CareFirst

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PD&G

Adult

CareFirst
Family of health care plans

2024 Patient-Centered Medical Home

Program Description & Guidelines - Adult Medicine

Key Terms and Definitions

Term	Definition
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 $100,000 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

Term	Definition
Panel	Change in the total cost of pharmacy claims for the CareFirst Members with the CareFirst Pharmacy Benefit
Panel Governance	CareFirst committee that reviews Panel structure, appeals and exceptions
Participation Inventive	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.

- Panel Viability
- Geography
- Panel Cohesion/Accountability
- 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 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.

Peer Panel 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:

- 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);
- 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;
- 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 covered services; and
- 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.

For PY2021, 2022, and 2023, CareFirst moved away from the rolling Base Period to avoid using inappropriate Base Years affected by the COVID-19 pandemic. PY 2024 will have a Base Period of 2021 and 2022. This Base Period puts the PCMH Program back on track with changes made in PY2019. Overall Medical Trend, Pharmacy Trend, and Illness Burden will be adjusted forward from 2021 and 2022, 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 PY2024 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 is 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 is restricted to Members age 18 and older, while attribution for Pediatric Panels is 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 2024 Performance Year will be calculated using the Base Period (2021 and 2022) PMPM Medical and Pharmacy costs. Those PMPMs are then risk adjusted and trended forward to create the budget for the 2024 Performance Year population. In 2024, 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 PY2024, ISL is set at $100,000 Per Member Per Year. Only 20 percent of any costs above $100,000 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. CareFirst will notify practices with an update to the PD&G as new specialty driven value-based programs become available.

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 Quality 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 2024 CareFirst Core Quality Measures for Adult Panels are shown below.

PCMH Clinical Quality Scorecard	Source	Measure Point Value
1. Optimal Care for Diabetic Population	**CareFirst Custom Measure**	**25**
Optimal Care for Diabetes Composite	CareFirst Custom Measure	5
HbA1c Control (<8%)	NCQA	4
Blood Pressure Control (<140/90)	NCQA	4
Retinal Eye Exam	NCQA	4
Kidney Health Evaluation for Patients With Diabetes	NCQA	4
Statin Therapy (80% adherence)	NCQA	4
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. Member Experience Composite	**CareFirst Custom Measure**	**15**
Overall Clinical Score		**100**

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. 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 are detailed below.

In PY2024, Panels will again 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 (i.e. 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 PY2023 to PY2024. 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)

2024 PCMH Quality Scorecard

MEASURES	PANEL SUMMARY					BENCHMARKS					# Compliant members needed to move to next tier
						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	50										
1. Optimal Care for Diabetic Population*	25										
- *Optimal Care for Diabetes Composite*	5										
- *HbA1c Control (<8%)*	4										
- *Blood Pressure Control (<140/<90)*	4										
- *Retinal Eye Exam*	4										
- *Kidney Health Evaluation for Patients With Diabetes*	4										
- *Statin Therapy (80% adherence)*	4										
2. Controlling High Blood Pressure	15										
3. Colorectal Cancer Screening	10										
EVENT-BASED MEASURES	20		Compliant Events	# Events	% Compliance	% COMPLIANCE TO ACHIEVE EACH TIER					
4. Screening for Depression	15										
5. Use of Imaging Studies for Low Back Pain	5										
RISK-ADJUSTED MEASURES	15		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										
SURVEY MEASURES	15		Average Score	Denominator	Success Rate	RATE TO ACHIEVE EACH TIER					
8. Clinical Experience Survey**	15										
Cinical Score	100										
Clinical Attainment Rate											
Improvement Bonus											
Overall Clinical Rate											

*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					
Measure	Previous Year's Rate	Current Year's	% Change	Points Available	Points Earned
1. Optimal Care for Diabetes Composite*				2	
2. Controlling High Blood Pressure				2	
3. Colorectal Cancer Screening				2	
4. Screening for Depression				2	
5. Use of Imaging Studies for Low Back Pain				2	
6. Acute Hospital Utilization**				2	
7. All-Cause Readmissions**				2	
8. Clinical Experience Survey				2	
Total Bonus Points				16	
*Based on composite rate only					
**Risk Adjusted measures with a decrease in rate from previous year that are equal to or greater than -1% will receive points					

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

Engagement in the PCMH Program is a requirement for a Participation Incentive and OIA eligibility. In PY2024, engagement will again be measured with a set of Panel, practice, and provider requirements. Failure to meet these requirements may result in the provider, practices, or Panel becoming ineligible to receive an OIA and/or retain the full Participation Incentive.

PCP Engagement Requirements

- Each Practice completes PCMH Practice Survey in Q1 of the Performance Year.
- 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.
- All PCMH providers in a practice complete CareFirst Health Equity Training by July 1, 2024. (More details below).

Care Management Expectations

While Care Management is no longer an engagement requirement for OIA eligibility, engagement with care coordination continues to be critical for success in the PCMH Program. CareFirst will continue to offer care coordination services for medical, behavioral health, and social determinants of health (SDOH) support.

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 2024, all PCPs in PCMH Panels will be expected to complete one of the CareFirst Health Equity Trainings found online at the CareFirst Learning and Engagement Center: https://www.carefirst.com/learning/health-equity/health-equity.html

PCPs will have their choice of CareFirst health equity trainings to complete but must complete at least one.

Important Note: Failure to complete the three 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:

- 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.
- The practice must be in a PCMH Panel that meets viability requirements by having at least 15,000 Member Months for the Performance Year.
- 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).
- 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
- The practice must meet all three engagement requirements.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2025, for **Performance Year #14 - 2024**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2026). 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 2025 based on 2024 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, 2025, for **Performance Year #15 - 2024**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2026).

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:

- If a Panel's participation falls below five PCPs it must, within one year, increase its membership to give 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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).
- 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 2024 Performance Year is September 1, 2025.

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:

- The practice, PCP and/or Panel repeatedly fails to comply with the terms and conditions of the Program.
- The practice, PCP and/or Panel has substantial uncorrected quality of care issues.
- 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.
- 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.

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.

CareFirst
Family of health care plans

2024 Patient-Centered Medical Home

Appendix A. 2024 Core 10 Measure Guide and Playbook

Introduction

The Core Measure List is a targeted list of metrics selected to help ensure best-in-class 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.

2024 Substantive Changes

- Removed Emergency Department Utilization (EDI) measure from the scorecard
- Added Social Needs Screening (SNS-E) measure to the scorecard—reporting only, no points
- Revised name of HbA1c Control (HBD) to Glycemic Status Assessment for Patients with Diabetes (GSD)
- Revised diabetes event/diagnosis criteria to only include members who were dispensed insulin or hypoglycemics/antihyperglycemics during the year or the year prior who **ALSO** have at least one diagnosis of diabetes during the calendar year or prior year.
- Revised Imaging for Uncomplicated Low Back Pain (LBP) age range, now 18-75 (was 18-50)

Population Health Measures
Optimal Diabetes Care (ODC) **CareFirst Composite
Controlling High Blood Pressure (CBP)
Colorectal Cancer Screening (COL-E)
Event-Based Measures
Use of Imaging for Low Back Pain (LBP)
Screening for Depression (BHEV)
Social Need Screening and Intervention (SNS-E) **Reporting Only
Risk-Adjusted Measures
All Cause Readmission (ACR)
Acute Hospital Utilization (AHU)
Survey Measures
Member Experience Composite (MEC)

Optimal Diabetes Care

Scoring: Higher is better.

Data Exchange: Supplemental Data (LOINC, CPTII, CPT) FigMD/MRO, Claims

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.
- Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the year or the year prior who have at least one diagnosis of diabetes during the calendar year or prior year. (revised)

The statin sub-measure reviews members aged 40-75 without atherosclerotic cardiovascular disease.

The kidney disease sub-measure 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 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 six sub-measures.

- Composite % Improvement from Prior Year
- HbA1c < 8.0%
- Blood Pressure <140/<90 mm Hg
- Chronic Kidney disease screening
- Retinal eye exam
- Statin therapy adherence

Sub-Measure 1 – Glycemic Status Assessment for Patients with Diabetes:

Members whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was less than 8% during the year and whose data is transmitted to CareFirst via FigMD/MRO data transmissions, CPT®-II code, Supplemental Data File (SDF) or directly from lab data during the years.

Criteria for Code	Code	Definition	Code System
HbA1c Lab Test	17855-8 17856-6 4548-4 4549-2 96595-4		LOINC
HbA1c Lab Test	83036 83037		CPT
HbA1c Level Less Than 8.0	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)	CPT-CAT-II
HbA1c Level 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	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

Sub-Measure 2 – Blood Pressure <140/<90 mm Hg:

Members whose most recent blook pressure is <140/<90 mm Hg and whose data is transmitted to CareFirst via FigMD/MRO data transmission, CPT®-II Code, Supplemental Data File (SDF) or directly from lab data during the year.

Criteria for Code	Code	Definition	Code System
Systolic and Diastolic Result	3074F 3075F 3077F 3078F 3079F 3080F	Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD) Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD) Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM) Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM) Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM) Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)	CPT-CAT-II
Diastolic BP	75995-1 8453-3 8454-1 8455-8 8462-4 8496-2 8514-2 8515-9 89267-9	Diastolic blood pressure by Continuous non- invasive monitoring Diastolic blood pressure--sitting Diastolic blood pressure--standing Diastolic blood pressure--supine Diastolic blood pressure Brachial artery Diastolic blood pressure Brachial artery - left Diastolic blood pressure Brachial artery - right Diastolic blood pressure Diastolic blood pressure--lying in L-lateral position	LOINC
Systolic BP	75997-7 8459-0 8460-8 8461-6 8480-6 8508-4 8546-4 8547-2 89268-7	Systolic blood pressure by Continuous non- invasive monitoring Systolic blood pressure--sitting Systolic blood pressure--standing Systolic blood pressure--supine Systolic blood pressure Brachial artery Systolic blood pressure Brachial artery - left Systolic blood pressure Brachial artery - right Systolic blood pressure Systolic blood pressure--lying in L-lateral position	LOINC
Diastolic 80-89	3079F	Most recent diastolic blood pressure 80-89 mm Hg	CPT®- CAT-II

Criteria for Code	Code	Definition	Code System
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 – Kidney Health Evaluation for Patients with Diabetes

Members who receive **both** an Estimated Glomerular Filtration Rate (eGFR) and a Urine Albumin Creatinine **Ratio** (uACR) during the year on the same or different dates of service. Codes most often come through via claims from labs, there is typically no need to submit eGFR or ACR codes through Supplemental Data.

PCPs can order a single Kidney Profile test from LabCorp or Quest using the test order below:

Test	Includes	Test Order Code	
		LabCorp	Quest
Kidney Profile	Albumin-to-creatinine ratio (uACR) **and** estimated glomerular filtration rate (eGFR)	140301	39165

Required Coding:

- One **Estimated Glomerular Filtration Rate Lab Test** and at least one uACR identified by either of the following:
  - Both **Quantitative Urine Albumin Lab Test Value Set** and a **Urine Creatinine Lab Test** with service dates four days or less apart (both tests ensure a ratio is calculated), or
  - One **Urine Albumin Creatinine Ratio Lab Test**

Criteria for Code	Code	Definition	Code System
Estimated Glomerular Filtration Rate Lab Test	80047 80048 80053 82565 80050 80069		CPT

Criteria for Code	Code	Definition	Code System
Estimated Glomerular Filtration Rate Lab Test	69405-9 98980-6 94677-2 98979-8 62238-1 77147-7 50384-7 50210-4 50044-7 70969-1		LOINC
Quantitative Urine Albumin Lab Test	82043		CPT
Quantitative Urine Albumin Lab Test	21059-1 1754-1 57369-1 30003-8 53530-2 43605-5 14957-5 53531-0 89999-7 100158-1	Albumin [Mass/volume] in 24 hour Urine Albumin [Mass/volume] in Urine Microalbumin [Mass/volume] in 12 hour Urine Microalbumin [Mass/volume] in 24 hour Urine Urine by Detection limit <= 1.0 mg/L Microalbumin [Mass/volume] in 4 hour Urine Microalbumin [Mass/volume] in Urine Microalbumin [Mass/volume] in Urine by Detection limit <= 1.0mg/L Microalbumin [Mass/volume] in Urine by Detection limit <= 3.0 mg/L Microalbumin [Mass/volume] in Urine collected for unspecified duration	LOINC
Urine Albumin Creatinine Ratio Lab Test	13705-9 9318-7 76401-9 32294-1 44292-1 14958-3 14959-1 59159-4 77254-1 30000-4 77253-3 89998-9	Albumin/Creatinine [Mass Ratio] in 24 hour Urine Albumin/Creatinine [Mass Ratio] in Urine Albumin/Creatinine [Ratio] in 24 hour Urine Albumin/Creatinine [Ratio] in Urine Microalbumin/Creatinine [Mass Ratio] in 12 hour Urine Microalbumin/Creatinine [Mass Ratio] in 24 hour Urine Microalbumin/Creatinine [Mass Ratio] in Urine Microalbumin/Creatinine [Ratio] in 24 hour Urine Microalbumin/Creatinine [Ratio] in 24 hour Urine by Detection limit <= 1.0 mg/L Microalbumin/Creatinine [Ratio] in Urine Microalbumin/Creatinine [Ratio] in Urine by Detection limit <= 1.0 mg/L Microalbumin/Creatinine [Ratio] in Urine by Detection limit <= 3.0 mg/L	LOINC
Urine Creatinine Lab Test	82570		CPT
Urine Creatinine Lab Test	57346-9 57344-4	Creatinine [Mass/volume] in 12 hour Urine Creatinine [Mass/volume] in 2 hour Urine	LOINC

Criteria for Code	Code	Definition	Code System
	20624-3 2161-8 58951-5 39982-4 35674-1	Creatinine [Mass/volume] in 24 hour Urine Creatinine [Mass/volume] in Urine Creatinine [Mass/volume] in Urine --2nd specimen Creatinine [Mass/volume] in Urine --baseline Creatinine [Mass/volume] in Urine collected for unspecified duration	

Who is Excluded?

Members with ESRD or dialysis, receiving palliative care or who are 66 years of age and older with frailty and advanced illness during the year.

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 and whose data is transmitted to CareFirst via FigMD/MRO data transmission, CPT®-II code, Supplemental Data File (SDF).

Criteria for Code	Code	Definition	Code System
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 (DM)	CPT-CAT-II
Eye Exam 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 (DM)	CPT-CAT-II
Eye Exam 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 (DM)	CPT-CAT-II
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 (DM)	CPT-CAT-II
Eye Exam 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 (DM)	CPT-CAT-II
Eye Exam 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 (DM)	CPT-CAT-II
Automated Eye Exam	92229	Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral	CPT
Diabetic Retinal Screen	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)	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 remained on a statin medication of any intensity for at least 80 percent of the treatment period. *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.
- A patient can self-report their most recent BP results during a telehealth or online visit.
- Statin Adherence- only assesses 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 reviewed for compliance.

Controlling High Blood Pressure

Scoring: Higher is better.

Data Exchange: Supplemental Data (LOINC, CPTII, CPT), FigMD/MRO, Claims

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 <140/<90 mm Hg and whose data is transmitted to CareFirst via FigMD/MRO data transmission, CPT-II code, or Supplemental Data (SDF).

Criteria for Code	Code	Definition	Code System
Systolic and Diastolic Result	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)	CPT- CAT-II
	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)	
	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)	
	3078F	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)	
	3079F	Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)	
	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)	
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 Brachial artery - right Diastolic blood pressure	
	8515-9		

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

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.

Data Exchange: Supplemental Data (LOINC, CPT-II, CPT), FigMd/MRO, Claims

Who is in the Measure?

Members aged 45-75.

Who is Excluded?

Members with colorectal cancer, who have a total colectomy, aged 66 and older with frailty and advanced illness, or who are in hospice or receiving palliative care or have died 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 (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	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.

Data Exchange: Supplemental (LOINC, HCPCS), Claims

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 year, or members in hospice or using hospice services during the year.

Who is Compliant?

Members with a documented result of a depression screening performed using an age-appropriate standardized instrument in the year.

Assessment Name	Code, Positive Finding	Code System
Beck Depression Inventory Fast Screen total score [BDI]	89208-3, ≥8	LOINC
Beck Depression Inventory II total score [BDI]	89209-1, ≥20	LOINC
Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]	89205-9, ≥17	LOINC
Clinically Useful Depression Outcome Scale total score [CUDOS]	90221-3, ≥31	LOINC
Duke Anxiety Depression Scale total score [DADS]	90853-3, ≥30	LOINC
Edinburgh Postnatal Depression Scale total score [EPDS]	71354-5, ≥10	LOINC
Geriatric depression scale (GDS) short version total score	48545-8, ≥5	LOINC
Geriatric depression scale (GDS) total score	48544-1, ≥10	LOINC
Patient Health Questionnaire 2 item (PHQ-2) total score	55758-7, ≥3	LOINC
Patient Health Questionnaire 9 item (PHQ-9) total score	44261-6, ≥10	LOINC
PROMIS 29 Depression total score	71965-8, ≥60	LOINC
My Mood Monitor Total score [M3]	71777-7, ≥5	LOINC
Screening for depression is documented as being positive and a follow-up plan is documented	G8431	HCPCS
Screening for depression is documented as negative	G8510	HCPCS

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 2021 QSC.

Social Need Screening and Intervention (SNS-E)

Scoring: Higher is better.

Data Exchange: LOINC

Who is in the Measure?

Members age 0+ continuously enrolled during the year.

Who is Excluded?

Members in hospice or using hospice services during the year or members who die in the year.

Who is Compliant?

Members who were screened, using prescribed instruments, at least once during the measurement period for unmet food, housing and transportation needs and received a corresponding intervention if they screened positive on or up to 30 days after the date of the first positive food insecurity screen (31 days total).

Interventions may include any of the following categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®1	95400-8	LA33-6
	95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6
Children's Health Watch Housing Stability Vital Signs™[1]	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel®[1]	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool/ Short Form	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
American Academy of Family	96778-6	LA31996-4

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Physicians (AAFP) Social Needs Screening Tool—short form		LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Norwalk Community Health Center Screening Tool [NCHC]	99134-9	LA33-6
	99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	99594-4	LA33093-8 LA30134-3
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®1	99553-0	LA33-6
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Discharge from Agency [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Resumption of Care [CMS Assessment]	93030-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS	93030-5	LA30133-5 LA30134-3

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Assessment]		
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93030-5	LA30133-5 LA30134-3
PROMIS®1	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

Note: The SNS-E screening numerator counts only screenings that use instruments in the measure specification as identified by the associated LOINC code(s). Allowed screening instruments and LOINC codes for each social need domain are listed above.

Use of Imaging Studies for Low Back Pain

Scoring: Higher is better.

Data Exchange: Claims

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- ex. ICD-10 “C” codes for active cancer, “Z” codes for history of cancer
- Recent trauma- ex. G89.11, Acute Pain Due to Trauma
- IV drug abuse- ex. ICD-10 “F” codes for IV drug abuse
- HIV- ex. B20, Z21
- Spinal infection- ex. A17.81, G06.1, M46.25-M46.28, M46.35-M46.38
- Major organ transplant- ex. Heart, Small intestine, Large intestine, Liver, Pancreas, etc.
- Members with Frailty Symptoms- ex. R26.2, Difficulty Walking

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.

Data Exchange: Claims

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

Acute Hospital Utilization

Scoring: Lower is Better

Data Exchange: Claims

Who is in the Measure?

Members aged 18 years or older.

Who is Excluded?

Members with a principal diagnosis of mental health, chemical dependency, or a live-born infant. A maternity-related principal diagnosis or stay 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.

Data Exchange: Member survey runs August-February by email/mail.

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,

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

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