BlueCross BlueShield of Oklahoma

Value-based Care Reference Manual for Primary Care

Best Health at Best Value

(Confidential and Proprietary)

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I. Introduction

The intent of the Value-based Care (VBC) Reference Manual (Manual) is to outline the operations of the Blue Cross and Blue Shield of Oklahoma (The Plan) Value-based Care payment model. This Manual outlines the major components of the model and describes how its methodology works. It is intended to be used as a reference guide to support the arrangement between the participating provider(s) and The Plan.

How to Use This Manual

The Manual is organized by key components of the Program that align with the agreement:

1. Value-based Care Overview
2. Primary Care Physician Attribution
3. Reconcile Financials
4. Measure Quality
5. Reports to Providers
6. Appendix
7. Quality Measure Details

Value-based Care Programs

VBC payment models fundamentally change the transactions between the clinicians and the payer, leading to new requirements for collaboration. These programs introduce new performance measurements, as well as new compensation processes. The VBC payment model seeks to partner with providers that deliver better than average clinical and functional outcomes while better managing health care costs.

By shifting provider relationships towards a VBC payment model, The Plan intends to pay for better value of health care services and expects to achieve this through increased collaboration with its provider partners. The VBC program is supported by:

- Defining financial incentive models that align the interests of all parties around achieving better outcomes for patients; and
- Improving coordination between providers and The Plan to reduce cost trends without reducing the level of benefit coverage or the options available to attributed members.

1. Program Timeframes

The options for program commencement dates include:

- January 1st; or
- July 1st.

2. Claims Submission

The provider will continue to submit claims for covered services in the same manner that they submit claims under their fee-for-service participation with The Plan.

3. Program Participation

Minor changes that involve individual providers entering and exiting a practice will be reflected on an ongoing basis as they occur. Services billed with a Tax Identification Number (TIN) owned by the Group will generally be considered for inclusion in the program. Should a major practice change occur involving a significant number of providers departing from the agreement then The Plan reserves the right to review the incentive payment target for appropriateness for the practice's new make-up. Should a major practice change occur involving the addition of a significant number of new providers to the practice then this may at The Plan's discretion be treated as an exception to the general rule that all claims tied to the TIN's owned by the Group are included in the program and such a change will be reflected only at the beginning of a next available effective date of the major change.

4. Eligible Healthcare Providers

Primary Care Provider (PCP) means a Participating Provider who is primarily responsible for treating and coordinating the Covered Person's health care needs. The following physicians are defined as PCPs for purposes of the VBC Programs:

- Family Practice
- Internal Medicine
- General Practice
- Geriatric Medicine
- Family Practice including Obstetrics

PCP category currently excludes Pediatrics, Obstetrics/Gynecology, Specialist and Advanced Practice Professionals as appropriate.

II. Primary Care Physician Attribution

1. Identify Eligible Members

The Plan first identifies members who qualify for inclusion in the VBC Programs based on the specific criteria outlined below. The Plan then assigns each member to a provider who will be accountable for that member's cost and quality of care. This assignment is based on the attribution methodology employed by The Plan.

While we want to include as many of The Plan members with medical coverage as possible, at this time, there are several exclusions to the Program. Following is the list of excluded members (not inclusive):

- Members of Administrative Services Only (ASO) accounts who have opted out of value-based care programs
- Members who have Medicaid Coverage
- Members who have Medicare Advantage Coverage and Medicare Supplemental Coverage
- Members who have secondary coverage with The Plan
- Members who have multiple Plan coverages that is either not continuous and overlap during the episode period
- Members with local government sponsored coverage where inclusion permission has not been received
- Dual coverage members with Medicare or other primary insurance coverage.

We reserve the right to change this list at any time.

2. Participating Group Provider Rosters

Each Group identifies the participating PCPs for VBC Program inclusion. The PCP Roster includes all PCPs who the Group selects for program inclusion. PCPs must be either employed or affiliated with your Group. The PCP roster will determine attribution to your Practices.

All providers on the Roster must be participating providers with The Plan.

Your Group must be able to attest that all affiliated PCP providers included on the PCP Roster are exclusive to your organization.

For accurate Covered Person attribution, it is important that Rosters are complete with no errors, omissions or duplications of PCPs.

The Plan needs the initial PCP Rosters twelve weeks before the start of your Practice's participation in a VBC Program i.e. Effective 1/1/YY; Roster due 10/1/YY.

3. Updating Provider Roster

The Group must provide the Plan an updated PCP Roster no later than the fifteenth (15th) day of each month the VBC program is in effect that is accurate and complete as of the first (1st) of such month. The Provider Roster will be effective two months following the month received i.e. Roster received 10/15/YY; effective 1/1/YY.

Only those Participating PCPs on a PCP Roster will be taken into account by the Plan when calculating Provider's performance.

Your Group is responsible for any loss or damages incurred by it or The Plan as a result of the Group's failure to provide accurate and up-to-date PCP Rosters.

4. Attribution Logic

The Attribution Logic Algorithm is designed and administered by The Plan. in which VBC Members are assigned to physicians, providers, or entities based on claims utilization, geographical indicators and other factors as determined by The Plan. This Attribution Logic Algorithm shall be considered final by the Group and The Plan as defined in the appropriate VBC Program Addendum.

- Monthly Attribution identifies the PCP being used by a member based on rolling 24-month claims activity.
- Members cannot have a specialist as a PCP, but a Specialist can supplement the PCP points at the TIN level.
- Attribution fluctuations occur due (not inclusive) to loss of coverage, change in participation, funding or program eligibility.
- A point system is utilized to determine the provider with the strongest relationship to the member.
- Points are weighted based on several factors, including the type of provider, the type of visit and the recentness of the visit.
- Points are based on Evaluation & Management codes from the American Medical Association's Current Procedural Terminology (CPT) Codes

New Patient Office Visits (Treatment)	99201-99205
Established Patient Office Visits	99211-99215
Preventive Office Services	99381-99397

Illustration:

Base Points:		Age of E&M Visit		
Provider Type	Visit Type	0-6 Mos.	7-14 Mos.	15-24 Mos.
PCP	Preventative Visits	12 pts	10 pts	8 pts
PCP	Treatment	8 pts	6 pts	3 pts
Specialist	Level 1 (Ex: Cardiology)	4 pts	2 pts	1 pts
Specialist	Level 2 (Ex: Rheumatology)	2 pts	1 pts	0 pts

Member interactions with primary care physicians are assigned more points than Level 1 specialist. Level 1 specialist are assigned more points than Level 2 specialist.

Illustration: List of primary care physician and specialist that may be included in attribution.

PCP*	
Family Practice	PCP
Internal Medicine	PCP
General Practice	PCP
Geriatric Medicine	PCP
Family Practice including OB	PCP

Level 1 Specialists	
Cardiovascular-Non-Interventional	Specialist
Endocrinology Diabetes and Metabolism	Specialist
Extenders as appropriate	Specialist
Gynecologic Oncology	Specialist
Hematology & Medical Oncology	Specialist
Nephrology	Specialist
Obstetrics-Gynecology	Specialist
Oncology	Specialist
Pediatric Hematology-Oncology	Specialist
Preventative Medicine	Specialist

Level 2 Specialists	
Advanced Practice Professional as appropriate	Specialist
Gastroenterology	Specialist
Infectious Disease	Specialist
Neurology	Specialist
Pediatric Cardiology	Specialist
Pediatric Endocrinology	Specialist
Pediatric Gastroenterology	Specialist
Pediatric Infectious Disease	Specialist
Pediatric Nephrology	Specialist
Pediatric Oncology	Specialist
Pediatric Pulmonary Disease	Specialist
Pediatric Rheumatology	Specialist
Pulmonary Disease	Specialist
Rheumatology	Specialist

*Members cannot have a specialist as a PCP, but a Specialist can supplement the PCP points for a Health System or TIN. A relationship must exist to qualify.

Members that have an assigned PCP (HMO) must utilize the PCP Election instead of point system for member PCP selection.

III. Measure Quality

Practices are expected to achieve average or better performance measures, in aggregate, for their attributed members while participating in the VBC Program. The Plan will utilize the outcome measures as set forth in the appropriate VBC Program Addendum.

IV. Reconcile Financials

To ascertain the incentive amount of a provider's eligible shared savings, The Plan will calculate Provider's shared savings as outlined in the Exhibit C Shared Savings. In order to participate in the Shared Savings Program, there must be savings realized by the VBC Program resulting from decreases in medical trends and attainment of quality metric benchmarks and performance-based standards scores. Contract fee-for-service rates will not be altered.

1. Calculation Steps

All values included in the Exhibit D Shared Savings Illustration are illustrative only (any correlation to contractual values in the appropriate VBC Program Addendum being coincidental) and shall have no applicability or bearing on Provider's compensation beyond illustrating the formula to calculate such compensation.

2. Measuring Shared Savings (Or Loss)

The VBC Program uses a risk-adjusted market trend calculation for shared savings payments made to providers. A program can be a single track or broken into multiple distinct financial tracks (i.e. Track 1 and Track 2) to accommodate varying levels of risk (track designated at Practice (PFIN) level) within a program.

The VBC Program utilizes a reference population, which contains members in the geographical area, or other factors defined by the VBC program population. The reference population can contain members of other programs meeting the same defined geographical area or other factors, varies by program.

Risk Algorithms are supported by external third-party vendors, which are utilized and administered by The Plan. The proprietary algorithms stratify members by risk and severity and assign each member a position along the continuum of care in mutually exclusive hierarchical groups. This allows The Plan to more efficiently utilize care management resources and predict claims dollars of a population.

The Shared Savings calculation is designed and administered by The Plan. To participate in the Shared Savings Program, there must be savings realized by the VBC Program resulting from decreases in medical trends and attainment of quality metric benchmarks and performance-based standards scores.

3. Payment Process and Timeline

The Plan will perform the shared savings calculations and they shall be considered final by the Group and The Plan as defined in the appropriate VBC Program Addendum. Payments, if applicable, will be realized no later than 12 months after the evaluated Performance Year.

BlueCross BlueShield of Oklahoma

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