals,
• Updates and additions to scheduling, available resources, and roles and responsibilities,
• An assessment of barriers to patients achieving their goals, and
• Modifications to initial/previous plan to adjust plan to progress level.
**Care Plan Assessment Domains**

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

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<tr>
<th>Domain</th>
<th>Informed Choices</th>
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<tbody>
<tr>
<td>Element 1</td>
<td>Life Planning Documents such as Durable Power of Attorney, Living Will, Health Care Proxy</td>
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<td>Element 2</td>
<td>Aggressive vs. Palliative Care—Hospice</td>
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<th>Domain</th>
<th>Functional Status and Safety</th>
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<tr>
<td>Element 1</td>
<td>Personal Safety Plan (Child Proof/Home Safety/Fall Prevention).</td>
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<td>Element 2</td>
<td>Level of Independence /Functional Deficits</td>
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<td>Element 3</td>
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<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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<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 3</td>
<td>Understanding of Condition Specific Action Plan/Monitoring Plan</td>
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<td>Element 4</td>
<td>Understanding of Condition &quot;Red Alerts&quot;</td>
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<td>Element 5</td>
<td>Pain Management</td>
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<tr>
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<th>Medication Management</th>
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<td>Element 3</td>
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<td>Element 4</td>
<td>Barriers to Adherence</td>
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<th>Domain</th>
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<td>Nutrition/Dietary Plan/Body Mass Index (BMI)</td>
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<td>Smoking Status</td>
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<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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<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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<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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<td>Element 3</td>
<td>Communication Impediments (Hearing/Vision Loss, unable to read, etc.)</td>
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<tr>
<th>Domain</th>
<th>Transitions of Care/Access to Care</th>
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<td>Element 1</td>
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<td>Element 2</td>
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<td>Element 4</td>
<td>Specialists/Other Provider Coordination</td>
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Identifying the Need for Care Planning

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

We provide access to clinical data to highlight opportunities for management of Attributed Members in an effort to improve patient outcomes. The Chronic Conditions and Readmission Hot Spotter views (as further described in the Reporting section of this Program Description) include a listing of high-risk Attributed Members identified by analytic reporting as those who would benefit from development of a care plan.

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

Although we provide a list of Attributed Members who, through analytic reporting, have been identified as being at high risk, you will have additional real-time information from patient assessments that allows you to identify other high-risk Attributed Members. UniCare will collaborate with your provider organization team as UniCare determines appropriate to identify Attributed Members who have been determined by your organization as candidates to receive a care plan.

The Provider Clinical Liaison (“PCL”) may periodically review provider organization-identified Attributed Members with your care coordinator and/or care managers during “Touch Points,” which are discussions that provide a recurring forum for collaboration between the PCL and the care coordinator. The PCL may request to extend the TouchPoints to include your organization’s clinical management team. These meetings provide a venue to discuss trends, opportunities and desired outcomes related to high risk members, chronic condition management, population health processes, clinical programs/interventions and patient engagement/education. This time spent together will help to ensure the desired outcomes to optimize coordination of patient-centered care, promote quality interactions, and produce appropriate cost savings in overall medical and pharmacy utilization.

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

- Have been diagnosed with complex medical conditions,
- Are receiving treatment from multiple specialists, thereby requiring coordination of care,
- Have complex treatment/management plans,
- Are impacted by psycho-social concerns (e.g., lack of transportation, live alone, no family support),
- Have multiple chronic conditions or a chronic condition with evidence-based gaps in care (e.g., heart failure and inability to adhere to developed treatment plans/medication regime or daily weight monitoring),
- Have a newly diagnosed chronic condition, such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease (“COPD”), coronary artery disease (“CAD”), migraine, hypertension, or morbid obesity,
- Have comorbid medical and behavioral health conditions,
- Have a behavioral health diagnosis (depression, schizophrenia, dementia, bipolar) which will amplify the patients risk score,
- Have specific risk drivers and/or high care gaps risk score, or
- Are taking multiple medications for health conditions.

**Comprehensive Assessment**

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

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

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

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

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

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

Self-Management Support

Self-management support means educating Attributed Members so that they may take a greater role and level of responsibility for improving their own health outcomes. Self-management support is the assistance caregivers offer to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two (2) ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership. The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.5

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

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5 Tom Bodenheimer, Helping Patients Manage Their Chronic Conditions, www.chcf.org, 2005
6 http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf
Section 4: Program Requirements and Transformation

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

PATIENT ENGAGEMENT

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

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

PRACTICE TRANSFORMATION

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

MEMBER MEDICAL HISTORY PLUS ("MMH+")

Physicians with Attributed Members enrolled in UniCare's commercial products ("commercial Attributed Member") participating in the Program are required to gain access to and utilize UniCare's 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 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, both within and outside their provider organization. Having access to more complete information than what may be contained in your medical record will enable you to develop data-informed comprehensive care plans for your patients.
From MMH+, users can learn the following information about a Covered Individual:

- Physicians seen
- Demographics and Eligibility history
- Diagnoses
- Procedures performed
- Medications filled
- Care Alerts
- Lab results (if performed at certain national labs)
- Utilization management and case management for services provided

Users 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 (2) levels 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. MMH+ can provide up to three (3) 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 Program participation. 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 Contract Advisor or local provider contract representative.

**PATIENT 360**

Physicians with UniCare Attributed Members participating in the Program are required to access and utilize UniCare’s Patient 360 system. This section will help you understand the benefits of this system and how to access and utilize this tool in a manner that will help you manage the health of your patients.

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

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

- Demographic information
- Care summaries
• Claims details
• Authorization details
• Pharmacy information
• Care management activities

With this level of detail at your fingertips, you’ll be able to:
• Quickly retrieve a medical history for new patients
• Spot utilization and pharmacy patterns
• Avoid service duplication
• Identify care gaps and trends
• Coordinate care more effectively
• Reduce the number of communications needed with case managers

There is no additional registration or sign up needed for Patient 360. To get started:
1. Log into Availity
2. Navigate to “My Payer Portals”
3. Select “UniCare Provider Self Service”
4. Select “Member Information” to go to the Patient 360 home page.

AVAILITY – Getting Started With Population Management

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

How 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 the Patient-Centered Primary Care Program

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

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 the 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.

Users 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
   Select “New users available to be registered”
4. The PAA may select the group, the role that is appropriate for the user needing access (i.e., to clinical reports, financial reports, or both clinical and financial), and Tax ID(s).
   **Note:** PAAs must ensure that users are only granted 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.

**PATIENT REGISTRY**

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

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

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

**MEMBER HEALTH INFORMATION**

Maintaining documentation of patient visits and of patients’ diagnoses and chronic conditions helps UniCare fulfill its requirements under the Affordable Care Act (“ACA”) Those requirements relate to the risk adjustment, reinsurance and risk corridor, or “3Rs” provision in the law.

Patient-Centered Primary Care providers are expected to partner with UniCare to meet these requirements, and we will periodically monitor providers’ participation. UniCare or its representative may ask you to provide documentation or to schedule a visit for a patient specifically to better meet these requirements.
COLLABORATIVE LEARNING EVENTS

To help ensure Program success, a culture of learning is deemed essential for participants. To meet this Program component, participants shall provide an email contact for learning event pre-registration with the expectation that at least one participant from the organization participate in scheduled events. The email contact provided shall be a designated person in the practice who helps to champion a culture of learning. Learning events include the following:

- A National Transformation webinar series that features state of the art transformation topics delivered by national experts.
- Practice Essentials, a virtual curriculum designed to help primary care practices take the first steps toward practice transformation and move along the medical home continuum. Through this comprehensive, customizable curriculum, we guide practices step-by-step through quality improvement methodology to achieve sustainable change and improve patient satisfaction, clinical outcomes and value.
- Achieving the Triple Aim Intervention bundles. This continuing education series promotes small, straightforward sets of evidence-based practices (generally three to five) that, when performed collectively and reliably, have been proven to improve patient outcomes. Note: CEU/CME credit is available.
- A pediatric-focused learning series that features transformation topics delivered by national pediatric experts.

All sessions are recorded in order to offer viewing at a time that is convenient for learners.

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

PROVIDER TOOLKIT

The Provider Toolkit, found on the Patient-Centered Primary Care webpage, serves to provide you with research and tools that will support your organization during transformation activities. These resources are available to help enhance your organization’s performance, quality, operations and establishment of care coordination and care management processes, as well as maximizing health information technology, including registry functionality. The Provider Toolkit offers resources that address self-management support, motivational interviewing, and enhanced access to care for your patients. In addition, you will find information for complimentary access to the American College of Physicians’ Practice Advisor (ACP Practice Advisor®). Our Care Consultants, as well as our other local transformation team members, are available to answer additional questions and provide you with more information about the Provider Toolkit and its contents.
PRACTICE ADVISOR

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 ACP Practice Advisor. Please notify your Contract Advisor or Care Consultant for any questions related to getting started with ACP Practice Advisor.

Practice Advisor module topics include:

- Building the foundation
- Specialty practice recognition
- Improving clinical care
- Managing your practice
- Maintenance of certification from the 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”), Utilization Review Accreditation Commission (“URAC”), 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 Section 8: Incentive Program. The scoring measures, methodology, calculations and other related parameters and criteria associated with quality measures and performance assessments may be updated from time to time.

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

COMMERCIAL LINE OF BUSINESS

QUALITY MEASURES & PERFORMANCE ASSESSMENTS

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

MEASURES - COMMERCIAL BUSINESS MEDICAL COST TARGET INCENTIVE MODEL

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

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

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

There are currently 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.

In some instances, pharmacy information may not be available for certain membership. Membership that is lacking pharmacy detail will be excluded from the measures that require pharmacy information. Once pharmacy information becomes available to UniCare, the data will be phased into the measures.

**Clinical Quality Measures**

The clinical quality measures currently included in the Performance Scorecard and outlined in the Commercial Business Medical Cost Target Measurement Period Handbook (referenced below) are grouped into two (2) categories: (1) Acute and Chronic Care Management and (2) Preventive Care. These categories may be further broken out into sub-composites. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.

**Utilization Measures**

The utilization measures in the Performance Scorecard and outlined in the Commercial Business Medical Cost Target 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 MEDICAL COST TARGET MEASUREMENT PERIOD HANDBOOKS**

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 Medical Cost Target Model). Approximately 90 days prior to the start of each Measurement Period, UniCare will provide you with a “Commercial Business Measurement Period Handbook” “Medical Cost Target Measurement Period Handbook” (MCT Measurement Period Handbook) specific to the program(s) in which you are participating which, among other things, will contain the applicable quality, utilization, improvement and other performance measures for the Measurement Period. It will also provide the scoring methodology for these measures, including the tiers of performance thresholds that explain how higher performance equates to higher scores. Performance benchmarks will not be included in the MCT Measurement Period Handbook but will be provided to you prior to the start of each Measurement Period or as soon thereafter as practicable.

If, upon receipt and review of the MCT Measurement Period 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 MCT Measurement Period Handbook was sent unless otherwise communicated to you by UniCare. If such notice is given, the Commercial Business provisions of the applicable program Addendum shall terminate. Your participation in the Program will end on the date communicated to you by UniCare, and the MCT Measurement Period Handbook will never apply to you. If you do not provide such notice, the Addendum shall remain in effect, and the MCT Measurement Period Handbook shall be deemed to have been accepted by you, and shall become effective and binding on the first day of the Measurement Period.
The provisions of this section entitled “Commercial Business Medical Cost Target” shall be effective, enforceable and implemented, notwithstanding any conflicting or contrary provision (including provisions relating to amendments or Program termination) contained in the Addendum or in the Agreement to which it is attached. To the extent that different notices or time frames than described above are required by law, then the provisions of law shall supersede the contractual provisions of this section.

PERFORMANCE ASSESSMENT – COMMERCIAL BUSINESS MEDICAL COST TARGET AND MEDICAL LOSS RATIO MODELS

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

Steps for Performance Improvement:

1) Choose a measure.
2) Determine a baseline.
3) Evaluate performance.
4) If performance is not to desired level, develop a performance aim.
5) Make changes to improve performance.
6) Monitor performance over time.

In addition to assessing performance against thresholds, a subset of the quality measures will be scored for improvement. The selection of these measures will take into account the current performance on measures.
These improvement measures will be assessed at the Provider level (as defined in the Addendum) 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 Medical Cost Target Model).

LINKING PERFORMANCE ASSESSMENT TO SHARED SAVINGS

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

**Quality Gate**

Your 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 performance as defined in the MCT Measurement Period Handbook.

**Proportion of Shared Savings Earned**

After the Quality Gate is satisfied, the proportion of shared savings you receive depends on scores on the quality 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.

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

OTHER UNICARE QUALITY INCENTIVE PROGRAMS

Unless otherwise indicated, the Program(s) will replace and supersede any other quality incentive programs currently in place. For services on or after your Program 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 provider based on their historical health care utilization. This process is critical to achieve the objectives of the Program, including transparent and actionable data exchange for the purposes of identifying opportunities for improvement and incenting desired medical outcomes. In this section, as is the case in the Incentive Program section of this Program Description, “Attribution” is the collective term used for assignment of Covered Individuals to a provider.

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

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

Due to certain contract restrictions, customer requirements, Program specific product limitations, and technological limitations, etc., it will not be possible to include all Covered Individuals as Attributed Members in the Program. For example, if an employer group prohibited us from including their employees in the Program, these Covered Individuals would not be Attributed Members. 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 whose coverage 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 the Program as operationally feasible and contractually permitted.
**Attribution with PCP selection**

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

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

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

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

3. **Covered Individual does not select a provider within the same 12-month period**
   - Then 
   - **Health plan selects a provider for the Covered Individual**

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

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

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

*Note: Unless otherwise notified, for practices in Measurement Periods starting prior to 10/1/16, Covered Individuals must have active coverage for at least six (6) months in the entire 24 month period (irrespective of product) and currently be Covered Individuals.
Distinctions between Attribution for Clinical Coordination Payments and Incentive Program Payments

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

There are also times when the total Member Months for an Attributed Member during a completed Measurement Period may be higher than the sum of Member Months attributed to that same individual in monthly attribution reports. For example, when a Covered Individual is attributed to a physician during a Measurement Period using visit-based attribution, that Covered Individual may be attributed to a physician for the full Measurement Period as long as he/she had medical coverage in those months, even if the member was not included in the monthly attribution reports for those months.

As a final example, when a physician with Attributed Members leaves a practice, if the Attributed Members for that physician may stay with the practice, and as long as the Attributed Members do not select a different PCP or have record of visiting another provider in the practice. In this circumstance, the Attributed Members will remain attributed to the practice for purposes of clinical coordination payments, but will not be counted as an Attributed Member for the incentive program payment calculations.
Section 7: Clinical Coordination Reimbursement

OVERVIEW

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

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

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

PAYMENT PROCESS

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

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 Addendum 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 MEDICAL COST TARGET MODEL

Note: The section below only pertains to providers who have Patient-Centered Primary Care Attachments that specifically include their participation in our Commercial business Medical Cost Target model. All terms and provisions in this and all Commercial business Medical Cost Target model designated subsections shall refer only to Commercial business Medical Cost Target model and not to the Medicare Advantage 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 prior 12 month period of time used to establish a “Medical Cost Target (“MCT”), which is defined below. In the event that the MCP is less than the MCT, you may share in a percentage of the savings realized, provided that you meet the Quality Gate and other Non-Cost Performance Targets (as described in Section 5, Quality Measures & Performance Assessment-Medical Cost Target Model).

The Incentive Program terms and details are described below.

DEFINITIONS

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

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

“Gross Savings” means any amounts by which the MCP is less than the MCT, adjusted by the Paid/Allowed Ratio, as calculated by 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), depending on the product or line of business.
“Measurement Period” means the twelve (12) month period during which Medical Cost Performance, and quality and utilization performance, will be measured for purposes of calculating shared savings between 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”), but excluding certain Covered Individuals with transplant or high cost Claims amounts. The formulae for setting the MCP takes 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 may account for any clinical coordination 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 Addendum. 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 using a UniCare developed actuarial trend factor and expressed in terms of a risk-adjusted per member per month (“PMPM”) but excluding certain Covered Individuals with transplant or high cost Claims amounts. The formulae for setting the MCT takes 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 Normalized Risk Score is applied for the Baseline Period. The MCT calculation may account for any clinical coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period. The MCT is 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). A new MCT is established for each separate Measurement Period.

“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 cumulative number of months the Attributed Members are enrolled in the applicable UniCare product for a Medical Panel 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 UniCare 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 Provider’s average risk score relative to the state’s average risk score. Risk scores are generated using the DxCG model from Verisk Health, which uses diagnosis and demographic 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, UniCare 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 a minimum threshold of performance on clinical quality measures that must be achieved to have the opportunity to earn a portion of the shared savings. The Quality Gate is a threshold defined by UniCare, and is set so that performance must be above a predetermined percentile of the market performance as defined in the Commercial Handbook.

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

“Upside Shared Savings Potential” means the maximum percentage of shared savings under the Incentive Program that a Provider may be entitled to, provided that it meets the Quality Gate and other Non-Cost Program Targets.
INCENTIVE PROGRAM TERMS AND DETAILS - MEDICAL COST TARGET MODEL

Upside Shared Savings Potential

The Upside Shared Savings Potential as defined above will be communicated to Provider by 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), 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.

(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 for each Provider within the Medical Panel and allocated accordingly. The weighting, which is based on Measurement Period Member Risk Months, is capped at two times the product-specific Baseline Member Risk Months to limit the impact of large scale membership changes.

(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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Group Count</td>
<td>3</td>
</tr>
<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>Trend</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)] x .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>Member 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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shared Savings Percentage: Total</strong></td>
<td><strong>22%</strong></td>
<td><strong>17%</strong></td>
<td><strong>30%</strong></td>
<td><strong>22%</strong></td>
</tr>
<tr>
<td>Net Aggregate Savings (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/MCP**

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

Tools and Information: 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, derived from risk adjustment tools applied to member data, etc.). In the event that any such tools or information are updated, modified or clarified (collectively, the “Modifications”) in a way that UniCare reasonably deems to materially change the calculation of the MCT and/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. As an 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 or MCP, then an appropriate adjustment may be made to MCT or MCP by UniCare. In such an event, UniCare will notify affected Provider(s) as to the adjusted MCT and/or MCP and the reason for the adjustment.

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

Member Population Shifts: UniCare shall have the option to periodically conduct a review of the Member Population to determine if the Member Population has increased or decreased in excess of ten percent (20%) from the start of the Measurement Period. If such change has occurred, UniCare shall have the option to conduct an impact analysis to determine whether the change has materially impacted MCT components such as Member Population, average risk score, and/or average cost. If UniCare determines the change is material, UniCare reserves the right to issue a revised MCT which shall become effective on the date designated by UniCare.*

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

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

We exclude Attributed Members with certain high-cost Claims amounts and organ transplants during either the Baseline Period used to determine the Medical Cost Targets or the Measurement Period for Medical Cost Performance calculations for Patient-Centered Primary Care providers. The members and all Claims associated with them who are excluded meet either of the following criteria:

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

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

## Upside Shared Savings Payment

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

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 the 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 the 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 reports that show quality, cost and utilization performance over time. These reports should be reviewed and discussed on a regular basis to determine how your organization is progressing toward established benchmarks and targets.
- Leverage tools that are available to your organization. PCMS, MMH+, P360, our collaborative learning events, virtual office hours, the Provider Toolkit, and ACP Practice Advisor tool are just a few ways to access information and drive quality improvement.
MEDICAL PANELS - COMMERCIAL BUSINESS MEDICAL COST TARGET MODEL

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

Formation of Medical Panels

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

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

Prior to the Measurement Period start date, 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. If a physician group would like to change the assigned Medical Panel to another Medical Panel, a form may be available prior to the Measurement Period to identify this preference. Practices will have a window of time to submit such preferences. After this preference time period is complete, 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 a single provider group represents a Medical Panel, both quality and utilization performance will be calculated at the group level.
Section 9: Reporting

As part of our commitment to sharing actionable data with Patient-Centered Primary Care Providers, reports, offering detailed information about your Attributed patient population are available on 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, potentially preventable visits (ER) as well as inpatient visits with Ambulatory Sensitive Conditions.

To support performance management, PCMS will help you monitor and improve your performance in the Program’s payment model, connecting the dots for you between the actionable activities that tie to the Program’s financial incentives. Additional detail about the tool and information we currently plan to make available to you is supplied below.

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

**POPULATION MANAGEMENT**

Attributed Patients

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

- Demographic(s)
- Attributed provider
- Attributed organization
- Attributed Member prospective risk score
- Number of care opportunities and corresponding details
- Number of related conditions and condition details
- Number of visits and corresponding details
- Total costs associated with an Attributed Member
- Enrollment in care management or disease management programs
Within the Attributed Patients dashboard, you have the ability to view your high-risk “Hot Spotter” Attributed Members, new Attributed Members, and Attributed Members with recent inpatient authorizations. An overview of these views is provided below.

Hot Spotter Chronic Conditions and Hot Spotter Readmission Views

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

New Patient View

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

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

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

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

Performance Scorecard

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

Medical Cost: Medical Cost Target ("MCT") and Medical Cost Performance ("MCP")

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

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 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
- 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 webpage.
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 help 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 Addendum, then the definition in the Addendum 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>
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</thead>
<tbody>
<tr>
<td>Addendum</td>
<td>Abbreviated reference to the Program Addendum or the Patient-Centered Primary Care Addendum of the contractual document the Provider signs to participate in the Patient-Centered Primary Care Program. This addendum is an amendment to the physician’s Provider Agreement with UniCare.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Attributed Members</td>
<td>Means those Covered Individuals who are attributed by UniCare to Represented Primary Care Physicians for Program purposes using the Attribution Methodology and adjusted for retroactive enrollment changes (as applicable). The term “Attributed Members” shall not include any Covered Individuals whom UniCare, in the exercise of its sole discretion, does not include on the attribution reporting tools that are made available to Provider. By way of example, if the monthly attribution report does not include Covered Individuals, then those Covered Individuals will not be considered Attributed Members for the purposes of the Program. 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.</td>
<td>Addendum</td>
</tr>
</tbody>
</table>
| Attribution Methodology | Means a process whereby UniCare, in it’s sole discretion, will assign Covered Individuals to the Represented Primary Care Physicians, in one of the following manners:  
   i) based on the formal selection of a Primary Care Physician by the Covered Individual; or  
   ii) based on the formal assignment of a Primary Care Physician, 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 Physician, utilizing the Attribution Methodology will not impose any limitations or constraints on the freedom of such Covered Individuals to refer themselves for Health Services except as may otherwise be set forth in the Health Benefit Plan. The Attribution Methodology is described further in the Program Description. | Addendum|
<table>
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<tr>
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<tbody>
<tr>
<td><strong>Baseline Period</strong></td>
<td>Means a defined twelve (12) month period preceding a Measurement Period. To ensure all Claims have been received and processed by UniCare, there will be a minimum of three (3) months paid for Claims run-out between the end of the Baseline Period and the beginning of the Measurement Period plus generally a three (3) month period to perform calculations. The Baseline Period is the time frame which is used to set Medical Cost Targets.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td><strong>Care Plan</strong></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><strong>Care Plan Assessment Domains</strong></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><strong>Clinical Quality Measures – Commercial Business</strong></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 sub-composites. These measures cover care for both the adult and pediatric populations. Nationally standardized specifications are used to construct the quality measures in conjunction with administrative data.</td>
<td>Program Description (Section 5)</td>
</tr>
<tr>
<td><strong>Gross Savings – Medical Cost Target Model</strong></td>
<td>Any amounts by which the Medical Cost Performance (“MCP”) is less than the Medical Cost Target (“MCT”), 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 Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Holdback Amount</strong></td>
<td>The percentage of any applicable annual distribution payment based on earned Net Aggregate Savings that may be retained by 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><strong>Incentive Program</strong></td>
<td>The opportunity for PCPs to increase their revenue as they participate in the Patient-Centered Primary Care Program. To be eligible, PCPs must first achieve a threshold level of quality based on physician quality performance criteria. A complete description of the Incentive Program is in the Program Description.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Glossary Term</td>
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<tr>
<td>Measurement Period – Medical Cost Target Model</td>
<td>The twelve (12) month period during which Medical Cost Performance, and quality and utilization performance, will be measured for purposes of calculating shared savings between UniCare and the Medical Panel.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</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”) but excluding certain Covered Individuals with transplant or high-cost claims amounts. The formulae for setting the MCP takes 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 may account for any clinical coordination 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 Addendum. 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>
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<tr>
<td><strong>Medical Cost Target (“MCT”)</strong></td>
<td>Means the historic cost experience in the defined Member Population during the Baseline Period, trended forward using a UniCare developed actuarial trend factor and expressed in terms of a risk-adjusted per member per month (“PMPM”) but excluding certain Covered Individuals with transplant or high-cost Claims amounts. The formulae for setting the MCT takes into account risk-adjusted (“PMPM”) Claims experience within theAttributed Member Population during the Baseline Period, but exclude certain transplant and high-cost Claims amounts. As part of the MCT calculation, a Normalized Risk Score is applied for the Baseline Period., The MCT calculation may account for any clinical coordination per member per month reimbursement or projection for Attributed Members during the immediately prior Baseline Period. The MCT is 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><strong>Medical Panel – Medical Cost Target Model</strong></td>
<td>A single provider organization or the grouping of multiple provider organizations for purposes of calculating statistically meaningful Medical Cost Targets (“MCTs”), 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-Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Member Months – Medical Cost Target Model</strong></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-Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Member Population – Medical Cost Target Model</strong></td>
<td>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).</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td><strong>Member Risk Months</strong></td>
<td>The Member Population’s average Normalized Risk Score multiplied by their Member Months in the applicable UniCare products during a Measurement Period.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Glossary Term</td>
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<tr>
<td>Minimum Risk Corridor (&quot;MRC&quot;) Medical Cost Target Model</td>
<td>The percentage of Medical Cost Target (&quot;MCT&quot;) 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-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Member Medical History Plus (&quot;MMH+&quot;)</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>Net Aggregate Savings – Medical Cost Target Model</td>
<td>The total allocated Savings Pool(s) multiplied by the Upside Shared Savings Percentage, and limited by the Upside Cap.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Non-Cost Performance Targets</td>
<td>The quality and utilization performance goals tied to shared savings under the Incentive Program. Quality measures are evaluated at the Provider level (subject to membership requirements identified in the Shared Savings Determination section below), whereas utilization measures are evaluated at the Medical Panel level.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Normalized Risk Score</td>
<td>Means Provider’s average risk score relative to the state’s average risk score. Risk scores are generated using the DXCG model from Verisk Health, which uses diagnosis and demographic 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, UniCare will provide notice to you.</td>
<td>Program Description (Section 8)</td>
</tr>
<tr>
<td>Paid/Allowed Ratio</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>
</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) |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician(s) or PCP(s)</td>
<td>Physicians whose primary specialty, as indicated in the UniCare provider files, is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Program</td>
<td>Abbreviated reference to our Patient-Centered Primary Care Program.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Program Addendum Effective Date</td>
<td>The date the 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>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 Physicians and Represented Physicians, as applicable, in creating a patient-centric practice environment and care model for their Covered Individuals as well as Program terms, conditions and requirements. A current copy of the Program Description and periodic updates thereto, is available on the 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 Practice Toolkit</td>
<td>The tools and information that will be made available to provider organizations to assist with population health management.</td>
<td>Program Description (Section 4)</td>
</tr>
<tr>
<td>Quality Gate – Medical Cost Target Model</td>
<td>A minimum threshold of performance on clinical quality measures that must be achieved to have the opportunity to earn a portion of the shared savings. The Quality Gate is a threshold defined by 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-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Represented Primary Care Provider(s) or Represented PCP(s)</td>
<td>Means all of the providers in the Provider’s practice whose primary specialty, as indicated in the UniCare provider files, is internal medicine, family practice/medicine, general practice/medicine or geriatrics (collectively, “Primary Care Physician(s)”) and nurse practitioners who participate in the Program by virtue of being covered under Agreement and this Addendum.</td>
<td>Addendum</td>
</tr>
<tr>
<td>Glossary Term</td>
<td>Definition</td>
<td>Source</td>
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<tr>
<td>Represented Providers</td>
<td>The physicians in the provider organization who bill under the Organization’s tax identification number(s), are board-certified or board eligible, and who participate in the Program by virtue of being covered under the Agreement and this Addendum.</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>
<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 – Medical Cost Target Model</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-Medical Cost Target Model)</td>
</tr>
<tr>
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<tr>
<td>Upside Shared Savings Percentage – Medical Cost Target Model</td>
<td>The percentage of shared savings under the Incentive Program that Provider is determined to be entitled to after (i) you meet the Quality Gate and (ii) all other applicable adjustments have been made to the Upside Shared Savings Potential based on the Non-Cost Performance Target scores for you and your Medical Panel. The Upside Shared Savings Percentage can be the same percentage as the Upside Shared Savings Potential if all Non-Cost Performance Targets are fully achieved by you and your Medical Panel under the Program. The Upside Shared Savings Percentage will be less than the Upside Shared Savings Potential if all Non-Cost Performance Targets are not achieved, and zero if the Quality Gate is not met.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>Upside Shared Savings Potential – Medical Cost Target Model</td>
<td>The maximum percentage of shared savings under the Incentive Program that you may be entitled to, provided that your provider organization meets the Quality Gate and other Non-Cost Program Targets.</td>
<td>Program Description (Section 8-Medical Cost Target Model)</td>
</tr>
<tr>
<td>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 (&quot;ER&quot;) 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>