Patient-Centered Medical Home (PCMH)

2020 Program Description & Guidelines – Adult Medicine

Key Terms and Definitions

Assessment Outcome	Formal assessment completed by PCP and Local Care Coordinator of Members on the Core Target List
Collaborative Panel	A CareFirst made Panel for PCPs who are unable to find their own Panel
Core Target Population	Group of CareFirst Members who meet specific criteria related to care coordination needs
Credits	A Panel's Performance Year budget, or expected cost of care of their attributed Members
Debits	Allowed amount of health care spend for Members attributed to a Panel in the Performance Year
Designated Provider Representative	PCP lead for the Panel who has certain administrative responsibilities
Episode of Care Debit Overlap	50% of the shared savings earned by specialists in an Episode of Care value-based model that is applied back to a Panel's Patient Care Account
Individual Stop Loss	Portion of Gross Debits representing 80% of costs Per Member Per Year above $90,000 debited back to the Patient Care Account
Member	CareFirst beneficiary of Medical, and Pharmacy benefits
Member Months	The number of individual months a CareFirst Member is attributed to a PCMH Panel
Outcome Incentive Award	Portion of shared savings awarded to eligible Panels who meet savings to budget, quality score, care coordination, and attribution requirements
Overall Medical Trend	Change in the total cost of care over time for CareFirst Members with the CareFirst Medical Benefit
Overall Pharmacy Trend	Change in the total cost of pharmacy claims for the CareFirst Members with the CareFirst Pharmacy Benefit
Panel	Group of Primary Care Providers formed for participation in the PCMH Program
Panel Governance	CareFirst committee that reviews Panel structure, appeals and exceptions
Participation Incentive	12 percentage point increase to standard base fee schedule for PCPs participating in the PCMH Program
Patient Care Account	A report that presents a Panel's budget and total health care spend in a performance year
Performance Year	The measurement period for PCMH ranging from January 1st through December 31st of any given year
Persistency	Increase in Outcome Incentive Award total for Panels who earn an Outcome Incentive Award multiple years in a row. Awarded at levels of 2, or 3+ years in a row
Provider Directory	A list of providers contracted to participate in the CareFirst Network, available to CareFirst Members

Panel Size

A Panel, or group of Primary Care Providers (PCPs), is the basic performance unit of the PCMH Program, forming a team where one otherwise may not exist. PCMH Participation Incentives and Outcome Incentive Awards (OIAs) are based on the performance of Panel s.

To form a Panel, PCPs must organize into a group of five to 15 PCPs. A Panel may be formed by an existing group practice, small independent group practices, and/or solo practitioners that agree to work together to achieve Program goals. When a Panel is between five and 15 PCPs, it is large enough to reasonably pool member experience for the purpose of pattern recognition and the generation of financial incent ives, yet

small enough for each PCP's contribution to be perceived as meaningful. The idea is to tie rewards as directly as possible to individual PCP performance while providing enough experience to support sound conclusions about overall performance for each Panel.

Nurse Practitioners (NPs) are considered to be Primary Care Providers and count towards the minimum of five PCPs required to comprise a Panel.

Practices that exceed 15 PCPs but practice in the same location may request in writing to CareFirst an exception to form one Panel. This request will be reviewed by Panel Governance to determine the appropriateness of the exception based on the following criteria.

1. Panel Viability
2. Geography
3. Panel Cohesion/Accountability
4. Point in the Performance Year of the Request

CareFirst reserves the right to deny the addition of PCPs beyond 15.

If the termination of a practice or individual PCP within the Panel causes a Panel to fall below minimum participation requirements of five PCPs, the Panel will have up to one year to restore itself to the minimum participation level of five PCPs.

Panel Viability

For performance results to be credible, a Panel must have a minimum level of 15,000 attributed Member Months over the course of the Performance Year, or an average of 1,250 attributed Members per month. This is the point at which a Panel is considered viable and therefore eligible to earn an OIA.

There may be some instances when Panels are not able to reach the number of attributed Members needed to be viable while staying within the permissible range of five to 15 PCPs per Panel. For example, a Panel located in a geographic area with a low volume of CareFirst Members may not have enough Members to be considered viable. In these instances, the Panel may request, in writing to add additional PCPs, with the approval of CareFirst, to exceed the 15 PCP maximum and achieve a viable Panel size.

In some circumstances, a PCP may have difficulty finding a Panel to join. In these instances, CareFirst will assign a PCP to a PCMH Collaborative Panel. Practices joining the PCMH Program without a prospect to become a viable Panel that meets the Program requirements are agreeing to be placed in a Collaborative Panel. The Collaborative Panels will be constructed to ensure viability requirements are met. As such, CareFirst may construct a Panel that exceeds the 15 PCP maximum and may be geographically spread.

CareFirst reserves the right to deny the addition of PCPs beyond 15 and addition of any PCP to a Collaborative Panel.

Panel Composition

A PCP is eligible for this Program if (s)he is a healthcare provider who: (i) is a full-time, duly licensed medical practitioner; (ii) is a participating provider, contracted to render primary care services, in both the CareFirst BlueChoice Participating Provider Network (HMO) and the CareFirst Regional Participating Preferred Network (RPN); and (iii) has a primary specialty in:

- Internal Medicine
- Family Practice (Adult Members Only)
- General Practice
- Geriatrics
- Family Practice/Geriatric Medicine
- Doctors of Osteopathy – Primary Care
- Nurse Practitioners – Primary Care (Adult Health, Family, and Gerontology)

No partial group practices are accepted into the PCMH Program. All practitioners who function as a PCP must join the Program or the practice will not be accepted. In addition, all providers in the same practice must participate in the same provider networks. Those who do not function as a PCP – such as those who are "floaters" or see urgent care/sick care – should not enroll in the PCMH Program.

Multi-specialty groups may also join the Program, but for the purposes of Panel formation and enhanced payments, only the PCPs in such practices may participate. If a PCP who is part of a multi-specialty group practice seeks to join the Program, all qualifying PCPs within the practice must agree to join in order to qualify for Program participation.

CareFirst considers NPs to be critical providers of primary care services and an option for enhanced access for CareFirst Members, and NPs are encouraged to participate in the PCMH Program. NPs who bill for professional services in their own name will have Members attrib uted to them, just as any other PCP, earning the 12 percent Participation Incentive and OIA if eligible. Alternatively, NPs who bill "incident to" a physician in the practice will not have any attributed Members, as these Members will appear under the name of the physician under whom the NP is billing.

NPs must comply with all statutory and regulatory obligations to collaborate with or operate under the supervision of a physician pursuant to applicable state and local laws. The inclusion of NPs is intended to provide Members with an expanded choice of providers. Physicians collaborating with NPs participating in the Program must also participate in the PCMH Program.

NPs may also form a Panel of their own, independent of physicians.

Panel Types

There are five types of Panels participating in the PCMH Program

Virtual Panel: A Virtual Panel is a voluntary association of small, independent group and/or solo practices formed by contract with CareFirst. The PCPs in the Panel agree to work together to provide services to CareFirst Members, use each other for coverage and work as a team in improving outcomes for their combined CareFirst population.

CareFirst reviews and approves the formation of all Virtual Panels. PCPs in these Panels should practice within a reasonably proximate geographic distance from each other to ensure meaningful interactions among PCP Panel members.

Independent Group Practice Panel: An Independent Group Practice Panel is an established group practice of PCPs who can qualify as is, because the practice falls within the required size range of five to 15 PCPs.

Multi-Panel Independent Group Practice: A Multi-Panel Independent Group Practice is a practice with more than 15 PCPs that is not employed by a Health System. All such practices are required to identify segments of five to 15 PCPs that constitute logical parts of the larger practice – for example, pediatric or adult, and/or by location. CareFirst reviews and approves the division of the practice into constituent Panels.

Multi-Panel Health System: A Multi-Panel Health System is under the ownership of a hospital or health system and consists of more than 15 PCPs. All such systems are required to identify segments of five to 15 PCPs that constitute logical parts of the larger system – typically by location and population served. CareFirst reviews and approves the division of the system into constituent Panels.

Collaborative Panel: Collaborative Panels are formed at CareFirst's sole discretion. In these instances, CareFirst will assign a PCP to a PCMH Collaborative Panel in order to meet a Member attribution count of 1,250 or greater. As CareFirst will assign PCPs to these Panels, the PCPs of a collaborative Panel may not decide to remove a PCP from the Panel. These Panels are not required to meet in person and may participate in Panel meetings by teleconference. All other Program requirements will remain the same for Collaborative Panels, including Quality Scorecard, engagement and savings to budget requirements to e arn OIA.

Panel Peer Types

To ensure more meaningful and consistent comparisons in Panel performance and data reporting, Panels are assigned to an Adult or Pediatric peer group, effective in 2019. Separate, customized programs have been established for Adult and Pediatric Panel Peer Types. Mixed Panels have been eliminated. PCPs caring for Members of all ages will only be measured on their Members in the corresponding peer type.

PCP Access

PCPs must be accessible to all CareFirst Members. However, there are times when a Practice or an individual PCP is "closed" (not accepting new Members) due to capacity limits. A practice or individual PCP within the PCMH Program is required to have an open Practice unless they are closed to all payers. If a practice is open to any other payer for any of its networks, it must be open to all CareFirst Members. However, a practice/PCP may have an open practice for CareFirst and a closed practice for other payers.

Concierge Practices

PCPs who require CareFirst Members to participate in a priv ate fee-based program on a concierge basis or require Members to pay any type of retainer, charge, payment, private fee or purchase additional benefits in order to receive services from the PCP, other than the deductibles, co-pays and co-insurance under the terms of the Member's CareFirst benefit contract, do not qualify for the Program.

PCPs who charge any fees for supplemental services beyond those covered by CareFirst, and who warrant that the fees charged are strictly voluntary and not required, must agree to and comply with the following conditions, in writing, before acceptance into the Program:

1. The Panel PCPs must make it clear that no fee, charge or payment of any kind is required of a CareFirst Member in order to become and/or remain a Member attributed to the PCP or medical practice (other than the payment of ordinary deductibles, co-pays and co-insurance under the member's CareFirst benefit contract);

2. There must be no differences in the treatment, care, access, responsiveness, engagement, communications, etc., provided to CareFirst Members who do not pay the fee compared to those who pay the fee;

3. The Panel PCPs must set up office procedures and processes in such a way that a Member could not misconstrue a voluntary fee for supplemental services as a requirement to receive covered services; and

4. The Panel PCPs must recognize and agree that CareFirst maintains the right to audit compliance with these assurances, which may include a survey of the PCPs and medical practices' members who are CareFirst Members.

If CareFirst determines that any PCP or medical practice has not abided by these requirements, the PCP, medical practice and/or Panel will be subject to immediate termination from the Program and will forfeit any additional reimbursements or incentives they may otherwise be entitled to.

Exceptions to the rules regarding concierge practices may be negotiated on a case by case basis according to CareFirst's need for access in a particular geography or to meet particular market needs.

Online Connectivity and Systems Requirements for PCPs

The PCMH Program is designed to empower PCPs with the tools and data to effectively manage the care of their members without placing a technology burden on the practice. The PCMH online iCentric System is available via CareFirst's provider website.

To access the CareFirst Provider Portal, a valid User ID/Password is required, in addition to a computer meeting standard internet access with a current browser.

PCMH Participation Incentive

A Panel becomes effective in the PCMH Program on the first day of the second month following CareFirst's receipt of a complete PCMH application and signed network contract addendum from the whole new Panel. Enrollment

with a retroactive date is not allowed.

Once effective, CareFirst will add 12 percentage points to professional fees for all practices in the Panel as an incentive for participation in the Program, known as the Participation Incentive. The Participation Incentive continues for as long as PCPs in the Panel meet certain engagement and Quality Scorecard minimums in the Program, as discussed below in the Quality Measurement Program Requirements section. Participation Incentive and OIAs (if any) do not apply to time-based anesthesia, supplies and injectable drug fees/billings. These additional fees are advance payments intended to fund the practice's work on transformation, including time to meet with CareFirst staff, reviewing data, and redesigning workflow to achieve optimal outcomes and value in the Program. If Panels do not invest in a way that achieves outcomes and value, the Participation Incentive is at risk of reduction or elimination.

One note to be clear: The 12-percentage point Participation Incentive is added to Base Fees, not multiplied against them, and may be reduced if certain conditions are not met.

The Participation Incentive is contingent upon meeting quality score and engage ment requirements in the PCMH Program and will terminate upon the effective date of a practice's or Panel's termination from the Program. In this event, the payments to the practice will revert to the then-current CareFirst HMO and RPN fee schedules applicable to the practice without any incentives or Participation Incentives.

Measuring a Panel's Total Cost of Care vs. Trend Target

Success in the PCMH Program is determined by a Panel's ability to keep the global spend within a yearly trend target. An expected budget is set each Performance Year, built from the Panel's global medical and pharmacy spend in a base period, and adjusted for changes in Overall Medical Trend and Overall Pharmacy Trend, the relative risk of the Panel's patient population, and the Panel's attributed Members.

Base Period

The Base Period for Panels in 2020 will be an average of Per Member Per Month (PMPM) Medical and Pharmacy Costs from 2017 and 2018. The two-year Base Period reduces volatility and reflects the realities of changes in the local health market. At the start of each Performance Year, the Base Period will shift forward one year and will be restated using the Panel's current PCP composition, lessening the impact of market shifts and adjusting for provider movement across Panels.

Risk Adjustment

In 2019, CareFirst transitioned to ICD 10 diagnosis codes and will continue in the 2020 Performance Year. Risk adjustment is calculated with ICD-10 applied to both the Base Period and the Performance

Year, assuring the most accurate risk adjustment possible. To further align with local and national value-based program, the PCMH Program will move to the U.S. Department of Health and Human Services (HHS) Hierarchical Condition Category (HCC) Coding in 2020 to calculate Medical Illness Burden Scores (IBS) for Medical Budget calculation. All risk calculations use the Platinum HCC version. Any changes to the applicable version of the HCC imple mented by HHS during a Performance Year will be retrospectively applied to the Base Period to ensure that the measures are comparable. Pharmacy budgets will be risk adjusted independently for Pharmacy Benefit Members based on the industry standard Pharmacy Risk Grouper which calculates Pharmacy Burden Scores (PBS). Panels'

Performance Year budgets are adjusted based on changes in the risk of these two populations from Base Period to Performance Year.

***Risk Adjustment Update: October 2020**

Since the start of the PCMH Program, CareFirst has used the industry leading DxCG Intelligence to calculate the Medical Illness Burden Score (IBS) for Medical Budget calculation. In an effort to further align with local and national value-based programs, the PCMH Program made plans in PY2020 to move to U.S. Department of Health and Human Services (HHS) Hierarchical Condition Category (HCC) Coding to measure risk. After a detailed analysis of both risk adjustment tools, it was determined that DxCG model captures a larger set of diagnoses and is a more precise risk adjustment tool for setting Panel budgets.

Although HHS-HCC risk scores are used in the ACA risk transfer program to offset the population risk differences between insurance carriers within a market, these scores were not intended to be applied for smoothing risk across smaller populations. The scores may not have the same level of precision when used for this purpose. The HHS-HCC risk score model focuses on adjusting for risk associated only with selected high-cost diagnoses, whereas the DxCG model captures many more diagnoses and reflects a more accurate risk level for individuals.

DxCG will continue to be used to set PCMH Panel budgets in PY2020. Since HHS-HCC methodology was never implemented, there will be no change to the risk scores in the Base Period and Performance Year.

Member Attribution

Attribution of Members will occur on a monthly basis using a 24-month claims lookback period. Plurality of PCP office visits will determine the attributed provider for each Member. Claims history is used to determine a plurality of visits first over the most recent 12 months and then, if necessary, over the preceding 12 months. In the case of a tie for either period, attribution is assigned to the provider with the most recent visit. In 2020, Member self-selection will no longer be used to attribute Members to Panels. Therefore, in the case of no visits in the 24-month period, a Member will remain unattributed until they visit a PCMH PCP. Attribution for Adult Panels will be restricted to Members age 18 and older, while attribution for Pediatric Panels will be restricted to ages 20 and younger.

PCMH Attribution will supersede attribution for all other CareFirst value-based programs.

Setting Budget Targets

Budgets for the 2020 Performance Year will be calculated using the Base Period (2017 and 2018) PMPM Medical and Pharmacy costs. Those PMPMs are then risk adjusted and trended forward to create the budget for the 2020 Performance Year population. In 2020, CareFirst will use actual Medical and Pharmacy trends specific to CareFirst's adult population. At the start of the Performance Year, a trend target will be established to set the Panel's budget and will be adjusted to match the actual trend at the end of the Performance Year. Trends will be set based on the portion of health care spending controlled by the owner of the Panels, as described below. Trend targets will adjust each year to bring growth in health care costs in line with wage inflation.

- Independent Panels
    - Medical: CareFirst Medical trend minus 1 percentage point
    - Pharmacy: CareFirst Rx trend minus 1 percentage point
- Health System Panels

- Medical: CareFirst Medical trend minus 2 percentage points
- Pharmacy: CareFirst Rx trend minus 2 percentage points

Pediatric Panels participating in the PCMH Program will have a trend factor based on the CareFirst trend specific to the pediatric population. See the Pediatric Program Description & Guidelines for details on the Pediatric Program.

Calculating Savings to Budget

Savings compared to expected is calculate at the end of the performance for each Panel. Panels that have less net Debits than Credits may be eligible to share in the savings in the form of an Outcome Incentive Award (OIA). The net Debits is the total allowed amount for the attributed patient population of the Panel in the Performance Year minus the Individual Stop Loss and Episode of Care Debit Overlap.

Individual Stop Loss Reduction

All Panels are protected against "shock claims" for extremely high costs cases that could distort their Debits and Credits and, therefore, Panel results. The Program includes an Individual Stop Loss (ISL) protection limit Per Member Per Year against these type of claims with respect to amounts shown as debits in each Panel's Patient Care Account

In 2020, ISL is set at $90,000 Per Member Per Year. Only 20 percent of any costs above $90,000 in the calendar year are debited against the Patient Care Account of a Panel. The ongoing 20 percent Debit is designed to keep the PCPs actively interested in their most complex Members.

The ISL threshold is examined on an annual basis and adjusted, if necessary, to maintain a constant percentage of costs subject to the ISL. Since Program inception, the target percentage of total cost above the ISL level has been in the 7.5-8.0 percent range (of total cost). Accordingly, total costs above the ISL are constantly measured to assure that this portion of total claim costs remain subject to ISL protection.

Episode of Care Debit Overlap

In 2020, CareFirst will launch new value-based programs for specialties that manage episodes of care for Members attributed to PCMH Panels. Because these models will operate in parallel, CareFirst Members attributed to PCMH may have discrete episodes with multiple providers operating in episode-based incentive agreements independent of one another. Reductions in overall cost of specialist-driven episodes benefit PCMH Providers. For this reason, any incentives paid to specialists will count toward the total cost of care budget for PCMH Panels but it should be noted that incentives are only paid when a specialty practice makes measurable improvement in the management of episodes vs. their prior history.

Quality Measurement Program Requirements

In addition to cost savings to budget, Panels must achieve clinical quality measures to be successful in the PCMH Program. CareFirst has selected quality measures that drive the most impactful health outcomes and align with those of other payers' programs where possible to maximize provider focus and minimize conflicting coding burdens.

CareFirst Core 10 Measures

Clinical Quality Scores will be a composite of 10 measures based on NCQA and HEDIS recommendations. Measures include process-based and outcomes-based measures collected through claims, and may require attestation, clinical data sharing, and survey responses in order for a Panel to achieve all Quality Scorecard points. Details of the inclusion and exclusion criteria for each measure can be found in the CareFirst Core10 Playbook, located in the appendix of this document. The 2020 CareFirst Core10 Measures for Adult Panels are shown below.

Adult Panel Clinical Measures	Points
POPULATION HEALTH MEASURES (35 Points)	
1. Optimal Care for Diabetic Population	**15**
§ *HbA1c Control (<8%)*	
§ *Blood Pressure Control (<140/90)*	
§ *Eye Exam*	
§ *Chronic Kidney Disease Screening (ACR and eGFR annually)*	
§ *Statin Therapy (adherence)*	
2. Controlling High Blood Pressure	**15**
3. Colorectal Cancer Screening	**5**
EVENT-BASED MEASURES (30 Points)	
4. Use of Imaging Studies for Low Back Pain	**5**
5. Follow Up for Mental Health and Substance Abuse Composite	**15**
§ Follow Up After ED Visit for Mental Illness (7 days)	
§ Follow Up After ED Visit for Alcohol/Drug Dependence (7 days)	
§ Follow Up Hospitalization for Mental Illness (7 days) - with Behavioral Health Practitioner	
6. Appropriate Opioid Prescribing	**10**
▪ Risk of Continued Opioid Use	
▪ Use of Opioids from Multiple Providers	
RISK-ADJUSTED MEASURES (20 Points)	
7. Hospitalization for Potentially Preventable Complications	**5**
8. All-Cause Readmissions	**5**
9. Emergency Department Utilization	**10**
SURVEY MEASURES (15 Points)	
10. Consumer Assessment of Healthcare Providers (CAHPS) Composite	**15**
▪ *Getting Care Quickly*	
▪ *Getting Needed Care*	
▪ *Coordination of Care*	
▪ *Rating of Personal Doctor*	

New measures for 2020 are highlighted in yellow

Scores are awarded in tiers based on national and peer benchmarks. No points will be awarded for Panels failing to meet the first tier of each measure, roughly the 25th percentile. Scoring is done at the PCP level and rolled up to the Panel level for final Panel scores at the end of the Performance Year. Diabetic Members must meet all five measures to be compliant with the Diabetes Composite. Population Health Measures are scored for the Members attributed to the Panel at the end of the Performance Year. Event-Based and Risk-Adjusted Measures are scored for Members attributed to the Panel at the time of the event, even if these Members are no longer attributed to the Panel at the end of the Performance Year. Survey Measures are scored for Members attributed to the Panel at the time of the survey. The Clinical Quality Scorecard with tiered quality score benchmarks is detailed below.

MEASURES	PANEL SUMMARY					BENCHMARKS				
						Not Tiered (0 Points)	Tier 4 (50% Points)	Tier 3 (65% Points)	Tier 2 (80% Points)	Tier 1 (100% Points)
POPULATION HEALTH MEASURES	**Points Available (35)**	**Points Obtained**	**Compliant Members**	**# Member Opportunities**	**% Compliance**	**% COMPLIANCE TO ACHIEVE EACH TIER**				
1. Optimal Care for Diabetic Population*	15									
▪ *HbA1c Control (<8%)*										
▪ *Blood Pressure Control (<140/90)*										
▪ *Eye Exam*										
▪ *Chronic Kidney Disease Screening (ACR and eGFR annually)**										
▪ *Statin Therapy (adherence)*										
2. Controlling High Blood Pressure	15									
3. Colorectal Cancer Screening	5									
EVENT-BASED MEASURES	**Points Available (30)**	**Points Obtained**	**Compliant Members**	**# Events**	**% Compliance**	**% COMPLIANCE TO ACHIEVE EACH TIER**				
4. Use of Imaging Studies for Low Back Pain	5									
5. Follow Up for Mental Health and Substance Abuse Composite	15									
▪ *Follow Up After ED Visit for Mental Illness (7 days)*	5									
▪ *Follow Up After ED Visit for Alcohol/Drug Dependence (7 days)*	5									
▪ *Follow Up Hospitalization for Mental Illness (7 days) - with Behavioral Health Practitioner*	5									
6. Appropriate Opioid Prescribing	10									
▪ *Risk of Continued Opioid Use*	5									
▪ *Use of Opioids from Multiple Providers*	5									
RISK-ADJUSTED MEASURES	**Points Available (20)**	**Points Obtained**	**Observed # Events**	**Expected # Events**	**Observed to Expected Ratio**	**OBSERVED TO EXPECTED RATIO TO ACHIEVE EACH TIER (Lower ratio is better)**				
7. Hospitalization for Potentially Preventable Complications	5									
▪ *Hospitalization for Potentially Preventable Chronic Complications*										
▪ *Hospitalization for Potentially Preventable Acute Complications*										
8. All-Cause Readmissions	5									
9. Emergency Department Utilization	10									
SURVEY MEASURES	**Points Available (15)**	**Points Obtained**	**Average Score**	**Denominator Success Rate**		**RATE TO ACHIEVE EACH TIER**				
10. Consumer Assessment of Healthcare Providers (CAHPS) Composite**	15									
▪ *Getting Care Quickly*										
▪ *Getting Needed Care*										
▪ *Coordination of Care*										
▪ *Rating of Personal Doctor*										
Overall Clinical Score	**100**	**#REF!**								

* Indicates a non-HEDIS measure for which the benchmarks were set using actual PCMH scores for currently active viable adult panels.

** minimum response rate will be applied for CAHPS like survey

Panels must achieve at least 65% of the total clinical quality points available to receive the full Participation Incentive and to be eligible for an OIA. This represents the 50th percentile in total Clinical Quality Scorecard points.

Engagement Program Requirements

PCP engagement continues to be critical for success in the PCMH Program. The PCP Engagement Scorecard measures a Panel's level of engagement with Local Care Coordinators and Practice Consultants and requires participation in care coordination and practice transformation. The scorecard is comprised of three sections, scored quarterly by Local Care Coordinators and Practice Consultants. Scores are awarded on a Likert scale for each measure ((0) Unmet, (1) Strongly Disagree, (2) Disagree, (3) Somewhat Agree, (4) Agree, (5) Strongly Agree). Scores are recorded for each PCP and averaged for the Panel each quarter. The final PCP Engagement Score is the average of all four quarters. Panel scores can be found in the Overall Quality Score section in SearchLight.

Having an active Care Plan (Behavior Health Care Plan included) is required for certain measures related to care coordination in order to receive points for that measure. Each measure can be unassessed if deemed appropriate by the Practice Consultant. An unassessed score by the Practice Consultant will be dropped from the denominator, however, unassessed scores for the same question, for an individual PCP in all four quarters, will result in a zero for the year. The PCP Engagement Scorecard is detailed below:

2020 ADULT Engagement Scorecard	Points
I. Engagement with Care Coordination (PCP Level Score by Local Care Coordinator)	**25**
PCP schedules monthly via SKYPE or in person meeting a Clinical Status Review of all Members presented by the Care Coordinator.	5.0
PCP has workflow in place to refer Members who may have emerging needs, obtaining consent and notifying the LCC of the referral. REQUIRES CARE PLAN	5.0
PCP identifies members for other Clinical Programs based on member needs and collaborates with the LCC on the referral.	2.5
PCP is collaborative with the LCC, ensuring that the LCC has access to needed clinical information, and provides EMR access to the Care Coordinator if EMR access is available. REQUIRES CARE PLAN	2.5
PCP is responsive to Care Coordinator. PCP has established point of contact and/or effective workflow for all PCMH matters.	5.0
PCP helps create an environment in the Practice that is conducive to conducting the PCMH Program and instructs staff to this end.	5.0
II. Engagement with Practice Consultant (PCP Level Score by Practice Consultant)	**35**
PCP attends and actively participates in PCMH Panel meetings, and demonstrates understanding of the Program through actions, behaviors, and words.	10
Panel has an engaged Designated Provider Representative (DPR) that helps to set Panel goals, develop presentation materials, and co-leads PCMH discussions (all PCPs in the Panel get the same score).	10
Practice participates in PCMH Survey in a timely manner and implements recommendations from the PCMH Team.	15
III. Practice Transformation (PCP Level Score by Practice Consultant)	**40**
Practice identifies cost-efficient specialists in the top specialty categories, has an effective workflow in place to refer Members to cost-efficient specialists in the top specialty categories, and communicate expectations with specialist through clinical compacts.	10

2020 ADULT Engagement Scorecard	Points
Practice participates in clinical data sharing with CareFirst through our preferred data sharing platform or preferred alternative method.	10
Practice has an effective plan for after-hours care to avoid unnecessary ER visits or breakdowns, such as after-hours appointments, the opportunity to speak with a clinician after hours, and telemedicine.	10
PCP effectively manages Members' transition from the hospital or emergency department, including timely post-discharge follow up and co-management with specialists. PCP identifies and communicates with frequently used hospitals, getting notifications of IP admissions and discharges as well as ED visits and discharges.	10
Total Points	**100**

New measures for 2020 are highlighted in yellow

Panels must achieve at least 70 out of 100 points to receive the full Participation Incentive and to be eligible for an OIA.

Eligibility for Outcome Incentive Awards

The PCMH Program pays substantial incentives to those Panels that demonstrate favorable outcomes and value for their Members. These incentives are called Outcome Incentive Awards (OIAs). All such incentives are expressed as add-ons to the professional fees paid to PCPs who comprise Panels who earn an OIA.

Panels must meet the conditions below to be eligible for an OIA:

1. The Panel must have joined the Program on or before July 1st of the Performance Year. If the Panel joins after this date, it will not be eligible for an OIA until the following Performance Year.
2. The Panel must have a cost savings to budget in their Patient Care Account (i.e., Credits must exceed Debits).
3. The Panel must achieve 70 out of 100 points on the Engagement Scorecard and 65% of the quality points available on the Clinical Quality Scorecard.
4. Each PCP must complete a clinical status review each month of all Members in their Core Target Population and document all results as an Assessment Outcome.
5. The Panel must be viable by having at least 15,000 Member Months for the Performance Year.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2021 for **Performance Year #10 - 2020**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2022.). In order to be paid an OIA, the practice must participate in the PCMH Program throughout the incentive pay out period (August 1st - July 31st) following each Performance Year.

All OIAs earned by each Panel are added on top of Base Fees and Participation Incentives.

OIAs are always calculated at the Panel level. Panels that are part of a larger entity may request to be paid their OIA at the entity level. The entity may elect to be paid this aggregated OIA amount based on combined, weighted results for all Panels (including non-viable and ineligible Panels) or be paid separate OIAs for each winning Panel. A group may alter this choice in advance of each Performance Year upon 60 days written request to CareFirst before the start of each Performance Year.

For a Panel that joins the Program within the first six months of the Performance Ye ar, any earned OIA will be prorated based on effective date of Panel's entry into the Program as shown below.

Proration of Outcome Incentive Award (OIA)

Effective Date	Prorated Percentage
1/1	100
2/1	92
3/1	83
4/1	75
5/1	67
6/1	58
7/1	50

OIA fees and the Participation Fees will cease immediately upon termination of a practice's participation in the Program and/or termination of a Panel from the Program.

Outcome Incentive Award Calculation

The OIA is the intersection of cost savings to budget and PCMH Quality Scorecard results. The incentive awarded back to the Panel is designed to be roughly one third of the Panel's savings. Panels can achieve a higher OIA by earning higher scores for PCP Engagement and Clinical Quality, winning multiple y ears in a row, and having a larger Panel attribution. The OIA formulas are described below. Quality Scores are an average of the Panel's Engagement Scorecard and Clinical Quality Scorecard results.

OIA Formulas Based on Panel Size and Win Years

Duration*	Average Members	Outcome Incentive Award	
Adult Panels			
1	**3,000+**	Fee Increase = [(Quality Score + 30)/100] * **9.00** * % Savings	
1	**2,000-2,999**	Fee Increase = [(Quality Score + 30)/100] * **7.59** * % Savings	
1	**1,250-1,999**	Fee Increase = [(Quality Score + 30)/100] * **6.75** * % Savings	
2	**3,000+**	Fee Increase = [(Quality Score + 30)/100] * **9.00** * %Savings	* 1.10
2	**2,000-2,999**	Fee Increase = [(Quality Score + 30)/100] * **7.59** * %Savings	* 1.10
2	**1,250-1,999**	Fee Increase = [(Quality Score + 30)/100] * **6.75** * %Savings	* 1.10
3+	**3,000+**	Fee Increase = [(Quality Score + 30)/100] * **9.00** * %Savings	* 1.20
3+	**2,000-2,999**	Fee Increase = [(Quality Score + 30)/100] * **7.59** * %Savings	* 1.20
3+	**1,250-1,999**	Fee Increase = [(Quality Score + 30)/100] * **6.75** * %Savings	* 1.20

Eligibility for Participation Incentive

Participation Incentives are intended to fund the providers' time and attention to the Program and to assure front line providers are properly informed of utilization, savings to budget and Quality Scorecard results necessary to drive transformation leading to better outcomes and value for the CareFirst population.

Practices can earn their 12-point Participation Incentive by engaging in practice transformation and by sharing all PCMH utilization, budget, Quality Scorecard and OIA data with PCPs. Panels who do not meet at least 70/100 on the PCP Engagement Scorecard and 65% of the quality points available on the Clinical Quality Scorecard may lose all or portions of their Participation Incentive based on market size category as shown below. Adjustments for Panels losing all or part of the 12 Points will go into effect in August of 2021 based on 2020 Performance.

The amount of the Participation Incentive at risk is dependent upon the size of the practices within Panels and their influence over the larger health care market. Six points will be at risk for independent, primary care centric practices and Panels part of independent, multi-specialty practices, and 12 points for Panels part of multi-hospital health systems.

Determining market size category

- Entrepreneurial and Corporate (6pts): All virtual Panels, single site independent Panels, and multi-site independent Panels
- Health System (12pts): Multi-Hospital health systems and/or hospitals that employ a comprehensive range of specialties.

Changes in Participation Incentive will be effective on August 1st of the year following the Performance Year (e.g., August 1, 2021 for **Performance Year #10 - 2020**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2022.)

OIA For Strong Cost Efficiency and Quality

Adult Panels can also be rewarded for demonstrating strong cost efficiency and high, quality scores even if they do not produce a saving compared to expected in their Patient Care Account. Panels finishing the Performance Year in the top 10% of Risk Adjusted Total PMPM spend and in the top 10% of total Clinical Quality Scorecard points, compared to all Adult PCMH Panels, will be awarded a 15 point OIA as long as all other OIA eligibility criteria is met. The top 10% represents the best performance in the respective category.

Changes in Panel Composition

A variety of circumstances may arise over time that may impact PCP membership of a Panel or practice. Panels or practices may dissolve, change their PCP membership via attrition or termination, or allow P CPs to leave and join other Panels.

A PCP may change Panels for any reason, including a change in his/her practice location or a change in his/her affiliation with a particular practice. In this case, the PCP may join another Panel in the new location, or another practice that is part of Virtual Panel.

The following rules govern these Panel changes:

1. If a Panel's participation falls below five PCPs it must, within one year, increase its membership to five or more or the Panel will lose OIA eligibility for the Performance Year. If the Panel participation falls below five PCPs for a full year, the Panel will be terminated from the Program. Exceptions may be granted with written request through Panel Governance.

2. A Panel may request an exception to the upper limit of 15 PCPs in writing. For an exception to be granted, the Panel must demonstrate that the Panel practices as a cohesive unit and must provide compelling justification as to why such larger size would not unduly diminish the contribut ion of each PCP to overall Panel performance.

3. Multi-Panel Independent Group Practices and Multi-Panel Health Systems may choose to have an OIA paid at the entity wide tax identification number (TIN) level, notwithstanding the fact that all OIAs are determined at the Panel level as a Program requirement. In the situation, all Panels under the same TIN will receive a single OIA, determined by the weighted average of each Panel, weighted on size of Panel Debits.

4. If a new PCP or practice joins an existing practice, the reimbursement level of the existing practice will be assumed by the new PCP or practice, including the Participation and OIA Incentive fees (if any), once the new PCP has signed on to the PCMH Program. A new PCP joining an existing practice will only be considered to be a member of the Panel on a prospective basis. No retroactive enrollment is allowed.

5. If a PCP leaves a Panel but remains in the CareFirst HMO and RPN networks without participating in another Panel, the PCP will lose the Participation Incentive and OIA incentive fees at the point they terminate from the Panel.

6. If a Panel changes ownership or Tax ID, but the actual PCPs making up the Panel remain the same, the Panel will be treated as having continuous participation in the PCMH Program for the purposes of OIA and persistency awards.

7. Any practice that joins a Panel is required to be an active PCMH participant of that Panel during the last two complete calendar quarters of the current Performance Year to be eligible for an OIA. That is, only practices that actively participate in the Program by July 1 of the Performance Year are eligible for an OIA for that Performance Year. If a practice joins a Panel after July 1, that practice is excluded from the OIA for that Performance Year. A practice will be considered active in the PCMH Program once the practice has signed both a Panel contract and the PCMH Addendum to their network agreement with CareFirst. A retroactive enrollment date is not allowed for practices that are new to PCMH.

8. Acceptance of a practice into an existing Panel requires unanimous agreement by the Panel, communicated in writing to CareFirst by the Panel's Designated Provider Representative (DPR).

9. If a practice leaves a Panel after the end of a Performance Year, joins another Panel and remains in good standing with the Program, the practice will keep the OIA earned in the previous Panel.

Appeals

Any PCP or Panel as a whole may submit a letter to CareFirst requesting review of any aspect of the calculation of an OIA that they believe to be made in error. CareFirst will promptly (within two weeks) contact the PCP and Panel to discuss the information submitted with the request as well as any other pertinent information. Following a thorough review, CareFirst will notify the appealing PCP and/or Panel of its response in writing within 90 days of the receipt of complete information from the PCP and/or Panel.

CareFirst will make corrections in Panel results if any errors are found. In carrying out corrections, CareFirst may provide a correction on a prospective basis or on a retrospective basis, depending on the circumstance s of the particular case.

Signing on with PCMH

Participation in the Program is entirely voluntary. There is no penalty or negative impact on existing CareFirst fee payments for network RPN and HMO PCPs or practices who elect not to participate.

Each PCP (or the practice to which they belong) will be required to sign an Addendum to its CareFirst RPN and HMO Participation Agreements.

If a PCP applying for participation in the Program is in an established large group practice that contains more than 15 PCPs, the practice and CareFirst will agree on the way the practice will be divided into Panels prior to the effective date of Program participation.

If a PCP applicant is in a solo practice or a small practice and wishes to participate in the Program by joining another Panel(s) or practice(s) as part of a Virtual Panel, then all of the PCPs who would make up the Virtual Panel must sign a PCMH enrollment form indicating that they are voluntarily forming a Virtual Panel for the purposes of the Program and are attesting to their commitment to work individually and collectively toward Program goals. If a Virtual Panel is not formed, the practice will be added to a Collaborative Panel at CareFirst's sole discretion.

All PCPs within a practice who submit claims to CareFirst for payment under a single tax ID number must join so that all participate in the Program. Any division of the practice into Panels made for performance tracking purposes as described above does not affect this participation requirement.

Each Panel must designate a lead provider called a Designated Provider Representative (DPR) to act as a primary point of contact between the Panel and CareFirst.

As stated above, practices receive formal PCMH Recognition by CareFirst immediately upon execution of the Participation Agreements, as defined by PCMH designation in the CareFirst Provider Directory.

Termination from PCMH

A Practice may terminate its participation in the Program upon ninety (90) calendar day's prior written notice to CareFirst for any reason.

A Panel may terminate participation in the Program with ninety (90) calendar day's prior written notice to CareFirst for any reason. This will terminate all participants within such Panel from the Program unless they join another Panel. If a PCP in a practice terminates participation in the Program, but does not terminate from the practice, the practice will be terminated from the Program. Notwithstanding this requirement, in the case of a PCP who is recalcitrant with Program engagement, an individual PCP may be terminated from the PCMH Program. Once the PCP is terminated, they will no longer receive the participation fee or OIA.

A Virtual Panel may change its self-selected team of PCPs at any time, if it continues to meet the minimum size requirements of the Program and notifies CareFirst. The consent of at least three-fifths (3/5) of the PCPs in the Virtual Panel is required to forcibly remove a practice from the Panel. A letter from the Panel's DPR is required to be sent to the practice that was voted to be removed informing them of the Panel's decision.

CareFirst may immediately terminate a practice, PCP and/or Panel from the Program under the following circumstances with written notice, unless the termination is related to the discontinuance of the entire Program which requires 90 calendar day's prior written notice:

1. The practice, PCP and/or Panel repeatedly fails to comply with the terms and conditions of the Program.

2. The practice, PCP and/or Panel has substantial uncorrected quality of care issues.

3. Termination of either the Master Group Participation Agreement, or the Primary Care Physician Participation Agreement which terminates the Group's, PCP's and/or Panel's participation in CareFirst's RPN or HMO networks.

4. Any other termination reason set forth in the termination provisions of the underlying Participation Agreements within the applicable notice periods set forth therein.

The payment of the Participation Fee and any OIA will immediately terminate upon the effective date of the PCP's, Group's or Panel's termination from the Program regardless of the reason for termination.

Termination for Failure to Engage in Care Coordination

CareFirst may also terminate a PCP or practice for persistent failure to engage in the care coordination components of the Program upon due notice and consultation in acc ordance with the process outlined below.

A PCP or practice that persistently fails to engage with the care coordination components of the Program will be terminated from the Program. The Regional Care Director (RCD), who is the PCMH Program lead for Care Coordination, will have oversight of the termination process as it relates to lack of engagement. When

the RCD determines that a PCP or practice, despite multiple in person visits to the PCP's office, fails to engage, the RCD will begin the process of terminating the PCP from the Program.

As a first step in the termination process, the PCP or practice that is not engaging with the components of the Program will receive a 90-day warning letter from the RCD, reminding him or her of the requirements for continued participation. This is the first of three letters sent with a copy to the other Panel PCP members. This letter identifies the termination date if engagement with CareFirst does not occur, as defined as an in - person meeting with the RCD and or Practice Consultant to discuss and agree to all requirements for participation in PCMH as defined in the PCMH Program Description and Guidelines. If the PCP or practice is still unwilling to engage after 30 days, the RCD will send the PCP or practice a final warning letter stating that termination from the Program will result from continued non -engagement. If the PCP or group still does not engage as described above, the PCP or group will be notified that termination will occur on the date originally presented in the 90–day letter and termination will occur on that date.

If the PCP or practice begins to engage with the care coordination components of the Program, as described above, during the termination process, the RCD may suspend the termination process. The termination process may be reinstated if the PCP or Group does not sustain their Engagement with the components of the Program.

The payment of the Participation Fee and any OIA will immediately terminate upon the effective date of the PCP's, Group's or Panel's termination from the Program regardless of the reason for termination.

Disqualification of Participants

In the event that a CareFirst PCMH practice does not meet the participant qualifications as defined above in the Panel Composition section of the Program Description and Guidelines, it must provide immediate notice to CareFirst whereupon the practice will be disqualified from participation in the Program. All PCMH related financial incentives will cease for claims with dates of service on or after the PCP's /Practice's/Panel's termination date.

2020 Core 10 Measure Guide

Introduction

The Core 10 is a targeted list of metrics selected to help ensure best-in-class care for our members. This guide provides a high-level overview of each measure. More detailed information can be found in the specifications of the relevant measure steward.

The Value of These Measures for Providers

Providers who proactively and effectively manage their patients' care are more likely to identify and address issues or complications which could result in an improved health outcome and a reduction of healthcare costs. In addition, it may help identify noncompliant patients and ensure they receive the appropriate treatment and follow up care.

Note: Reimbursement for these services will be in accordance with the terms and conditions of your provider agreement.

2020 Substantive Changes

+Added codes for HbA1c measure, Retinal eye exam measure and Colonoscopy screening measure
+Combined follow up for behavioral health/mental illness visit measures
+Added Opioid Use composite (UOP, COU)
+Added Scoring Detail for each measure
+Changed age range for HPC from 18 years of age and over to 67 years of age and older
+Expanded the Member Experience Composite description to include all survey questions; scored questions highlighted in blue

Population Health Measures	
1	Optimal Diabetes Care (ODC)
2	Controlling High Blood Pressure (CBP)
3	Colorectal Cancer Screening (COL)
Event-Based Measures	
4	Use of Imaging for Low Back Pain (LBP)
5	Follow-up After Visit for Behavioral Health Composite (FUM/FUA/FUH)
6	Opioid Use Composite (UOP, COU)
Risk-Adjusted Measures	
7	All Cause Readmission (ACR)
8	Emergency Department Utilization (EDU)
9	Hospitalization for Potentially Preventable Complications (HPC)
Survey Measures	
10	Member Experience Composite (MEC)

OPTIMAL DIABETES CARE

Scoring: Higher is better

Who is in the Measure?

Members aged 18-75 with type 1 or 2 diabetes who have had one of the following:

- Two outpatient, observation or emergency department visits on different dates of service with a diagnosis of diabetes during the calendar year or prior year. The visit type doesn't need to be the same for the two visits.
- One nonacute inpatient encounter with a diagnosis of diabetes during the calendar year or prior year.
- Insulin or hypoglycemics/antihyperglycemics dispensed on an ambulatory basis during the calendar year or prior year.

The statin sub-measure focuses only on members aged 40-75 without atherosclerotic cardiovascular disease.

Who is Excluded?

Members who had only gestational diabetes or steroid-induced diabetes during the calendar year or prior year or who are 66 years of age and older with frailty and advanced illness during the year are excluded. The statin sub-measure has additional exclusions, which can be found in the healthcare effectiveness data and information set (HEDIS®) technical specifications.

Who is Compliant?

Note: This measure is divided into **five** sub-measures. Members must meet **all** 5 sub-measures they are included in to be compliant:

- HbA1c <8.0%
- Blood pressure <140/<90 mm Hg
- Chronic kidney disease screening
- Retinal eye exam
- Statin therapy adherence

Sub-Measure 1 – HbA1c <8.0%: Members whose most recent HbA1c level is less than 8.0 percent and whose data is transmitted to CareFirst via FIGmd data transmission, CPT®-II code, attestation, data transfer or lab data during the year.

Criteria for Code	Code	Definition	Code System
HbA1c Level Less Than 7.0	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	CPT®-CAT-II
HbA1c Level Less Than 8.0	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	CPT®-CAT-II

Sub-Measure 2 – BLOOD PRESSURE <140/<90 mm Hg: Members whose most recent blood pressure is <140/<90 mm Hg and whose data is transmitted to CareFirst via CPT-II code, attestation, data transfer or lab data during the year.

Criteria for Code	Code	Definition	Code System
Diastolic 80-89	3079F	Most recent diastolic blood pressure 80-89 mm Hg	CPT®-CAT-II
Diastolic Less Than 80	3078F	Most recent diastolic blood pressure less than 80 mm Hg	CPT®-CAT-II
Systolic Less Than 140	3074F	Most recent systolic blood pressure less than 130 mm Hg	CPT®-CAT-II
Systolic Less Than 140	3075F	Most recent systolic blood pressure 130-139 mm Hg	CPT®-CAT-II

Sub-Measure 3 – CHRONIC KIDNEY DESEASE SCREENING: Members who receive screening for chronic kidney disease (CKD) using **both** albumin-to-creatinine ratio (ACR) and estimated glomerular filtration rate (estimated GFR, eGFR) tests during the year. PCPs can order a single Kidney Profile test from LabCorp or a combination of two tests for ACR and eGFR. *Compliance for this measure can be transmitted to CareFirst via LOINC codes below.*

Test	Includes	Test Order Code	
		LabCorp	Quest
Kidney Profile	Albumin-to-creatinine ratio (ACR) **and** estimated glomerular filtration rate (eGFR)	140301	N/A
eGFR	Estimated glomerular filtration rate (eGFR) only	1007684	19107
ACR	Albumin-to-creatinine ratio (ACR) only	140285	6517
Basic Metabolic Panel	Estimated glomerular filtration rate (eGFR) only	322758	10165

LOINC Codes for CKD Screening		
ACR LOINC	**eGFR LOINC**	
13705-9	33914-3	69405-9
14958-3	48642-3	70969-1
14959-1	48643-1	76633-7
32294-1	50044-7	77147-7
9318-7	50210-4	88293-6
	50384-7	88294-4
	62238-1	

Sub-Measure 4 – RETINAL EYE EXAM: Members who receive a retinal or dilated eye exam by an eye care professional during the year or who had a negative retinal or dilated eye exam by an eye care professional during the prior year.

Criteria for Code	Code	Definition	Code System
Dilated retinal eye exam with evidence of retinopathy	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	CPT®-CAT-II
Dilated retinal eye exam without evidence of retinopathy	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	CPT®-CAT-II
Stereoscopic retinal photos with evidence of retinopathy	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	CPT®-CAT-II
Stereoscopic retinal photos without evidence of retinopathy	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	CPT®-CAT-II
Eye imaging with evidence of retinopathy	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy	CPT®-CAT-II
Eye imaging without evidence of retinopathy	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	CPT®-CAT-II
Low risk for retinopathy	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)	CPT®-CAT-II

Sub-Measure 5 – STATIN THERAPY ADHERENCE:

Who is in the Measure?

Members **with the pharmacy benefit** aged 40-75 without atherosclerotic cardiovascular disease who have been **prescribed and dispensed** at least one statin medication during the year.

Who is Excluded?

Members discharged from inpatient setting with MI, CABG, PCI, or other revascularization of limbs (arm/leg). Members with IVD, pregnancy, IVF, ESRD, Cirrhosis, Myalgia/Myositis/Myopathy or other muscular pain. Members dispensed at least one prescription of clomiphene.

Who is Compliant?

Members who achieved adherence, defined as a proportion of days covered of at least 80 percent. *Compliance for this measure cannot be transmitted to CareFirst via CPT-II codes.*

$$\frac{\text{Total days covered by a statin medication in the treatment period}}{\text{Total Days in treatment period}}$$

Diabetes Composite Tips

- Blood pressures taken during an acute inpatient stay or ED visit are excluded
- Statin Adherence- only looks at members who are **prescribed** a Statin medication. If Statin is not clinically recommended, a member has an allergic reaction, etc. then adherence will not be measured
- EGFR/ACR- This measure looks at lab completion, results of the labs are not required for compliance

Controlling High Blood Pressure

Scoring: Higher is better

Who is in the Measure?

Members aged 18-85 who have had at least two outpatient visits on different dates with diagnoses of hypertension during the calendar year or the prior year. The visit type doesn't need to be the same for the two visits.

Who is Excluded?

Members with any of the following:

- Aged 66-80 with frailty and advanced illness during the calendar year
- Aged 81 and older with frailty during the calendar year
- End Stage Renal Disease (ESRD) diagnosis or a kidney transplant
- Pregnancy during the calendar year
- Nonacute inpatient admission during the calendar year

Who is Compliant?

Members whose most recent blood pressure is less than <140/<90 mm Hg and their data is transmitted to CareFirst via FIGmd data transmission, CPT-II code, attestation, data transfer or lab data during the calendar year.

Criteria for Code	Code	Definition	Code System
Diastolic 80-89	3079F	Most recent diastolic blood pressure 80-89 mm Hg	CPT®-CAT-II
Diastolic Less Than 80	3078F	Most recent diastolic blood pressure less than 80 mm Hg	CPT®-CAT-II
Systolic Less Than 140	3074F	Most recent systolic blood pressure less than 130 mm Hg	CPT®-CAT-II
Systolic Less Than 140	3075F	Most recent systolic blood pressure 130-139 mm Hg	CPT®-CAT-II

Blood Pressure Tips

- BP taken during an emergency room, an acute inpatient stay, diagnostic test/procedure and/or member reported DO NOT meet standards for this measure
- Multiple readings may be taken during the appt, use the lowest systolic and diastolic BP results from the visit to represent that day's visit BP results
- Example: readings of 140/90 are non-compliant, readings at or below 139/39 are complaint

COLORECTAL CANCER SCREENING

Scoring: Higher is Better

Who is in the Measure?

Members aged 50-75.

Who is Excluded?

Members with colorectal cancer, a total colectomy or aged 66 and older with frailty and advanced illness during the calendar year.

Who is Compliant?

Members must have been screened appropriately for colorectal cancer using any of the tests below:

- Fecal occult blood test during the calendar year (FOBT)
- Flexible sigmoidoscopy during the calendar year or the four prior years
- Colonoscopy during the calendar year or the nine prior years
- CT colonography during the calendar year or the four prior years
- Fecal Immunochemical Test DNA, such as Cologuard®, during the calendar year or the two prior years (FIT DNA)

Compliance for this measure cannot be transmitted to CareFirst via CPT-II codes.

Criteria for Code	Code	Code System
FOBT	82270, 82274	CPT®
	G0328	HCPSC
Flexibility Sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45346, 45347, 45349, 45350	CPT®
	45.24	ICD9PCS
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 4539, 45392, 45393, 45398	CPT®
	G0105, G0121	HCPCS
	45.22, 45.23, 45.25, 45.42, 45.43	ICD9PCS
CT Colonography	74261, 74262, 74263	CPT®
Fit DNA (Cologuard)	81528	CPT®
	G0464	HCPCS

USE OF IMAGING STUDIES FOR LOW BACK PAIN

Scoring: Higher is Better

Who is in the Measure?

Members aged 18-50 with a **principal diagnosis** of uncomplicated low back pain.

Who is Excluded?

Members with a condition that requires regular imaging tests, including:

- Cancer
- Recent trauma
- IV drug abuse
- Neurologic impairment
- HIV
- Spinal infection
- Major organ transplant
- Prolonged use of corticosteroids

Who is Compliant?

Members who did **not** have an imaging study (e.g. plain X-ray, MRI, CT scan) within 28 days of a principal diagnosis of uncomplicated low back pain during the calendar year.

Use of Imaging Studies for Low Back Pain Tips

- If a member does not have **complicated** low back pain, they will not fall into the measure
- Review the value set directory for complete list of **uncomplicated** back pain conditions for applicable codes

FOLLOW-UP AFTER VISIT FOR BEHAVIORAL HEALTH COMPOSITE

Scoring- Higher is Better

Note: This measure is divided into **three** sub-measures, each with specific requirements as follows:

Sub-Measure 1 – FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL (FUH)

Who is in the Measure?

Members aged six and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.

Who is Excluded?

Nonacute inpatient stays, or admissions resulting in readmission or direct transfer to a nonacute inpatient care setting within 30 days following discharge regardless of the reason for readmission.

Who is Compliant?

Members who receive a follow up visit with a **mental health practitioner** with a principal diagnosis of mental illness or intentional self-harm within seven days after discharge during the calendar year

Sub-Measure 2 – FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)

Who is in the Measure?

Members aged 6 and older who were in the ED for mental illness or intentional self-harm.

Who is Excluded?

Nonacute inpatient stays, or admissions resulting in readmission or direct transfer to a nonacute inpatient care setting within 30 days following discharge regardless of the reason for readmission.

Who is Compliant?

Members who receive a follow up visit with **any practitioner** with a principal diagnosis of mental illness or intentional self-harm on the same day or within seven days after discharge during the calendar year.

Sub-Measure 4 – FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE (FUA)

Who is in the Measure?

Members aged 13 and older who were in the ED for Alcohol and Other Drug Abuse or Dependence (AOD).

Who is Excluded?

Members whose ED visit resulted in an acute or nonacute inpatient stay, or who were admitted to an inpatient care setting on the same day or within 30 days after the visit regardless of the reason for admission.

Who is Compliant?

Members who receive a follow up visit with any practitioner with a principal diagnosis of AOD on the same day or within seven days after discharge during the calendar year.

Behavioral Health Composite Tips

- The primary diagnosis must be related to behavioral health (found in the value set directory) however it doesn't have to be the **same diagnosis** as the initial hospital or ED diagnosis.

OPIOID USE COMPOSITE

Scoring: Lower is better

Note: This measure is divided into **two** sub-measures, each with specific requirements as follows.

*The following opioid medications are excluded from both measure Injectables, opioid cough and cold products, single agent in combination buprenorphine products used as part of medication assisted treatment of opioid use disorder, Ionsys, and methadone for treatment of opioid use disorder.

Sub-Measure 1 – USE OF OPIOIDS FROM MULTIPLE PROVIDERS (UOP)

Who is in the Measure?

Members aged 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from two or more dispensing events.

Who is Excluded?

No exclusions for this measure

Who is Compliant?

Members in the measure who receive opioids from less than four prescribers.

Sub-Measure 2 – RISK OF CONTINUED OPIOID USE (COU)

Who is in the Measure?

Members aged 18 years and older who have a new episode of opioid dispensing after 180 days of no pharmacy claims for an opioid medication.

Who is Excluded?

Members with cancer or sickle cell disease

Who is Compliant?

Member's with less than 15 days of prescription opioids within the 30 day period after initial opioid dispensing date.

Opioid Composite Tips

- Review prescription monitoring program registry to ensure patients aren't being over-prescribed opioids

ALL-CAUSE READMISSION

Scoring: Lower is Better

Who is in the Measure?

Members aged 18-64 with an acute inpatient stay.

Who is Excluded?

Members who experience any of the following scenarios:

- Nonacute inpatient stays
- Death during stay
- Pregnancy
- Planned admission for any of the following:
  - Maintenance chemotherapy
  - Rehabilitation
  - Organ transplant
  - Potentially planned procedure without a principal acute diagnosis

Who is Compliant?

Members who observe fewer readmissions within 30 days following an acute inpatient stay than expected based on the risk adjustment model during the calendar year.

EMERGENCY DEPARTMENT (ED) UTILIZATION

Scoring: Lower is Better

Who is in the Measure?

Members aged 18 and older.

Who is Excluded?

ED visits for psychiatry or electroconvulsive therapy, or ED visits with a principal diagnosis of mental health or chemical dependency, or ED visits that result in an inpatient stay.

Who is Compliant?

Members with fewer ED visits than expected based on risk-adjusted model during the calendar year.

HOSPITALIZATION FOR POTENTIALLY PREVENTABLE COMPLICATIONS

Scoring: Lower is Better

Who is in the Measure?

Members aged 67 and older.

Who is Excluded?

No exclusions for this measure.

Who is Compliant?

Members with fewer admissions than expected based on a risk-adjusted model during the calendar year for the following chronic and acute ambulatory care sensitive conditions (ACSC):

Chronic ACSC

- Diabetes short-term complications
- Diabetes long-term complications
- Uncontrolled diabetes
- Lower-extremity amputation among patients with diabetes
- COPD
- Asthma
- Hypertension
- Heart Failure

Acute ACSC

- Bacterial pneumonia
- Urinary tract infection
- Cellulitis
- Pressure ulcer

Hospitalization for Potentially Preventable Conditions Tips

- This measure is based on discharges and not patients therefore each admission is counted. For exclusions that include multiple events, codes must be on the same claim.
- Ensure accurate inpatient and outpatient coding of ambulatory care sensitive conditions in the medical record

MEMBER EXPERIENCE COMPOSITE

Scoring: Higher is better

Only questions in blue (2,4,5,6,7,8,9,10) are scored

Who is in the Measure?

All members aged 18 and older who had a visit with a PCMH provider during the calendar year.

Member Survey Questions*

Rating Scale as follows: 1 (Poor) 2 (Fair) 3 (Average) 4 (Good) 5 (Excellent)

Thinking about your most recent experience…

1. Would you recommend this doctor to your family and friends? (Yes, No)
2. **How would you rate your overall satisfaction with this doctor? (1-5)**
3. Do you have any additional comments about this doctor? (Comment)
4. **How would you rate this doctor's availability to see you? (1-5)**
5. **How would you rate your experience with the staff? (1-5)**
6. **How would you rate this doctor's being up to date about the care you received from other doctors? (1-5)**
7. **How would you rate this doctor's helpfulness in getting you the…**

		Poor	Fair	Avg	Good	Excellent	Not applicable
a.	Care you needed (e.g. specialist visits, other doctor visits)	1	2	3	4	5	9
b.	Tests you needed (e.g. lab tests, scans, x-rays)	1	2	3	4	5	9
c.	Treatment you needed (e.g. medications)	1	2	3	4	5	9

8. **How would you rate this doctor's ability to explain things in a way you could understand? (1-5)**
9. **How would you rate this doctor's ability to spend enough time with you, given the reason you needed to visit them? (1-5)**
10. **How would you rate this doctor's kindness towards you? (1-5)**

** Only the measures highlighted in blue are included in the Member Experience Composite score*