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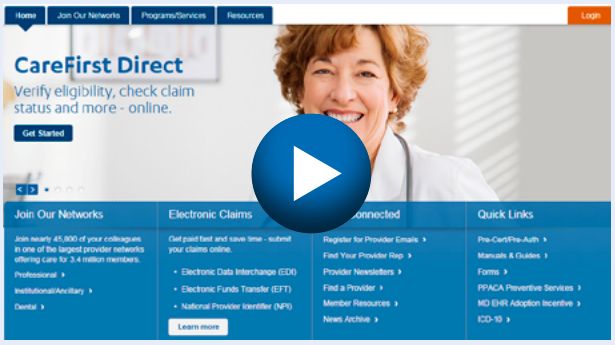
DECEMBER 2014 VOL. 16, ISSUE 8

New Provider Website Design

As you may have noticed, we've redesigned our provider website with a fresh, new look and feel. Our new design gives you faster access to the information you need – in fewer clicks.

Watch this short video for a visual overview of the new site.



Some highlights include:

- Our new Home page offers Provider News, Quick Links and Features to get you directly to the information you use the most. You can even register for provider emails right from the Home page.
- Our new Join Our Networks tab is designed to make it easier for new providers to complete the CareFirst credentialing process.
- Under the new Programs/Services tab, our new Care Management section offers information to help you provide quality, cost-effective care for your patients, whether you are looking for lower-cost settings or interested in enrolling in our Patient-Centered Medical Home (PCMH) Program.
- The new Resources tab is your one-stop-shop for administrative resources. From information on submitting claims to provider manuals, guides and forms – everything you need to conduct business with CareFirst is all in one place.
- CareFirst Direct has also been updated with a new look and feel. You can still verify eligibility, check claim status and more – online. And, you can login from every page by clicking the orange "Login" button. Find out more.

Check out our new website today and tell us what you think. Email your feedback to newsletter.editor@carefirst.com.

If you have technical issues, contact the Help Desk at (877) 526-8390.

IN THIS ISSUE:

WHAT'S HAPPENING

Dr. Winn Says. . .

In this recurring feature, Dr. Daniel Winn, an internist and CareFirst Vice President and Senior Medical Director, offers tips of importance to you and your staff.

Listen as Dr. Winn discusses the importance of preventive services.

Don't Forget to Validate Your Provider/Practice Information

CareFirst has implemented a new requirement for providers to review and verify practice information twice per calendar year.

When Should You Validate?

Validation must occur once between January 1 and June 30, and once between July 1 and December 31 (but not less than three months apart).

How to Validate Your Information

Follow the instructions on our updated Step-By-Step Guide to Verify Your Data Online.

Questions?

Contact your Provider Relations Representative.

Start the new year off right and validate your information by December 31.

What's In It for You?

When you update your information online, you will be entered into a quarterly drawing* to win lunch for your office (up to 20 people).

There will be three raffle drawings, each occurring on the fifth business day of every calendar quarter. An office cannot win the lunch raffle if an individual has won previous cash raffles and the same office cannot win more than one office lunch. Winners must have validated information in the quarter immediately preceding the drawing. A list of winners will be included in *BlueLink* each quarter.

**The odds of winning will be determined based on the number of entries. No purchase necessary.*

Better Care at Lower Costs

CareFirst's Patient-Centered Medical Home (PCMH) Program

The demand for higher quality, more efficient care remains central to keeping health coverage affordable. Since 2011, CareFirst's PCMH model has made real strides in delivering quality care and reducing costs.

- How did PCMH start?
- What has PCMH accomplished?
- Where is PCMH going?

Join your fellow PCPs to find out.

Visit www.carefirst.com/joinpcmh to learn how the Program can benefit you and your patients.

WHAT'S HAPPENING (CONTINUED)

Preventive Screenings – Let the Conversation Begin

It's important for your patients to realize the importance of preventive screenings.

You can help your patients – our members – understand the importance of disease prevention, early detection and follow-up – all of which go hand in hand to support a healthy life. Print this flyer for tips to help you keep the preventive care conversation going.

You know your patients better than anyone, which is why we recently asked you about your approaches to preventive services and how you motivate your patients to maintain good preventive health habits.

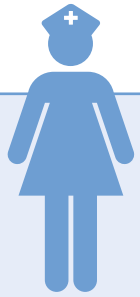
Here's what some of you had to say:

"I teach body awareness, self-care and leading a balanced life. People are so fixated in the doing of life, they forget why they work so hard. I also recommend books such as the Blue Zones. These offer great insight into the people who live the longest and what they do in their lifestyle and diet to live so long."

–Brian W.

"Be sure to leave a few minutes in each primary care visit to review the preventive care services appropriate for them. Let them know if they are up-to-date or where their needs are."

–Anonymous



"I discuss my personal beliefs about why preventive care is important and explain to them that I would be making the same recommendations to my family."

–Anonymous

"We make follow-up appointments at each visit before they leave and make an effort to remind them of the importance of preventive care, especially for those who are overweight and have other medical conditions. If we make 3 attempts and cannot locate the patient for their appointment, we notify the local health department so the follow-up continues. "

–Nathalie D.

Congrats to Nathalie D. for being our 3rd quarter feedback winner.

Want your feedback to be featured in *BlueLink*? Make sure you send it to newsletter.editor@carefirst.com.

CLAIMS AND BILLING

State of Maryland Employer Group Benefit Changes

Wellness Program

The State of Maryland is introducing an incentive-based Wellness Program beginning Jan. 1, 2015.

Employees/retirees and their covered spouses must complete the following steps by Sept. 30, 2015, to avoid surcharges beginning Jan. 1, 2016.

- Designate a primary care physician (PCP)
- Complete a health risk assessment (HRA)
- Discuss HRA results with their PCP and have the PCP sign the Physician Verification Form

Once the member completes these steps, PCP copays are waived.

- PCP copayment is not indicated on the identification card.
- PCPs are encouraged to verify member copays on Care First Direct.
- PCPs may not charge the member for signing the form.

Note: The Wellness Program is not a requirement for Medicare primary members and their spouses. The wellness program is not available to State Law Enforcement Officers Labor Alliance (SLEOLA) employees.

Mental Health and Substance Abuse

Mental Health benefits will be administered through CareFirst for State of Maryland (SOM) and State Law Enforcement Officers Labor Alliance (SLEOLA) members.

Diagnostic and Laboratory Services

Diagnostic and laboratory services related to hypertension, coronary artery disease, asthma, COPD and diabetes (including test strips) are covered in-network at 100 percent of the allowed amount.

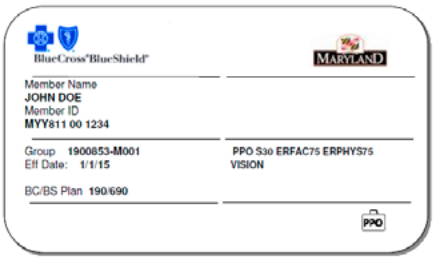
Outpatient diagnostic and lab services at in-network hospitals are already covered at 100 percent of the allowed benefit.

Pre-authorizations

Effective Jan. 1, 2015, the follow services require preauthorization:

- Outpatient surgery for morbid obesity
- Outpatient Transplant –Bone Marrow
- Gender Re-assignment

To identify members who have State of Maryland coverage, look for the Maryland state logo on the member's identification card.



Electronic Submission Now Available for Institutional Medicare Secondary Claims

Institutional providers now have the ability to submit Medicare secondary claims electronically if they did not automatically cross over directly from Medicare to CareFirst.

Claims must be filed according to the Blue Cross and Blue Shield Association regulations which require you to:

- Wait 30 days from the Medicare EOB date before submission of your secondary claim
- Include the Medicare EOB or remittance advice date
- Wait for an out-of-area member's home plan to reject the claim. After receiving a rejection notification, then providers must resubmit these claims to CareFirst for processing through BlueCard.

How to Submit

Medicare secondary claims must contain specific information in the 837 claims transaction set. View the 5010 Companion Guide for details.

Claims received without the required information will be returned at the front-end with one of the following messages:

- 286 – Missing or invalid Primary Payer payment information
- 530 – Adjustment cannot be sent electronically
- 589 – Provider must accept assignment to send Medicare Crossover electronically
- 672 – Claim is out of balance
- 556 – Demonstration Project Claims cannot be submitted electronically

Important: To avoid claims being rejected for additional information, all Medicare payments must be posted exactly as received from Medicare. You must submit claims to CareFirst along with all codes and details (e.g. 2% sequestration amount, non-covered amounts, co-insurance, etc.) in the appropriate fields. These charges should not be combined and reported as co-insurance.

Questions?

Contact your clearinghouse with questions. Or visit www.carefirst.com/electronicclaims for FAQs and more.

As a reminder, all institutional providers must contact their clearinghouse to make sure these capabilities are set-up correctly.

FEP

FEP Benefit Changes for 2015

CHANGES FOR STANDARD AND BASIC OPTIONS	2015 BENEFIT	PREVIOUS BENEFIT
Preventive Care Hepatitis C Benefit	Hepatitis C screening will now be available for adults as part of the Preventive Care Benefit, one screening per calendar year.	Hepatitis C screening was not included as part of the Preventive Care Benefit.
Preventive Care Breast Cancer Reducing Drugs Benefit	Preventive Care Benefits will be provided for two breast cancer risk reducing drugs (Tamoxifen and Raloxifene) for asymptomatic women, aged 35 and over, who have an increased risk for breast cancer. Benefit will be administered by CVS Caremark for prescriptions dispensed through the pharmacy program.	Prescription drug benefits required member cost-share for risk reducing drugs for breast cancer for asymptomatic women and were not included in Preventive Care.
Preventive Care BRCA Testing Benefit: Females	Benefits for preventive BRCA testing for females will be expanded to include family history of fallopian tube and peritoneal cancers.	Preventive BRCA testing required family history criteria that only included breast and/or ovarian cancers.
Preventive Care BRCA Testing Benefit and Preventive Genetic Counseling/ Evaluation: Males	Preventive Care benefits will now include coverage for genetic counseling and evaluation and BRCA for males; ■ Males must meet family criteria as described in the brochure ■ Requires that members receive genetic counseling and evaluation prior to testing ■ Prior approval is required. No prior approval will need medical review to validate family history and if genetic counseling was done.	Preventive BRCA testing benefits only applied to females.
Preventive Care Lung Cancer Benefit	Preventive Care Benefits for adults, aged 55 to 80, will allow for one low dose lung CT screening per calendar year; eligible members must have history of tobacco use.	Preventive Care Benefits were not provided for CT screening for lung cancer in adults.
Preventive Care Diabetes Mellitus Benefit	Preventive Care Benefits will allow for one diabetes mellitus screening per calendar year for adults.	Preventive Care Benefits did not include screening for diabetes mellitus.
Blue Health Assessment Reward	Blue Health Assessment Reward will be increased to $50 upon completion.	Blue Health Assessment Reward was $40 upon completion.
Retention of Healthy and Engaged: Blood Pressure Monitor Benefit	Members meeting the following criteria will be eligible for one Blood Pressure Monitor per calendar year: members must be eligible for and enrolled in Local Plan's Cardiovascular Disease Management Program. Note: This benefit change will not be in the Service Benefit Plan Brochure.	Benefits were not provided for Blood Pressure Monitors.

FEP (CONTINUED)

CHANGES FOR STANDARD AND BASIC OPTIONS	2015 BENEFIT	PREVIOUS BENEFIT
Urgent Care Centers Benefit: Reduce member cost share for Preferred UCCs	Standard Option: $30 copayment per visit. Basic Option: $35 copayment per visit.	Standard Option: $40 copayment per visit. Basic Option: for accidental injury and medical emergency care $50 copayment per visit.
Blue Distinction Centers Benefit: Reduce member inpatient cost share for select bariatric, hip, knee and spine surgeries when performed in a BDC facility	Standard Option: $150 copayment per admission. Basic Option: $100 copayment per day ($500 per admission maximum).	Standard Option: $250 copayment per admission. Basic Option: $175 copayment per day ($875 per admission maximum).
Blue Distinction Centers Benefit: Reduce member outpatient cost share for laparoscopic gastric banding surgery when performed at a BDC facility for bariatric Surgery	Standard Option: $100 copayment, no deductible. Basic Option: $25 copayment per day per facility.	Standard Option: 15 percent coinsurance after the $350 calendar year deductible. Basic Option: $100 copayment per day per facility.
Residential Treatment Centers: Outpatient MHSA service benefits will now be eligible provided in RTCs for all members, including coverage of inpatient ancillary services provided and billed by RTCs when those services would have been covered on an outpatient basis	Standard Option: subject to $350 calendar year deductible and coinsurance as determined by the contracting status of the RTC. Basic Option: $25 copayment per day per facility limited to Preferred RTCs only.	Benefits were not available for outpatient services provided and billed by RTCs, additionally, benefits were not provided for ancillary services provided and billed by an RTC during a non-covered inpatient admission.
Maternity Benefit: Home Uterine Monitoring and Outpatient Tocolytic Therapy	Maternity benefits will now exclude Home Uterine Monitoring and Tocolytic Therapy.	These two services were included in Maternity Benefits.
Artificial Heart Benefit	Benefits will be provided for implantation of an artificial heart as a bridge to transplant or destination therapy.	Benefits were excluded for artificial hearts and their implantation as part of the exclusion for implants of artificial organs.

FEP (CONTINUED)

CHANGES FOR STANDARD AND BASIC OPTIONS	2015 BENEFIT	PREVIOUS BENEFIT
TRANSPLANT BENEFITS		
Blue Distinct Center for Transplants Travel Benefit	Benefits will be provided for transportation and lodging expenses, per transplant, for members who received a covered transplant at a BDCT facility that is 50 miles or more from their home. For members over 21 and one companion, receiving care for a covered transplant up to a maximum of $5,000 per transplant period. For members age 21 and under and two companions, receiving care for a covered transplant up to a maximum of $10,000 per transplant.	Benefits were provided for travel expenses related to covered transplants performed as part of a covered clinical trial. Travel benefits were limited to $5,000 per year, inclusive of food expenses.
Other Transplant Benefit Changes	Food expenses will now be eliminated from travel expenses. Valid facilities for Organ and Stem Cell Transplants include: BDCTs, FACT-accredited Facilities and Cancer Research Facilities. Benefits for single/double lung, pancreas and simultaneous liver-kidney transplants in a BDCT are limited to adults. Consolidate myeloablative, non-myeloablative and reduced intensity conditioning transplants into a single class of transplants and expand facility access for many transplants that we previously limited to BDCT facilities. Benefits are not available for Allogeneic Pancreas Islet Cell Transplants (language added to brochure for clarification). Expand access for covered transplants performed as part of a clinical trial to include FACT-accredited and BDCT facilities.	

FEP (CONTINUED)

Note: The below changes are contract specific.

CHANGES FOR BASIC OPTION ONLY	2015 BENEFIT	PREVIOUS BENEFIT
Cardiovascular Monitoring Services	Now requires a $40 copayment for all Cardiovascular monitoring services, when performed by Preferred professional and facility providers.	There was no copayment required for diagnostic cardiovascular monitoring services when performed by professional and facility providers.

CHANGES FOR STANDARD OPTION ONLY	2015 BENEFIT	PREVIOUS BENEFIT
Elimination of Non-Member Inpatient MHSA Admission Copayment	Standard Option members will now be responsible for 35 percent of the PA plus any remaining balance.	Standard Option members were responsible for the $350 per admission copayment plus 35 percent of the PA.
Elimination of Deductible for Non-Preferred Professional MHSA inpatient Visits	Standard Option members will now be responsible for 35 percent of the PA plus any remaining balance.	Standard Option members were responsible for the $350 calendar year deductible, plus 35 percent of the PA.
Inpatient MHSA Care for Residential Treatment Centers	Standard Option members who have Medicare Part A primary coverage will now have benefits for IP MHSA admission to RTCs. Benefits will be provided in full, up to the PA, for unlimited days.	Benefits were not available for IP MHSA admission to a RTC.

HEALTH CARE POLICY

Medical Policy Updates

Our Health Care Policy department continuously reviews medical policies and operating procedures as new, evidence-based information becomes available regarding advances on new or emerging technologies, as well as current technologies, procedures and services.

The table below is designed to provide updates on changes to existing or new local policies and procedures during our review process. Each local policy or procedure listed includes a brief description of its status, select reporting instructions and effective dates. Policies from non-local accounts, such as NASCO and FEP, may differ from our local determinations. Please verify member eligibility and benefits prior to rendering service through *CareFirst on Call* (professional and institutional) or CareFirst Direct.

Note: The effective dates for the policies listed below represent claims processed on and after that date.

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
2.01.019 Treatments of Tinnitus	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® unlisted code 92700.	Periodic review and update. **Effective date 10/20/2014**
2.01.043 Hair Analysis	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® codes 83015 and 83018.	Periodic review and update. **Effective date 10/20/2014**
2.02.014 Long-term Wireless Ambulatory Cardiac Rhythm Monitoring	Continuous wireless ambulatory cardiac rhythm monitoring for longer than 48 hours is considered experimental / investigational. Report service with Category III CPT® codes 0295T, 0296T, 0297T and 0298T. Refer to policy for details.	New Policy **Effective date 12/23/14**
6.01.014 Ultrasound for the Evaluation of Paranasal Sinuses (e.g., Echosine)	Under Policy Guidelines, added 2014 rationale statement. Report service with HCPCS code S9024.	Periodic review and update. **Effective date 10/20/2014**
6.01.018 Neutron Beam Radiotherapy	Under Policy Guidelines, added 2014 rationale statement. Policy to be archived effective 10/20/14.	Periodic review and update. **Effective date 10/20/2014**
7.01.003 Bone-Anchored Hearing Aids	Under Policy Guidelines, added 2014 rationale statement. Report service with appropriate CPT® and HCPCS codes. Refer to policy for details.	Periodic review and update. **Effective date 10/20/2014**
7.01.006 Dynamic Cardiomyoplasty	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 33999.	Periodic review and update. **Effective date 10/20/2014**
7.01.074 Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions	Under Policy Guidelines, added 2014 rationale statement. Report service with Category III CPT® code 0019T, 0101T, 0102T or Category I CPT® code 28890.	Periodic review and update. **Effective date 10/20/2014**

HEALTH CARE POLICY (CONTINUED)

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
7.01.094 Mechanical Embolus Retrieval for Acute Ischemic Stroke	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® 37799.	Periodic review and update. **Effective date 10/20/2014**
7.01.095 Endoscopic Therapies for Gastroesophageal Reflux (GERD)	Under Policy added statement: radiofrequency energy application to the lower esophageal sphincter (Stretta procedure) may be considered medically necessary for patients meeting criteria outlined in the Policy Guidelines. Under Policy Guidelines added 2014 rationale statement. Report service with Category I CPT® code 43257 or 43499. Refer to Policy for details.	Periodic review and update. **Effective date: 8/1/2014**
7.01.096 Dynamic Spinal Stabilization	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 22899.	Periodic review and update. **Effective date 10/20/2014**
11.01.039 Genetic Testing for Cardiac Ion Channel Mutations	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® 81280, 81281, 81282 or HCPCS S3861. Refer to policy for details.	Periodic review and update. **Effective date 10/20/2014**
11.01.049 Noninvasive Prenatal Testing for Fetal Aneuploidy	Under Policy, first bullet under medically necessary indication changed to women aged 35 years or older at time of delivery. Report service with Category I CPT® code 81507 or 81479. Refer to policy for details.	Revision **Effective date 10/20/2014**
2.01.038A Diagnostic Eye Procedures with Companion Table	In Companion Table, CPT codes moved from unilateral to bilateral procedure section to reflect changes in CMS Guidelines. Refer to operating procedure for details.	Revision **Effective date: 1/1/2014**
2.01.022 Archived Rabies Treatment	Under Policy Guidelines, added "out of network provisions are not applicable as treatment is considered an emergency medical service." Refer to policy for details.	Revision **Effective date: 10/1/2014**
2.01.024 Sensory Stimulation for Coma Patients	Under Policy Guidelines, added 2014 rationale statement. Report service with HCPCS code S9056. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
2.01.060 Electromagnetic and Electrical Stimulation for Care of Chronic Wounds	Under Policy Guidelines, added 2014 rationale statement. Report service with appropriate HCPCS code. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**

HEALTH CARE POLICY (CONTINUED)

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
2.02.003 Thoracic Electrical Bioimpedance Measurement	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 93701. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
2.03.004 Hyperthermia in the Treatment of Cancer	Under Policy Guidelines, added 2014 rationale statement. Report service with appropriate Category I CPT® code. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
6.01.003 Electron Beam Computed Tomography to Detect Coronary Artery Calcification	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 75571. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
6.01.042 Dual X-Ray Absorptiometry (DEXA scan) for Determining Body Composition	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 76499. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
7.01.008 Vascular Angioscopy	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 35400. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
7.01.029 Thermal Capsulorrhaphy for Joint	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® code 29999. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
7.01.037 Electrophrenic Pacemaker	Under Policy Guidelines, added 2014 rationale statement. Report service with Category I CPT® codes 64575 and 64585. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
7.01.047 Functional Neuromuscular Stimulation	Under Policy Guidelines, added 2014 rationale statement. Report service with appropriate Category I CPT® and HCPCS codes. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
7.01.075 Vagus Nerve Stimulation	Under Policy Guidelines, added 2014 rationale statement. Report service with appropriate Category I CPT® and HCPCS codes. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
7.01.118 Minimally Invasive Interventions for Fecal Incontinence	Under Policy Guidelines, added 2014 rationale statement. Report service with appropriate Category I CPT® codes 64561, 64581 and 64590. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**
11.01.020 Salivary Estriol for Assessment of Risk for Preterm Labor	Under Policy Guidelines, added 2014 rationale statement. Report service with HCPCS code S3652. Refer to policy for details.	Periodic review and update. **Effective date: 11/17/2014**

QUALITY IMPROVEMENT

Quality Improvement (QI) Program: Raising the Bar for Improved Care and Service

CareFirst and CareFirst BlueChoice are committed to providing high quality care and service. The QI program strives to continuously improve the quality and safety of care (clinical and behavioral health) and services provided to members in all health care settings and at all levels. The QI Council (QIC) works with community physicians to develop and implement the QI program. As part of this effort, QI works to provide access to health care that meets the Institute of Medicine's goals of being safe, timely, effective, efficient, equitable and patient-centered.

CareFirst annually implements a QI work plan that outlines specific clinical and service-related improvement activities. Data are collected and analyzed for each clinical and service-related improvement activity throughout the year, including the analysis for an increasingly diverse population. The QI program is comprehensive and dynamic, and includes processes to identify, monitor, analyze, prioritize and implement interventions as necessary to promote accessible, efficient, quality health care for every member.

Below is a detailed description of our QI program, including objectives and our progress toward meeting our goals. You can also phone Clinical Innovations/Quality Improvement at (410) 605-2677 to request a paper copy.

Our Quality Improvement Program

The goal of CareFirst's QI program is to constantly improve the quality and safety of clinical care, including behavioral health care, and the quality of services provided to our members. CareFirst works to provide access to health care that meets The Institute of Medicine's aims of being "safe, timely, effective, efficient, equitable and patient centered."

The quality process supports ongoing efforts to improve clinical care and services through activities such as:

- assessment and improvement of clinical care
- safe clinical practices
- measuring quality of services and satisfaction
- efficient use of resources
- interventions to provide accessible, efficient, quality health care for every member

The QI program objectives are to:

- Support and promote all aspects of the CareFirst Patient-Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) programs in order to improve quality of care, safety, access, efficiency, coordination and service.
- Meet targeted TCCI goals, in order to achieve a measurable reduction in the need for hospital inpatient and outpatient services.
- Meet PCMH "Measures That Matter" goals related to the number of emergency room visits, hospital admissions and hospital readmissions.
- Establish partnerships with clinicians and organizations to put into action interventions that address the identified health and service needs of our membership and that are likely to improve desired health outcomes.
- Provide data that encourages clinicians to practice evidence-based medicine and make informed choices when making referrals.
- Maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety and efficiency of clinical care and quality of service.
- Assess the cultural, ethnic and language needs of our members and consider such diversity when analyzing data and implementing interventions to reduce health care disparities.
- Monitor and oversee the performance of delegated functions of certain vendors and large provider groups.
- Develop and maintain a high quality network of health care providers.

continued

QUALITY IMPROVEMENT (CONTINUED)

- Operate a QI Program that meets federal, state and local public health goals, and requirements of plan sponsors, regulators and accrediting bodies.
- Address health needs of the communities we serve.
- Support quality improvement principles throughout CareFirst, acting as a resource in process improvement.

CareFirst recognizes that large racial and ethnic health disparities exist and that communities are becoming more diverse. Racial, ethnic and cultural background influence a member's view of health care and its results. CareFirst uses member race, ethnic and language data to find where disparities exist, and uses the information in quality improvement efforts.

The QI team, with input from appropriate CareFirst staff, writes a detailed description of all the completed and ongoing QI activities on the QI Work Plan for the year. The Quality Improvement Council and the Service & Quality Oversight Committee review the QI Program Evaluation at least once a year.

2013 QI PROGRAM GOALS	EVALUATION OF 2013 GOALS
Support and promote all aspects of the CareFirst Patient-Centered Medical Home (PCMH) Program.	■ Program launched January 2011. ■ More than 85 percent of CareFirst Primary Care Practitioners (PCPs) (including Nurse Practitioners) participate in the PCMH Program. ■ More than 1 million CareFirst members are cared for by PCMH practitioner panels.
Form partnerships with clinicians and organizations to identify our members' health and service needs and work on programs to make improvements in these areas.	■ Partnership with Healthways, Inc. to provide Local Care Coordinators to CareFirst's PCMH practices. ■ Working with Holy Cross Hospital to provide Community Based services. ■ Behavioral health visits to CareFirst PCPs are now part of PCMH and focus on educating PCP practices about the role of Magellan in the PCMH Program and making them aware of the services offered to members. Magellan staff has also educated physician groups on behavioral health issues, provided simple screening tools to assess potential behavioral health issues and outlined referral processes to access services.
Provide data that encourages clinicians to practice evidence-based medicine and make informed choices when making referrals.	■ Continuing to use the MedVantage HealthSmart application, used to build a library of evidence-based clinical quality measures and care alerts. CareFirst monitors and reports compliance with guidelines by using claims data and verification from practitioners. Physicians can monitor their patients' compliance and any gaps in care. ■ Providing SearchLight reports to PCMH panels, allowing PCMH practices access to secured, web-based data and reporting. ■ Providing Program Consultants to PCMH practices; the consultants visit with practitioners to review SearchLight data and highlight opportunities for increased cost savings and improved quality. The consultants also reinforce the availability and functionality of portal tools that are available to PCPs to assist them with population management.
Maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety and efficiency of clinical care (physical and behavioral health), and quality of service.	Conducted HEDIS® and CAHPS® surveys, showing use of services and satisfaction. Ongoing monitoring of PCMH outcomes in both clinical care and service – practitioners provided with a yearly PCMH report card, which stores and tracks all quality measures that play a key role in the panel's Outcome Incentive Award. Assess and measure quality, safety and efficiency of clinical care and quality of service through the annual Quality Improvement Program Evaluation.

continued

QUALITY IMPROVEMENT (CONTINUED)

2013 QI PROGRAM GOALS	EVALUATION OF 2013 GOALS
Assess the cultural, ethnic and language needs of our members and consider such diversity when analyzing data and implementing interventions to reduce health care disparities.	■ To meet the language needs of members, CareFirst offers the AT&T Language Line at no cost to members and providers. CareFirst also provides an online site in Spanish and produces educational materials, brochures and mailings in Spanish. ■ CareFirst's Disease Management and Wellness programs offer printed educational materials in English and Spanish. In addition, multi-lingual nurses are employed in our call centers. Our Health Risk Assessment is available in Spanish for online and printed formats. ■ CareFirst donated funds to reduce or eliminate racial disparities and to improve the quality and safety of care in the communities we serve. Through CareFirst Commitment, CareFirst has formed partnerships with community groups to address infant mortality in the District of Columbia, Maryland and Northern Virginia. CareFirst also provides care coordination and PCMH services to safety net clinics in those areas. ■ Local Care Coordinators (LCCs), assigned to PCMH practices, live in their specific region and are familiar with the health care systems in that area, allowing them to tailor care to the population they serve.
Monitor and oversee the performance of delegated functions of certain vendors and large provider groups.	■ CareFirst oversees delegates' performance against standards for quality improvement, utilization management, case management, pharmaceutical safety, disease management, credentialing, and member connections. We create and monitor corrective action plans as needed.
Develop and maintain a high quality network of health care practitioners and providers.	■ 2,818 new practitioners credentialed in 2013. ■ 3,750 practitioners re-credentialed in 2013. ■ CareFirst monitors and oversees credentialing for our delegated provider groups.
Operate a QI Program that meets federal, state and local public health goals, and requirements of plan sponsors, regulators and accrediting bodies.	■ Awarded National Committee for Quality Assurance (NCQA) accreditation for both HMO/POS (BlueChoice) and PPO (BluePreferred). ■ Demonstrated full regulatory compliance in Maryland for BlueChoice and in Virginia for BlueChoice and BluePreferred.

continued

QUALITY IMPROVEMENT (CONTINUED)

2013 QI PROGRAM GOALS	EVALUATION OF 2013 GOALS
Address health needs of the communities we serve.	■ Program, the centerpiece of which is our PCMH Program. TCCI includes a number of key components designed to engage individuals and improve and manage health, including: ■ Hospital Transition of Care Program (HTC) – ensures coordination and continuity of health care as patients transfer between different locations following a hospital admission. ■ Complex Case Management (CCM) – available for patients with advanced or critical illnesses – case managers provide care coordination services together with all specialists involved in the patient's care. ■ Chronic Care Coordination Program (CCC) – Local Care Coordinators are assigned to each PCMH practice and carry out Care Plans developed under the direction of the PCP to provide coordination of care for patients with multiple chronic illnesses ■ Home Based Services Program (HBS) – available to patients in CCM or CCC who need support at home, sometimes for a long period of time ■ Enhanced Monitoring Program (EMP) – focuses on patients at high risk for breakdown leading to a hospital admission or emergency room visit due to ongoing, usually chronic conditions and illnesses. ■ Comprehensive Medication Review Program (CMR) – assess and review pharmacy claims to identify high possibility of drug interaction, overdosing, side effects, etc. – local pharmacists provide patient-specific counseling and education ■ Pharmacy Coordination Program (RxP) – available for patients with certain diseases that require high-cost biologic or other pharmaceuticals that must be given according to rigorous treatment plans. ■ Expert Consult Program (ECP) – offers an outside expert opinion from leading physicians in the field(s) needed by the patient with a highly complex diagnosis, condition or disease. ■ Community Based Program (CBP) – a group of local programs, such as diabetes education/management, cardiac rehab and palliative care, highly specialized, high cost categories of care that are accessed by targeted referrals to centers throughout the country that have been prescreened and certified by the Blue Cross and Blue Shield Association. ■ Urgent Care & Convenience Access Program (UCA) – offers, where available, organized backup to PCMH panels as after-hours support for patients with urgent care need. ■ Continuing to expand TCCI to include: ■ Centers of Distinction Program (CDP) – to include highly specialized, high cost categories of care that are accessed by targeted referrals to centers throughout the country that have been prescreened and certified by Blue Cross and Blue Shield Association. ■ Substance Abuse and Behavioral Health Program (SBH) – to include a range of services that deal with the mental health issues of a member that often accompany physical illnesses or that may stand alone – also will include substance abuse services. ■ Provide Wellness programs to keep members healthy – health risk assessment, health advisor, telephonic and online coaching, onsite screenings and wellness seminars. ■ Supporting Safety Net Health Centers as Primary Care Medical Homes – in early 2012, CareFirst committed $8.5 million in grants over three years to community health centers in Maryland, the District of Columbia and Northern Virginia to create and/or enhance patient- centered medical home and care coordination programs for the region's most vulnerable, chronically ill populations.

continued

QUALITY IMPROVEMENT (CONTINUED)

2013 QI PROGRAM GOALS	EVALUATION OF 2013 GOALS
Support Quality Improvement principles throughout the organization, acting as a resource in process improvement.	Continuing to work with other CareFirst departments on an ongoing basis.

As part of our QI effort, CareFirst participates in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) project. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Results are used to measure performance, identify gaps in care and ascertain opportunities for improvement. The measures are sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA). CareFirst is required to participate and report results to NCQA in order to maintain our accreditation. HEDIS participation is also a requirement of the State of Maryland and the Commonwealth of Virginia.

Your cooperation and participation in the HEDIS project are important to the success of the completion of the project and the final outcome. Your documentation presents evidence of the quality of care you provide your patients. We appreciate and encourage your assistance in helping us collect data and report the results of the care you provided.

CPET CORNER

CPET Corner- Your Interactive Training Center

The Center for Provider Education and Training (CPET) offers convenient, accessible and resourceful webinars and seminars for you and your staff. If you are a Professional, Institutional or Ancillary provider, the webinar featured below might pique your interest.

- Blue Rewards – This training will enable you to learn more about the Blue Rewards incentive process. Effective Jan. 1, 2015, and upon renewal,

Visit www.carefirst.com/cpet to sign up today or call (877) 269-2219 for more information.

PHARMACY UPDATES

New Drugs

Below are new drugs that are now available or will become available soon.

BRAND NAME	GENERIC NAME
Orbactiv	oritavancin
Tybost	cobicistat
Havroni	sofosbuvir/ledipasvir
Esbriet	pirfenidone
Contrave	bupropion sustained release/ naltrexone sustained release
Ofev	nintedanib
Akynzeo	netupitant/palonosetron
Obizur	antihemophilic factor VIII [recombinant], porcine sequenced
Trumenba	meningococcal group B vaccine
Belsomra	suvorexant
Bio-T-Gel	testosterone
Bunavail	buprenorphine/naloxone
Embeda	morphine/ naltrexone
Epanova	omega-3-carboxylic acids
HyQvia	immune globulin 10% [human] / recombinant human hyaluronidase
Incruse Ellipta	umeclidinium

New Generics

The following drugs will be available as generic. The generics will be covered on tier 1 and the Brand Name drugs will be on tier 3 or non-preferred.

BRAND NAME	GENERIC NAME
Patanese	olopatadine
Stromectol	Ivermectin
Rapamune	sirolimus

For the most current preferred drug list, visit www.carefirst.com/preferreddrugs. For information about medications that require prior authorizations, visit www.carefirst.com/preauth. For a paper copy of the formulary and pharmaceutical management procedures, call (887) 800-3086.

Literature Lovers: We Await Your Feedback

Friends, Romans, countrymen, lend me your ears. I come to bury. . .

Oh, so it takes a little Shakespeare to get your attention, huh? Ok, here goes.

Over the last year or so, *friends,* we've made numerous changes to *BlueLink*, some big, some small, some good, some so-so, some poetic. But all were designed to make it easier for you, *Romans* (or from wherever you may hail), to work better with your patients – our members – to get the best care possible.

So tell me, *my countrymen:* Do you like *BlueLink*? Do you enjoy reading all of the helpful tips and articles that we stuff inside each issue? Ok, I'm not asking you to be a chatterbox and rant and rave (either positively or negatively). I just ask for a few words from you.

Email your comments to me, Bob Hilson, the bard of *BlueLink*, at newsletter.editor@carefirst.com.

CHIEF MEDICAL OFFICER AND SR. VICE PRESIDENT OF MEDICAL AFFAIRS
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CareFirst
The CareFirst BlueCross BlueShield family of health care plans