Patient-Centered Medical Home (PCMH)
2022 Program Description & Guidelines – Adult Medicine

Key Terms and Definitions

Assessment Outcome	Formal assessment completed by PCP and Care Management Team of Members on the Identification Stratification List
Collaborative Panel	A CareFirst made Panel for PCPs who are unable to find their own Panel
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 (DPR)	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
Identification Stratification Population	Group of CareFirst Members who meet specific criteria related to care coordination needs
Individual Stop Loss	Portion of Gross Debits representing 80% of costs Per Member Per Year above $95,000 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 and practices who meet savings to budget, quality score, engagement, 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 Panels.

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 incentives, 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:

1. Internal Medicine
2. Family Practice (Adult Members Only)
3. General Practice
4. Geriatrics
5. Family Practice/Geriatric Medicine
6. Doctors of Osteopathy – Primary Care
7. 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 attributed 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 earn an 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 private 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 Searchlight System is available via CareFirst's provider website. Member level detail is available in the Care Management Platform, Guiding Care via the PCP's Director of Regional Care Management.

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. Please contact CareFirst Help Desk (410-998-6400) or ProviderCFDAccess@carefirst.com for additional assistance.

PCMH Participation Incentive

A Panel or practice becomes effective in the PCMH Program 60 days following CareFirst's receipt of a complete PCMH application and signed network contract addendum from the whole 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 all engagement requirements and Quality Scorecard minimums, 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. More details can be found in the Eligibility for Participation Incentive section below.

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 engagement 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 is the average Per Member Per Month (PMPM) Medical and Pharmacy Costs from a two-year period prior to the Performance Year. In PY2019, CareFirst moved to a two-year rolling Base Period no more than three years prior to the Performance Year. 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.

COVID-19 Adjustment

The 2022 Performance Year was originally anticipated to have a Base Period of 2019 and 2020. The impact of the COVID-19 pandemic on 2020 costs and utilization makes 2020 an inappropriate year to be included in the Base Period for the 2022 Performance Year. As a result, the Base Period for the 2022 Performance Year will remain 2018 and 2019. Overall Medical Trend, Pharmacy Trend, and Illness Burden will be adjusted forward from 2018 and 2019, and all adjustment for changes in Panel composition will be applied as described above.

Risk Adjustment

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 diagnosis and is a more precise risk adjustment tool for setting Panel budgets. DxCG will continue to be used to set PCMH Panel budgets in PY2022 and moving forward.

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.

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.

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. Effective 2021, 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.

A visit will only impact attribution if an evaluation and management code is submitted from a primary care place of service. Video and audio only calls may impact attribution if the appropriate evaluation and management codes are submitted. Vaccinations, such as COVID-19 and flu shots, or COVID-19 testing will not impact attribution unless an evaluation and management service is included.

Setting Budget Targets

Budgets for the 2022 Performance Year will be calculated using the Base Period (2018 and 2019) PMPM Medical and Pharmacy costs. Those PMPMs are then risk adjusted and trended forward to create the budget for the 2022 Performance Year population. In 2022, 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 PY2022, ISL is set at $95,000 Per Member Per Year. Only 20 percent of any costs above $95,000 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 2021, CareFirst launched new value-based programs for specialties that manage episodes of care for Members attributed to PCMH Panels. Since these models 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 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 2022 CareFirst Core10 Measures for Adult Panels are shown below.

PCMH Clinical Quality Scorecard	Source	Measure Point Value
1. Optimal Care for Diabetic Population	CareFirst Custom Measure	20
Optimal Care for Diabetes Composite	CareFirst Custom Measure	5
HbA1c Control (<8%)	NCQA	3
Blood Pressure Control (<140/90)	NCQA	3
Retinal Eye Exam	NCQA	3
Kidney Health Evaluation for Patients With Diabetes	NCQA	3
Statin Therapy (80% adherence)	NCQA	3
2. Controlling High Blood Pressure	NCQA	15
3. Colorectal Cancer Screening	NCQA	10
4. Use of Imaging Studies for Low Back Pain	NCQA	5
5. Screening for Depression	CareFirst Custom Measure	10
6. Acute Hospital Utilization	NCQA	10
7. All-Cause Readmission	NCQA	5
8. Emergency Department Utilization	NCQA	10
9. Member Experience Composite (10 questions)	CareFirst Custom Measure	15
Getting Care Quickly	CareFirst Custom Measure	
Getting Needed Care- Care you needed	CareFirst Custom Measure	
Getting Needed Care- Tests you needed	CareFirst Custom Measure	
Getting Needed Care- Treatment you needed	CareFirst Custom Measure	
Coordination of Care	CareFirst Custom Measure	
Rating of Personal Doctor-Ability to spend time	CareFirst Custom Measure	
Rating of Personal Doctor- Ability to explain	CareFirst Custom Measure	
Rating of Personal Doctor- Kindness towards you	CareFirst Custom Measure	
Rating of Personal Doctor- Overall satisfaction	CareFirst Custom Measure	
Rating of Personal Doctor- Rate your experience	CareFirst Custom Measure	
Overall Clinical Score		**100**

New measures for 2022 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. Optimal Care for Diabetic Population Composite Measure requires Members to meet all five measures to be compliant. New in PY2022, Panels can also earn points for compliance on the individual HEDIS diabetes measures. 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.

In PY2022, Panels will also have an opportunity to earn bonus points for demonstrating improvement in member compliance rate year over year for certain measures. Two bonus points will be available for each core measure* in the Population Health and Risk-Adjusted Measure categories, totaling 16 available bonus points. Bonus points are added to clinical attainment rate as a percentage point increase (ie: Clinical attainment plus 2 percentage points for each measure where improvement is earned). In order to receive two bonus points for a measure, a Panel must demonstrate a one percent or greater change in the compliance rate [(# of Compliant Members / # of Member Opportunities) x 100] from PY2021 to PY2022. Bonus point achievement will be displayed in the Clinical Quality Scorecard and is detailed below.

*Bonus points will only be available for the Optimal Care for Diabetic Composite measure, not individual sub measures (HbA1c control, Blood Pressure Control, Retinal Eye Exam, Kidney Health Evaluation for Patients with Diabetes, and Statin Therapy).

2022 PCMH Clinical Quality Scorecard

MEASURES	PANEL SUMMARY					BENCHMARKS				
						Not Tiered (No Points)	Tier 4 (50% Points)	Tier 3 (65% Points)	Tier 2 (80% Points)	Tier 1 (100% Points)
	Points Available	Points Obtained	# Members Compliant	# Member Opportunities	% Compliance	% COMPLIANCE TO ACHIEVE EACH TIER				
POPULATION HEALTH MEASURES	45									
1. Optimal Care for Diabetic Population*	20									
- Optimal Care for Diabetes Composite	5									
- HbA1c Control (<8%)	3									
- Blood Pressure Control (<140/90)	3									
- Retinal Eye Exam	3									
- Kidney Health Evaluation for Patients With Diabetes	3									
- Statin Therapy (80% adherence)	3									
2. Controlling High Blood Pressure	15									
3. Colorectal Cancer Screening	10									
EVENT-BASED MEASURES	15		Compliant Events	# Events	% Compliance	% COMPLIANCE TO ACHIEVE EACH TIER				
4. Screening for Depression	10									
5. Use of Imaging Studies for Low Back Pain	5									
RISK-ADJUSTED MEASURES	25		Observed # Events	Expected # Events	Observed to Expected	OBSERVED TO EXPECTED RATIO TO ACHIEVE EACH TIER (Lower ratio is better)				
6. Acute Hospital Utilization	10									
7. All-Cause Readmissions	5									
8. Emergency Department Utilization	10									
SURVEY MEASURES	15		Average Score	Denominator	Success Rate	RATE TO ACHIEVE EACH TIER				
9. Clinical Experience Survey**	15									
How would you rate this doctor's availability to see you?										
How would you rate this doctor's helpfulness in getting you care you needed (e.g. specialist visits, other doctor visits)?										
How would you rate this doctor's helpfulness in getting you tests you needed (e.g. lab tests, scans, x-rays)?										
How would you rate this doctor's helpfulness in getting you treatment you needed (e.g. medications)?										
How would you rate this doctor's being up to date about the care you received from other doctors?										
How would you rate this doctor's ability to spend enough time with you, given the reason you needed to visit them?										
How would you rate this doctor's ability to explain things in a way you could understand?										
How would you rate this doctor's kindness towards you?										
How would you rate your overall satisfaction with this doctor?										
How would you rate your experience with the staff?										
Overall Clinical Score	100									
Overall Clinical Attainment Rate										
Improvement Bonus Points	16									
Total Clinical Quality Score										

* 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

Improvement Bonus Points					
2 points available for each measures below if change in rate from PY 2021 to PY2022 is greater than or equal to 1% change					
Measure	2021 Rate	2022 Rate	% Change	Points Available	Points Earned
1. Optimal Care for Diabetes Composite*				2	0
2. Controlling High Blood Pressure				2	0
3. Colorectal Cancer Screening				2	0
4. Screening for Depression				2	0
5. Use of Imaging Studies for Low Back Pain				2	0
6. Acute Hospital Utilization				2	0
7. All-Cause Readmissions				2	0
8. Emergency Department Utilization				2	0
Total Bonus Points				16	0
*based on composite rate only					

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

In Performance Year 2022, Panels will no longer be scored on PCP Engagement at the Panel level. However, engagement in the PCMH Program is still a requirement and expectation for participation and OIA eligibility. Replacing the Panel level Engagement Scorecard will be a set of Panel, practice, and provider requirement that must be met to receive an OIA and retain the full Participation Incentive.

PCP Engagement Requirements

1. Each Practice completes PCMH Practice Survey in Q1 of the Performance Year.
2. Each Panel identifies a Designated Provider Representative (DPR) who helps set Panel's expectations, co-leads PCMH discussion, and signs off on changes to Panel structure.
3. Each Practice identifies a Care Management Lead that collaborates with Care Managers to identify members with the care management needs and fulfills the expectations of care management. (More details below)
4. All PCMH providers in a practice complete CareFirst Health Equity Training by July 1, 2022. (More details below)

Care Management Expectations

PCP engagement with care coordination continues to be critical for success in the PCMH Program. Monthly review of members on the Identification and Stratification List remains a standard and integral part the care management process. The Care Management Lead at each practice is expected to engage in the following:

- Create an environment that is conducive to collaboration with CareFirst Care Manager and instructs staff to support Member identification and care management referrals.
- Establish a monthly clinical status review workflow with CareFirst Care Manager to review members with care management needs and refer members to CareFirst Care Manager.
- Ensure CareFirst Care Manager has access to needed clinical information and provides EMR access when available.

Director of Regional Care Management will notify the provider of any engagement concerns identified and work collaboratively with the provider to help the practice meet the Care Management engagement requirement. Failure to meet the above expectation will result in the practice not meeting PCP Engagement Requirement #3. Continued lack of engagement in care management, as determined by CareFirst in its sole discretion, may result in termination from PCMH as described in the Termination for Failure to Engage in Care Coordination section of the Program Description and Guidelines.

Health Equity Training

As racial and ethnic disparities in health continue to grow, CareFirst is committed to advancing health equity to all residents in the jurisdictions we serve. Patient centered care must accommodate an increasingly diverse patient population. In 2022, all PCPs in PCMH Panels will be expected to complete the CareFirst Health Equity Training found online at the CareFirst Learning and Engagement Center (link coming soon).

Failure to complete the four engagement requirements detailed above will result in the practice becoming ineligible to receive an OIA and a reduction in Participation Incentive as described in Eligibility for Participation Incentive section of the PD&G.

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.

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

1. The practice must be in a PCMH Panel that 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 practice must be in a PCMH Panel that meets viability requirements by having at least 15,000 Member Months for the Performance Year.

3. The practice must be in a PCMH Panel that has a cost savings to budget in their Patient Care Account (i.e., Credits must exceed Debits).

4. The practice must be in a PCMH Panel that achieved a minimum of 65% of the quality points available (50th percentile compared to national benchmarks) on the Clinical Quality Scorecard.

5. The practice must meet all four engagement requirements.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2023 for **Performance Year #12 - 2022**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2024.). 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 practice are added on top of Base Fees and Participation Incentives.

OIAs are always calculated at the Panel level based on savings, quality score, Panel size, and date of Panel formation. Individual practices within a Panel will be ineligible for an OIA if any or all providers in the practice do not meet the four PCP Engagement Requirements. All other practices in a Panel that meet conditions one through five above will be eligible for an OIA.

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 Year, 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 Clinical 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 a higher Clinical Quality Score, winning multiple years in a row, and having a larger Panel attribution. The OIA formulas are described below. Quality Score represents the Panels clinical attainment rate on the PCMH Clinical Quality Scorecard plus any improvement bonus points.

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. Practices who do not complete the four PCP engagement requirements will lose all or portions of their Participation Incentive based on market size category as shown below. Panels that do not meet a minimum of 65 percent of the points available on the Clinical Quality Scorecard, and do not achieve a savings, will also lose all or portions of their Participation Incentive based on market size category. Panels and practices that save compared to expected and meet PCP Engagement Requirements but fall below 65 percent on the Clinical Quality Scorecard will retain the full 12 percent Participation Incentive but will not be eligible for an OIA. Adjustments for practices losing all or part of the 12 Points will go into effect in August of 2023 based on 2022 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 for 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.

Entrepreneurial and Corporate Panels who fail to meet eligibility for the Participation Incentive two years in a row will risk the remaining six points, bringing the Participation Incentive to 0 percent, and will remain at 0 percent until engagement and Clinical Quality Scorecard minimums are met. Panels who lost all or a portion of the Participation Incentive are eligible to receive the full 12 percentage point Participation Incentive upon meeting all eligibility requirements in the next Performance Year.

Changes in Participation Incentive will be effective on August 1st of the year following the Performance Year (e.g., August 1, 2023, for **Performance Year #12 - 2022**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2024).

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 PCPs 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 contribution 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 circumstances of the particular case.

The deadline to submit an appeal for the 2022 Performance Year is September 1, 2023.

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 Designated Provider Representative (DPR) is required to be sent to the practice that was voted to be removed informing them of the Panel's decision. CareFirst may choose to remove PCPs whose lack of participation and cooperation with Panel goals is harming Panel performance, at its option.

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.

5. 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 accordance 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.

Appendix A. 2022 Core10 Measure Guide and Playbook

2022 Core 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 health care 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.

2022 Substantive Changes

+Removed Opioid Use Composite
+Added new Optimal Care for Diabetic Population Measure: Composite %
+Expanded age range for Use of Imaging for Low Back Pain to 75 years of age
+Added additional reference codes to measures requiring the submission of supplemental data
+Added additional detail on Value Set names for groups to review all possible inclusion/exclusion/etc codes when needed (any title underlined indicates a value set that can be looked up in the (HEDIS MY 2022-Value Set Directory)

Supplemental Data

Supplemental data is needed for several core measures but not all. Please provide supplemental data through use of FigMD or by using the CareFirst provider portal to submit a Supplemental Data File (SDF).

Measures that require the use of FigMD or SDF are:

1. Diabetes Sub-measures: Hba1c <8%, Blood Pressure <140/<90, Diabetic Retinal Eye Exam
2. Controlling High Blood Pressure
3. Colorectal Cancer Screening
4. Screening for Depression

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	Screening for Depression (SFD)
Risk-Adjusted Measures	
6	All Cause Readmission (ACR)
7	Emergency Department Utilization (EDU)
8	Acute Hospital Utilization (AHU)
Survey Measures	
9	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 Value Sets, Observation Value Set 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 Stay 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 reviews members aged 40-75 without atherosclerotic cardiovascular disease. The kidney disease sub measures reviews members aged 18-85.

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 Symptom Value Set 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, Supplemental Data File (SDF) or lab data during the year.

Criteria for Code	Code	Definition	Code System
HbA1c Lab Test	17856-6	Hemoglobin A1c/Hemoglobin.total in Blood by HPLC	LOINC
HbA1c Lab Test	4548-4	Hemoglobin A1c/Hemoglobin.total in Blood	LOINC
HbA1c Lab Test	4549-2	Hemoglobin A1c/Hemoglobin.total in Blood by Electrophoresis	LOINC
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	CPT-CAT-II

HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	CPT-CAT-II
HbA1c Test Result or Finding	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	CPT-CAT-II
HbA1c Lab Test	83036	HbA1c Lab Test	CPT
HbA1c Lab Test	83037	HbA1c Lab Test	CPT

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, or Supplemental Data File (SDF) during the year.

Criteria for Code	Code	Definition	Code System
Diastolic BP	75995-1	Diastolic blood pressure by continuous non-invasive monitoring	LOINC
	8453-3	Diastolic blood pressure--sitting	
	8454-1	Diastolic blood pressure--standing	
	8455-8	Diastolic blood pressure--supine	
	8462-4	Diastolic blood pressure	
	8496-2	Brachial artery Diastolic blood pressure	
	8514-2	Brachial artery - left Diastolic blood pressure	
	8515-9	Brachial artery - right Diastolic blood pressure	
	89267-9	Diastolic blood pressure--lying in L-lateral position	
Systolic BP	75997-7	Systolic blood pressure by Continuous non-invasive monitoring	LOINC
	8459-0	Systolic blood pressure--sitting	
	8460-8	Systolic blood pressure--standing	
	8461-6	Systolic blood pressure--supine	
	8480-6	Systolic blood pressure	
	8508-4	Brachial artery Systolic blood pressure	
	8546-4	Brachial artery - left Systolic blood pressure	

	8547-2 89268-7	Brachial artery - right Systolic blood pressure Systolic blood pressure--lying in L-lateral position	
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 < 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 a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during the measurement year. PCPs can order a single Kidney Profile test from LabCorp or a combination of two tests for ACR and eGFR from other labs to ensure compliance. *Compliance can be achieved through claims data, CKD screening does **not** need to be submitted via Supplemental Data File (SDF).*

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	100768	19107
ACR	Albumin-to-creatinine ratio (ACR) only	140285	6517
Basic Metabolic Panel	Estimated glomerular filtration rate (eGFR) only	322758	10165

Sub-Measure 4 – RETINAL EYE EXAM: Members who receive a retinal or Diabetic Retinal Screening 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. The below codes can be transmitted to CareFirst via CPT-II code, or Supplemental Data File (SDF) during the 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 with Diabetes without atherosclerotic cardiovascular disease (ASCVD) 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 and Disease. 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.

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

Diabetes Composite Tips

- Blood pressures taken during an acute inpatient stay or ED visit are excluded
- A patient can self-report their most recent BP results during a telehealth or online visit
- 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 Essential 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) 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, Supplemental Data File (SDF) during the calendar year.

Criteria for Code	Code	Definition	Code System
Diastolic BP	75995-1	Diastolic blood pressure by continuous non-invasive monitoring	LOINC
	8453-3	Diastolic blood pressure--sitting	
	8454-1	Diastolic blood pressure--standing	
	8455-8	Diastolic blood pressure--supine	
	8462-4	Diastolic blood pressure	
	8496-2	Brachial artery Diastolic blood pressure	
	8514-2	Brachial artery - left Diastolic blood pressure	
	8515-9	Brachial artery - right Diastolic blood pressure	
	89267-9	Diastolic blood pressure--lying in L-lateral position	
Systolic BP	75997-7	Systolic blood pressure by Continuous non-invasive monitoring	LOINC
	8459-0	Systolic blood pressure--sitting	
	8460-8	Systolic blood pressure--standing	
	8461-6	Systolic blood pressure--supine	
	8480-6	Systolic blood pressure	
	8508-4	Brachial artery Systolic blood pressure	
	8546-4	Brachial artery - left Systolic blood pressure	
	8547-2	Brachial artery - right Systolic blood pressure	
	89268-7	Systolic blood pressure--lying in L-lateral position	

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 < 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 DO NOT meet standards for this measure
- A patient can self-report their most recent BP results during a telehealth or online visit
- 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 Lab test, FOBT Test Result or Finding)
- 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 Lab Test, FIT DNA Test Result or Finding)

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

Criteria for Code	Code	Code System
FOBT	82270, 82274	CPT®
	G0328	HCPCS
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

Screening For Depression
Scoring: Higher is Better

Who is in the Measure?
Members aged 12 and older

Who is Excluded?
Members with bipolar disorder in the year prior to the measurement year or depression that starts during or prior to the Measurement Period, or members in hospice or using hospice services during the Measurement Period.

Who is Compliant?
Members with a documented *result* of a depression screening performed using an age-appropriate standardized instrument in the measurement year.

Depression Screening Tool	Code	Definition	Code System	Positive Finding
Beck Depression Inventory Fast Screen	89208-3	Beck Depression Inventory Fast Screen	LOINC	≥8
Beck Depression Inventory II	89209-1	Beck Depression Inventory II	LOINC	≥20
Center for Epidemiologic Studies Depression Scale-Revised	89205-9	Center for Epidemiologic Studies Depression Scale-Revised	LOINC	≥17
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Clinically Useful Depression Outcome Scale (CUDOS)	LOINC	≥31
Duke Anxiety Depression Scale	90853-3	Duke Anxiety Depression Scale	LOINC	≥30
Edinburgh Postnatal Depression Scale	71354-5	Edinburgh Postnatal Depression Scale	LOINC	≥10
Geriatric depression scale (GDS) short version	48545-8	Geriatric depression scale (GDS) short version	LOINC	≥5
Geriatric depression scale (GDS)	48544-1	Geriatric depression scale (GDS)	LOINC	≥10
Patient Health Questionnaire 2 item (PHQ-2)	55758-7	Patient Health Questionnaire 2 item (PHQ-2)	LOINC	≥3
Patient Health Questionnaire 9 item (PHQ-9)	44261-6	Patient Health Questionnaire 9 item (PHQ-9)	LOINC	≥10
Patient Health Questionnaire 9: Modified for Teens	89204-2	Patient Health Questionnaire 9: Modified for Teens	LOINC	≥10
PROMIS 29 Depression score	71965-8	PROMIS 29 Depression score	LOINC	≥60
My Mood Monitor	71777-7	My Mood Monitor	LOINC	≥5
Depression Screen using Standardized Tool	G8431	*Screening for depression is documented as being positive and a follow-up plan is documented*	HCPCS	Positive
Depression Screen using Standardized Tool	G8510	*Screening for depression is documented as negative, a follow-up plan is not required* are not covered by CareFirst; hence not eligible for reimbursement.	HCPCS	Negative

Depression Screening Tips

- Screening does not need to be administered by PCP; RN, HRA/EMR, etc. may administer
- Swift follow up if result is positive is recommend however not measured for 2022 QSC
- HCPCS codes can be submitted via claims, LOINC through SDF or FIGmd

USE OF IMAGING STUDIES FOR LOW BACK PAIN

Scoring: Higher is Better

Who is in the Measure?

Members aged 18-75 with a **principal diagnosis** of Uncomplicated Low Back Pain.

Who is Excluded?

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

- Cancer (Malignant Neoplasms, Other Neoplasms, History of Malignant Neoplasm, Other Malignant Neoplasm of Skin)
- Recent trauma (Trauma)
- IV drug abuse (IV Drug Abuse)
- Neurologic impairment (Neurologic Impairment)
- HIV (HIV)
- Spinal infection (Spinal Infection)
- Major organ transplant (Organ Transplant Other Than Kidney; Kidney Transplant; History of Kidney Transplant)
- Prolonged use of corticosteroids (Corticosteroid Medications List)
- Osteoporosis *(*Osteoporosis Medication Therapy Value Set, Long-Acting Osteoporosis Medications) (Osteoporosis Medication List)
- Fragility fracture (Fragility Fractures)
- Lumbar surgery (Lumbar Surgery)
- Spondylopathy (Spondylopathy)
- Palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set)

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

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:
  - Chemotherapy Encounter
  - Rehabilitation
  - Organ Transplant Other Than Kidney, Bone Marrow Transplant, Kidney Transplant
  - Potentially planned procedure without a principal acute diagnosis

Who is Compliant?

Members with 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 and Behavioral Disorders or chemical dependency, or ED visits that result in an Inpatient Stay.

Who is Compliant?

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

ACUTE HOSPITAL UTILIZATION

Scoring: Lower is Better

Who is in the Measure?

Members aged 18 year and older.

Who is Excluded?

Members with a principal diagnosis of Mental and Behavioral Disorders, Deliveries Infant Record, Maternity Diagnosis, Maternity, Chemotherapy Encounter, Rehabilitation, Kidney Transplant, Bone Marrow Transplant, Organ Transplant Other Than Kidney, Introduction of Autologous Pancreatic Cells, Potentially Planned Procedures, or Inpatient and observation stays with a discharge for death.

Who is Compliant?

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

MEMBER EXPERIENCE COMPOSITE

Scoring: Higher is better

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)

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