Medicare Advantage Measurement Period Handbook

For Enhanced Personal Health Care

Measurement Period beginning: 01/01/17

Version 010117

Introduction:

Welcome to your Medicare Advantage Measurement Period Handbook. As explained in the Program Description, the Incentive Program gives you the opportunity to share in savings achieved by your Medicare Medical Panel during a given Medicare Measurement Period. If you meet both quality and cost performance targets, your provider organization could share in the cost savings.

To determine whether or how much of a shared savings payment for which you are eligible, we measure your performance against quality and cost targets. In this handbook, you will learn more about those targets and how your performance impacts the calculation of shared savings. Below you will see definitions of some of the most important terms used in this handbook and the details of your Incentive Program:

- **Medical Loss Ratio Report**. The MLR report shows Total Medical Costs incurred by your Medicare Advantage Attributed Patients divided by the total Premiums received by Anthem* over the course of the MA Measurement Period. You are eligible to earn shared savings when the Measurement Period Medical Loss Ratio (MPMLR) is less than the Medical Loss Ratio Target (MLRT) and your measured performance on quality metrics and outcomes meets or exceeds the Program's Quality Gate.
- **Measurement Period Start Date**. The first day of the twelve (12) month period during which we measure MPMLR and quality performance for purposes of calculating shared savings between Anthem and the Medical Panel. If your organization starts a Measurement Period after the first day of a given year, the initial MA Measurement Period would be less than a twelve (12) month period. In the subsequent years, the new MA Measurement Period would begin on the first day of the new year for a complete twelve (12) month period. Your Measurement Period will be from 01/01/16-12/31/2016.
- **Quality Gate**. The minimum clinical quality scores that your provider organization must deliver in order to earn any shared savings under the Incentive Program. Your quality gate is set at an average weighted four Star level for the Standard Measures Composite. Further information about the Quality Gate is reviewed in the shared savings section, on page 10.
- **Shared Savings Percentage.** The percentage of shared savings under the Program to which Provider is determined to be entitled after all other applicable adjustments have been made to the Shared Savings Potential based on the Quality Target scores as shown in the Program Description and this MA Measurement Period Handbook. The Shared Savings Percentage can be the same percent as the Shared Savings Potential if all Quality Targets are fully achieved by Provider under the Program. The Shared Savings Percentage will be less than the Shared Savings Potential if any Quality Targets are not achieved by Provider under the Program.
- **Shared Savings Potential**. The maximum percentage of shared savings under the Shared Saving Program to which Provider may be entitled, as delineated in this MA Measurement Period Handbook. The Shared Savings Potential percent shown in this MA Measurement Period Handbook is subject to the performance adjustments described in this Program Description and in the MA Measurement Period Handbook. Your Shared Savings Potential is 50%.
- **Substantial Financial Risk Limit.** The limit applied to the total incentive-based payments to Provider from Anthem, inclusive of payments under the Agreement. The Substantial Financial Risk Limit is no more than 25% of the total reimbursement the Provider and Represented Providers receive from Anthem for direct services delivered to Anthem Medicare Advantage Attributed Members during the applicable MA Measurement Period year.
- **Performance Scorecard Report**. In addition to the MLR report, you will also be able to access your provider organization's performance scorecard via our secure website (www.Availity.com). The performance scorecard shows your performance on the selected clinical quality measures listed in this handbook. The performance scorecard is a tool to help you assess your quality and utilization performance on a quarterly basis.

The information included in this handbook is designed to help you understand your MLR report, your performance scorecard and the scoring methodology. It is not intended to change the terms of your EPHC document, and should not be interpreted as such.

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Section 1: Medical Loss Ratio

Overview

As part of our Enhanced Personal Health Care Program, we track overall medical costs incurred by Attributed Members, and under the incentive portion of the Program, we reward participating providers who are able to provide appropriate care in a cost-effect manner while maintain or improving performance against nationally recognized quality measures. The Program is based upon the same structure implemented by the Centers for Medicare and Medicaid Services (CMS) in their Comprehensive Primary Care initiative.

The Medical Loss Ratio Report shows Total Medical Costs incurred by a given Medical Panel's Medicare Advantage Attributed Members divided by the total Premiums received by Anthem for the Medicare Advantage Attributed Members associated with the Medical Panel over the course of the Measurement Period.

As a reminder, the Measurement Period Medical Loss Ratio used to reconcile your final shared savings payment (should you qualify) uses the following equation:

$$Measurement\ Period\ MLR = \frac{\sum Total\ Medical\ Expense_{Measurement\ Period}}{\sum Premium_{Measurement\ Period}}$$

Total Medical Expenses - means the costs incurred by Anthem for payment of all Covered Services (including hospital, medical, pharmacy and non-hospital) provided to each Medicare Advantage Attributed member by all providers (participating and non-participating, and including Provider and its PCPs) furnishing such services to Medicare Advantage Attributed Members, adjusted by the Stop-Loss Expense and Stop-Loss Credit where appropriate. Total Medical Expenses include:

A. Claims, capitation and PMPM reimbursement, where applicable, incurred during the MA Measurement Period, paid through a three month Claims run-out period.
B. Plus a reasonable amount for IBNR
C. Plus the Stop-Loss Expense (if included)
D. Minus the Stop-Loss Credits (if included)
E. Plus the costs associated with supplemental benefits

Premium - means the total of all payments (including Medicare Part C and Part D premiums) paid by CMS and member to Anthem for the Member Population under a Anthem Health Benefit Plan during a MA Measurement Period less any Part B rebates payable or credited for any Medicare Advantage Attributed Members within the Member Population, less any taxes levied by the Affordable Care Act, less any cost and reinsurance subsidies, and less any other amount otherwise offset against or deducted from amounts payable by CMS to Anthem with respect to the Member Population during such MA Measurement Period, exclusive of any Retroactive Addition Amount or Retroactive Deletion Amount, for such Medicare Advantage Member Population for the same MA Measurement Period.

The items listed in the definitions above are included in the Measurement Period MLR report. An example of an MLR report is shown below. At this time the MLR report is not available for the Medicare Program in PCMS and will be manually delivered.

Example: Measurement Period Medical Loss Ratio Report

EPHC Medical Panel "A" MP MLR for 1/1/2015-12/31/2015 Measurement Period	
Member Months	19,081
Average Number of Members	**1,590**
Average Risk Score	1.034
Medical CMS Revenue	13,883,062
Medical Revenue Adjustments	460,269
Medical Sequestration	(306,867)
Medical Member Premium	225,863
Medical ACA Tax	(279,301)
Part D CMS Revenue	672,151
Part D Revenue Adjustments	(10,873)
Part D Sequestration	(16,108)
Part D Member Premium	605,638
Part D ACA Tax	(27,357)
Total Revenue	**$15,206,476.01**
Target Medical Loss Ratio (MLR)	**85.0%**
Total Medical & Part D Expense Target	**13,945,505**
Inpatient Claims	4,988,618
Outpatient Claims	2,507,963
Professional Claims	3,456,767
Medical Claims IBNR	182,171
Other Claims Payments	52,567
Pharmacy Part D Claims	1,598,468
Pharmacy Rebates	(813,959)
Stop Loss Expense	279,623
Stop Loss Claims over Deductible	(179,608)
Quality Improvement Programs	443,788
Mangement Fee	75,317
Total Medical Expenses	**$12,591,715.46**
Actual Panel MLR	**82.8%**
Gross Savings ((Program Target - Actual MLR) * Total Rev)	**$333,789.15**
Passed Quality Gate - yes	
Shared Savings Potential (50% Maximum Potential)	**27.65%**
Provider Share of Net Surplus/(Deficit)	**$92,301**

In the case above, the Total Medical Expenses divided by the Total Premium is 82.8% is the Measurement Period MLR.

$$\mathbf{82.8\%} = \frac{\mathbf{\$12,591,715.46}}{\mathbf{\$15,206,476.01}}$$

Understanding the Medical Loss Ratio (MLR)

The MLR is created using two figures – (1) the Premiums received by CMS for your Attributed MA Members, and (2) the Medical Expenses it costs to take care of those members for the year. Understanding how to impact both of those is the key to lowering the Measurement Period MLR. The MLR can be impacted by comprehensive documentation of burden of illness on the claims submitted for your Attributed Members and their medical records to insure the Premiums received for your Attributed MA Members are correct for their documented medical conditions, and lowering the Medical Expenses for your Attributed Medicare Members. Below are several ways your groups can impact both of these.

Validating Premiums received from CMS:

Hierarchical Condition Categories (HCCs) are used in CMS's methodology for determining Premiums for the Medicare Advantage program members. The codes identify the conditions that a patient has and allow payments to be risk-adjusted based on those conditions. The methodology uses a patient's documented 12-month diagnostic coding history to predict future financial utilization and risk. This review of the claims received from Anthem creates a risk adjustment factor (RAF) "score" for a patient that determines the amount of Premium received for each Attributed Member.

At the beginning of each New Year, the patients HCC scores are "reset", dropping the codes from the prior year each December 31st. This means that even if a patient was documented in the prior year with diabetes, at the beginning of the new-year that diagnosis is no longer considered valid for that patient until a claim is received with the Diagnosis code reaffirming that the patient has diabetes. Bringing the patient in for their Annual Wellness Visit and reaffirming the previous conditions, or documenting the diagnosis during a sick visit, is referred to as "closing an HCC gap." This will allow the Premium received to reflect the health of the patient and provide the revenue needed to cover the expenses associated with the diagnosis.

Several times a year, Anthem sends claims to CMS used to determine the RAF (Risk Adjustment Factor) score that will set the Premium received by Anthem for your Medicare Advantage Attributed Members. The claims sent to CMS will include the HCC codes that have been submitted by your practice for your Attributed Members. By properly coding the claims with the patient's diagnosis – the premiums received will be more accurate to properly reflect the health of your population.

Lowering Medical Costs:

The second piece of the MLR equation is Medical Expenses. Several key components make up the Medical Expenses, and are identified on the Measurement Period MLR report. The key areas are:

- Inpatient
- Outpatient
- Professional
- Pharmacy
- Other Claims – This can include but is not limited to Lab and imaging.

These costs can be impacted by your practice through:

- Creating Care Plans, as described in the Program Description, to manage patient's chronic conditions to possibly limit an in-patient stay, frequent office visits, and trips to the Emergency Room.
- Assure that referrals for specialists, lab and imaging work are In-Network
- Prescribing generic prescriptions when available
- Direct a patient to a cost effective free-standing radiology center when appropriate.

Section 2: Performance Scorecard & Your Measures

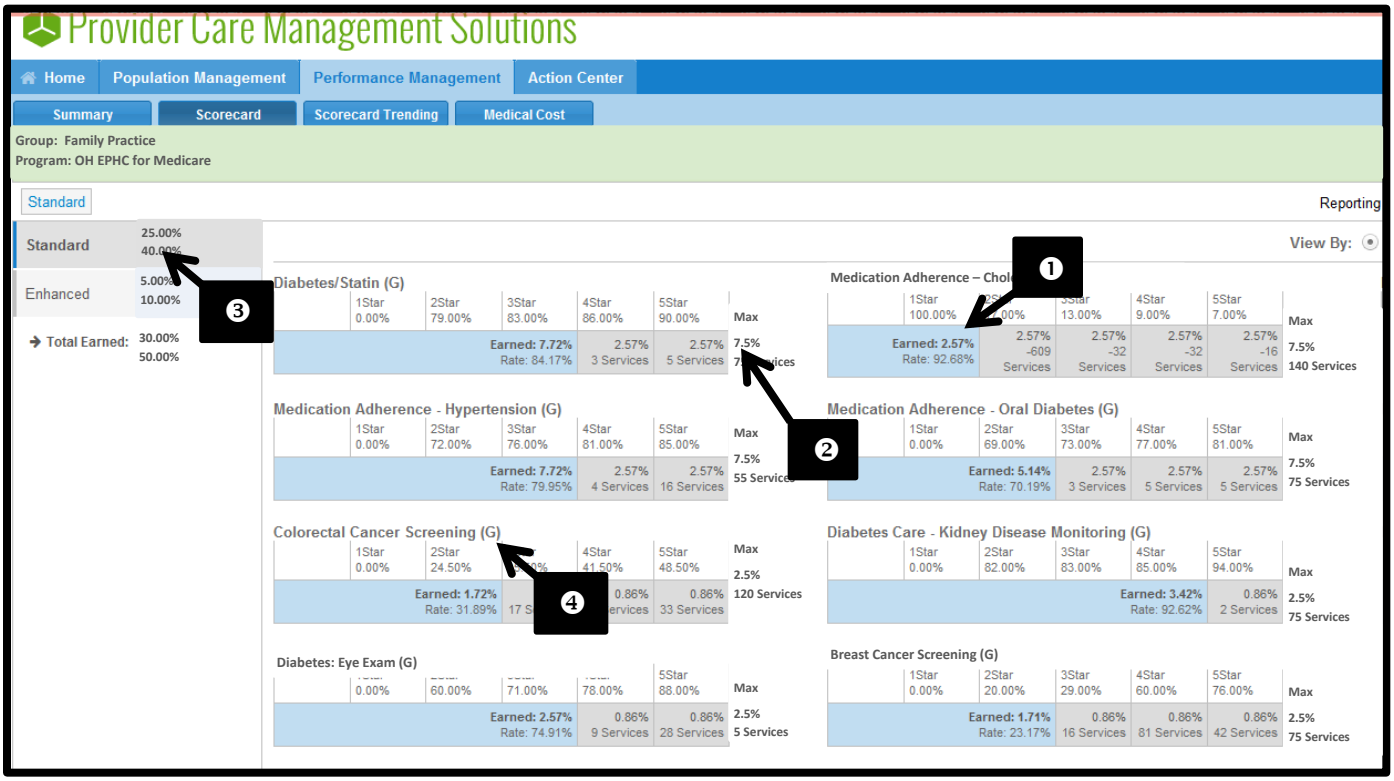
Performance Scorecard Overview

The performance scorecard is comprised of Quality Measures based on CMS Stars Measures. In addition to serving as a basis for Incentive Program shared savings calculations, these measures are used to establish a minimum level of performance expected of you under the Program and to encourage improvement through sharing of information.

The performance scorecard allows you to monitor your progress in these measures throughout the year. It will identify:

- Current measure rate
- Current measure numerator and denominator
- Benchmarks for your Measurement Period

Scorecard Report *Example* - The scorecard below is an *example* of the information the scorecard will provide and what it will look like. Your scorecard will be provided through the PCMS once available. The Shared Savings Potential percentages shown below are examples only and do not reflect the percentages for your Measurement Period.



(1) Earned Contribution: The proportion of the Shared Savings Potential earned for each measure and for the overall Program. Your earned contribution is shown in each bar that measures your performance.

(2) (3) Shared Savings Potential: The maximum percentage of Shared Savings to which a provider is entitled under the Incentive Program. The scorecard shows this at the measure (2) and composite (3) level.

(4) Level of Measurement: If the Measure has been evaluated at the Group or Medical Panel level.

Performance Scorecard Measurement Interval – New for 2017 - Calendar Year View

The scorecard is based on Calendar Year View compliance. This means that at the beginning of every New Year, the compliance rate will be zero for all measures that show compliance on an annual basis, and will remain non-compliant until the MA Attributed Member fulfils the specifications to show compliance for that measure. The scorecard will be available

Example: *Diabetes Eye Exam* – A member must have an eye exam each year. In the previous Scorecards, if that member had an exam on November 10th of the previous year, that member would still show as compliant on January 1st, and would remain compliant until November 9th of the next year. In the new Calendar Year View Scorecard, that member will show as non-compliant on January 1st and will remain non-compliant until the member has an eye exam during the calendar year.

Measures that have a compliance time frame outside of a calendar year may have members showing as compliant in January, at the beginning of the Measurement Period.

Example: *Breast Cancer Screening* – the compliance time period for a mammography is 27 months. In this case, if a member has a mammogram in November of the previous year, the MA Attributed Member would still be compliant on January 1st of the next year because the MA Attributed member has met the criteria of having a mammogram in the past 27 months. The two measures that fall into this category are Breast Cancer Screening and Colorectal Cancer Screening.

Performance Benchmarks

Starting in 2017, the benchmarks that will be used for the Program will be internally created projections to more accurately reflect the anticipated results for the 2017 Measurement Period, which will be reported by CMS in 2019. These internally created benchmarks will be available prior to the start of the Measurement Period.

Quality Measures for Your Measurement Period

Clinical Quality Measures Overview

The Medicare Advantage Program scorecard is comprised of Quality Targets that align with the Centers for Medicare & Medicaid Services' ("CMS") Stars Program. The applicable Quality Targets are listed below under Standard Measures and Enhanced Measures. In addition to serving as a basis for Medicare Advantage Incentive Program savings calculations, these measures are used to establish a minimum level of performance expected of you under the Medicare Advantage Program, and to encourage improvement through sharing of information. The measures encourage efficient, preventive, high quality and cost-effective health care practices for the Medicare Advantage (MA) Attributed Member population. Eligible providers who meet the Quality Gate can participate in the Medicare Advantage Incentive Program as described in Section 8, *Incentive Program- Medicare Advantage Business*.

The Quality Targets included in the scorecard for the Medicare Advantage Incentive Program are divided into two categories, referred to as composites, in the Quality Scorecard: (1) Standard Measures and (2) Enhanced Measures. All measures that have at least 20 MA Attributed Members in the denominator will be scored at your provider organizations level. If a measure is categorized as information only, that measure will be evaluated for the compliance rates and Stars ranking but do not have any shared savings potential assigned to them. If your provider organization does not have 20 MA Attributed Members in the denominator of a given measure, that measure will be scored at your assigned MA Medical Panel's level. Measures that have been scored at the MA Medical Panel level are marked with a (P) next to the measure name on the scorecard, whereas measures that have been scored at your individual group level will have a (G) next to the measures name.

Composite Overview:

- *Standard Measures* are measures that are scored using the procedure and diagnosis codes submitted on medical or prescription drug Claims that are readily available, widely used by many providers, and that provide conclusive evidence as to whether or not the measure has been achieved. These measures' results are derived solely based on an evaluation of Claims submitted to Anthem. An example of a Standard Measure is Breast Cancer Screening. A review of Claims we receive during a Measurement Period for Medicare Advantage Attributed Members that fit the specifications for the Breast Cancer Screening Measure and will provide all the information needed to conclusively determine if the test was performed per the technical specification and is the member compliant for that measure during the current MA Measurement Period. The Standard Measures that will be included on the scorecard for this MA Measurement Period are:

    - Diabetes Care – Eye Exam
    - Diabetes Care – Kidney Disease Monitoring
    - Breast Cancer Screening
    - Colorectal Cancer Screening
    - High Risk Medication – information only
    - Medication Adherence- Oral Diabetes
    - Medication Adherence- Hypertension
    - Medication Adherence- Cholesterol
    - Diabetes/Statin

- *Enhanced Measures* are measures that, for scoring purposes, require additional information to be submitted in addition to the Claim (in addition to standard CPT IV codes), and also require documentation in the Medicare Advantage Attributed Member's medical record. In order to evaluate success with Enhanced Measures, you must submit a CPT II code or Z code on the Medicare Advantage Attributed Member's Claim along with a corresponding note in their medical record that supports the use of this code. An example of an Enhanced Measure is diabetes: blood sugar controlled. A review of Claims received for a given Medicare Advantage Attributed Member with diabetes, during the Measurement Period, requires the inclusion of the CPT II code that identifies the member's

HbA1c level. The Enhanced Measures serve as a bonus opportunity to increase your overall shared savings potential, and will not reduce your shared savings if not achieved. The use of CPT II codes and Z V codes are further explained below. The Enhanced Measures that will be included on the scorecard for this MA Measurement Period are:

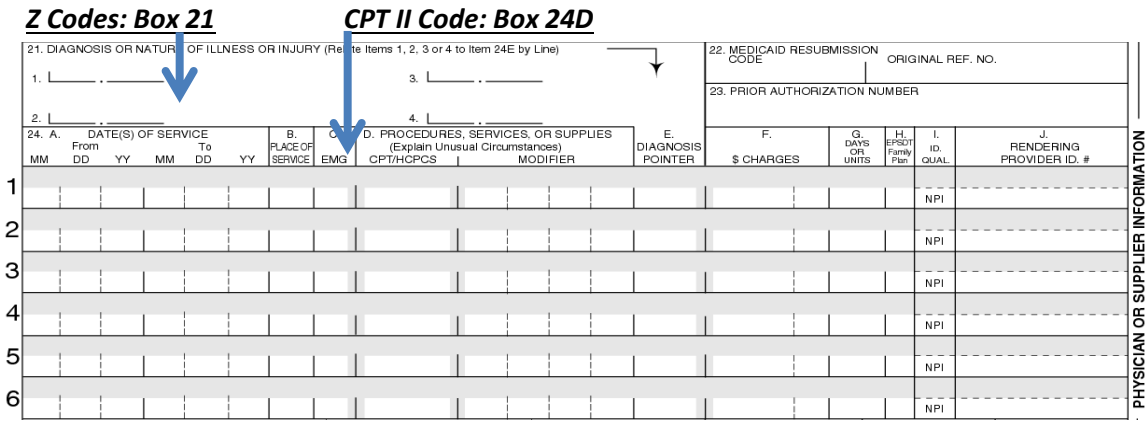
- Diabetes Care – Blood Sugar Controlled
- Controlling Blood Pressure
- Adult BMI Assessment

The use of CPT Category II (CPT II) & Z codes to evaluate Enhanced Measures:

As mentioned above, Enhanced Measures require additional information to be submitted on a Claim, in addition standard CPT IV codes, in order to be evaluated and scored as the measure being compliant, or controlled. A CPT II code or Z code needs to be included on a MA Attributed Member's Claim to demonstrate a patient's compliance for the Enhanced Measures. The information reflected by the CPT II and Z codes also needs to be documented in their medical record to support the use of this code.

- **What is a Category II Code?**
  CPT II codes are tracking codes that facilitate data collection for performance measurement in the Program for the Medicare Advantage Attributed Members. The use of these codes enables us to monitor performance for the Enhanced Measures throughout the MA Measurement Period.
- **How does a CPT II code work in capturing quality data for measurement?**
  An example of the process and outcome measurement of Comprehensive Diabetes Care HbA1c testing and control includes the following: The process of caring for a diabetic patient by testing for the HbA1c to monitor the patient's blood sugar control over time. The outcome part of that measure is the result or value of the HbA1c, i.e. result level <7.0%. The CPT II coding allows for the results data to be captured easily on a claim, rather than sending in medical records. See example-1 below:
  - Process: CPT IV - HbA1c Testing: 83036=Glycosylated (A1C) or 83037=at home glycosylated (A1C). The CPT IV code captures the fact that the test was indeed performed at the point of care.
  - Outcome: CPT Category II - HbA1C Result: 3044F=Most recent HbA1c level <7.0%. The CPT Category II code captures the outcome or result of the screening above and completes the measure without performing an onsite chart review or submission of a medical record.
- **What is a Z Code?**
  Z codes identify circumstances when a patient presents with issues other than a disease or injury. Z codes are also used to report problems or factors that may influence care. The Z code is a supplemental classification of ICD-10-CM For example, Z23 indicates an Encounter for Flu vaccine under ICD-10-CM.
- **Where are CPT II and Z codes captured on a standard claim form?**
  - CPT II CODES: Box D on a standard claim form captures CPT codes, since the CPT II code is a category of CPT, it also is placed in Box D (see Diagram 1 below).
  - Z CODES: Z codes are a supplemental classification of ICD-10-CM; therefore, the Z code will appear in box 21 below (see Diagram 1below).

Diagram 1: Placement of CPT II and Z Codes (*Note: Please refer to CMS for rules and regulations on coding for payment.)*



Individual Measure Weighing

CMS assigns weighting to the Stars measures each year. The weighting, as assigned by CMS, is listed below in Table 1. The measures that are triple weighted will carry more weight when calculating your scorecard results. The measure weighting also plays a role in determining the Shared Savings Potential, as shown on the scorecard and described in further details on the following pages. Measures that are informational only have a zero weighting. Those measures are made available to your group to evaluate the compliance rates but do not have any shared savings potential assigned to them.

Table 1: Measure weighting

STANDARD MEASURES	Weight
Diabetes Care – Eye Exam	1
Diabetes Care: Kidney Disease Mntr	1
Breast Cancer Screening	1
Colorectal Cancer Screening	1
High Risk Medication- Information Only	0
Medication Adherence- Oral Diabetes	3
Medication Adherence- Hypertension	3
Medication Adherence- Cholesterol	3
Diabetes/Statin - adding shared savings potential	3
ENHANCED MEASURES	
Diabetes Care – Blood Sugar Controlled	3
Controlling Blood Pressure	3
Adult BMI	1

Section 3: Calculating Your Shared Savings

Overview

The opportunity to share in savings that are realized for your MA Attributed Members is a key characteristic of the Program. After savings are determined, the proportion of shared savings that you can earn depends on your organization's performance on a scorecard. Your scorecard serves two functions: (1) it will let you know if you met the Quality Gate, and (2) it will show you the overall percentage of the shared savings you earn. Below, we review the four major steps to determine your shared savings:

STEP 1: Were Gross Savings Demonstrated?

In order to participate in shared savings, the Gross Savings must be demonstrated. For that to happen, your Medical Panel's MA Attributed Member population must demonstrate savings over the course of your Measurement Period. As described more fully in the Program Description; *Section 8: Incentive Program - Medicare Advantage Business,* Anthem will calculate Gross Savings by comparing the Measurement Period Medical Loss Ratio for your MA Attributed Member population for a specified 12 month Measurement Period to the established Medical Loss Ratio Target (MLRT). In the event that the MPMLR is less than the MLRT, the Gross Savings can be calculated. Ultimately, the Gross Savings is multiplied by your Shared Savings Percentage to calculate your shared savings payout.

STEP 2: Quality Gate – Did you pass the Quality Gate?

Your provider organization must meet a minimum threshold of performance on the clinical quality measures in order to share a portion of the Gross Savings. That threshold, referred to as the Quality Gate, is based on each individual Stars Measure. Your provider organization's clinical quality score must meet or exceed a four Star rating for each measure in order to earn shared savings for that measure.

Weighting Composites

As mentioned above, the measures that form the composites contribute differently to the Shared Savings Potential depending on their weighting (Table 1). This same concept applies to the weighting of the composites that make up the scorecard.

- The Standard Measure Composite is weighted at 80% of the Shared Savings Potential.
- The Enhanced Measures Composite is weighted at 20% of the Shared Savings Potential.

The individual weighting of the measures and the weighting of the composites result in a range of Shared Savings Potential across the measures. Table 5 brings the weighting details together for the measures and the composites and shows the Shared Savings Potential for each measure, and per composite. The Shared Savings Potential for each measure below corresponds to the earned contributions shown on the scorecard.

Table 5: Weighting – Composites and individual measure Shared Savings Potentials. This table shows the weighting of the measures, and how that measure translates to the total Shared Savings Potential.

COMPOSITE	Weight		Max SS potential	SS Potential	Quality Gate	Composite weighting
STANDARD MEASURES		4 Stars potential	5 Stars potential	40%		80.00%
Diabetes Care – Eye Exam	1	1.75	2.50		4 Stars	
Diabetes Care: Kidney Disease Mntr	1	1.75	2.50		4 Stars	
Breast Cancer Screening	1	1.75	2.50		4 Stars	
Colorectal Cancer Screening	1	1.75	2.50		4 Stars	
High Risk Medication	0	0.00	0.00		4 Stars	
Medication Adherence- Oral Diabetes	3	5.25	7.50		4 Stars	
Medication Adherence- Hypertension	3	5.25	7.50		4 Stars	
Medication Adherence- Cholesterol	3	5.25	7.50		4 Stars	
Diabetes/Statin	3	5.25	7.50		4 Stars	
ENHANCED MEASURES:				10%		20.00%
Diabetes Care – Blood Sugar Controlled	3	3.00	4.29		4 Stars	
Controlling Blood Pressure	3	3.00	4.29		4 Stars	
Adult BMI	1	1.00	1.43		4 Stars	
				50%		

STEP 3: Earned Contribution Calculated ➔ Calculating the Two Composite Scores

As mentioned above, there are two composites that are calculated for the scorecard, and the Quality Gate sits at each individual measure.

COMPOSITE – STANDARD and ENHANCED MEASURES:

Step 1. ***Calculate compliance rate for each measure.***

Each measure is calculated by identifying the compliance rate for providers Medicare Advantage Attributed Members eligible for that measure. The compliance rate is the numerator (*the number compliant with measure)* for each of the measures divided by the denominators *(eligible population). In order to be measured for compliance, your practice must have at least 20 members qualify for that measure. If you do not, the measure will default to the Medical Panel Level.*

Step 2. ***Compare compliance rate to measure benchmark to assign Star rating achieved***.

The compliance rate is compared to the benchmarks to assign a Star rating achieved for each measure.

Step 3. ***Identify earned shared savings contribution for each measure.***

If the compliance rate achieved meets the Quality Gate of 4 Stars or better, shared savings will be earned. If 4 Stars is earned, the shared savings percentage, as shown in table 5 above will be earned. If 5 Stars are earned, then the shared savings percentage for that ranking will be earned.

Step 4. ***Sum the total of shared savings earned for all measures in the standard and enhanced composites.***

After the percentage of earned contribution for each measure is determined, the shared savings earned is calculated by summing the earned contribution across all measures within the composite.

In the example below, the provider achieved 4 and 5 Star rankings on 7 measures and achieved 19.43% Shared Savings Earned. Note: ***these are not the 2017 benchmarks*** – these are for demonstration purposes only. The 2017 Benchmarks will be available prior to the start of your Measurement Period.

COMPOSITE	4 Stars benchmarks	5 Stars benchmarks	Numerator	Denominator	Compliance Rate	Weight		3	Max SS potential	Shared Savings Earned
STANDARD MEASURES	benchma 2 ow are not the 2017 benchmarks and are for demonstration purposes only				1			4 Stars potential	5 Stars potential	
Diabetes Care – Eye Exam	***70.00%***	80.00%	72	100	***72.00%***	1		***1.75***	2.50	***1.75***
Kidney Disease Monitoring	60.00%	74.00%	52	100	***52.00%***	1		1.75	2.50	***0.00***
Breast Cancer Screening	***82.00%***	90.00%	130	150	***86.67%***	1		***1.75***	2.50	1.75
Colorectal Cancer Screening	***60.00%***	68.00%	120	200	***60.00%***	1		***1.75***	2.50	1.75
High Risk Medication	***5.00%***	3.00%	5	200	***2.50%***	0		***0.00***	0.00	0.00
Medication Adherence- Diabetes	***85.00%***	90.00%	89	100	***89.00%***	3		***5.25***	7.50	5.25
Medication Adherence-	82.00%	89.00%	75	150	***50.00%***	3		5.25	7.50	0.00
Medication Adherence- Cholesterol	74.00%	85.00%	70	120	***58.33%***	3		5.25	7.50	0.00
Diabetes/Statin	65.00%	***75.00%***	79	100	***79.00%***	3		5.25	***7.50***	7.50
ENHANCED MEASURES:										
Blood Sugar Controlled	65.00%	79.00%	35	100	***35.00%***	3		3.00	4.29	0.00
Controlling Blood Pressure	65.00%	70.00%	60	120	***50.00%***	3		3.00	4.29	0.00
Adult BMI	80.00%	***90.00%***	180	200	***90.00%***	1		1.00	***1.43***	***1.43***
								35	***50*** 4	***19.43***

STEP 4: Overall Shared Savings is calculated *by adding the total of shared savings earned for each measure in which the Quality gate was passed. In the example above, the Quality Gate was met by achieving four or five Stars on six measures for a total of 19.43% out of the 50% Maximum Shared Savings Potential.*

2017 Scorecard Summary Snapshot

COMPOSITE	4 Stars benchmarks	5 Stars benchmarks	Weight			Max SS potential	Shared Savings Earned	Shared Savings Potential	Quality Gate	Composite weighting
STANDARD MEASURES	The 2017 Benchmarks will be available prior to the start of the Measurement Period and will be available on the scorecard in PCMS when it is available in January 2017. The Benchmarks are projected by our internal Anthem Stars team to properly reflect the Stars benchmarks expectation when final results are presented.				4 Stars potential	5 Stars potential		40.00		80.00%
Diabetes Care – Eye Exam			1		1.75	2.50			4 Stars	
Kidney Disease Monitoring			1		1.75	2.50			4 Stars	
Breast Cancer Screening			1		1.75	2.50			4 Stars	
Colorectal Cancer Screening			1		1.75	2.50			4 Stars	
High Risk Medication			0		0.00	0.00			4 Stars	
Medication Adherence- Diabetes			3		5.25	7.50			4 Stars	
Medication Adherence-			3		5.25	7.50			4 Stars	
Medication Adherence- Cholesterol			3		5.25	7.50			4 Stars	
Diabetes/Statin			3		5.25	7.50			4 Stars	
ENHANCED MEASURES:								10.00		20.00%
Blood Sugar Controlled			3		3.00	4.29			4 Stars	
Controlling Blood Pressure			3		3.00	4.29			4 Stars	
Adult BMI			1		1.00	1.43			4 Stars	
					35	**50**	**0.00**			

TECHNICAL SPECIFICATIONS

The technical specifications for the 2017 Scorecard will be made available prior to the start of the Measurement Period.

Amerivantage is a D-SNP plan with a Medicare contract and a contract with the State Medicaid program. Enrollment in Amerivantage depends on contract renewal.