Enhanced Personal Health Care (EPHC) Essentials Program Description 2022

Commercial Business

UniCare

TABLE OF CONTENTS

INTRODUCTION

The UniCare Enhanced Personal Health Care (EPHC) Essentials Program (Program) structure rewards our valued Providers for the quality of care they provide our Members. The Program seeks to encourage efficient, preventive, and cost-effective healthcare practices by using a system of Scorecard Measures designed based on shared savings principles. Primary Care Physicians (PCPs) who meet certain eligibility requirements and Targets will receive payment as described below.

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 practice name, and phone number with area code.

Market	Mailbox
Massachusetts	UniCareProviderRelations@anthem.com

GENERAL PROGRAM INFORMATION

OBJECTIVES

The *objectives* of the Program are to:

- Support the transition from a fragmented and transactional healthcare delivery system to a patient-centered system by investing in primary care and focusing on improving patient health.
- Redesign the current reimbursement model to move from volume-based to value-based payment, align financial incentives, and provide financial support for the work and tools that facilitate patient- centered care.
- Make available to providers tools, resources, and meaningful information that promote the key elements of patient-centered care: shared decision-making, proactive health management, coordinated care delivery, adherence to evidence-based guidelines, and care planning – all built around the needs of the individual patient.
- Improve the patient experience by (the following list is not exhaustive):
    - Facilitating better access to a primary care provider (PCP) who will care for the "whole person," be each patient's healthcare champion, and help patients navigate the complex healthcare system.
    - Inviting patients' active participation in their healthcare through shared decision-making.
    - Focusing Providers' attention on opportunities to lower cost of care while improving quality outcomes.

PROGRAM COMMUNICATIONS

Communications regarding Program changes, updates, and activities will be available through direct communication from UniCare or via the web-based reporting tool known as Provider Care Management Solutions (PCMS). Complete the PCMS registration for UniCare to receive important communications. Review the contact information that we have on file on a quarterly basis and update as needed.

PROGRAM RESOURCES

As part of our commitment to sharing actionable data with EPHC Essentials Providers, reports offering detailed information about your attributed patient population are available on PCMS. An important requirement to ensure your success in the Program is to register for, and use PCMS. Follow the steps below to register. Through alerts, dashboards, and reports, PCMS supports both population health management as well as Program-specific financial performance management.

AVAILITY AND PROVIDER CARE MANAGEMENT SOLUTIONS (PCMS) – GETTING STARTED WITH POPULATION HEALTH MANAGEMENT

Population health management and the sharing of health information are core components of the Program.

AVAILITY

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.

How to get started

If your organization is not currently registered for Availity, go to https://www.availity.com and select Register to complete the online application.

Once logged into Availity, your Administrator will need to take the following steps to assign access to Provider Online Reporting:

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

Access Program reports:

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

PROVIDER CARE MANAGEMENT SOLUTIONS (PCMS)

To support population health management, our web-based reporting tool, PCMS will help you evaluate and manage your membership and offer actionable clinical insights, such as care gap messaging and preemptive flagging of Attributed Members with high risk for readmission, Potentially Avoidable ER (PAER) visits and Inpatient Admissions. To support performance management and improved health outcomes for your patients, the tool not only provides member-level information, such as potential gaps in care, but also will help you monitor and improve your performance with respect to the Program. Additional detail about the tool and information 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 reviewed and restated if applicable. As a condition of participation in the Program, you accept the limitations that may be inherent in our systems, data processing, and time constraints.

Examples of some reports available in PCMS are displayed below. For the full list of reports, refer to the PCMS Overview User Guide

- Attributed Patients Report
    - The **Attributed Patients Report** details information about the Provider's Attributed Members, including information on each Member's attribution method and attribution duration.
- ER Visits Report
    - The **ER Visits Report** identifies Members with ER visits in the past rolling 12 months. It includes a flag for Members identified for PAER visits as well as drop-down summary chart views to identify avoidable ER visits and utilization by Member population.
- Care Opportunities Report
    - The **Care Opportunities Report** identifies Attributed Members who are found to have care opportunities. Care opportunities are situations in which there are active or potential gaps in care associated with recommended evidence-based care and our clinical quality metrics. Care opportunities that have been completed are also included.
- Scorecard
    - The **Scorecard** view displays the user's performance against the composites and sub composites of their Program's Scorecard. Content displayed will vary based upon the user's line of business, Measurement Period and Program contract.

OPIOID RELATED MEASURES

Information about your Attributed Members in select opioid-related measures will be provided to you in PCMS as informational-only, meaning we are providing the data for educational purposes and awareness. Incentive Payments will not be offered on these measures, nor will there be any adverse impact on other Incentive Payments covered later in this document. More information on the opioid-related measures and how they are measured will be provided in the measure technical specifications.

DEFINITIONS

Actual Performance: The results achieved by a Provider for each measure in the Program Scorecard during the Measurement Period.

Allowed Amount: The maximum eligible amount paid for a service, including the amount paid by UniCare and any Covered Individual copayments and deductibles.

Attribution: A process used to assign Covered Individuals to a Provider based on their historical healthcare utilization, or, in some instances, based on his/her own selection or selection performed on the Covered Individual's behalf.

Baseline Period: A defined period preceding a Measurement Period determined by UniCare used to set Targets and/or give Providers an indication of their performance at the start of the Measurement Period.

Earned Per Member Per Month PMPM: The Earned PMPM by a Provider based on performance during the Measurement Period and paid out after the Measurement Period. It is calculated as the sum of the Earned PMPM on each Program Scorecard Measure.

Episode Treatment Groups (ETG®) Cost Efficiency Ratio: The value, determined by UniCare, derived from dividing observed total Allowed Amounts for episodes of care for a Provider's Attributed Members during the Measurement Period by the expected total Allowed Amounts for those episodes. Expected total Allowed Amounts are based on average Allowed Amounts

for the same types and severity of episodes for peers within the Provider's Peer Group during the Measurement Period.

Full Credit PMPM: The maximum Potential Earned PMPM set for each measure.

Good Standing: Conditions the Provider must adhere to for inclusion in the Program. These include: the Provider's Participating Provider Agreement is in full force and effect, and that (i) neither party has notified the other of its intent to terminate the Agreement with or without cause; (ii) the Provider is not in breach of the Agreement; (iii) the Provider (or any participating Provider under the Agreement) has not been suspended or restricted in the performance of such Agreement for any reason; (iv) the Provider does not have any outstanding obligation under a corrective action plan that has not been timely met to the reasonable satisfaction of UniCare, or (v) the Provider has not failed or refused to refund any outstanding overpayment to UniCare following notice and opportunity to cure.

Incentive Payment: The total dollar amount earned for the Measurement Period is based on the product of the Earned PMPM multiplied by the total Member Months; this term can be used in reference to the Scorecard Measures either individually, or in aggregate.

Measurement Period: The twelve (12) month period during which cost, quality and utilization performance, will be measured for purposes of calculating the Incentive Payment.

Member Months: The cumulative number of months Attributed Members in the Member Population are assigned to the Provider during the Measurement Period.

Minimum Threshold: The minimum number of measurable observations required for a Scorecard Measure to be eligible for an Incentive Payment. This does not apply to all measures; refer to the Program Scorecard section below to identify which measures have a Minimum Threshold.

Partial Credit PMPM: Any Potential Earned PMPM that is less than the Full Credit PMPM amount set for each measure.

Peer Group: A group of similar Providers, based on predetermined demographics and geography used to determine the Targets on the Program Scorecard.

Potential Earned PMPM: The available PMPM that a Provider can earn on the Scorecard Measures.

Program Scorecard: The aggregate set of Scorecard Measures used to determine Provider's Actual Performance and Earned PMPM.

Quality Gate: The minimum level of performance on specified measures that a Provider must achieve in order to be eligible for an Incentive Payment on any of the Scorecard Measures. Refer to the Quality Gate section below for further details.

Quality Measures: The set of indicators that will be used each year to determine the quality performance of the Provider.

Scorecard Measures: The quality, utilization, and cost measures described in this Program Description that will be evaluated during each Measurement Period; Scorecard Measures may be based on standards established or adopted by UniCare related to appropriateness, cost or utilization of medical services or administrative requirements.

Self-Reported Measures: The set of pre-defined Scorecard Measures that cannot be assessed using standard claim or quality data. The results for these measures are collected at the end of the Measurement Period.

Target(s): Thresholds set for each Program Scorecard Measure. Refer to the table below for Target examples. Some Scorecard Measures will have a low and high Target to determine if the Provider will receive Partial Credit PMPM or Full Credit PMPM for the Scorecard Measure.

Utilization Measures: The set of indicators that will be used each year to determine the utilization performance of the Provider.

ATTRIBUTION

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 the list will be available in PCMS. Provided below is an overview of the Program's Attribution algorithm for: (1) a product where Covered Individuals select a PCP or a PCP is selected on their behalf, and (2) visit based Attribution.

The minimum threshold for Provider attributed membership is 250 Attributed Members for Commercial. If a Provider fails to meet this minimum threshold for two consecutive Measurement Periods, they will be evaluated for removal from the Program.

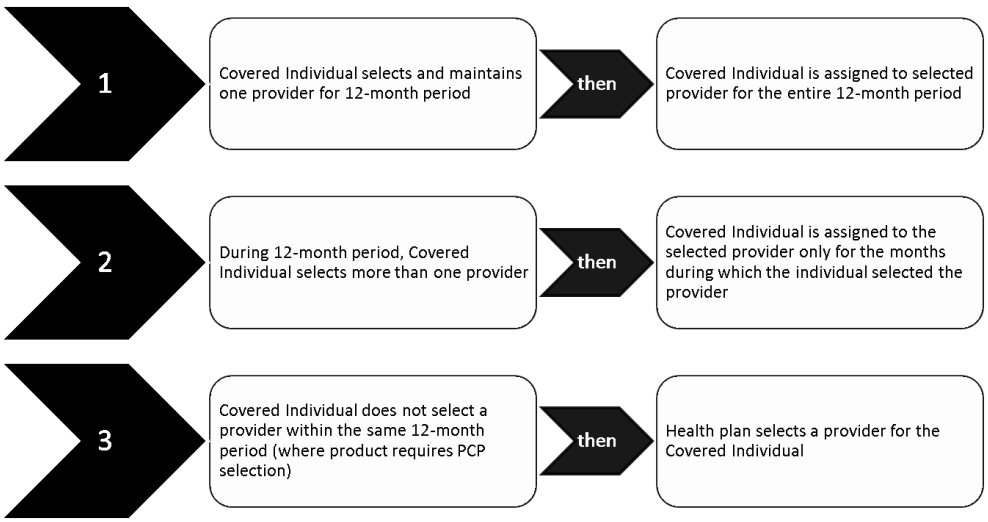
A Covered Individual may become attributed to a Provider when:

- The Member and Provider have affinity to each other based on historical medical encounters
- The Provider is participating in a value based program such as EPHC
- The Member meets all the requirements of that value based Program so that they count towards the Provider's performance score

Provider Attribution algorithm:

1. Self-Selection

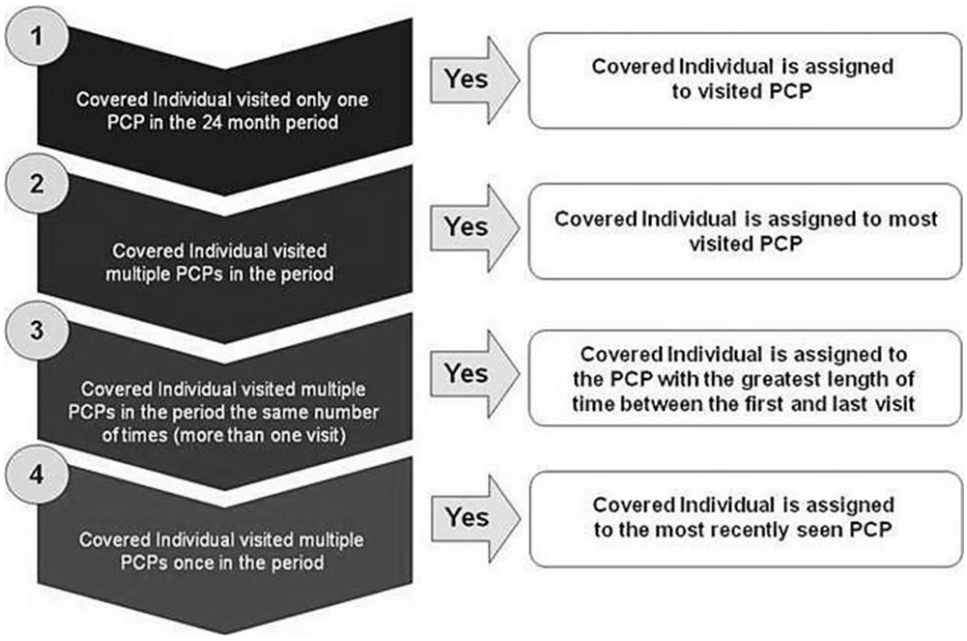
A Member self-selects a PCP, or is assigned one by UniCare. This method is typically used for HMO products.



2. Visit Based

A sophisticated algorithm looks at Evaluation & Management (E&M) visits **over a two year period** to determine which Provider was acting as the PCP in that timeframe.

- This method is typically used for Members with PPO products.
- A Member must have UniCare primary medical coverage for at least 3 months within the two-year period.
- There is a preference in the logic to identify a PCP specialist as the affinity provider.
- If multiple doctors have an equal number of E&M visits, the logic has rules to break the tie. The two-year window of claims rolls forward once a month.



ATTRIBUTION FOR INCENTIVE PAYMENT

The following distinctions are applicable for the Member Months used for the Incentive Payment:

- An Attributed Member who has Member Months associated with 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.
- The total retrospective Member Months for an Attributed Member during a completed Measurement Period may be higher than the sum of months that the Attributed Member appeared on the web-based reporting tool, which are prospective. 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 web-based reporting tool for those months.
- When a physician with Attributed Members leaves a practice, the Attributed Members for that physician may stay with the practice as long as the Attributed Members do not select a different PCP or have record of visiting another provider in the practice. In this circumstance, the Attributed Members will remain attributed to the practice for purposes of clinical coordination payments, but will not be counted as an Attributed Member for the Incentive Payment calculations.
- Attribution for the Incentive Payment is based on retrospective Member Months for Attributed Membership during the associated Measurement Period. Attribution is not prorated for partial months; rather, it is determined by eligibility as of the last day of the month. If an Attributed Member is active as of the last day of a month, a Member Month will be counted for the Attributed Member. If an Attributed Member is not active as of the last day of a month, a Member Month will not be counted for the Attributed Member.

ATTRIBUTION FOR CLINICAL COORDINATION PAYMENTS

Attribution that is used for clinical coordination payments (when applicable) is 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 Members are considered part of the Program for that month. For Attributed Members added after the 15th day of the month, the Member will not be considered in the Program until the following month. Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a Provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such Provider in order to promote cost-effective distribution of payments. Such payment will be made to the Provider one month after it would otherwise have been paid even if the total amount payable to the Provider at that time is still less than $5.

EPHC ESSENTIALS PROGRAM COMPONENTS

ELIGIBILITY REQUIREMENTS

PCPs must meet all of the following requirements to be eligible for the Program and to potentially earn an Incentive Payment:

- Execute an EPHC Essentials contract, in the form established by UniCare prior to the start of the Measurement Period.
- Be a participating Provider for the entire Measurement Period.
- Remain in Good Standing at all times during the Measurement Period.
- Register for, and use Provider Care Management Solutions (PCMS) during the Measurement Period.
- Provide a contact name and email address of the practice individual responsible for PCMS registration and communicating with the health plan associates during the Measurement Period; this person does not need to be a physician, it can be any individual who is permitted to view PHI.

PROGRAM SCORECARD

References to performance assessments in this section refer to performance during the Measurement Period unless otherwise specified. UniCare will provide enrolled PCPs with both interim (quarterly) and year-end reports through PCMS.

The Program Scorecard assesses your performance on quality, utilization, and cost using a series of Scorecard Measures. UniCare has the ability to choose these Scorecard Measures and apply a PMPM incentive amount to them. Not all Scorecard Measures will have a PMPM incentive amount attached to them, but the data will still be reflected on the Program Scorecard. Both incentivized & non-incentivized (Informational only) Scorecard Measures are determined at the market level by UniCare. The Scorecard Measures are used to establish a minimum level of performance expected of you under the Program, to encourage improvement through sharing of information, and to determine any Incentive Payment earned.

QUALITY MEASURES

The Quality Measures included in the Program Scorecard cover care rendered during a Measurement Period for both the adult and pediatric populations. This Program uses a limited set of Quality Measures to allow Providers to significantly impact Attributed Members' health outcomes. Nationally standardized specifications are used to construct the Quality Measures in conjunction with UniCare administrative data.

Table 1 provides a list of example Quality Measures. Some Providers may have a different subset of the measures listed; a final list of the Quality Measures will be provided in the Technical Specifications prior to the start of the Measurement Period. The Quality Measures will display in 3 available cohorts (Pediatric, Adult and Family) of which a Provider can participate. A Provider can only participate in one of the cohorts. The cohort the Provider participates in is dependent on the TIN Member mix. The Quality Measures and cohort will be provided in the first quarter of the Measurement Period. An example of the calculation of the Quality Measures is provided below.

Table 1: **The Quality Measures**

As mentioned above, your Quality Measures may be a subset of the measures listed below.

Quality Measure Name
Adult Prevention - Breast Cancer Screening
Diabetes: HbA1c Testing
Kidney Health Evaluation
Medication Adherence: Cholesterol (Statins)
Medication Adherence: Hypertension
Medication Adherence: Oral Diabetes
Pediatric Prevention - Childhood Immunization Status: MMR
Pediatric Prevention - Childhood Immunization Status: VZV
Pediatric Prevention – W30- Well-Child Visits in the first 30 months of Life: Ages 0-15 Months Cohort
Pediatric Prevention – WCV – Child and Adolescent Well Care Visit : Ages 3-6 Years Cohort
Other Acute/Chronic/Safety - Adult - Asthma Medication Ratio
Other Acute/Chronic/Safety - Pediatric - Asthma Medication Ratio
Other Acute/Chronic/Safety - Pediatric - Appropriate Testing for Children with Pharyngitis
Other Acute/Chronic/Safety - Pediatric – Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

QUALITY GATE

Your practice must achieve a Minimum Threshold of performance on the Quality Measures to have the opportunity to earn an Incentive Payment in the Program. The Quality Gate is set on specific Quality Measures and will be supplied (along with the Targets) to your practice prior to the start of the Measurement Period, or soon thereafter.

After the Quality Gate is satisfied, the total Incentive Payment that a Provider is eligible to receive will vary depending on their results on each Scorecard Measure. If the Quality Gate is not passed, there can be no potential to achieve an Earned PMPM regardless of performance in other areas of the Program Scorecard.

In the example below, the Quality Gate metric for the Measurement Period is the Provider's average performance for all scoreable Quality Measures. This score must exceed the 33rd percentile of the Peer Group's average performance across all Quality Measures.

The Quality Gate is calculated as follows:

1. Determine which of the measures are scoreable for the Provider. Quality Measures are deemed scoreable if the denominator is ≥ five.
2. Additionally, the summation of denominators for all of the Quality Measures (regardless of denominator size) will be calculated.
3. In order to proceed with calculating the Quality Gate, there must be at least four scoreable measures (Step 1) or the sum of denominators (Step 2) must be ≥ 30.
4. Calculate the Provider's overall performance for the scoreable Quality Measures by dividing the summation of the numerators by the summation of the denominators for each of the scoreable Quality Measures (expressed as a percent).
5. If the percentage from Step 4 is equal to or greater than the Quality Gate threshold, the Provider will have satisfied the requirements to pass the Quality Gate and can now be eligible (but not guaranteed) to receive an Incentive Payment in the Measurement Period.

CALCULATING THE QUALITY MEASURES

Each of the Quality Measures are scored individually and have individual Potential Earned PMPMs assigned to them. Each measure must meet the Minimum Threshold of ≥ five Attributed Members in the denominator to be scored. Once those criteria are met, the following steps take place:

1. The compliance rate will be calculated for each measure by dividing the numerator into the denominator.
2. The compliance rate will be compared to the low and high Targets for each measure. The low Target must be met in order to receive a Partial Credit PMPM. The high Target must be met in order to receive a Full Credit PMPM.
3. For any of the Quality Measures that do not meet the Minimum Threshold, the Potential Earned PMPM assigned to that measure will be redistributed among the remaining scoreable Quality Measures.

The Quality Measures will be continuously monitored and data will be available for the entire Measurement Period, even if the Minimum Threshold is not met or the Quality Gate is not initially met.

Table 2: Calculating the Quality Composite

In this example, the total performance of 74.88% would be used to determine if the Provider passed the Quality Gate of 33rd percentile. The 33rd percentile Quality Gate equates to a 35.23% compliance rate and there are 14 scoreable measures; two measures did not meet the Minimum Threshold. In PCMS, the scoreable measures will be highlighted in green.

Quality Scorecard Measures	Numerator	Denominator	Scoreable Indicator	Compliance Rate
Breast Cancer Screening	60	82	Y	73.17%
HbA1c Testing	13	15	Y	86.67%
Kidney Health Evaluation	14	23	Y	60.87%
MA: Cholesterol (Statins)	55	69	Y	79.71%
MA: Hypertension	1	1	N	100.00%
MA: Oral Diabetes	28	42	Y	66.67%
Childhood Immunization Status: MMR	24	40	Y	60.00%
Childhood Immunization Status: VZV	23	28	Y	82.14%
W30- Well-Child Visits in the first 30 months of Life: Ages 0-15 Months Cohort	18	19	Y	94.74%

WCV – Child and Adolescent Well Care Visit : Ages 3-6 Years Cohort	31	40	Y	77.50%
Adult - Asthma Medication Ratio	25	30	Y	83.33%
Pediatric - Asthma Medication Ratio	31	40	Y	77.50%
Pediatric - Appropriate Testing for Children with Pharyngitis	1	2	N	50.00%
Pediatric – Avoidance of Antibiotic Treatment for cute Bronchitis/Bronchiolitis	9	16	Y	56.25%
Overall Quality Performance	**331**	**444**		**74.88%**
Quality Gate Threshold:				35.23% (33rd Percentile)
Scoreable Measure Count				12

COST AND UTILIZATION MEASURES

Cost and Utilization measures are part of the Scorecard. Utilization measures (usually 3-4) are required. Cost and Utilization measures will be provided prior to the start of the Measurement Period. Example Cost and Utilization measures below:

Table 3: Cost and Utilization Measures

Measure Name
ETG® Cost Efficiency Ratio
Inpatient Admission/1,000
Potentially Avoidable ER Visits

CALCULATING THE COST AND UTILIZATION MEASURES

Similar to the Quality Measures, each of the cost and Utilization Measures are scored individually and have individual Potential Earned PMPMs assigned to them. The rate for the Cost and Utilization Measures will be compared to the low and high Targets for each measure. The low Target must be met in order to receive a Partial Credit PMPM. The high Target must be met in order to receive a Full Credit PMPM. For any of the cost and Utilization Measures that do not meet the Minimum Threshold (if applicable), the Potential Earned PMPM assigned to the measure(s) will be redistributed among the remaining scoreable measures on the Program Scorecard, excluding Quality Measures. The Provider must pass the Quality Gate to be eligible for the Potential Earned PMPM for these measures.

MORE INFORMATION ON THE ETG COST EFFICIENCY RATIO

The ETG Cost Efficiency Ratio is measured as an observed to expected ratio, with the “observed value” representing the Allowed Amount cost of episodes of care attributed to Provider and the “expected value” representing average cost for the same types and severity of episodes within a Provider’s Peer Group, as determined by UniCare.

Criteria:

- The analysis aggregates condition-based costs into episodes of care, where all of the costs (professional, institutional inpatient, institutional outpatient, ancillary, and pharmacy) reasonably associated with a given chronic or acute condition are grouped together into a total cost of care for that given condition. Optum® Symmetry’s ETG grouper is used to aggregate episodic costs for the analysis.

- The ETG grouper includes severity indicators for episodes in which patient risk is significantly related to episode costs. All comparisons are based on the risk-adjusted ETG's as applicable.

The following steps are performed by UniCare to determine ETG Cost Efficiency Ratio:

1. "Expected" episode costs are calculated based on network averages within a Provider's Peer Group. Norms are calculated separately by episode type, severity and Peer Group, so that comparisons are made using similar information.
2. The Provider is assigned all episodes for their Attributed Members. A "responsible" Provider is also assigned for each episode. Total costs (including hospital, ancillary and pharmacy costs) are then assigned to that episode. The "responsible Provider" is the Provider generating the highest percentage of dollars associated with an episode.
3. The ETG Cost Efficiency Ratio is calculated for each episode by dividing the actual episode cost by the expected episode cost. The Provider's overall result is the average of the ETG Cost Efficiency Ratios for all episodes for their Attributed Members.

HOW TARGETS ARE SET FOR THE PROGRAM SCORECARD

Most of the Targets for the Program Scorecard are based on Peer Group performance for each Scorecard Measure. UniCare determines the Targets prior to the start of the Measurement Period, by calculating the performance of each Provider in the Peer Group and determining the value for each Percentile Result that must be surpassed to earn an Incentive Payment.

For example, the Targets for the Quality Measures may be set as follows:

- Low Target - 60th Percentile
- High Target - 80th Percentile

The values of Targets will be communicated prior to the start of the Measurement Period (or shortly thereafter) based on the Peer Group average performance for each of the Quality Measures.

LINKING PERFORMANCE ASSESSMENT TO THE INCENTIVE PAYMENT

The opportunity to earn an Incentive Payment is achieved through enhanced care management and delivery of care. The Program Scorecard serves two functions: (1) determines if the Provider met the Quality Gate, and (2) determines the total Incentive Payment earned.

Example:

1. We assume the Provider passed the Quality Gate.
2. The Provider's Earned PMPM for each measure is shown in the Earned PMPM column.
3. If a Provider's performance did not meet or exceed the low Target for a measure, the Earned PMPM for that measure will be $0.00. The sum of the Earned PMPM amounts on each of the Quality Measures in Table 4 equals the total quality Earned PMPM.
4. The total Earned PMPM is then calculated as the sum of the Earned PMPM amounts on each of the Scorecard Measures including cost, access and Quality Measures. In Table 5 below, the total Earned PMPM is $3.35.
5. The total Incentive Payment is calculated by multiplying the total Earned PMPM by the final Member Months for the Measurement Period. We will use 6,000 Member Months shown in Table 6 below.
6. Table 6 takes the total Earned PMPM from Table 5 and then is multiplied by the Member Months to calculate the total Incentive Payment.

Table 4: Calculating the Earned PMPM for the Quality Measures

Quality Scorecard Measures	Numerator	Denominator	Compliance Rate	Low Target	High Target	Partial Credit PMPM	Full Credit PMPM	Earned PMPM
Breast Cancer Screening	60	82	73.17%	73%	80%	$0.09	$0.18	$0.09
HbA1c Testing	13	15	86.67%	76%	82%	$0.09	$0.18	$0.18
Kidney Health Evaluation	14	23	60.87%	83%	92%	$0.09	$0.18	$0.00
MA: Cholesterol (Statins)	55	69	79.71%	57%	78%	$0.09	$0.18	$0.18
MA: Oral Diabetes	28	42	66.67%	93%	98%	$0.09	$0.18	$0.00
Childhood Immunization Status: MMR	24	40	60.00%	50%	60%	$0.09	$0.18	$0.18
Childhood Immunization Status: VZV	23	28	82.14%	72%	79%	$0.09	$0.18	$0.18
W30- Well-Child Visits in the first 30 months of Life: Ages 0-15 Months Cohort	18	19	94.74%	81%	85%	$0.09	$0.18	$0.18
WCV – Child and Adolescent Well Care Visit : Ages 3-6 Years Cohort	31	40	77.50%	75%	85%	$0.09	$0.18	$0.09
Adult - Asthma Medication Ratio	25	30	83.33%	83%	87%	$0.09	$0.18	$0.09
Pediatric - Asthma Medication Ratio	31	40	77.50%	89%	97%	$0.09	$0.18	$0.00
Pediatric – Avoidance of Antibiotic Treatment for cute Bronchitis/Bronchiolitis	9	16	56.25%	86%	88%	$0.09	$0.18	$0.00
Overall Quality Performance	**331**	**444**	**74.88%**	**Total Quality Earned PMPM**				**$1.17**
Quality Gate Threshold			**35.23%**					
The actual low and high Targets will be provided prior to the start of the Measurement Period								

Table 5: Calculating Total Earned PMPM

Measure	Rate	Low Target	High Target	Partial Credit PMPM	Full Credit PMPM	Earned PMPM
Quality Measures	See Table 4				$2.16	$1.17
Potentially Avoidable ER Visits	55.23	60.25	50.36	$0.68	$1.35	$0.68
ETG Cost Efficiency Ratio	0.91	0.96	0.92	$0.50	$1.00	$1.00
Inpatient Admissions/1000	60.12	65.78	55.26	$0.50	$1.00	$0.50
				Total Earned PMPM		**$3.35**

Table 6: Calculating the Incentive Payment

Incentive Payment Calculation		
Provider Member Months		6,000
Total Earned PMPM		$3.35
Incentive Payment to Provider	**$**	**20,100.00**

EARNED INCENTIVE PAYMENT ADMINISTRATION

1. Within 180 days from the end of the relevant Measurement Period, UniCare will determine performance on all Program Scorecard Measures for the Measurement Period. This timeframe allows for a three-month claim run out period prior to calculating performance of the Scorecard Measures.
2. Assuming all preconditions and terms have been satisfied, on an annual basis, but no later than 210 days after the end of the relevant Measurement Period, UniCare shall make the applicable Incentive Payment to the Provider that was earned during the Measurement Period. Notwithstanding any provision to the contrary contained in this Program Description or any other Program-related document, to the extent allowed by law, we will withhold any payment to a Provider that is less than $5 for a period of one month beyond the point when it would otherwise have been paid to such Provider in order to promote cost-effective distribution of payments. Such payment will be made to the Provider one month after it would otherwise have been paid even if the total amount payable to the Provider at that time is still less than $5.
3. A Provider must meet all eligibility requirements in the Measurement Period in order to receive the Incentive Payment under the Program.
4. Except as specifically agreed otherwise by the parties, payments earned 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 Provider level, UniCare will pay the Provider.
5. If Provider does not pay UniCare any deficit that is due within two-hundred and seventy (270) days following the end of the relevant Measurement Period, Provider agrees that UniCare shall be entitled to offset the shortfall against any reimbursement otherwise payable to Provider under any agreement between Provider and UniCare or its affiliates. Notwithstanding the foregoing, if there is an incentive payment due from UniCare to Provider for another value-based program, UniCare shall be entitled to offset the deficit against that incentive payment at any time following the end of the relevant Measurement Period.

PROGRAM CHANGES

UniCare will review Program components on an annual basis, and update them as necessary, to ensure that evidence-based information (information gathered from working with providers like you) is used to measure and incentivize Providers. UniCare reserves the right to modify or amend the Program at any time at its discretion within our contractual notification guidelines provided to Provider.

EXPECTATIONS OF PARTICIPATING PROVIDERS

Provider will obtain access to and utilize PCMS when the tool is made available by UniCare. Provider shall ensure that one of its practice physicians, practice owner, or office manager participate in EPHC Essentials meetings to review outcomes, trends, and opportunities.

Data Sharing Agreement

As part of the enhanced incentive Provider will make best efforts to work with UniCare when requested to enable supplemental/clinical electronic medical record (EMR) data sharing, optimally in a bi-directional fashion, in order to facilitate the delivery of quality care to UniCare Covered Individuals. This obligation includes, but is not limited to:

- identifying key contacts within Provider's organization who will engage in data-sharing work with UniCare;
- working with UniCare to establish connectivity and address any initial and ongoing issues as applicable; and
- providing two years of historical data and engaging in ongoing data sharing using accepted formats.

PROVIDER CONSIDERATIONS

UniCare wants every Provider in the Program to be successful. Below are some actions a Provider may want to consider:

- Engage with your UniCare representative for assistance with report interpretation and identifying opportunities for improvement.
- Establish a process to review your organization's performance on a regular basis. We will provide you with useful data and reporting that show quality, cost, and utilization performance. These reports should be reviewed and discussed on a regular basis to determine how your organization is progressing toward established Targets.
- Leverage PCMS and the Provider Toolkit to access information and drive quality improvement.

IMPORTANT NOTE ABOUT PROGRAM INFORMATION, RESOURCES AND TOOLS

The information, resources, and tools that UniCare provides to you through the EPHC Essentials 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 Covered Individuals 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 necessarily 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 it 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.

EPHC Essentials Program offers an incentive to PCPs to provide quality, cost-effective care while keeping Members' best interests paramount. Eligible PCPs are prohibited from encouraging Member selection or deselection and from discriminating against Members based on location, ethnicity, culture, race, religion, disability, political belief, sex, age, socioeconomic status, health status, or medical history. Participating PCPs are also prohibited from withholding or preventing medically necessary services from being delivered to UniCare Members. The Program is not intended to limit the PCP's exercise of professional judgment in treating Members or to limit the PCP's ability to discuss available treatment options with Members. EPHC Essentials Program does not discriminate against PCPs who provide services to any Member; any particular ethnic, cultural or socioeconomic groups; or groups in particular geographic locations or groups with specific medical conditions.

For self-funded plans claims are administered by UniCare Life & Health Insurance Company.