2016 Quality-In-Sights® Primary Care Incentive Program

Please note: This brochure is intended to provide a description of the Anthem Blue Cross and Blue Shield (Anthem) Quality-In-Sights® program, methodology and measures. For specific information regarding scoring, rewards and results please refer to your program notification letter.

Anthem is pleased to announce the 2016 Quality-In-Sights® Primary Care Incentive Program for eligible participating primary care physicians throughout the state of Colorado. This program rewards performance for select primary care physicians based on nationally endorsed industry standard measures of quality as well as technology adoption, applicable external recognitions and resource measures aimed at improving quality and cost effective patient care.

The Quality-In-Sights® Primary Care Incentive Program is designed to help address some of the most pervasive and costly health concerns facing our nation. Quality-In-Sights® is redefining the relationship that health care physicians traditionally have had with insurers by creating a mutually beneficial, patient-focused collaboration that is right for today's health care environment.

The 2016 Quality-In-Sights® Primary Care Incentive Program will reward eligible physicians who render primary care services to our members and meet or exceed established performance thresholds. It is just one more example of how we are working to fulfill our mission of improving the lives of the people we serve. We are committed to leading the way in improving the quality and affordability of health care benefits and delivery.

This Program was developed to foster positive, collaborative relationships with our participating physicians that will help enable us to promote improved health outcomes through an emphasis on quality primary care services.

Who is eligible for the program?

- Select participating physicians (MDs or DOs) who specialize in Family Practice/Medicine, General Practice/Medicine, Internal Medicine or Pediatrics as their designated primary specialty and are participating in our commercial networks.
- A physician group is defined as an organization at the Tax Identification Number (TIN). A group may include one or more physicians. A physician group must have a minimum number of Anthem commercial members for each component or other criteria, as outlined in the chart on the following page, to be eligible for points related to that component of the program. This helps to ensure that we will be able to effectively and fairly assess the physician group.
- For those physicians who are part of a multi-specialty group, participation in this program is limited to those providers in the group who are in the specialties listed above. Scoring and any compensation increases will be limited to those primary care physicians who are eligible to participate in the program.
- Physician groups such as Physician Hospital Organizations (PHOs) and other entities may not be eligible for the program.
- Anthem will use your current TIN found in our records as of December 31, 2016 for the final measurement and scoring process.
- A group office practice is defined as a medical office location under a TIN which is the primary place of service.

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- A group is eligible for the program if at least one physician in the group is eligible as of December 31, 2016.

What period of time does the program cover?

The measurement year for the program is January 1, 2016 through December 31, 2016.

Whose data will be included in the Quality-In-Sights Primary Care Incentive Program's measurement calculations?

Only Anthem member data will be included in the Quality-In-Sights Primary Care Incentive Program's measurement calculations.

When will my performance results be available?

Final performance results will be available late spring 2017. If you have any questions, please e-mail us at prrprogramsco@wellpoint.com

What are the program measures and eligibility criteria?

Component	Unique Criteria Required for Eligibility Within a TIN
Clinical Quality Measures	
Preventive Care and Screening	30 unique members, in total, for all measures combined in each composite
Care Management	Requires five or ten members per measure to be scored in each composite (see scoring)
External Physician Recognition	Requires at least 50% of eligible physicians within a TIN to have an active External Physician Recognition during the measurement year (1/1/2016-12/31/2016)
Resource Measures	
Overall Cost Performance Index	Requires at least 20 episodes of an Episode Treatment Group® (ETG) over the entire specialty for a 2 year look back period in order to compare a physician's performance to their specialty average
Generic Dispensing Rate	25 minimum Express Scripts® prescriptions filled for a TIN during measurement year (1/1/2016–12/31/2016) and only include members with Express Scripts® benefit
Care Systems (Technology)	
Electronic Prescribing or CCHIT Technology Implementation	Requires at least one group office practice (100% eligible physicians in that office practice) within the TIN to have at least one of the technologies implemented and in use prior to 1/1/2017
AIM Specialty Health® (AIM) ***Opti****Net* Radiology Adoption	Requires at least 1 user within a TIN has signed up and has used the AIM ***Opti****Net* tool to pre-certify for at least 1 health plan member by the last day of the measurement period
Availity Adoption	Requires at least 1 user within a TIN has signed up and has access to Availity by the last day of the measurement period
MMH+® Adoption	Requires at least 1 user within a TIN has signed up and has access to MMH+ by the last day of the measurement period
OR	
Certified Electronic Health Record Technology that has met the Centers of	Requires at least one group office practice (50% eligible physicians in that office practice) within a TIN

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Medicare and Medicaid (CMS) Meaningful Use Requirements.	has implemented a Certified Electronic Health Record Technology that met the CMS Meaningful Use Requirements during the measurement year

How were the measures developed?

We used a variety of resources, including a literature search for evidence- based guidelines, clinical health care experts and data analysis in the development of the set of clinical measures. The clinical quality measures have been derived from sources such as The Healthcare Effectiveness Data and Information Set (HEDIS®) National Quality Forum (NQF) and Ambulatory Care Quality Alliance (AQA). The methods used are consistent with those recommended by the National Committee for Quality Assurance (NCQA) and reflect the most current standards on measuring physician quality of care. HEDIS reporting is the standard for data collection and performance measurement of managed care organizations.

CLINICAL QUALITY MEASURES

The clinical quality measurement analysis is performed by Resolution Health, Inc.™ (RHI) utilizing their Physician Quality Profiler tool.

RHI is a leading data analytics-driven personal health care guidance company that has compiled evidence-based care guidelines and clinical best practices, sourced from organizations such as the NCQA, the American Heart Association (AHA), the American Diabetes Association (ADA), the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), clinical literature and health care experts.

Anthem's administrative claims including professional, facility, pharmacy and lab will only be utilized in the Physician Quality Profiler analysis. Final clinical quality scoring will be performed by Anthem at the TIN level.

More information on RHI can be found at http://www.resolutionhealth.com.

There are two Clinical Quality Components: Preventive Care and Screening, and Care Management Measures.

PREVENTIVE CARE AND SCREENING

Women's Health

Rationale

The American Congress of Obstetricians and Gynecologists (ACOG) states prevention and early detection are the keys to reducing deaths from breast cancers and incidence of Chlamydia infection. ACOG reported that breast cancer is the second leading cause of cancer death in the United States. According to the latest figures from the Centers for Disease Control and Prevention (CDC), approximately 211,731 women were diagnosed with breast cancer. Chlamydia is a major cause of infertility, pelvic inflammatory disease (PID) and ectopic pregnancy in women, and the direct and indirect costs of these illnesses exceed $2 billion as historically reported by the CDC.

Measures

Breast Cancer Screening: This measure identifies women age 52 to 74 as of December 31st of the measurement year who had a mammogram during the measurement year or during the year prior to the measurement year. (Source: NCQA, HEDIS)

Chlamydia Screening: This measure identifies women age 16 to 24 identified as sexually active who had at least one Chlamydia test during the measurement year. (Source: NCQA, HEDIS)

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Cervical Cancer Screening: This measure identifies female members 24-29 years of age who received one or more Pap tests during the measurement year or the two years prior to the measurement year. (Source: NCQA, HEDIS)

Childhood Immunizations

Rationale

Vaccines prevent disease in the people who receive them, and protect those who come in contact with unvaccinated individuals. Vaccine-preventable diseases have a costly impact, resulting in doctors' visits, hospitalizations and premature deaths. Although these diseases aren't as common in the U.S. as they used to be, they do still occur and can lead to pneumonia, choking, brain damage, heart and liver problems and blindness in children who are not immune.

Measures

Varicella Zoster Virus (VZV): This measure identifies the percentage of children 2 years of age during the measurement year who had one chicken pox (VZV) vaccination on or before their second birthday. (Source: NCQA, HEDIS)

Measles, mumps and rubella (MMR): This measure identifies the percentage of children 2 years of age during the measurement year who had one measles, mumps, and rubella (MMR) vaccination on or before their second birthday. (Source: NCQA, HEDIS)

Diptheria Tetanus acellular Pertusis (DTaP): This measure identifies the percentage of children 2 years of age during the measurement year who had ≥4 diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations on or before their second birthday. (Source: NCQA, HEDIS)

Inactivated polio virus (IPV): This measure identifies the percentage of children 2 years of age during the measurement year who had ≥3 inactivated poliovirus (IPV) vaccinations on or before their second birthday. (Source: NCQA, HEDIS)

Haemophilus influenza type B (HiB): This measure identifies the percentage of children 2 years of age during the measurement year who had ≥3 haemophilus influenza type B (HiB) vaccinations on or before their second birthday. (Source: NCQA, HEDIS)

Pneumococcal immunizations: This measure identifies the percentage of children 2 years of age during the measurement year who had ≥4 pneumococcal conjugate vaccinations on or before their second birthday. (Source: NCQA, HEDIS)

CARE MANAGEMENT

Diabetes

Rationale

In 2013, the American Diabetes Association (ADA) estimated that 25.8 million children and adults in the U.S. or 8.3% of the population have diabetes, with recent figures showing almost 2 million new cases diagnosed annually. The rate of diabetes related complications can be significantly reduced with appropriate care. Direct and indirect costs of diabetes in the U.S. in 2012 were estimated at around $245 billion.

Measures

HbA1c annual test: This measure identifies patients between 18 and 75 years old during the measurement year who have diabetes and who had at least 1 HbA1c test during the measurement year.

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(Source: AQA, Centers for Medicare and Medicaid Services-Physician Quality Reporting Initiative /CMS-PQRI/, NCQA, NQF, HEDIS)

Nephropathy screening: This measure identifies patients between 18 and 75 years old during the measurement year who have diabetes and at least one nephropathy screening; or who had evidence of medical attention for existing nephropathy (diagnosis or treatment of nephropathy), who are taking ACE-I/ARBs, or who have had at least one visit with a nephrologist. (Source: NCQA, HEDIS)

Eye exam: This measure identifies patients between 18 and 75 years old who have diabetes and who had a retinal eye exam from an eye care professional in the last 2 years. (Source: NCQA, HEDIS)

Diabetes/Hypertension: This measure identifies patients with diabetes plus hypertension or nephropathy who are taking an ACE inhibitor or ARB during the measurement year. (Source: National Heart Lung and Blood Institute (NHLBI, ADA)

Hypertension

Rationale

The American Heart Association (AHA) reported in 2013 that about 77.9 million people in the U.S. age 20 and older have high blood pressure. One in three adults has high blood pressure and nearly one-third of those adults do not know they have high blood pressure. According to the AHA of all people with high blood pressure, 74.9% were under current treatment, but only 52.5% had it under control. Uncontrolled high blood pressure can lead to stroke, heart attack, heart failure or kidney failure.

Measures

Blood glucose test: The percentage of patients with newly diagnosed hypertension with a lab claim for a blood glucose test within 30 days of the time of diagnosis. (Source: NHLBI)

Proportion of Days Covered (PDC)

Measures

Oral diabetes: This measure identifies patients with at least two prescriptions for diabetic oral agents (non-insulin diabetes medications) in the measurement year who have at least 80% days covered (PDC) since the first prescription of an oral diabetic agent during the year. (Source: CMS Part D Specifications 2012)

Hypertension (ACE or ARB): This measure identifies patients with at least two prescriptions for an ACE/ARB in the measurement year who have at least 80% days covered (PDC) since the first prescription of an ACE/ARB during the year. (Source: CMS Part D Specifications 2012)

Cholesterol (statins): This measure identifies patients with at least two prescriptions for a statin medication in the measurement year who have at least 80% days covered (PDC) since the first prescription of a statin during the year. (Source: CMS Part D Specifications 2012)

Wellness

Rationale

The American Medical Association (AMA) and the American Academy of Pediatrics (AAP) stress the need for annual well care visits for young children and adolescents. During a child's life, the periodic assessment of physical, social and emotional health status is of great importance.

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Measures

Children who turned 15 months old during the measurement year and who had 6 well-child visits during their first 15 months of life. (Source: NCQA, HEDIS)

Children ages 3 to 6 years old during the measurement year who have ≥1 well-child office visit(s) during the measurement year. (Source: NCQA, HEDIS)

Children ages 12 to 21 years old during the measurement year who have ≥1 well-child office visit(s) during the measurement year. (Source: NCQA, HEDIS)

Appropriate Use of Antibiotics

Rationale

According to the Centers for Disease Control (CDC), antibiotic resistance is a serious and growing concern worldwide. The Infectious Diseases Society of America (IDSA) estimates that treating antibiotic resistant infection costs the U.S. between $21 and $34 billion dollars each year. Smart use of antibiotics is a key to controlling the spread of antibiotic resistance.

Measures

The percentage of children 3 months to 18 years old with a diagnosis of an **upper respiratory infection (URI)** who did not receive an antibiotic prescription on or within three days after diagnosis. (Source: NCQA, HEDIS)

The percentage of children 2 to 18 years old, who were diagnosed with **pharyngitis**, prescribed an antibiotic and received a test for group A streptococcus. (Source: NCQA, HEDIS)

The percentage of adults 18 to 64 years old with a diagnosis of **acute bronchitis** who were not dispensed an antibiotic prescription on or within three days after the Index Episode Start Date. (Source: NCQA, HEDIS)

Asthma

Rationale

The American Lung Association estimates that approximately 25.9 million Americans have asthma, with annual associated direct costs of $50.1 billion. Asthma ranks within the top ten prevalent conditions causing limitation of activity. Asthma is the leading chronic illness of children in the U.S., with an estimated 7.1 million Americans impacted under the age of 18.

Measure

This measure identifies members between 5 and 64 years old during the measurement year who have persistent asthma and were appropriately prescribed medication during the measurement year who remained on an asthma controller medication for at least 75% of their treatment period. (Source: NCQA, HEDIS)

Annual Monitoring for Patients on Persistent Medications

Rationale

The NCQA reported that patient safety is highly important for patients at increased risk of adverse drug events from long-term medication use. In addition, the NCQA notes persistent use of these drugs warrants monitoring and follow-up by the prescribing physician to assess for side effects and adjust drug dosage/therapeutic decisions accordingly. According to the NCQA, over $85 billion is spent per year to treat drug-related problems caused by misuse in the ambulatory setting.

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Measures

ACE/ARB: This measure identifies patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for ACE inhibitors or ARBs during the measurement year and at least one therapeutic monitoring event for therapeutic agent in the measurement year. (Source: NCQA, HEDIS)

Digoxin: The percentage of adults who are taking digoxin on a regular basis and have received a serum creatinine and potassium check during the measurement year. (Source: NCQA, HEDIS)

Diuretics: The percentage of adults who are taking diuretics on a persistent basis with a serum potassium or creatinine check during the measurement year. (Source: NCQA, HEDIS)

Medication Compliance

Rationale

Studies showed that only 63% of cardiovascular and diabetic patients are compliant with medication over a year period and take their medication 72% of the time. In 73% of the studies reviewed, compliance had a positive effect on clinical outcomes which led to a decrease in medical events and non-drug costs.

Measure

Beta-blocker treatment: The percentage of patients who were hospitalized for acute myocardial infarction (AMI) and discharged from the hospital sometime between July 1 of the year prior to the measurement year and June 30 of the measurement year who have been on beta-blocker treatment for at least 6 months post discharge. (Source: AQA, CMS-PQRI, NCQA, HEDIS, NQF)

Arthritis

Measure

Disease Modifying Anti-rheumatic Drug (DMARD) Therapy in RA: This measure identifies patients who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a DMARD during the measurement year. (Source: NCQA, HEDIS)

New Episode of Depression

Measures

Effective Acute Phase Treatment: This measure identifies patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Source: NCQA, HEDIS)

Effective Continuation Phase Treatment: This measure identifies patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 180 days (6 months). (Source: NCQA, HEDIS)

ATTRIBUTION LOGIC

A physician algorithm is applied attributing a member result for a measure to one or more physicians depending on both the physician's primary specialty and the specialties considered to be reasonably responsible for the care of the clinical issue upon which a specific measure is based. For example, we would consider that internal medicine and family medicine are specialties relevant to a measure which identifies adult members with diabetes who have received an annual lipid test.

The attribution of a member result to a physician was undertaken in three steps. First, each measure was assigned a set of relevant clinical specialties considered to be reasonably responsible for the care

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addressed in the measure. Second, all relevant specialists associated with the member being evaluated for a measure were considered for attribution. The third step differed for chronic or acute conditions as explained below.

A member result for a given measure addressing a chronic condition was attributed to a physician if that physician had the greatest number of contacts with the member among physicians of the same specialty during the last 18 months of the study period and the specialty of the physician is considered to be reasonably responsible for the care of the issue addressed by the measure. Hence, measures for chronic conditions can be attributed to one physician from each relevant specialty.

A member result for a given measure addressing an acute episode (e.g., URI) was attributed to a physician if that physician was associated with the greatest number of claims for that episode and the specialty of the physician was considered to be reasonably responsible for the care of the acute episode addressed by the measure. Thus, only a single physician can be assigned to a member result for an acute condition.

EXTERNAL PHYSICIAN RECOGNITION

In order to emphasize the clinical quality of care, physicians will receive points for the measure based on the successful completion of a clinical performance assessment program sponsored by either Bridges to Excellence® (BTE) or the NCQA. More information is available on the Bridges to Excellence Recognition Programs at Health Care Incentive Improvement Institute website http://www.hci3.org or http://www.ncqa.org.

Requires at least 50% of eligible physicians within the TIN have current active External Physician Recognition during the measurement year (January 1, 2016 – December 31, 2016).

Bridges to Excellence®	National Committee for Quality Assurance
Asthma Care	Diabetes Physician Recognition Program (DPRP)
Cardiac Care	Heart/Stroke Recognition Program (HSRP)
Congestive Heart Failure	Patient-Centered Medical Home Recognition
COPD Care	
Coronary Artery Disease Care	
Depression Care Management	
Diabetes Care	
Hypertension Care	
IBD Care Recognition	
Spine Care	
BTE Medical Home	

What information is required from practices for the External Physician Recognition Component?

The External Physician Recognition Component will be scored based on the completion of a survey and a list of those physicians within the TIN that have a current (unexpired) External Physician Recognition during the measurement year (January 1, 2016 – December 31, 2016).

The completed survey questions with attestation and list of physicians needs to be submitted to Anthem no later than February 28, 2017. Information on how to obtain the survey can be found on the following pages.

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RESOURCE MEASURES

Overall Cost Performance Index

Rationale

The National Committee for Quality Assurance (NCQA) reported that Americans spend twice as much as other developed countries on health care and are concerned about affordable health care. Little information is publicly available about the delivery of effective and efficient health care services. In order to understand the value of services paid, it is important to see how effectively resources are used when delivering health care.

Measure

Overall Cost Performance Index is determined by a cost performance evaluation that encompasses all costs of care, including Professional, Institutional Inpatient, Institutional Outpatient, Ancillary and Pharmacy costs. Evaluations will be risk adjusted utilizing the Ingenix/Symmetry Episode Treatment Group® (ETG) methodology.

Methodology

The following methodology outlines how the ETG Cost Efficiency Ratio Performance metric is calculated:

1. All costs of care are included, e.g., professional, institutional inpatient, institutional outpatient, ancillary and pharmacy. The ETG methodology is our standard for this analysis because it captures all types of treatment costs, explicitly and addresses patient risk variation, and generates homogeneous patient categories.
2. The ETG grouper includes risk categories for episodes in which patient risk is significantly related to episode costs. All comparisons are based on the risk-adjusted ETG's as applicable.
3. An "expected" episode cost based on network averages is calculated. Norms are calculated separately by specialty and by region so that comparisons are always made with a physician's same-specialty peers to recognize the inherent differences in treatment patterns, even when caring for similar patients, across specialties. The physician's primary specialty is determined at the individual physician level.
4. A "responsible" physician is attributed for each episode. We identify the single physician with the highest total medical and surgical professional costs in the episode (that is, only services directly performed by the physician, not including any facility, pharmacy or other aspects of the patient's care). Total episode costs (including professional, institutional inpatient, institutional outpatient, ancillary and pharmacy) are then assigned to that physician.
5. The cost ratio for each physician, based on a (specialty specific) case mix-adjusted "expected" cost per episode is calculated. The ratio of a physician's actual average costs for treating each episode type (ETG) is divided by their same-specialty peers' average costs for treating that same ETG (in the same geographic region). This ratio is calculated for each ETG treated by each physician, and then these ETG-by-ETG ratios are averaged, and weighted by frequency, to compute their overall Cost Ratio. The actual ETG unit of analysis consists of a base ETG (Condition Class and Body Location) plus a severity indicator. The full ETG also includes more specific episode information, e.g., complication, comorbidity, and treatment indicators which are not used in the analysis. Information in the complication and comorbidity codes is captured by the severity indicator (or risk adjustment), which takes into account all of the clinical factors that reflect actual clinical differences between patients.

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6. Non-specific, routine, and preventive care episodes from the analysis are excluded. Preventive examination or immunization episodes are excluded because we want to encourage providers to perform such services. Episodes without physician involvement (such as pharmacy-only episodes) are also excluded.
7. The primary analysis has been performed at the individual physician level. The results are then aggregated and reported at the physician group/TIN (tax identification) level.

For further detailed information on the methodology, please contact us by e-mail at prrprogramsco@wellpoint.com.

Generic Rate

Rationale

When used as a first line therapeutic option, generics may offer cost-effective treatment when prescribed appropriately. Moving from selected therapeutic classifications to an overall generic dispensing rate measure allows physicians a greater opportunity in the measure.

Measure

The generic rate is based on the number of written and filled Express Scripts® generic scripts (captured for each for the individual providers then aggregated to the TIN) as a percentage of the total number of scripts for a TIN during the measurement periods. The overall generic rate will then be compared to the peer network state rate.

Calculation is found below:

Number of Express Scripts® generic prescriptions / Total number of Express Scripts® prescriptions

CARE SYSTEMS (TECHNOLOGY)

Rationale

Appropriate technology care systems can improve the quality, safety, efficiency and care coordination of patient care and simplify transactions. Meaningful use of technology focuses on the effective use of Electronic Health Records with certain defined capabilities. Centers of Medicare and Medicaid (CMS) Electronic Health Technology certification program requires that eligible professionals must successfully demonstrate meaningful use of a certified electronic health record technology every year they participate in the program.

Measures

A. Technologies

Requires at least one group office practice (100% physicians at the group office location) within the TIN to have at least one of the following technologies implemented and in use prior to January 1, 2017.

- Electronic prescribing, or
- Use of any CCHIT Certified Ambulatory EHR

B. AIM ***Opti****Net* Radiology Adoption

Requires at least 1 user within a TIN has signed up and has used the AIM ***Opti****Net* tool to pre-certify for at least 1 health plan member by the last day of the measurement period.

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Opti*Net* utilizes an easy web tool to facilitate provider registration of equipment, services and staffing. Using its proprietary evaluation criteria, AIM uses this information to generate provider value scoring, which allows ordering physicians and members to determine the best place to receive imaging services.

More information is available at www.aimspecialtyhealth.com

C. Availity Adoption

Requires at least 1 user within a TIN has signed up and has access to Availity by the last day of the measurement period.

Availity offers a secure multi-plan portal at no charge to doctors and other providers and improves efficiencies in the health care system by simplifying many aspects of health plan administration – an important step toward advancing affordable patient care. Availity's "one-stop-shop" approach benefits patients, providers and health plans by streamlining the health care administration process and providing a consistent user experience.

More information is available at www.availity.com.

D. MMH+® Adoption

Member Medical History Plus (MMH+) provides patient-based personal health information via the internet. It's easy to use, secure, and free. This tool combines our rich claims-based data to create a longitudinal patient record.

More information is available at www.anthem.com.

OR

Certified Electronic Health Record Technology that has met the CMS Meaningful Use Requirements.

Requires at least one group office practice (50% eligible physicians in that office practice) within a TIN has implemented a Certified Electronic Health Record Technology that has met the CMS Meaningful Use Requirements during the measurement year.

Required support documentation - Centers for Medicare and Medicaid Services (CMS) Certification of Meaningful Use Requirements submitted to Health plan prior no later than February 28, 2017.

The table below provides only a few examples of Meaningful Use requirements. Please refer to the following website for the complete CMS Meaningful Use requirements.

More information is available at http://www.cms.gov.

Examples of Meaningful Use
Record patient demographics (gender, race, ethnicity, date of birth, preferred language
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)
Maintain up-to-date problem list of current and active diagnoses
Maintain active medication list
Maintain active medication allergy list
Record smoking status for patients 13 years of age or older
For individual professionals, provide patients with clinical summaries for each office visit
On request, provide patients with an electronic copy of their health information (including

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diagnostic test results, problem, list, medication lists, medication allergies
Generate and transmit permissible prescriptions electronically
Computer provider order entry (CPOE) for medication orders
Implement drug-drug and drug-allergy interaction checks
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities
Implement one clinical decision support rule and ability to track compliance with the rule
Implement systems to protect privacy and security of patient data in the Electronic Health Record
Report clinical quality measures to CMS or states.

What information is required from practices for the Care Systems Component?

The Care Systems Component will be scored based on the completion of survey questions, a list of those physicians within the group office practice that have implemented and used the technology prior to January 1, 2017 and applicable external certification documentation. The completed survey with attestation and required support documentation needs to be submitted to Anthem no later than February 28, 2017.

Where is the required survey located?

The required survey for the External Physician Recognition, Clinical Improvement and Care Systems component questions is found on the Provider Online Interactive Tool (POIT) on Anthem's website. POIT is designed to provide program information for our Quality-In-Sights® program through a secure portal. POIT provides you with detailed Quality-In-Sights® program documentation, communications and the ability to contact the Reward and Recognition team with inquiries or additional support. The Quality-In-Sights® 2016 Program Survey is available on POIT for your completion and submission by February 28, 2017.

Access to POIT is through Anthem's secure provider portal at www.anthem.com.Select **Provider** link in top center of the page. Select **Colorado** from drop down list and **enter**. From the Provider Home page, go to the "**ProviderAccess Login**" tout (blue box on left side of page), and select "**Medical**" from the drop down, and select "**Login**". Enter your ProviderAccess user name and password to login. Next, click on the **Rewards and Recognition box**, and select **Programs**. Then select **Quality-In-Sights**, and click **start survey** access the **POIT** tool and complete the survey. *Please note: your ProviderAccess Account Administrator will need to grant access to individual users to be able to view this tool.*
Once logged into POIT, under the "Health Link" box on the left hand side, there is a POIT demonstration available that gives an overview of navigation and key features of the portal.

The survey is completed once for all group office practice locations under a single TIN.

How are the measurements scored?

Each physician/group will be scored on their aggregate points. The maximum achievable points are 100. The chart to the right depicts the maximum achievable points for each component.

Program Components:	**Maximum Points**
Clinical Quality Measures/External Recognition Preventive Care Measures	10
Care Management Measures* OR One External Physician Recognition (25 pts) Two External Physician Recognitions (30 pts)	30
Resource Measures	

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Overall Cost Performance Index Generic Dispensing Rate	20 15
Care Systems / Technology** Electronic Prescribing or CCHIT Technology Implementation (6.25 pts) AIM ***Opti**Net* Radiology Adoption (6.25 pts) Availity Adoption (6.25 pts) MMH+® Adoption (6.25 pts) OR Current certification regarding attainment of Electronic Health Record Technology implemented that has met the CMS Meaningful Use Requirements (25 pts) https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/	25
Maximum Points Available	**100**

*Physicians are eligible for points in either the Care Management measures or the External Physician Recognition measures in the Clinical Quality composite section. The Care Management or External Physician Recognition measures with the highest total point value (maximum of 30) will be included in the final scoring.

How is the incentive determined, how much is the incentive and when and how is the quality incentive paid?

Points and corresponding incentive rates are as follows:

Points Earned	Incentive Rate
80+	3%
66-79	2%
55-65	1%

The incentive rate is applied to the following CPT® codes:

CPT® Codes	E&M Category
99201-99205	New Patient
99211-99215	Established Patient
99381-99387	Preventative
99391-99397	Preventative

The 2016 Quality-In-Sights® Primary Care Incentive program will reward qualifying physicians through an incentive to applicable payments over the period August 1, 2016 through July 31, 2017.

For PCPs in a physician group practice, the eligibility criteria and performance results of all PCPs in the group will be aggregated at the TIN level.

The above rewards are non-cumulative, and a physician group cannot qualify for more than one fee enhancement. In a multi-specialty group, any fee enhancement will apply only to the primary care physicians in the group.

Anthem reserves the right to exclude groups from the program that Anthem considers highly compensated.

Who do I contact with questions?

If you have any questions about the 2016 Anthem Pay for Performance Program, please e-mail us at prrprogramsco@wellpoint.com

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Quality-In-Sights® Primary Care Incentive Program
2016 Goals and Scoring

Clinical Quality Composite			
Preventative Care and Screening: **Requires the following in order to be scored: A. 30 overall unique members for a TIN and B. Five or ten members per measure for a TIN**			
Measures	**Goals** (points distributed equally amongst measures that meet the minimum member threshold)	**Possible Points**	**Maximum Possible Points**
Women's Health (3 measures) **Requires at least 10 members per measure** Childhood Immunizations (6 measures) **Requires at least 5 members per measure**	Each measure group rate must be greater than or equal to the 50th percentile target and below the 75th percentile target.	4	10
	Each measure group rate must be greater than or equal to the 75th percentile target and below the 90th percentile target.	8	
	Each measure group rate must be greater than or equal to the 90th percentile target.	10	

Preventive Care & Screening Point Distribution (based on the number of measures that meet the minimum member threshold)			
# Measures that meet the minimum member threshold	Points per measure group rate that is greater than or equal to the 50th Percentile and below the 75th Percentile **(4 maximum points)**	Points per measure group rate that is great than or equal to the 75th Percentile and below the 90th Percentile **(8 maximum points)**	Points per measure group rate that is greater than or equal to the 90th Percentile **(10 maximum points)**
1	4.0	8.0	10.0
2	2.0	4.0	5.0
3	1.3	2.7	3.3
4	1.0	2.0	2.5
5	0.8	1.6	2.0
6	0.7	1.3	1.7
7	0.6	1.1	1.4
8	0.5	1.0	1.3
9	0.4	0.9	1.1

Care Management: **Requires the following in order to be scored on: A) 30 overall unique members for a TIN and B) 10 members per measure for a TIN**			
Measures	**Goals** (points distributed equally amongst measures that meet the minimum member threshold)	**Possible Points**	**Maximum Possible Points**
Diabetes (4 measures)	Each measure group rate must		30*

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Hypertension (1 measure)	be greater than or equal to the 50th Percentile target and below the 75th Percentile target.	20	
Proportion of Days Covered (3 measures) Wellness - Childhood well visits (3 measures)	Each measure group rate must be greater than or equal to the 75th Percentile target and below the 90th Percentile target.	25	
Appropriate Use of Antibiotics (3 measures) Asthma (1 measure) Persistent Medications (3 measures) Medication compliance (1 measure) Arthritis (1 measure) New Episode of Depression (2 measures)	Each measure group rate must be greater than or equal to the 90th Percentile target.	30	

Care Management Point Distribution
(based on the number of measures that meet the minimum member threshold)

# Measures that meet the minimum member threshold	Points per measure group rate that is greater than or equal to the 50th Percentile and below the 75th Percentile **(20 maximum points)**	Points per measure group rate that is greater than or equal to the 75th Percentile and below the 90th Percentile **(25 maximum points)**	Points per measure group rate that is greater than or equal to the 90th Percentile **(30 maximum points)**
1	20.0	25.0	30.0
2	10.0	12.5	15.0
3	6.7	8.3	10.0
4	5.0	6.3	7.5
5	4.0	5.0	6.0
6	3.3	4.2	5.0
7	2.9	3.6	4.3
8	2.5	3.1	3.8
9	2.2	2.8	3.3
10	2.0	2.5	3.0
11	1.8	2.3	2.7
12	1.7	2.1	2.5
13	1.6	1.9	2.3
14	1.5	1.8	2.1
15	1.4	1.7	2.0
16	1.3	1.6	1.9
17	1.2	1.5	1.8
18	1.1	1.4	1.7
19	1.1	1.3	1.6
20	1.0	1.3	1.5
21	1.0	1.2	1.4
22	0.9	1.1	1.4

OR*

Physicians are eligible for points in either the Care Management measures or the External Physician

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Recognition measures in the Clinical Quality composite section. The Care Management or External Physician Recognition measures with the highest total point value (maximum of 30) will be included in the final scoring.			
External Physician Recognition Composite			
Measure	**Goals and Scoring**	**Possible Points**	**Maximum Possible Points**
External Physician Recognition (BTE® or NCQA)	At least 50% of the eligible providers in a TIN need to have one, active external physician recognition during the measurement period (1/1/2016-12/31/2016).	25	30*
	At least 50% of the eligible providers in a TIN need to have two, active external physician recognitions during the measurement period (1/1/2016-12/31/2016)	30	
Measure	**Goals and Scoring**	**Possible Points**	**Maximum Possible Points**
Overall Cost Performance Index - ETG Cost Efficiency Ratio Performance Requires at least 20 episodes of an Episode Treatment Group (ETG) over the entire specialty for a 2 year look back period in order to compare a physician's performance to their specialty average	CI (confidence interval) Straddles 1.00	10	20
	CI (confidence interval) is < 1.00	20	
Generic Pharmacy Composite - Members must have active Express Scripts® benefits during the measurement period. Must have at least 25 Express Scripts® prescriptions for a TIN dispensed in order to be measured			
Generic Dispensing Rate - Note: Comparison peer network is made up of the eligible providers in the Quality-In-Sights program within each state	Greater than or equal to the 75th percentile and below the 90th percentile of the comparison peer network	10	15
	Greater than or equal to the 90th percentile of the comparison peer network	15	
Care Systems Composite **25 points is the maximum number of points available – points may be earned via technology adoption OR meaningful use certification.**			
Measure	**Goals and Scoring**	**Possible Points**	**Maximum Possible Points**
Implementation and use of Electronic Prescribing or Implementation and use of any CCHIT Certified Ambulatory EHR	A TIN must have at least one entire group office practice (100% providers at the group office location) implemented and is in use prior to 1/1/2017	6.25	25
AIM ***Opti****Net* Radiology Adoption	Requires at least 1 user within a TIN has signed up and has used the AIM ***Opti****Net* tool to pre-certify for at least 1 health plan member	6.25	

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	by the last day of the measurement period.		
Availity Adoption	Requires at least 1 user within a TIN has signed up and has access to Availity by the last day of the measurement period.	6.25	
MMH+ Adoption	Requires at least 1 user within a TIN has signed up and has access to MMH+ by the last day of the measurement period	6.25	
OR			
Certified Electronic Health Record Technology that has met the CMS Meaningful Use Requirements.	Requires at least one group office practice (50% eligible physicians in that office practice) within a TIN has implemented a Certified Electronic Health Record Technology that met the CMS Meaningful Use Requirements during the measurement year.	25	
Total Maximum Composite Points			**100**

Physicians participating in this program and Anthem desire and intend that medically appropriate services be provided to patients. Physicians will use their own expertise and best judgment to evaluate and treat patients. Nothing in this program is intended to affect physicians' or other providers' best judgment and responsibility to provide quality health care services at medically appropriate levels in accordance with professionally recognized standards. Under no circumstances should this program be construed to suggest or incentivize the withholding of medically necessary services or the withholding of approved benefits to which a patient is entitled.

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