CareFirst
Family of health care plans

# PROGRAM DESCRIPTION AND GUIDELINES

*for*

# CAREFIRST PATIENT-CENTERED MEDICAL HOME PROGRAM (PCMH)

*and*

# TOTAL CARE AND COST IMPROVEMENT PROGRAM ARRAY (TCCI)



Q4 2017

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Family of health care plans

# PROGRAM DESCRIPTION OVERVIEW

*and*

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Q4 2017

## Overview of This Program Description and Guidelines

This Program Description and Guidelines ("Guidelines") document presents an integrated approach to obtaining high quality, cost effective health care services for CareFirst BlueCross BlueShield and CareFirst BlueChoice (collectively, "CareFirst") Members.

As the region's largest private payer, CareFirst undertook the Patient-Centered Medical Home ("PCMH") Program at the start of 2011 as a way to tackle the continuing steep increases in health care costs occurring in its service area which includes Maryland, the District of Columbia and Northern Virginia. In the years since, the company has added a range of other supporting programs known as the Total Care and Cost Improvement ("TCCI") Program Array. These programs are in furtherance of the legislatively mandated mission of the company which directs the company to:

1) Provide affordable and accessible health insurance to the Plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the Plan.

2) Assist and support public and private health care initiatives for individuals without health insurance.

3) Promote the integration of a health care system that meets the health care needs of all residents of the jurisdictions in which the nonprofit health service plan operates.

All three of these legislative directives came into play with the launch of the PCMH Program and TCCI Program Array that are intended to focus on the root causes of suboptimal quality and continuing cost growth. Beginning in 2011 and continuing through the current period, CareFirst has progressively brought the capabilities now in the TCCI and PCMH Programs to full operation in furtherance of the three goals above.

As of January 2017, just under 1.2 million CareFirst Members were in the PCMH Program while all 3.2 million CareFirst Members are served by one or more programs in the TCCI Program Array. Fueled by an Innovation Award from the Centers for Medicare and Medicaid Services ("CMS"), on July 1, 2013, CareFirst embarked on a pilot of the PCMH Program with over 40,000 Maryland residents enrolled in traditional Fee-For-Service ("FFS") Medicare. CareFirst hopes to extend the Program even further into the Medicare beneficiary population in the near future.

The PCMH Program is the core of the larger TCCI Program Array. The PCMH Program was established for the purpose of rewarding Primary Care Providers ("PCPs") for providing, arranging, coordinating, and managing quality, efficient, and cost-effective health care services for individuals enrolled in health benefit plans issued or administered by CareFirst. It provides the central organizational building block (the Medical Panel) as well as the key incentive system built on a global outcome and Member-centric accountability structure.

In all, there are 10 distinct but highly interrelated Design Elements in the PCMH Program and 20 distinct additional interconnected components of the TCCI Program Array that are described in these Guidelines. The PCMH and TCCI Programs necessarily rely on all parts of the health care delivery system to deliver needed services to Members. This includes hospitals, free-standing clinics, pharmacies and other allied providers that are part of the more than 43,000 providers under contract with CareFirst as participating providers.

In Maryland, the PCMH Program is offered under the authorization provided in Md. Code, Health-General § 19.1A.01 – 19.1A.05 (2011) and Md. Code, Insurance § 15-1801 – 15-1802 (2011) which became law in May, 2010. The Program was authorized after regulatory review in September, 2010 and became operational on January 1, 2011. No further statutory or regulatory authorization was necessary for implementation in the District of Columbia or Virginia.

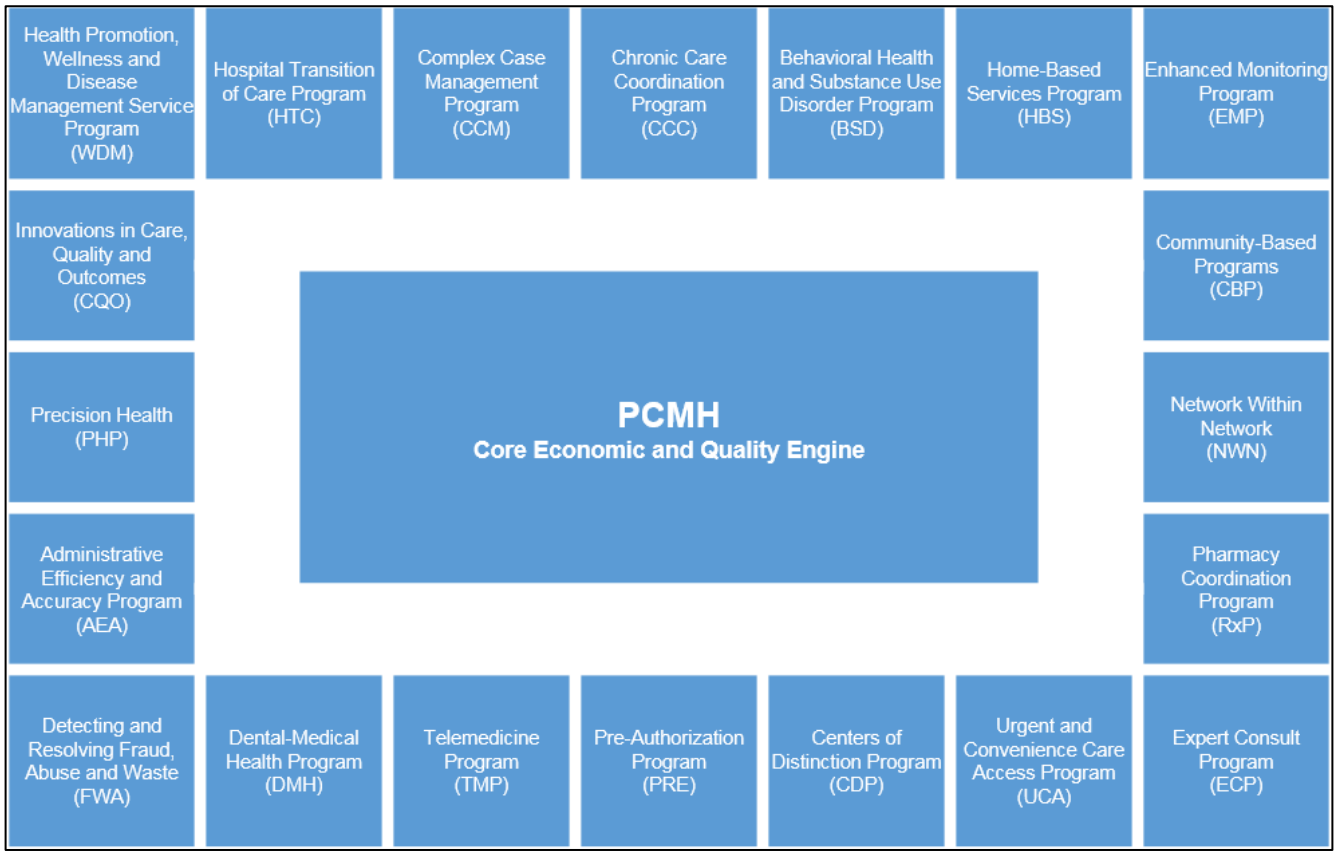
The PCMH Program seeks to build a sound foundation for long term initiatives in primary care, continuous quality improvement and lower Member use of high-cost hospital services. In so doing, the Program is intended to form lasting, stable partnerships among providers and CareFirst in the belief that this is essential to sustained improvements in quality and cost restraint.

### TCCI and PCMH: An Integrated Whole

As can be seen from the Table of Contents, the PCMH Program and the TCCI Program Array, presented in these Guidelines constitute the CareFirst framework for increasing quality while stemming the rate of rise in health care costs. As stated, all Parts and Programs are meant to operate as a single, unified whole.

The 20 surrounding and supporting TCCI Programs that support the PCMH Program are depicted in **Figure 1** below.

**Figure 1: TCCI Program Array**



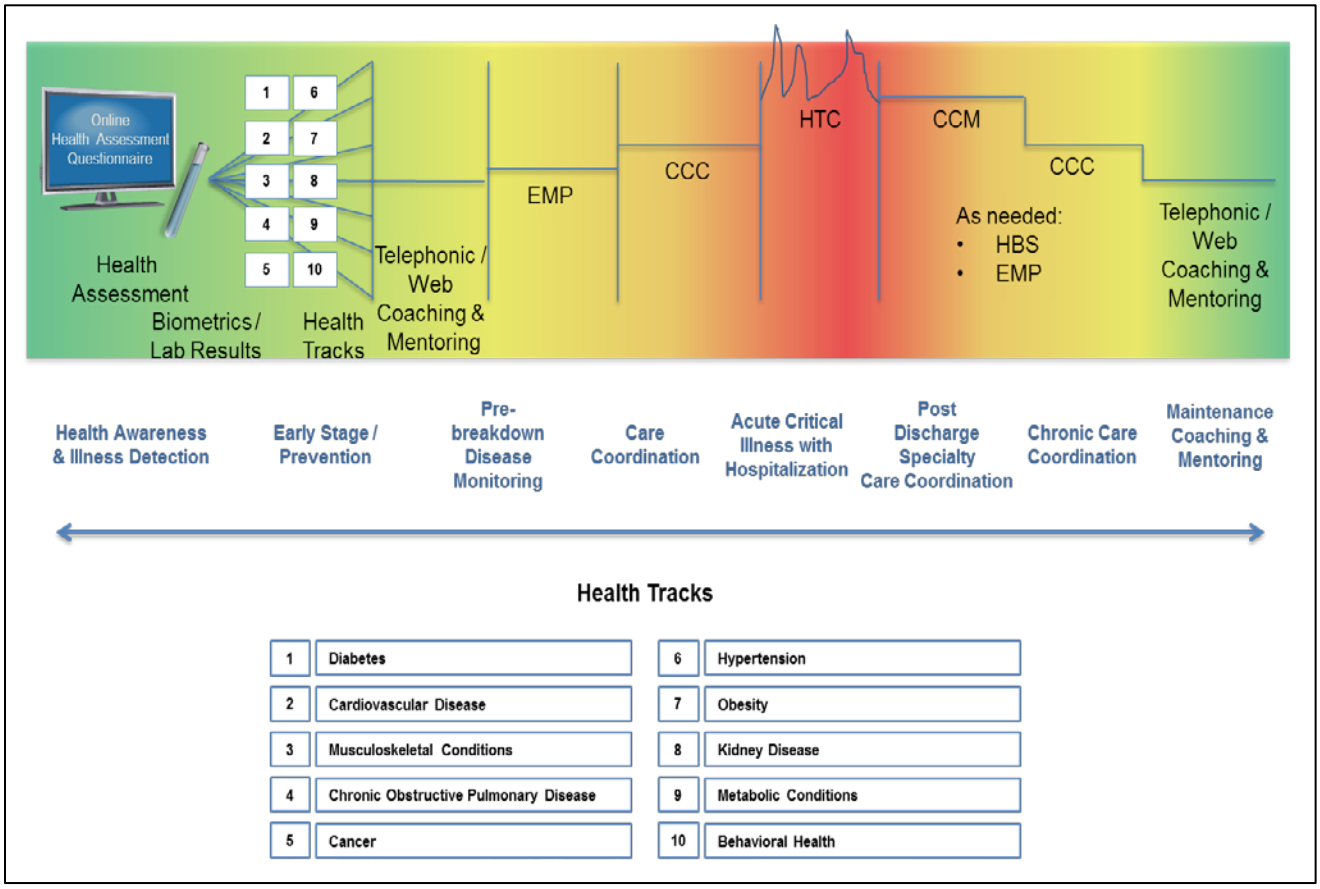

While a substantial portion of CareFirst's enrollment in its service area is in the PCMH Program, most of the programs in the TCCI Program Array apply to all Members – whether or not they are in the PCMH Program. However, some Programs depend on the attribution of a Member to a PCP in the PCMH Program.

It is also important to note that most TCCI Programs are administered uniformly for Members who live within or outside the CareFirst service area. CareFirst's goal is to maximize this uniformity in how the whole Program works regardless of where in the United States a Member lives. This is particularly important for large accounts whose membership is often scattered throughout the country.

### TCCI as a Continuum

The TCCI Program Array is designed to act in a coordinated way as a continuum that is intended to bring the right intervention/Program to bear at the right time for the right Member in order to get the best possible outcome at the lowest possible cost. This continuum is shown in **Figure 2** below.

**Figure 2: TCCI Continuum: Wellness Through Acute Illness And Recovery**

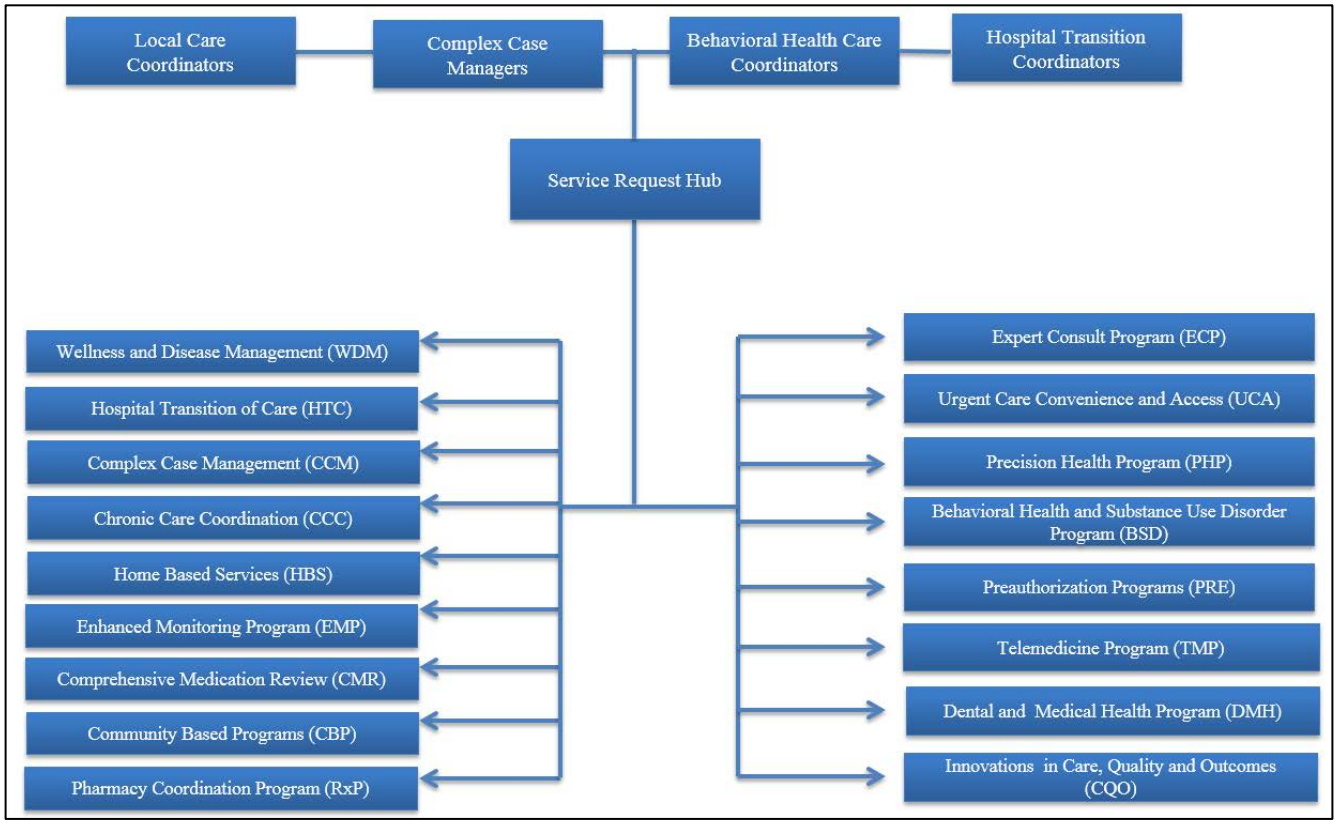



Ideally, the continuum starts with a Health Risk Assessment each year for each Member and brings the right Program to bear as the Member progresses through various stages of health and illness.

The thrust of TCCI is two-fold: To differentially focus on the minority of Members who are either at high-risk for illness or who are experiencing illness as well as raise the awareness and vigilance of those who are healthy so that they stay that way through healthier lifestyle habits and behaviors.

When TCCI Programs are needed – either individually or in combination – they are initiated at the request of a Local Care Coordinator ("LCC") or a Complex Case Manager ("CCM"), both of whom are registered nurses. This is accomplished through an online request to the iCentric Service Request Hub (the "Hub"). The Hub is an online capability that receives, tracks, and monitors fulfillment of all requested TCCI services. This is depicted in **Figure 3** on the next page.

**Figure 3: Service Request Hub: All TCCI Programs Are Only A Click Away**




In essence, the TCCI Program Array – through the integrated working of all its Programs – seeks to coordinate care for those who so often fall through the cracks in today's highly fragmented health care delivery system. That is, it seeks to create an organized system of care where no true system otherwise exists. To do so, it brings to bear infrastructure, organization, data, online interconnectivity and other resources in a focused way for Members who need help.

The TCCI Program Array takes the point of view that the greatest increase in quality can be achieved when there is coordination of all services – across provider type, setting and time – for Members at high risk or with full blown disease. And, the core PCMH Program is founded on the belief that quality outcomes can be improved through the attentive guidance of a motivated PCP who is rewarded for differentially attending to these Members across time and setting. When done well, this can lower the rate of Member breakdowns resulting in more effective, and less unnecessary or inappropriate care.

In other words, with better coordination and purposeful design, a virtuous process can be initiated that seeks continuous quality improvement over time. This essential feature of quality improvement programs in all manufacturing and economic fields of endeavor has been late coming to the complex health care system. However, no meaningful attempt at cost control over the long term can occur without it.

So, the CareFirst TCCI Program Array – along with the core PCMH Program – seeks to coordinate that which was not well coordinated before its inception, provide focused resources where they were not appropriately focused before, provide an infrastructure to do this that had not existed before, and provide information feedback to the core player – the PCP – that was not available before the Program's onset.

In this way, the various Parts and Programs described in these Guidelines seek to directly confront the problems and challenges outlined in **Part I**.

## Organization of This Program Description and Guidelines

There are many subjects covered in this Guidelines document. To make the entire compendium of these subjects more accessible and easier to use as a reference, the material is organized into eight discrete Parts, organized into separate Volumes as noted in the Table of Contents. These various Parts are explained briefly below.

### VOLUME I

**Part I presents the key problems and challenges that compel a new approach.** These challenges – driven mostly by the ever-increasing cost and use of health care services – have brought employers and individuals to a precipice. If costs continue to rise in the next 10 years as much as they have in the past 10 years, virtually no one except the extremely affluent will be able to afford coverage. Lack of coverage or inadequate coverage will predominate, despite the good intentions of the Patient Protection and Affordable Care Act ("ACA"). We are rapidly moving to the point where the "under insured" may exceed the "uninsured" as a regional and national issue, particularly if some form of the American Health Care Act is ultimately enacted. Nothing so threatens the quality of care and access to care as the high cost of it.

**Part II presents the basic principles, core ideas and goals of the PCMH Program.** These shape the specific elements of the Program's design in a purposeful way. The Program's emphasis on information transparency, incentives and accountability is explained as is its conceptualization as a market-based model (rather than a model-based on regulation or risks/penalties).

**Part III presents the building blocks of the CareFirst PCMH Program – Element by Element.** Each Design Element is explained as is the interaction among them. These Elements are designed to form a new weave of ideas – some of which are tried and true approaches from the past and some of which are entirely new. All are supported by new technologies available today – including online connectivity, stronger "on demand" analytics and an online Member Health Record.

**Part IV presents the terms and methods under which Medicare Beneficiaries covered under Parts A and B were included in the PCMH and TCCI Programs** in a manner that assures that the application of Program rules and incentives to Medicare beneficiaries were virtually identical to what is done for CareFirst Members. This "Common Model" created one set of rules and incentives for both Medicare and CareFirst's commercial population, thereby strengthening the attentiveness of Panel PCPs to these rules and incentives. Both the Common Model Pilot, funded by the Center for Medicare and Medicaid Innovation's ("CMMI") Health Care Innovation Award through 2015 and funded directly by CareFirst through 2016 is explained, as is CareFirst's approach to expanding the Common Model to a broader population of Medicare beneficiaries.

**Part V presents CareFirst's approach to fostering Member well-being through benefit design by greater focus on healthier lifestyles through Member behavioral change brought about by benefit plan designs** that offer rewards for improved health and increased awareness of one's health as well as incentives for value-based access to health care services. Health coaching on lifestyle and behavioral health is available as is coaching on management of early stage chronic diseases to impede their progression. Financial rewards are used as a catalyst for change.

### VOLUME II

**Part VI presents the additional surrounding and supporting Programs** that comprise the overall **TCCI Program Array**. These are intended to detect high-risk and high-cost Members as early as possible and place them in a care management program best suited to their needs – all under the watchful eye of the Member's clinician.

### VOLUME III

**Part VII presents the data that is available to Providers in the PCMH Program through SearchLight® Reports – available online 24/7.** SearchLight Reports show the cost, quality, illness and demographic patterns that are most important for Panels to focus on in order to understand how best to improve quality and control costs for their population of Members.

**Part VIII presents the features of the online iCentric System** that undergirds all aspects of the PCMH and TCCI Programs. This System facilitates all workflows, stores all data and provides the infrastructure through which all elements and parts of the PCMH Program and TCCI Program Array are made to operate as a single, integrated whole.

## Summary And Detailed Table Of Contents

In the pages that follow, a summary and detailed Table of Contents is presented to provide an easy guide to the extensive material contained in the Program Description and Guidelines.

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**Appendices**

**USE OF THIS DOCUMENT**

This document contains the Program description, guidelines, and operating procedures for CareFirst BlueCross BlueShield's and CareFirst BlueChoice's ("CareFirst's") Patient-Centered Medical Home (PCMH) Program and Total Care and Cost Improvement (TCCI) Program Array. CareFirst reserves the right to modify the descriptions, guidelines, and operating procedures presented herein. The portions of this document that provide background and general descriptions of the TCCI or PCMH Programs are for descriptive purposes only. However, parts that describe the PCMH Program and various TCCI Programs are meant to create, expand, or modify contractual obligations of either CareFirst or applicable contracts with providers of PCMH and/or TCCI Services.

This document does not create or supplement any coverage provided under any CareFirst health plan. References to and descriptions of business relationships, specific products, business partners or plan designs, whether existing or proposed, are subject to change without notice.

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## PROGRAM DESCRIPTION OVERVIEW AND MASTER TABLE OF CONTENTS



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### PART I: THE PROBLEM AND THE CHALLENGE



### PART II: PCMH: THE CORE ECONOMIC AND ACCOUNTABILITY MODEL

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## PART VIII: iCENTRIC: THE ESSENTIAL ONLINE INTEGRATION OF ALL ELEMENTS AND PROGRAMS



**Overview Of The 10 Major Domains Of iCentric Functionality**



## APPENDICES

# CAREFIRST PCMH PROGRAM: BACKGROUND, HISTORY, AND RESULTS (2011-2016)

The Patient-Centered Medical Home ("PCMH") Program and its supporting Total Care and Cost Improvement ("TCCI" Program Array constitute one of the largest and longest efforts of any such programs in the nation. Clear results have emerged that are encouraging and sobering in what it takes to achieve and sustain improved quality and costs results on a large population of people. This overview tells the story from its beginning through 2016.

### The Creation and Launch of a Pilot of the CareFirst PCMH Program in 2008-2010

The Company's initial foray into the PCMH environment to address the issue of rising cost occurred in 2008 when CareFirst launched a small, but intensive, pilot program in which 11 select primary care practices received a Per Member Per Month ("PMPM") payment to provide care management services to CareFirst Members. Unfortunately, after three years, this pilot did not produce better outcomes. Each practice took an idiosyncratic approach to the use of funds and adopted their own differing approaches that compromised the ability to conduct meaningful analysis, thwarted reporting to self-insured groups and produced uneven delivery of benefits. Further, the practices had no effective accountability for achieving better outcomes on cost or quality.

We learned many things in this predecessor pilot. Among these learnings was the observation that, without accountability for global outcomes and incentives to achieve them, the additional resource "inputs" were consumed without impact on the goals of the pilot. CareFirst's experience in this pilot led to the creation of a much different model – the PCMH Program and TCCI Program Array described in this document.

A program similar to CareFirst's initial pilot, which provided Primary Care Providers ("PCP") with a monthly capitation fee for practice transformation services, was undertaken by the State of Maryland in its PCMH Pilot Program from 2011-2015. As in CareFirst's initial pilot with 11 practices, this, too, produced little in the way of discernable results and experienced the same problems as the earlier CareFirst pilot. Of note, the current CPC+ model launched by CMS on January 1, 2017, follows the same essential design as these two earlier failed attempts in Maryland. Further, a model similar to this failed model is now proposed by the State (mid-2017) for Phase 2 of the Maryland All-Payer Waiver.

The current CareFirst PCMH Program was first expressed in a written document that constituted the initial version of a Program Description & Guidelines in the summer of 2010. The surrounding and supporting capabilities of the TCCI Program Array were developed subsequently in furtherance of the goals of the PCMH Program.

Following passage of enabling legislation in 2010 (CareFirst played a key role in seeking this legislation), the company sought approval from the Maryland Health Care Commission (MHCC) on August 26, 2010, to launch the Program. The MHCC promptly approved the Program on September 16, 2010, making the CareFirst PCMH Program the first of its kind in Maryland under the new legislation. The State then launched its own pilot PCMH Program, referred to above, on July 1, 2011, which has since ended per its sunset provisions on December 31, 2015.

The current CareFirst PCMH Program was never intended to be conducted as a pilot since it followed the pilots described above. CareFirst intended from the start, to place the Program in full operation for all segments of its business as soon as possible following regulatory approval in 2010. The company did just that on January 1, 2011.

### Current CareFirst PCMH Design

The CareFirst PCMH design creates a global budget target composed of all health care costs for Members attributed to small primary care teams of five to 15 PCPs – called Medical Panels ("Panels"). The global targets for Panels are based on the historical claims experience of the Member population that is attributed to each Panel. All costs in all care settings are included in the targets for each attributed Member and are then risk adjusted and trended forward into the then current Performance Year. This is done so that the total budget target given a Panel represents the expected costs of care for each Panel's specific population of Members. The average Panel has 2,500 Members and a $12 million annual budget target.

Hence, the central idea in the Program is that the total care of Members is to be provided, organized, coordinated or arranged through small Panels of PCPs who are accountable – as a team – for the aggregate quality and cost outcomes of their pooled Member population. Any savings they achieve against their shared, pooled global budget target is shared with them as long as their quality of care achieves certain standards.

In this way, the Program seeks to powerfully incent PCPs – as a team to:

- control costs for their pooled Member population and share savings actually achieved against budget targets; and
- improve quality outcomes that are measured on a Panel-by-Panel basis.

For each Panel, higher quality outcomes achieved with greater cost savings against global targets produce greater rewards. Lower quality with lesser savings yields smaller rewards. Failure to achieve any savings yields no reward, regardless of quality performance.

The Program is, therefore, fully based on the concepts of overall population health management with a Member-centric focus, built squarely on the belief that a primary care team is the essential core upon which to build – even though PCPs, themselves, provide only a small portion of all services rendered to Members (especially for those Members who are sickest). However, PCPs are the gateway to most services under the current CareFirst PCMH Program design.

Although there is little remaining similarity between the Program design that CareFirst piloted in 2008-2010 and the PCMH Program in broad use today, the lessons learned from the pilot about the effectiveness (or lack thereof) of certain design features have proven invaluable in informing the current design. It is this collective and cumulative experience that has caused CareFirst to express to the State of Maryland its serious concerns regarding the primary care portion of the State's approach to Phase 2 of the Maryland All-Payer Waiver, and to decline participation in the next phase of the Waiver.

**Region-wide Recruitment Effort from the Outset**

Given the scale of CareFirst's intent to move its new Program design into full region-wide production, the MHCC approval in 2010 triggered an intensive effort by CareFirst to recruit and enroll PCPs throughout Maryland, Northern Virginia and the District of Columbia (the "CareFirst service area") in pursuit of the goal of launching the Program region-wide on January 1, 2011.

To this end, all fully credentialed PCPs in good standing (about 4,400) in the CareFirst Regional PPO and HMO networks throughout the CareFirst service area were invited to join the Program on a voluntary basis. If interested, each was required to sign an addendum to their network contract with CareFirst in which they agreed to:

- abide by Program rules as presented in the Guidelines;
- form or become part of a Medical Care Panel (i.e., the primary care team); and
- become engaged in the Care Coordination activities at the heart of the Program.

The voluntary nature of the Program was an essential feature of the recruitment message from the outset.

Efforts at recruitment began with an invitation on October 1, 2010 to join the new Program that was sent to all PCPs in the CareFirst Regional PPO and HMO networks. Throughout the fall of 2010, a substantial number of town hall meetings were conducted to explain the Program as presented in the Guidelines. These meetings were followed by one-on-one and small group meetings with PCPs to further explain the Program. Hundreds of PCPs attended the various town hall meetings throughout the region and thousands were reached individually or in small groups.

The meetings were generally marked by extensive question and answer sessions that revealed the topics of greatest interest to PCPs. It became apparent that many PCPs had carefully read and made extensive notes on the Guidelines. The Program's design stood up very well to this questioning – giving some degree of confidence to recruiter and "recruitee" alike.

On January 1, 2011, the Program was launched on schedule, with 1,947 physicians and 205 nurse practitioners in just over 150 newly formed Medical Care Panels spread throughout the CareFirst service area. The average Panel had nine PCPs.

Four different types of Panels were established. The most prevalent and the type with the most CareFirst Members is called a "Virtual Panel". This Panel-type is composed of small, one to four-person primary care practices and is formed by contract. In this type, each practice remains its own separate legal entity. A second Panel-type involves group practices of between five and 15 PCPs who formed a Panel of their own. A third type is group practices, typically multi-site, larger than 15 PCPs

that are broken down into multiple Panels. The fourth Panel-type is composed of Panels that are part of large health care delivery systems in which PCPs are typically employed by the health system.

The substantial initial base of PCPs that formed the first network of the PCMH Program instantly made it one of the largest such networks of its kind in the nation – and the single largest based on a completely uniform model with one set of Program rules, financial incentives and quality standards on a broad regional basis. The design made the role of the PCP central even as it extended the scope of PCP accountability beyond primary care services to global cost and quality outcomes for Members in their care.

**Unique Model Unlike Most Accountable Care Organization ("ACO") Attempts**

In many respects, the CareFirst PCMH Program is unlike the ACO models that have been developing since 2011. ACO models are commonly built around a single or multi-hospital health care delivery system – each with its own idiosyncratic way of coordinating care, providing incentives and achieving results. While federal rules form a common high-level framework, most ACOs today remain one-of-a-kind models that are difficult to extend beyond the particular ACO involved and have limited appeal to large employer groups whose employee populations constitute the majority of enrollment in private health plans. This is due to the fact that differing approaches taken by ACO's greatly complicate uniform benefit administration as well as comparative data analysis and reporting that is so essential to employers.

In contrast, from the start, CareFirst intended to create a single, uniform, region-wide model not tethered to any hospital-based health care delivery systems. Indeed, the model did not place hospitals or health systems in a central or leading role, but rather, formed a network of PCPs that was nested within the far larger provider networks CareFirst maintains for its membership.

These larger networks were intended to provide all non-primary care services needed by PCMH Members. PCPs are free to refer anywhere they choose in the larger networks in order to arrange services for their Members. However, they are given easily accessible online cost information that makes them more informed "buyers" of specialty, hospital and ancillary services – a critically important key to success in controlling cost.

It is important to note that the recruitment of PCPs did not affect any non-PCPs directly. But, it did set up PCPs with the freedom to refer for specialty and ancillary care that best serves their Members. However, those PCPs employed by large health care delivery systems have turned out to be restrained in making referrals to specialists. This constraint is imposed by the systems themselves (not the PCMH Program) as these large systems seek to "capture" all health care services within their own providers in order to protect or enhance the volume of services on which their revenue depends. To the contrary, the CareFirst PCMH Program seeks to maximize freedom in referral-making based on decision support data that points PCPs to the highest value referral targets wherever they may be.

**The Larger CareFirst Networks – Maximizing Referral Choices**

To understand the breadth of provider choice CareFirst offers, it is important to recognize that CareFirst's large and complete network of providers includes all hospitals in the CareFirst service area and over 43,000 different providers of all types.

During the 2008-2016 period, the CareFirst network grew substantially and currently includes the vast majority (well over 90 percent) of all actively practicing providers in CareFirst's service area of all types – specialty, hospital and ancillary service providers – in two large and highly overlapping networks – the Regional PPO and HMO networks. Of all payments for services rendered to Members – as measured by claims paid – nearly 97 percent are made to network providers for Members who live in the CareFirst service area.

CareFirst categorizes all hospital and specialty providers into one of four cost tiers: High, Mid-High, Mid-Low and Low and leaves the "shopping" decision to the PCP. These four tiers roughly correspond to quartiles. Decisions on quality are left to the PCP who is in the best position to make the most informed decision in this regard on behalf of the Member.

From 2008 to 2017, the CareFirst Regional PPO network grew from 30,976 participating providers to 43,731 participating providers while the HMO regional network grew from 26,355 to 39,998 providers. These networks offer the broadest choice of in-network providers in the CareFirst service area of any payer or health care delivery system.

It was into this large and growing network that the PCMH Program was placed – all on the basis of a voluntary agreement with willing PCPs who participated in both the Regional PPO and HMO networks. In short, the entire network strategy was intended to give PCPs the widest possible choice in referral decision-making – but, with a powerful incentive to make a high value choice based on data that supports that choice.

**Early Member Enrollment**

With the signing of the initial network of PCPs, the PCMH Program started its first day of operation on January 1, 2011, with approximately 650,000 Members who were attributed to the initial participating PCPs. This initial enrollment was principally derived from Members who were covered by CareFirst as individuals or as part of small or medium size employer groups (fewer than 200 employees). This constituted the fully-insured portion of CareFirst's total book of business.

Thereafter, a special effort was undertaken to gain the voluntary participation of large self-insured employers, many of whom joined the Program by the end of the first year of operation. The Federal Employee Health Benefit Plan also joined the Program during the first year of its operation. All remain in the Program as of mid-2017.

It must be stressed that were it not for the substantial number of PCPs and the far larger scale of the surrounding PPO and HMO networks in which the Program is nested, it would not have been possible to attract and serve the full range of individual and employer-based membership that CareFirst maintains – approximately two million of whom live in the CareFirst service area.

The uniformity in program design, rules, incentives and data have made the Program understandable and acceptable to diverse business segments and helped present and illuminate its value by fostering discipline in the way underlying data regarding patterns of cost and quality are displayed in the online iCentric Data System that supports the Program on an end- to-end basis. From the outset, it was CareFirst's intent that groups and individuals who are covered under risk (premium-based) and non-risk contracts with PPO and HMO designs would all be served by the common, scalable and uniform model that is the core of the Program. Meanwhile, broad network availability provides ubiquitous access, making the whole Program more attractive to a full range of buyers.

**Constancy in Design is Key to Behavioral Change and Understanding Emerging Results**

While refinements in the Program have been made continuously since the Program's launch in 2011, all basic Design Elements as outlined in **Part III** of the Program Description and Guidelines have remained intact. In the main, refinements have served to further clarify the functioning of Program rules or have provided more detailed explanation of core Design Elements.

This constancy in design and rules has lent great stability to the incentive features of the Program and has provided a consistent framework within which to train all key players in the Program – from nurses to administrative staff to PCPs themselves.

It was assumed at the outset, and has been seen with clarity since, that were it not possible for PCPs to count on the constancy in the rules that relate to incentives (Outcome Incentive Awards or OIAs), it would be highly doubtful that behavioral change on the part of these providers could have been stimulated.

Thus, the Program, in its seventh Performance Year (that began on January 1, 2017), is in every major respect, the same as the one initially launched in January of 2011. We recognize that even now, not all PCPs understand the rules with equal depth and clarity. But, once they embrace the Program, behavior change becomes evident and then accelerates. In recent years, surveys and other assessments have shown that the level of awareness of the Program has broadened and deepened among PCPs as well as among the 25,000 employer accounts that rely on the Program.

This persistence in design and operation – together with the uniformity of the model throughout the CareFirst service area – also provides an unparalleled opportunity to view the impacts achieved by a consistently applied set of Program rules across enough time and on a large enough scale to draw conclusions regarding results. Of particular interest are the underlying changes in the behavior of PCPs that are driving these results.

While keeping the core economic and care management model consistent, there have been refinements to the Program that center around five major themes:

1. **Increased Quality** – Since the initial year of the Program CareFirst has consistently increased quality thresholds needed for Panels to earn an Outcome Incentive Award. Specific clinical measures were chosen for adult, mixed, and pediatric Panels and a much greater focus has been placed on the Panel's engagement with Program standards and the consistency of that engagement across all PCPs in the Panel. Even with the increased quality standards, Panels are producing savings and earning OIAs at high rates.

2. **Better Targeting of High-Risk Members** – Each year CareFirst has improved the precision with which high-cost/high-risk Members are selected for Care Coordination and ancillary TCCI Programs, culminating in the development of the Core Target Population in 2016. The Core Target uses a matrix of clinical and utilization based indicators to identify the highest priority Members for Care Coordination. The care coordinator and PCP have a collaborative in-person discussion about every Member in the Core Target to assure the Member receives the appropriate services necessary to become stable.

3. **Higher Standard of "Viability"** – In order for a Panel's financial results to be meaningful, a Panel must have a minimum level of attributed Members over the course of the Performance Year. This is considered the point at which a Panel is considered "viable". To gain greater confidence in the results being produced by the Panels CareFirst has begun to gradually increase the minimum viability threshold. By 2018 a Panel must have on average, at least 1,500 attributed Members to be considered viable.

4. **Greater Focus on Specialty Referral Patterns** – Over the last few years, CareFirst has shared specialist cost rankings with PCMH PCPs. Quality judgment is left to PCPs and PCPs still refer where they will get the best result. Since providing this cost information, CareFirst has seen evidence of changes in referral patterns from independent PCPs, as many have become convinced of the efficacy of referring to lower cost Specialists and Hospitals for common, routine illnesses.

5. **Introduction of an Element of Risk –** While CareFirst continues to believe that it is inappropriate to place down-side insurance risk on primary care practices, the PCMH Program did introduce an element of PCP risk in 2017. That is, the 12 percent Participation Fee is tied to each Panel's continuing "engagement" in the PCMH Program. Beginning January 1, 2017 CareFirst reduces or eliminates this fee for Panels that fail to achieve minimum engagement and quality scores. Hence, this "at risk" feature is tied to actual quality performance, not insurance risk for Panels.

### TCCI Provides Additional Supports and Capabilities

It quickly became evident, based on early experience, that the incentives and accountability structure of the PCMH Program – by themselves – were not enough to achieve the goals of the Program. Extensive additional supports would be necessary. Hence, over the past five years, the TCCI Program Array has been created and continuously enhanced to provide programmatic supports to the core design of the PCMH Program. Specifically, the TCCI Program Array provides adjunct or supplementary capabilities that are designed to work as direct enablers of the incentive, accountability and organizational structure of the PCMH Program and to further the ability of PCPs to reach their Members with the services needed to better manage their health care risks, diseases and conditions. The long-term effects of the TCCI Program Array are just coming into view.

The 20 programs of the TCCI Program Array are:

1. Health Promotion, Wellness and Disease Management Services Program (WDM)
2. Hospital Transition of Care Program (HTC)
3. Complex Case Management Program (CCM)
4. Chronic Care Coordination Program (CCC)
5. Behavioral Health and Substance Use Disorder Program (BSD)
6. Home-Based Services Program (HBS)
7. Enhanced Monitoring Program (EMP)
8. Community-Based Programs (CBP)
9. Network Within Network (NWN)
10. Pharmacy Coordination Program (RxP)
11. Expert Consult Program (ECP)
12. Urgent and Convenience Care Access Program (UCA)
13. Centers of Distinction Program (CDP)
14. Pre-Authorization Program (PRE)
15. Telemedicine Program (TMP)
16. Dental-Medical Health Program (DMH)
17. Detecting and Resolving Fraud, Waste and Abuse (FWA)
18. Administrative Efficiency and Accuracy Program (AEA)
19. Healthworx (HWX)
20. Clinical Quality Measurement (CQM)

Underlying and enabling all aspects of PCMH and TCCI is the CareFirst-developed iCentric System that provides a web-based set of online capabilities that are available 24/7 serving all network providers. Among its many capabilities, the System documents and tracks all Care Coordination activities and reports on all of these activities across the entire Program.

The value of claims, for all services passing through the PCMH Program under the direction of the Panels reached nearly $5 billion in 2016 – double the $2.5 billion in 2011. This represents well over 50 percent of all the claims CareFirst pays on behalf of its membership and makes the Program the largest single uniform model design in the United States.

**PCMH/TCCI Programs Status as of January 1, 2017**

The PCMH/TCCI Programs entered their seventh full year of operation on January 1, 2017, with 447 Medical Care Panels composed of 4,397 PCPs. This represents nearly 90 percent of eligible PCPs in the CareFirst Regional and HMO networks (up from 47 percent when the Program began in 2011).

PCP participation and membership in the CareFirst PCMH Program by Panel type as of January 1, 2017 is shown in **Figure 4.** Also shown is the breakdown of enrollment by Panel-type and for the Program as a whole. Virtually every major health care delivery system in the region is participating as are the vast majority of privately practicing independent PCPs.

**Figure 4: Panel Characteristics By Panel Type As of January, 2017[1]**

| Panel Type | Panels | PCPs | PCPs/ Panels | Members | Members/ Panel |
|---|---|---|---|---|---|
| **Virtual Panel** | 155 | 1,388 | 8.9 | 356,726 | 2,301 |
| **Independent Group Practice Panel** | 81 | 680 | 8.3 | 186,438 | 2,302 |
| **Multi-Panel Independent Group Practice** | 110 | 1,086 | 9.8 | 269,479 | 2,450 |
| **Multi-Panel Health System** | 127 | 1,243 | 9.7 | 328,249 | 2,585 |
| **January 2017** | **447** | **4,397** | **9.2** | **1,140,892** | **2,552** |

As already noted, Member enrollment in the PCMH Program is rising toward 1.2 million to date. Enrollment in the Program is now automatic for individual and small or medium group Members as well as for large self-insured group Members who live in the CareFirst service area. That is, the right to the Care Coordination features of the PCMH and TCCI Programs is intended by CareFirst to be part of the intrinsic value proposition of the company as it offers benefits to all of its Members.

While Member consent is required to receive PCMH and TCCI Care Coordination services, all Members are entitled to receive these services unless they or their employer opts out. Among self-insured groups, only a tiny handful of groups have exercised this option. Hence, the PCMH and TCCI Programs have become the ubiquitous backbone of CareFirst's efforts to better control health care costs and improve the quality of care for its Members. Today (mid-2017), the Program serves over 25,000 employer groups and one-quarter of a million Members who buy policies as individuals – regardless of product or risk arrangement (fully-insured, self-insured, credibility rated, etc.).

Enrollment in the PCMH Program automatically triggers enrollment in the TCCI Program Array. However, a number of TCCI Programs also apply to Members not covered by the PCMH Program. The number of TCCI Programs has grown over recent years as greater needs of Members and PCPs have become evident. The number of Members served by these Programs has also consistently grown year-over-year, since the launch of the Program. The number of Members served in the array of TCCI Programs over the previous six years is shown in **Figure 5**.

[1] *Source: HealthCare Analytics – May 2017. Member counts include the "NA" Panels for multi-Panel entities (except Hopkins). These Members are attributed to an active practice within the entity, but do not have attribution to an active PCP (required for assignment to a specific Panel).*

**Figure 5: TCCI Member Engagement, 2011-2016, 2017 Targets**

| TCCI Element | Annual Volumes for Each TCCI Program | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 Target |
| Hospital Transition of Care | N/A | 103,500 | 92,852 | 89,958 | 84,655 | 79,002 | 72,000 |
| Complex Case Management Care Plans | 17,060 | 22,222 | 22,250 | 30,283 | 36,781 | 38,526 | 40,000 |
| Chronic Care Coordination Care Plans | 1,022 | 2,611 | 6,248 | 11,800 | 16,694 | 14,472 | 17,500 |
| Behavioral Health & Substance Use Disorder Care Plans | 1,667 | 1,903 | 942 | 3,515 | 5,307 | 9,041 | 15,000 |
| Home-Based Services – Service Requests | N/A | 154 | 1,719 | 4,645 | 6,781 | 7,068 | 12,000 |
| Enhanced Monitoring – Service Requests | N/A | N/A | 15 | 863 | 2,341 | 2,791 | 7,500 |
| Comprehensive Medication Review<br>CMR 1 Service Requests<br>CMR 2 Drug Advisories | 8,300<br>N/A | 34,000<br>N/A | 6,800<br>N/A | 10,144<br>N/A | 2,499<br>92,967 | 3,343<br>90,234 | 7,500<br>100,000 |
| Specialty Pharmacy Coordination Managed Cases | N/A | N/A | 6,568 | 2,343 | 8,255 | 10,516 | 15,000 |
| Community-Based Programs – Service Requests | N/A | N/A | 8 | 763 | 2,135 | 5,873 | 10,000 |
| Expert Consult<br>Tier 1 Completed Cases<br>Tier 2 Completed Cases | N/A<br>N/A | N/A<br>N/A | 34<br>N/A | 346<br>N/A | 878<br>87 | 1,016<br>156 | 2,500<br>1,000 |
| **Annual Total** | **28,049** | **164,390** | **137,436** | **154,660** | **259,380** | **262,038** | **300,000** |

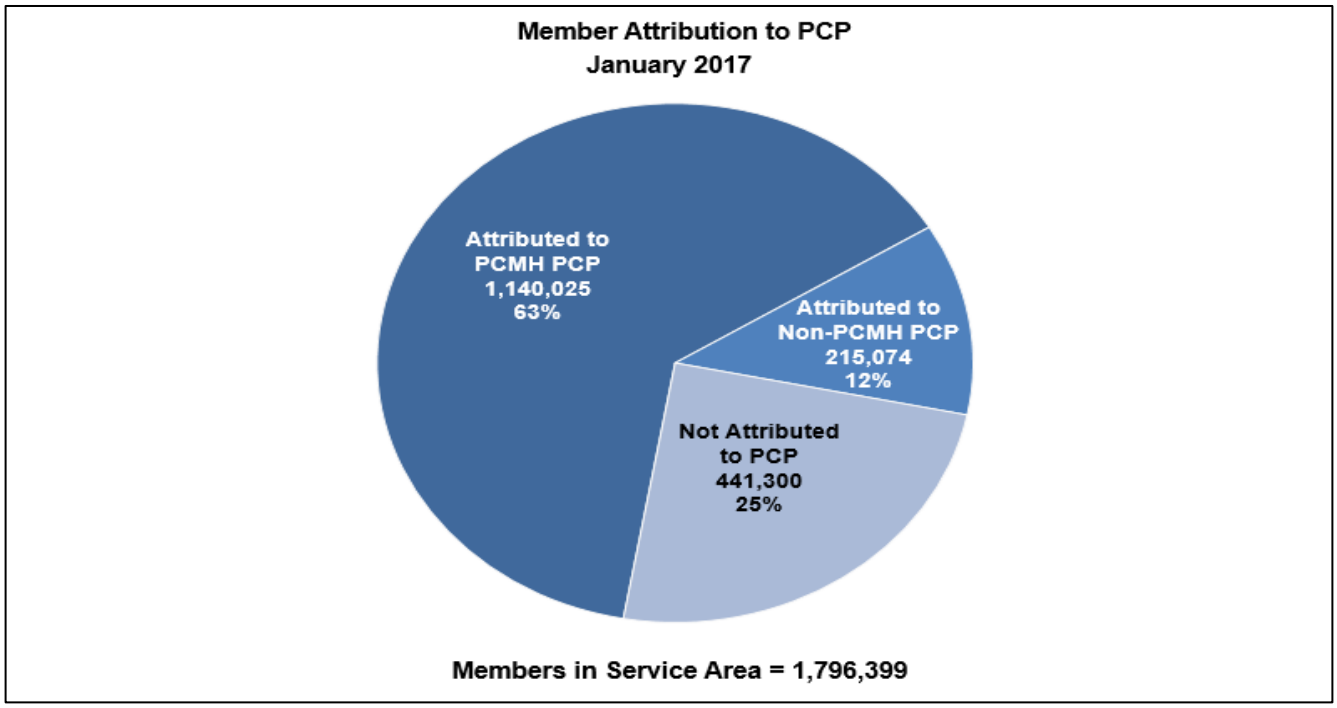
It is noteworthy that a large portion of Members who are non-participants in the PCMH Program are those who have no PCP. This approximates 25 percent of all Members living in the CareFirst service area. This subgroup of Members is composed mostly of two groups: younger Members who see no provider or older Members who see only specialists for established diseases or conditions for which they are being treated. These non-PCMH Members are, however, covered by the TCCI Program Array.

Beyond this, the largest grouping of non-participation is Members in large national or multi-regional employer groups that are headquartered outside of the CareFirst service area (but who have Members in the area). These Members are typically not participants in the Program since their coverage plans are determined by their employers without regard to CareFirst capabilities, since the groups have headquarters elsewhere. For these groups, CareFirst participates in supplying coverage, but does not do so based on its own Programs and rules. This is expected to change as the results of the PCMH/TCCI Programs prove their value and these national groups elect to opt in.

The second largest cohort of non-participants is composed of those Members who live in the area, but see a non-PCMH participating PCP. This cohort constitutes 12 percent of CareFirst Members, is continually declining, and underscores the importance of continuing efforts to enroll the remaining PCPs still not in the Program.

In total, the nearly 1.2 million Members now in the PCMH Program, who are considered "home" Members of CareFirst, considerably exceeds the number of Members who live in the region, but are not in the Program for the reasons mentioned above. **Figure 6** below shows the breakdown of attributed and non-attributed Members in the PCMH Program.

**Figure 6: PCMH Attribution For Members Who Live In CareFirst's Service Area**[2]




Highly targeted recruitment efforts continue for those PCPs who still do not participate in the PCMH Program in order to raise enrollment in the Program. As of January 2017, 4,397 PCPs participate in the Program. The goal is to have nearly 4,450 participating PCPs by January 1, 2018.

**PCPs Stay in the Program**

It is interesting to note that physician loyalty to the PCMH Program has been extremely high, even with the entirely voluntary nature of the Program. Since the inception of the Program, of the 394 PCPs who have terminated their participation in the Program, 81 percent retired, left practice or moved out of the area while 19 percent were terminated by CareFirst due to lack of Program engagement. Of those terminated due to lack of engagement, five percent returned to the Program.

Involuntary termination by CareFirst has been undertaken only for those PCPs who have shown persistent failure to abide by Program rules or to engage in Program Care Coordination activities. These patterns of noncompliance became evident as the Program matured. However, persistent failure to engage in Care Coordination activities remains rare and CareFirst has become more forceful in dealing with this when it occurs.

Additionally, few Panels (less than 12 percent) have changed their PCP membership more than 50 percent since the inception of the Program. Further, Panel size has remained constant at about nine PCPs per Panel over the 2011-2017 period. Thus, the PCP base of the Program has remained highly stable throughout the first six years of the Program's existence even as there has been steady growth in the number of providers participating. However, considerable change of lesser magnitude occurs continually as PCPs join or leave Panels one at a time. This is accommodated as it occurs on a voluntary basis.

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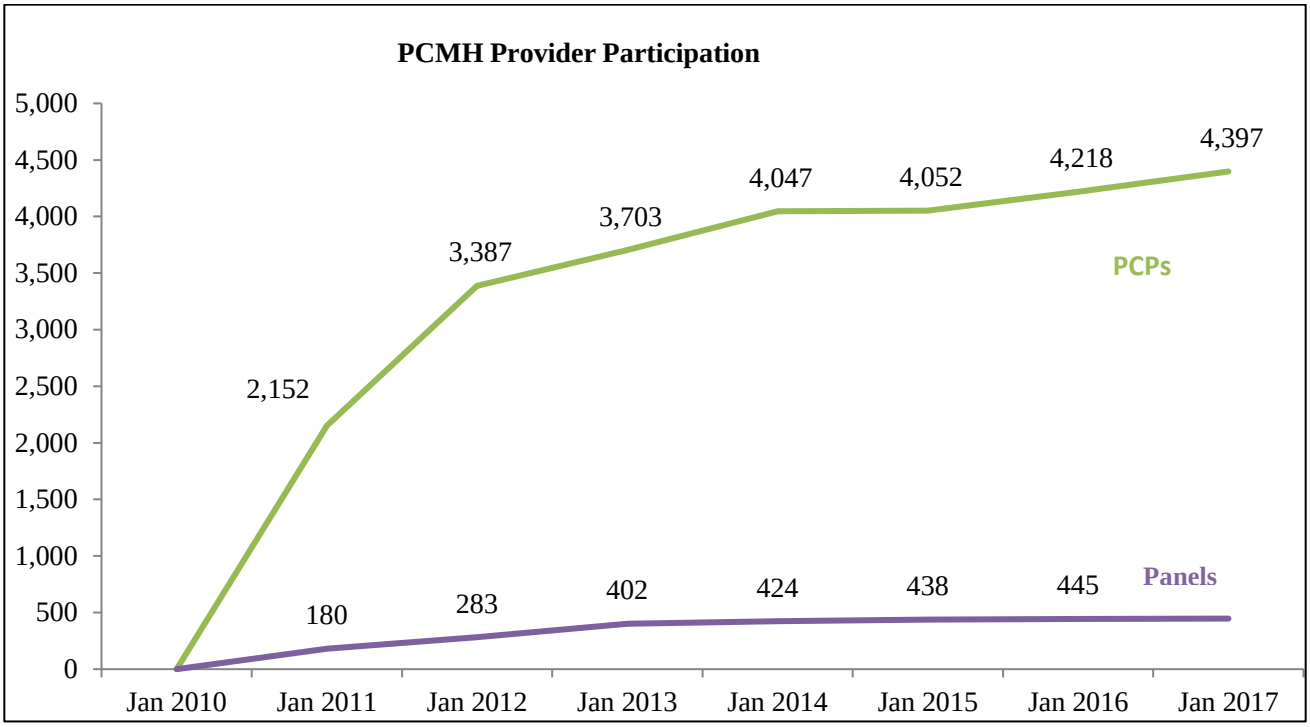
2 *Excludes Medicare Primary. Source: CareFirst HealthCare Analytics*

The net growth in the Program can be readily seen as shown in **Figure 7** below.

**Figure 7: PCP And Panel Counts Over Time**




**Finding a PCMH PCP has not been Difficult for Members, so far**

So far, the PCMH network has been able to absorb CareFirst membership without difficulty. As a condition of their participation, PCP practices must remain open for CareFirst Members or closed to all new Members from all payers. As of May 2017, only 86 PCPs have closed their practice to all new Members. This represents under two percent of all PCPs participating in the Program.

With this said, it has become clear how significant Nurse Practitioners ("NPs") and physician extenders (e.g., physician assistants) have become in assuring access to primary care services. The busiest and most significant Panels in the Program often make extensive use of their services. NPs constitute approximately 19 percent of the providers in the PCMH network. It is also noteworthy that some Urgent Care Centers ("UCCs") are transforming themselves into Medical Panels and have begun to qualify as PCPs under the PCMH Guidelines. While this is still a small portion of the PCP network in the PCMH Program, it is expected to grow.

Finally, it is also worth noting that the merger/acquisition of independent provider practices into large health systems has increased significantly since the start of the Program. In May 2017, approximately 29 percent of PCMH participating PCPs were employed by health systems. Only 17 percent were employed in these large systems in 2013 and 11 percent at the start of the Program in January 2011. This compares favorably against the rest of the nation, where recent reports estimate that over half of practicing physicians are employed by hospitals.

Nevertheless, the pace of hospital employment of physicians continues to rise and is of concern. This trend toward employment of PCPs by the large health care delivery systems has turned out to be significant since the incentives and information on care patterns provided in the Program are often intercepted by the large systems and do not reach the PCPs they employ.

That is, the employed PCPs of these large systems are paid in accordance with the incentives given to them as part of their employment arrangement. Invariably, these large system incentives reward higher volumes of service, referrals to system-only specialists and no reimbursement for Care Coordination activities performed by the employed PCPs. This weakens and interferes with the behavioral change design at the heart of the Program – as well as weakens cost control and attention to the engagement and quality measures in the Program over the long term. This places the large system Panels in the PCMH Program at a disadvantage – at least as to the total cost of care for their Members on a risk adjusted basis. In a cost- conscious environment, this is a dangerous place to be.

**Five Focal Points for Panel Attention and Action**

There are five areas of emphasis that Panels are asked to focus on in improving the quality of care while lowering cost for Members in their care. These are shown in **Figure 8**, below.

**Figure 8: Five Focus Points For Panel Attention And Action For PCP Panels**

| Five Focus Areas | Weight |
|---|---|
| 1. Effectiveness of Referral Patterns | 35% |
| 2. Extent of Engagement in Care Coordination | 20% |
| 3. Effectiveness of Medication Management | 20% |
| 4. Consistency of Performance within the Panel | 15% |
| 5. Gaps in Care and Quality Deficits | 10% |

Panel performance in each of these areas is reported in the HealthCheck Scorecard maintained for each Panel every month and on a cumulative basis each Performance Year. This scorecard in available online 24/7 through the iCentric System and is included in the ongoing, more extensive online reporting available for each Panel through the PCMH SearchLight analytics capability in the iCentric System.

Searchlight Reports contain hundreds of different views of each Panel's demographic, diagnostic, clinical, Care Coordination and cost patterns. These reports are available online 24/7 to each and every Panel PCP with a few clicks of the mouse as is comparative information which tells each Panel how it compares to its own historic patterns as well as to other Panels. The views are updated monthly.

The HealthCheck Scorecard draws from these extensive underlying views and brings forward to the attention of each Panel's PCPs, the most relevant of these so that they can be acted upon. HealthCheck is, in effect, the equivalent of a periodic checkup on how each Panel is doing in improving quality and lowering cost growth for its Members.

Each of the five HealthCheck areas of emphasis has its own relative impact on overall results that is reflected in the weightings given to each area in constructing the aggregate score achieved by each Panel.

**The Five Areas of Emphasis are:**

1. **Effectiveness of Referral Patterns (35 percent weight) -** Each specialist and specialty group in the larger CareFirst network is ranked on cost based on the pattern of episodes of care they treat. Using the average cost of each episode in the network as a benchmark, each specialist and specialty group is placed in one of four cost categories: High, Mid-High, Mid-Low or Low. Each Panel, in turn, is shown the degree to which they use High, Mid-High, Mid-Low or Low-cost specialists. Panels are free to refer anywhere they wish, but to maximize their overall performance it is important to maximize use of the most cost-effective specialists.

2. **Extent of Engagement with Care Coordination (20 percent weight) -** The establishment of Care Plans by PCPs for the multi-chronic Member is intended to reduce hospital admissions and readmissions (and ER use) and to overcome fragmentation in the health care system that is essential to improving outcomes for these Members. Breakdowns in the health status of Members are common due to the lack of coordination of services for the multi-chronic Member. This area of emphasis within the HealthCheck Scorecard measures the degree to which each Panel and each PCP in the Panel is engaged in providing Care Coordination services to Members who could benefit from Care Plans.

3. **Effectiveness of Medication Management (20 percent weight) -** Pharmacy costs exceed 30 percent of all medical costs in the average Panel. Members with multiple chronic conditions or acute illness can often be on 10 to 20 (or more) prescriptions. A comprehensive review of these pharmacy "cocktails" often yields changes that greatly benefit the Member, improve chances for adherence and save considerable amounts of unnecessary spending. Panels that actively pursue and act on such reviews generally improve their chances for better Panel results and improvement in care outcomes for their Members.

4. **Consistency of Performance within the Panel (15 percent weight)** - As Panels mature in their understanding of the PCMH/TCCI Programs and learn how to produce better results for their Members and themselves, a more uniform pattern of engagement among the Panel PCPs emerges. This is accelerated by peer pressure within the Panel itself, which brings less involved/committed PCPs within the Panel along farther and faster than would otherwise have been the case. This focal area is intended to get the Panel to work effectively together as a team in its population health/Care Coordination and cost control efforts by showing which PCPs are contributing to effective results and those that are not.

5. **Reducing Gaps in Care and Quality Deficits (10 percent weight) -** The reduction of gaps in care for the chronic Member is the object of this focal area. Every month, each Panel is shown which of its Members have gaps in care that, if not addressed, could lead to costly breakdowns later on. The score in this area reflects how each Panel is doing in closing these gaps.

**CMMI Innovation Pilot to Integrate Medicare Fee-For-Service (FFS) Enrollment was a Success**

In 2012, CareFirst was awarded a three-year, $20 million Health Care Innovation Award ("Innovation Award" or "Award") by the Centers for Medicare and Medicaid Innovation ("CMMI"). This was the largest grant to a payer in the country and the third largest overall. The Award was to pilot the application of CareFirst's TCCI and PCMH Program to Medicare Fee-For-Service ("FFS") beneficiaries in Maryland. This "Common Model", as it became referred to, offered identical incentives, data/analytic supports, rules, and quality standards for both Medicare beneficiaries and CareFirst Members.

The Common Model Pilot involved 140 PCPs in 14 Panels of PCPs with 60,000 attributed CareFirst Members and over 40,000 attributed Medicare Primary FFS beneficiaries. These Panels were selected to be representative (in structure and geography) of the larger PCMH Program CareFirst operates in its service area involving over 4,300 PCPs in over 440 Panels. The Common Model Pilot began to serve Medicare beneficiaries in July 2013 and concluded on December 31, 2016 – a time span of three and a half years. For the entire period of the Common Model Pilot, Panels assumed responsibility for total cost and quality outcomes for their attributed Medicare FFS and CareFirst Member populations.

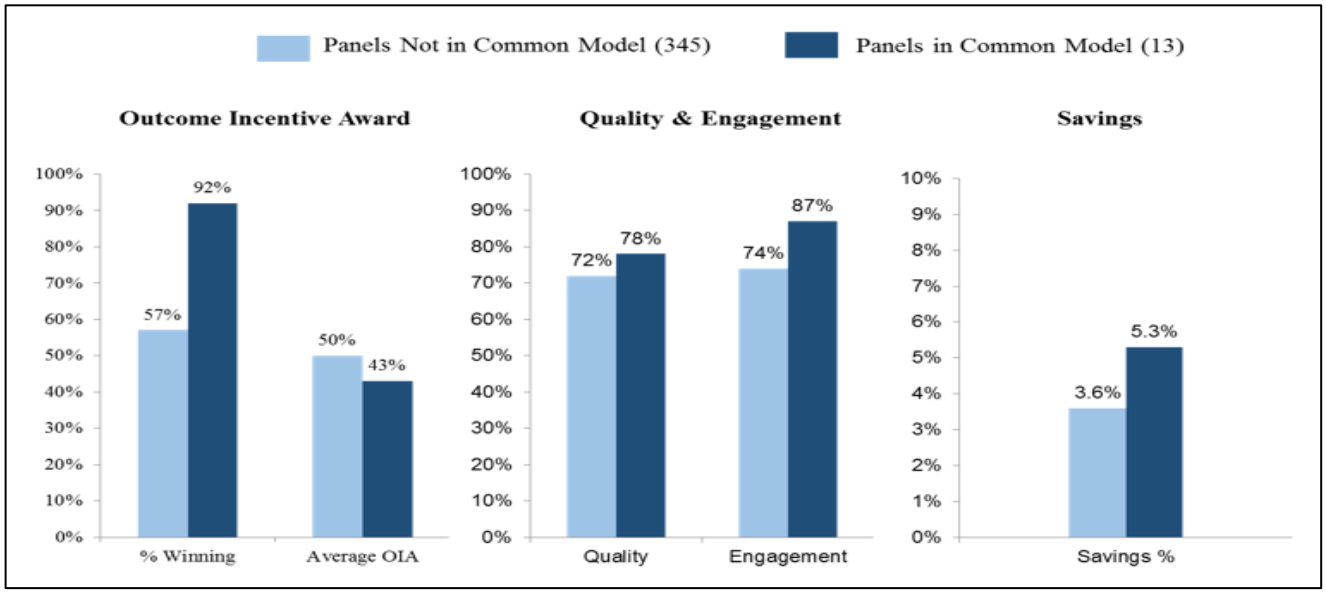
Within the CareFirst service area, combined CareFirst membership and total Medicare FFS beneficiaries account for approximately half the population and half the region's total health care spending. With this much economic purchasing power, it was theorized that the 14 participating Panels in the Common Model Pilot – who constituted a representative microcosm of the larger system - would be able to have great impact in the way they exercise their referral decision making and Care Coordination activities. And, it was thought that the commonality of all other features of the Program would reinforce Panel PCPs' understanding and attention to the action categories in HealthCheck necessary to make the most of the TCCI Program Array to maximize achievement of OIAs.

In this connection, it is useful to keep in perspective that a Panel with 2,500 CareFirst Members and 2,000 Medicare beneficiaries has an annual target budget for the two payers combined of over $50 million. Shared savings on a budget of this size could be a powerful motivator. In the Common Model with the same rules, data, infrastructure, supports and incentives, we have seen that learning based on experience with CareFirst Members can quickly and effectively be applied to the greater needs of Medicare beneficiaries who more frequently suffer from multiple chronic diseases and conditions.

The Common Model Pilot ended on December 31, 2015 with remarkable results. Engagement of the PCP is the single most essential element in obtaining the outcomes desired from the Common Model and is the driving force of the Program. Engagement of the PCPs in each Panel leads to knowledge, not only of the Program but of each Panel's Member population – especially when data on episodes and patterns of care is displayed in the same way for both Medicare and CareFirst populations. Panels participating in the Award achieved significantly high levels of engagement.

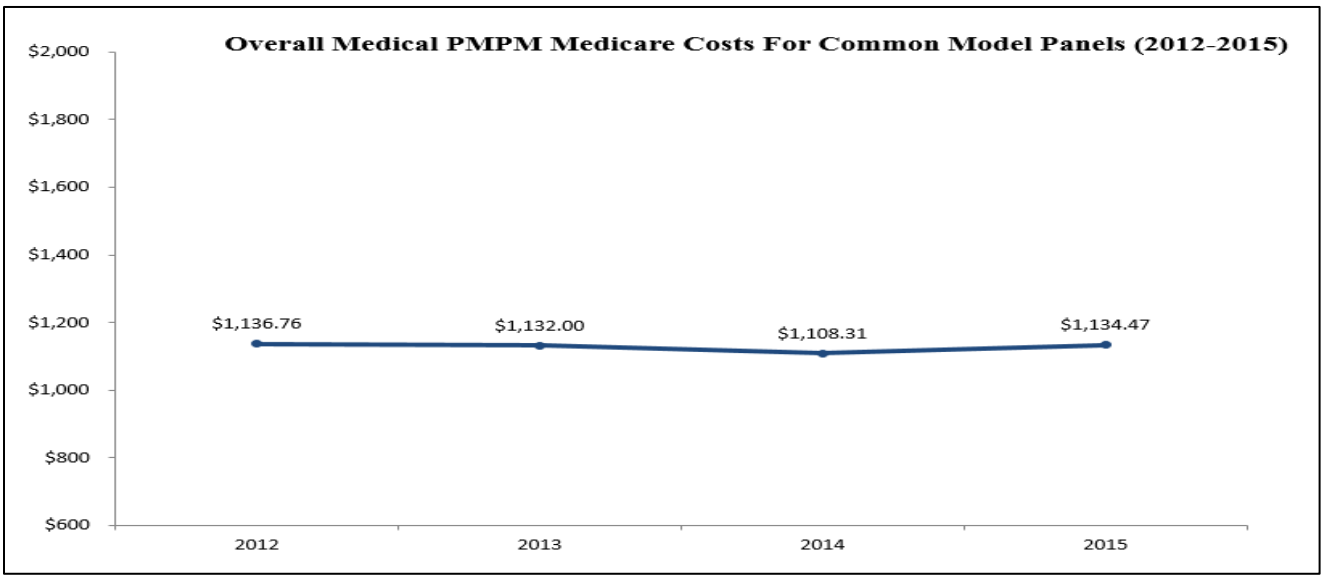
Engagement Scores at the end of the Award of the 13 remaining Panels show a striking picture when compared to the 345 viable Panels not participating in the Award show a striking picture as is shown in **Figure 9.** This supports the theory that such a common approach between the region's largest private payer and the region's largest public payer would drive a more powerful transformation of the health care delivery system since a far larger portion of Members and health care spending would be impacted and subjected to the incentives and accountability structure built into the PCMH/TCCI Programs.

**Figure 9: Common Model Impact On Commercial Success, 2016**




This robust level of engagement helped move utilization and cost trends in the desired direction. The Common Model showed credible evidence of cost savings. When analyzing the Medicare claims data received from CMS during the entire length of the Award (with three months claims run out), the data show Overall Medical PBPM costs remained essentially flat from the Program's 2012 base-year through the end of 2016. This can be seen in **Figure 10**. This trend is remarkable when considering that these costs include the costs of Care Coordination and ancillary benefits currently not covered by the Medicare FFS Program.

**Figure 10: Part A & B Costs Per Beneficiary Remained Flat Over The Course Of The Award[3]**




[3] *Trend is for CareFirst's In-Service Area Book of Business and excludes the Individual Market Segment Source: HealthCare Analytics – Includes data through May 2016, paid thru August 2016. CareFirst Book of Business, excluding Medicare Primary, Catastrophic and TPA members.*

Other utilization metrics also improved. The number of hospital admissions per 1,000 beneficiaries, which continuously increased prior to the launch of the Program, declined by over 17 percent since the Common Model was implemented and ER visits also saw a slight decline as illustrated in **Figure 11.** These are distinctively better than patterns in the non-Common Model population during this period and are noteworthy in a pilot population that averaged 76 years old.

**Figure 11: Common Model Beneficiary Hospital Utilization**

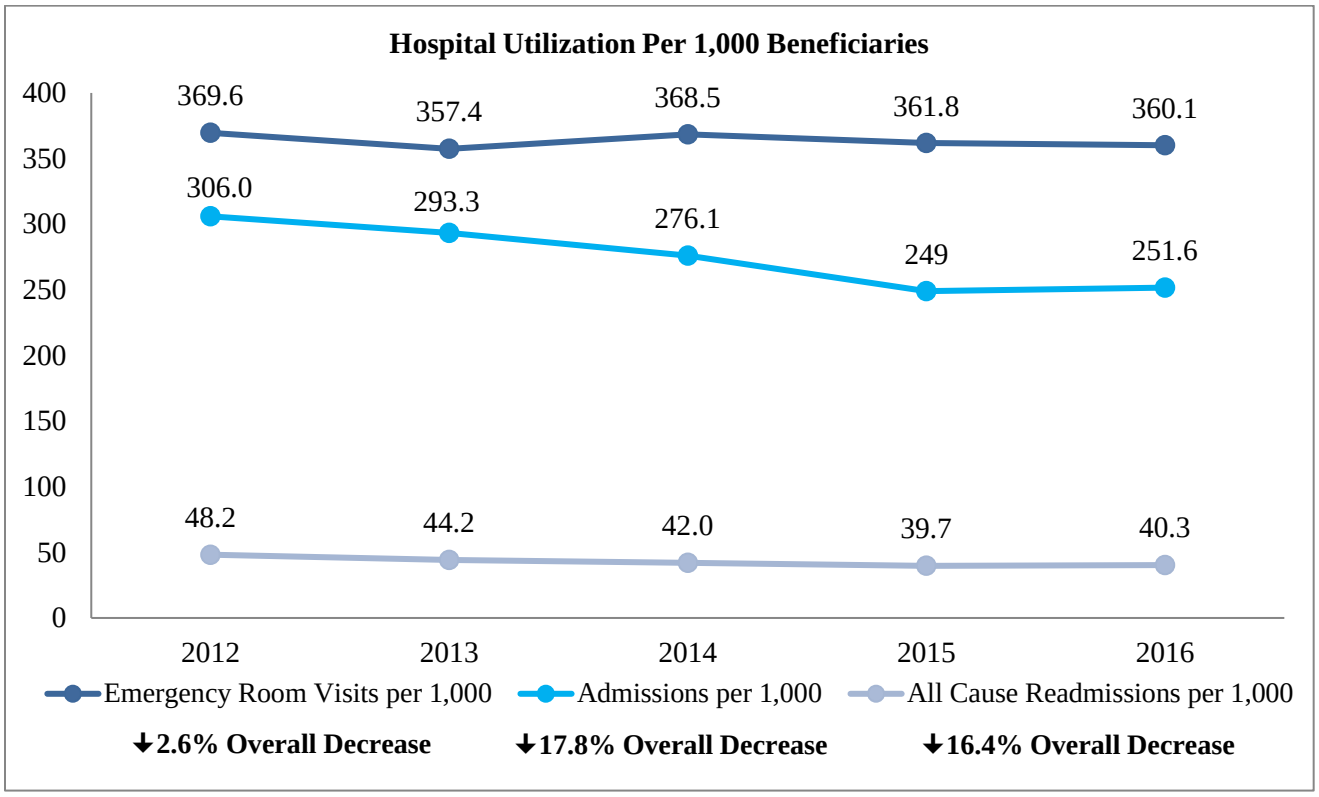
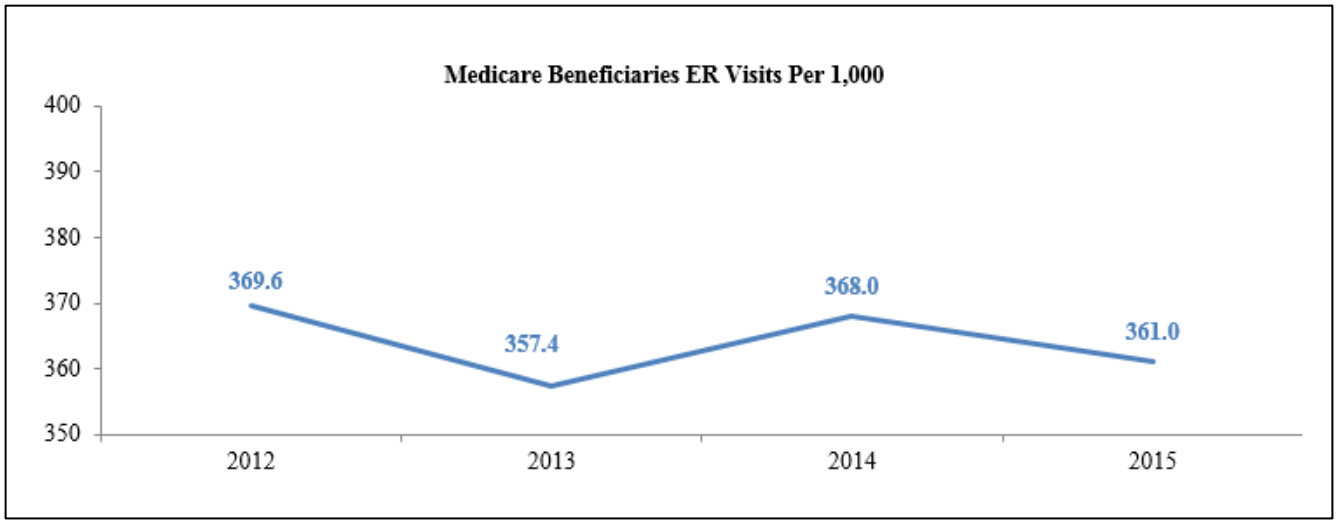



**Figure 12: Total Emergency Room (ER) Visits Per 1,000 Beneficiaries**



The full, final report of the results of the CMMI Common Model Pilot is included in **Part IV** of these CareFirst Program Description & Guidelines.

**Bending the Cost Curve**

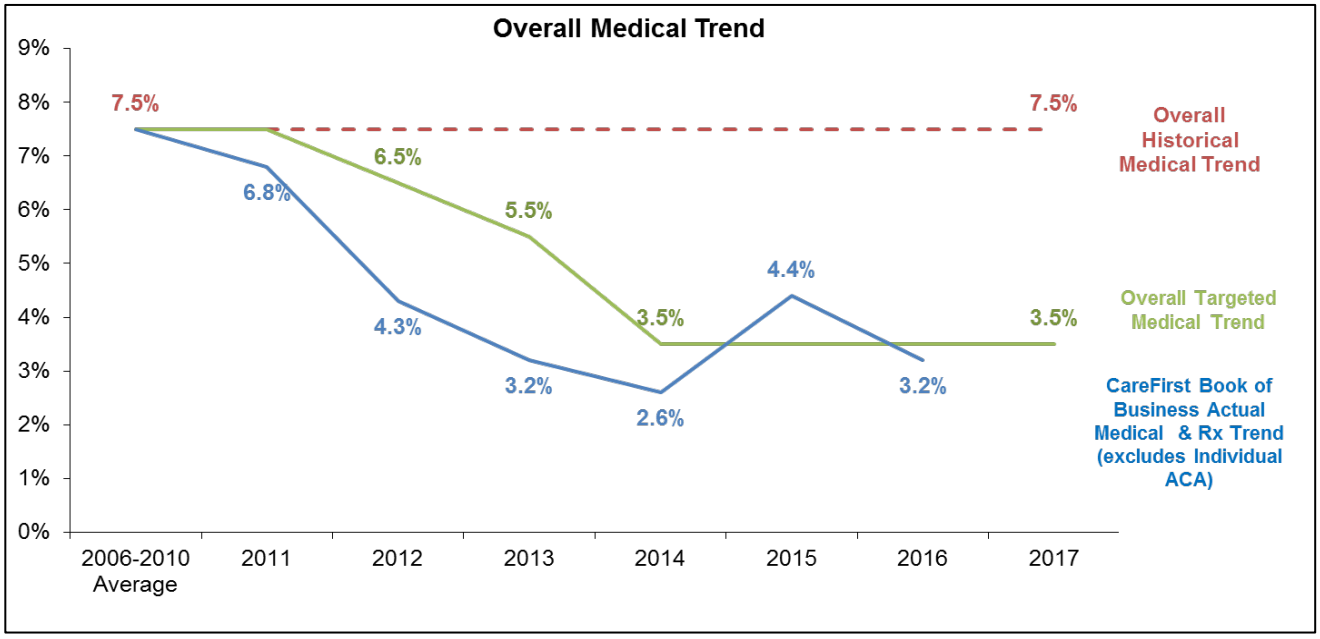
Prior to the advent of the PCMH Program, overall medical trends ("OMTs") in the CareFirst service area showed a rate of increase of total cost of care for CareFirst Members (on a PMPM basis) in the 7.5 percent range year-over-year. This rate of increase was largely driven by an ever-increasing volume of services – particularly for inpatient and outpatient hospital-based services. It seemed that the persistency of this year-over-year growth in costs was unstoppable.

Specifically, the rate of hospital admissions and re-admissions in the region has been among the highest – if not the highest – in the nation on an all-payer basis. The level of health care costs PMPM approximates $500 PMPM for many employers – a base that is not sustainable with a rate of escalation at historical levels.

Given this, the central purpose of the PCMH/TCCI Programs is to slow the rise in the OMT on a PMPM basis. This has, indeed, happened as is shown in **Figure 13**.

For the period 2011-2016, the rate of rise in OMT had slowed to the lowest level ever experienced by CareFirst. It is important to view OMT, after 2013, without the impact of the ACA Individual Market. The ACA brought a population of Members who are sicker and whose high costs distort the overall OMT results. As can be seen in **Figure 13**, the rate of increase has been considerably lower than was planned since the launch of the Program and continued through 2016.

**Figure 13: Targeted Medical Trend vs. Actual Medical Trend (CareFirst's Book Of Business)**




It would not be fair to claim that this dramatic slowing was caused solely by the PCMH/TCCI Programs – particularly since the larger national picture has also shown a dramatic slowing. Nor would it be fair to assume that these Programs had nothing to do with this slowing. While it is not possible to determine the exact causal relationships, the reinforcing picture presented in the categories of Program performance shown in **Figure 14**, suggests that the combined PCMH/TCCI Programs are having their intended affects.

**Sharp Improvement in Key Measures that Matter have Occurred and have been Sustained**

The fact that CareFirst in-area membership is split between Members who choose PCPs in the PCMH Program and those who choose primaries who are not program participants (as cited earlier) affords an interesting opportunity to observe the differences in the experience of these two populations on certain key measures ("Measures That Matter") such as inpatient admissions and readmissions as well as the nature and extent of hospital-based outpatient use.

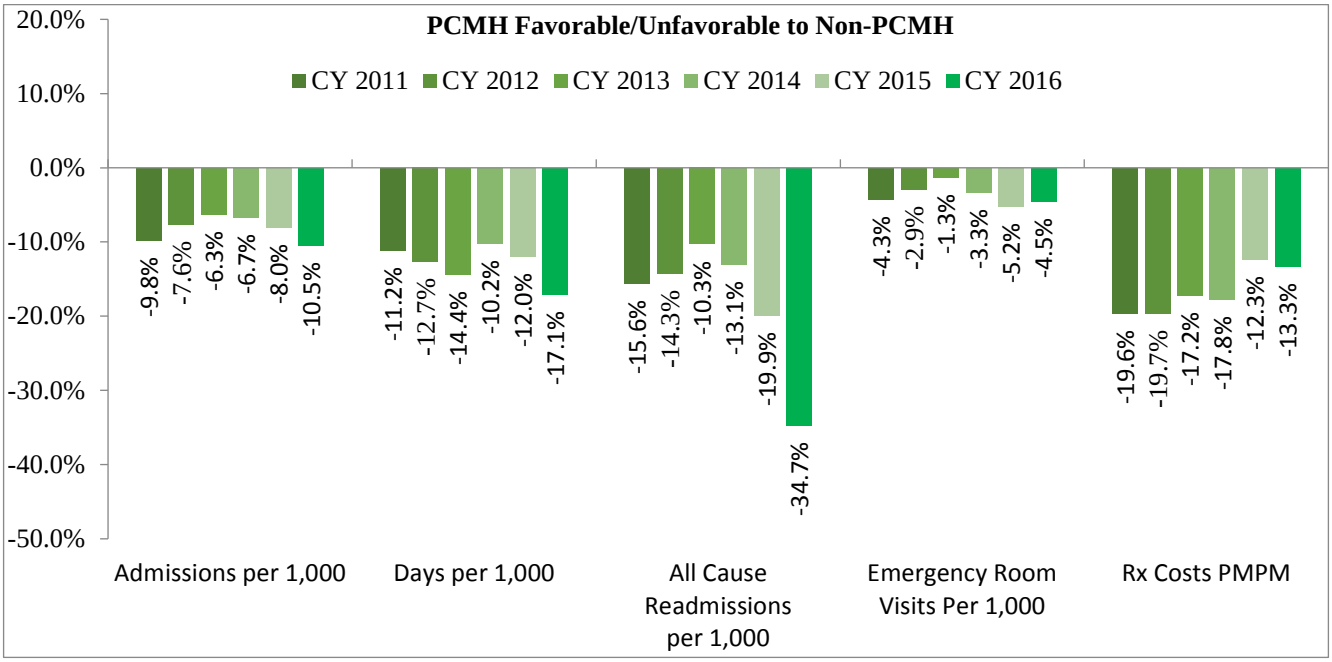
Of these, there are five "Measures that Matter" that have been the most impacted by the Program since the outset. These are listed below.

1. Admissions per 1,000
2. Days per 1,000
3. All Cause Readmissions per 1,000
4. Emergency Room ("ER") Visits per 1,000
5. Drug Costs Per Member Per Month ("PMPM")

Since the PCMH and non-PCMH populations are of substantial size, they are fully credible from an actuarial standpoint and they provide a solid basis for comparison on the key measures. This is further strengthened by the fact that both populations live in the same region, are covered by similar CareFirst benefit plan designs, use the same CareFirst provider networks and are served by the same CareFirst administrative capabilities.

As shown in **Figure 14**, there are marked differences in the way the two populations appear with regard to the key measures of use of health care services.

**Figure 14: Measures That Matter[4]**




[4] *Source: CareFirst HealthCare Analytics - Attributed PCMH Primary Care Provider (PCP) population compared to attributed non-PCMH Primary Care Provider (PCP) population. Includes data through December 2016, paid through April 2017. Exclusions: Medicare Primary, Catastrophic and TPA.*

It is noteworthy that the pattern of use reflected in these measures has generally held up over time and has had significant impact on the utilization measures of CareFirst's entire book of business as can be seen in **Figures 15 and 16** below**.** All measures reflect the results intended in the Program design and bode well for future results as the Program continues to mature.

**Figure 15: CareFirst Book Of Business Admission Measures**[5]

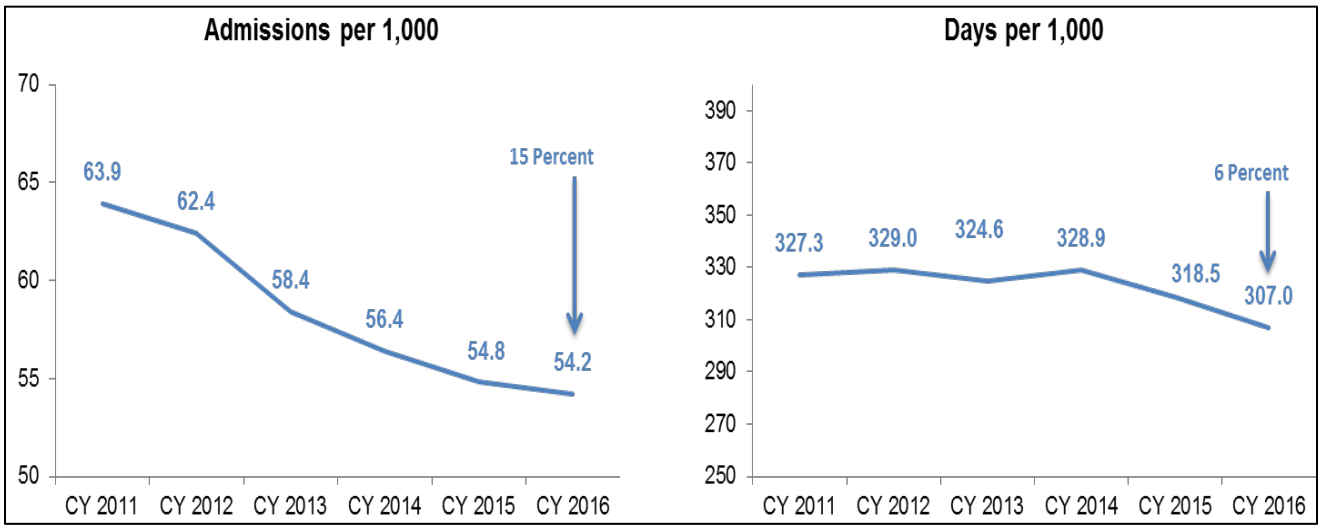
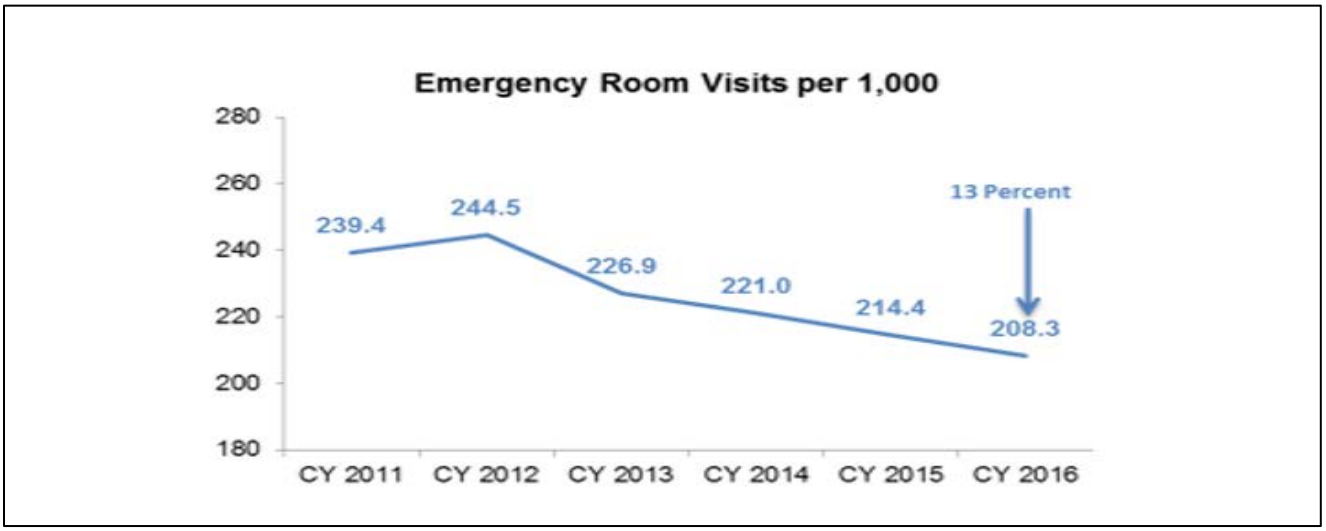



**Figure 16: CareFirst Book Of Business Emergency Room (ER) Visit Measures**[6]




[5] *Source: CareFirst HealthCare Analytics – In-Service Area Book of Business Claims Incurred December 2016, paid through April 2017*

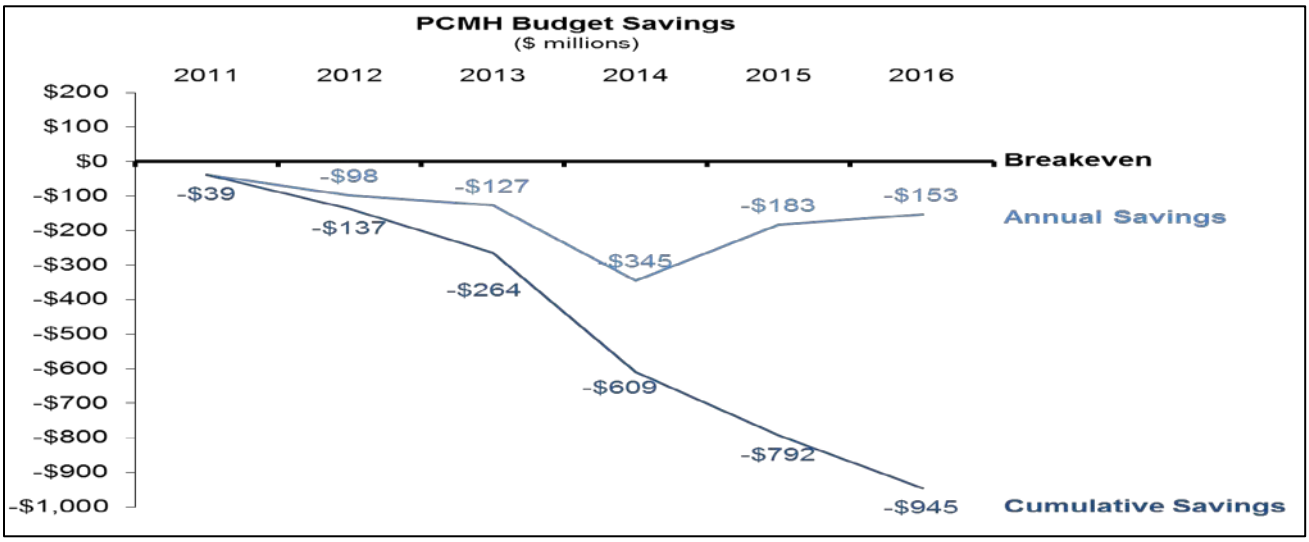
[6] *Source: CareFirst HealthCare Analytics – In-Service Area Book of Business Claims Incurred December 2016, paid through April 2017*

**Winning Panels Outperform Non-Winners by a Substantial Margin**

The PCMH Program provides strong incentives to Panels to earn OIAs on an annual basis. In essence, these awards share the savings that Panels achieve against their global budget targets and ratchet these awards up when savings are achieved with higher Quality Scores and with consistently strong results over multiple consecutive years.

In the Program's first **Performance Year #1 (2011)**, 60 percent of Panels won an OIA by beating their global budget targets by 4.2 percentage points while those Panels that did not produce savings were above target by four percent. This spread in performance - over eight percentage points - between the winning and non-winning Panels caused a net savings of $39 Million, larger than expected in the first year. This pattern continued in following years, producing a net savings for the Program, so far, of $945 Million, as show in in **Figure 17** below.

**Figure 17: PCMH Net Savings 2011-2016**




After the initial year of the Program, the percentage of Panels that won an OIA rose to a high of 68 percent in 2013 and was still at 60 percent in **Performance Year #6 (2016)** of the Program. The average OIAs in each year ranged from 25 percent in the first year to a high of 59 percent in **Performance Year #4 (2014)**.

It is noteworthy that since **Performance Year #4 (2014)**, the percent of Panels that received OIAs is materially lower than the percentage of Panels that produced savings. This is due to increased quality standards that caused a number of Panels to forfeit OIAs. In 2016, this pattern continued. However, the percentage of Panels who produced a savings but did not realize an OIA was at its lowest level, seven percent, since the increased performance standards in 2014.

The results for each Performance Year are shown in **Figure 18**.

**Figure 18: Outcome Incentive Award (OIA) Results By Performance Year**

| Performance Year | Percentage of Panels with Savings | Percentage of Panels Receiving OIA | Average Award | Net Savings % (all Panels)* |
|---|---|---|---|---|
| 2011 | 60% | 60% | 25% | 1.5% |
| 2012 | 67% | 66% | 33% | 2.7% |
| 2013 | 68% | 68% | 37% | 3.1% |
| 2014 | 84% | 48% | 59% | 7.6% |
| 2015 | 74% | 57% | 42% | 3.9% |
| 2016 | 67% | 60% | 49% | 3.0% |

These results have exceeded the expectations that existed at the outset of the Program by a substantial margin.

**Value-Based Incentives Drive Behavior-Change without Risk of Base Fees**

It is important to understand that these results have occurred in a model that does not share down-side risk with or penalize PCPs for underperforming on cost targets. CareFirst offers three different types of value-based payments to PCPs in the PCMH Program that are explicitly tied to value-based activities as well as global cost and quality outcomes. PCPs receive substantial value-based payments to encourage strong Care Coordination and substantial bonus payments for attaining better quality and total cost outcomes for the CareFirst members that are attributed to them.

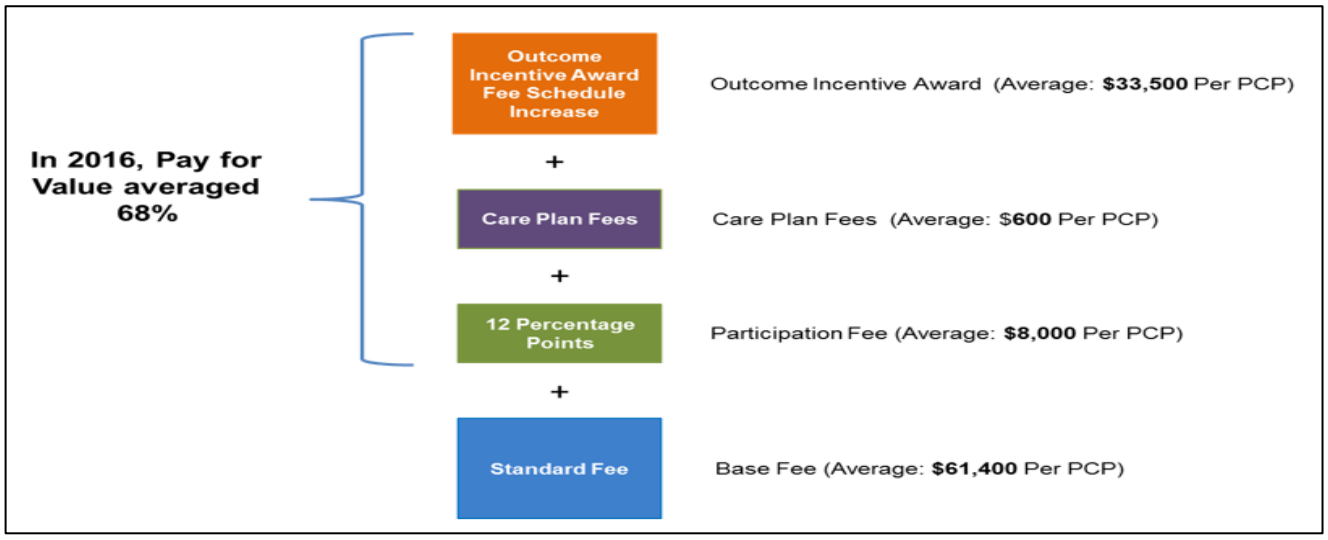
First, all PCPs are paid an ongoing Participation Fee equal to a 12-percentage point supplement to their professional fee schedule. The Participation Fee is tied to each Panel's continuing "engagement" and good standing in the PCMH Program. Beginning January 1, 2017 CareFirst will reduce or eliminate this fee for Panels that consistently fail to achieve minimum engagement scores. This refinement makes the participation fee an "at risk" payment that is tied to actual quality performance, but that does not burden primary care practices with potential loss of their base income due to insurance-type risk.

Second, PCPs are paid $200 to develop and $100 to maintain care plans (in addition to regular visit fees) in active oversight of registered nurses assigned to their practice through the PCMH Program. These amounts recognize the additional time involved in setting up and monitoring Member compliance with care plans. CareFirst arrived at this approach based on analysis from our early pilots with PCMH incentives.

Third, Panels may earn an OIA for achieving better than target overall cost and quality outcomes for the attributed population in each Panel. The OIA is analogous to a shared savings payment. This payment is critical to motivate PCPs to achieve improved results and undertake the additional workload of Care Coordination and practice transformation. In other words, Panels must produce demonstrable results that are consistent with Program objectives in order to achieve an OIA. As you can see in **Figure 19**, this third category of value-based payment is the most significant of the three value-based components in the Program.

The average PCP earns just over $60,000 in standard FFS claims payments from CareFirst. This base fee is never reduced for any PCP because of performance in the Program. And when combining the three value-based payments in the PCMH Program, the average additional payments approximated $42,000 in additional annual income, - or approximately 68 percent greater income than had the Program not existed.

**Figure 19: Average Value-Based Payments For Winning PCPs, 2016**




We reduce the Participation Fee if not engaged.

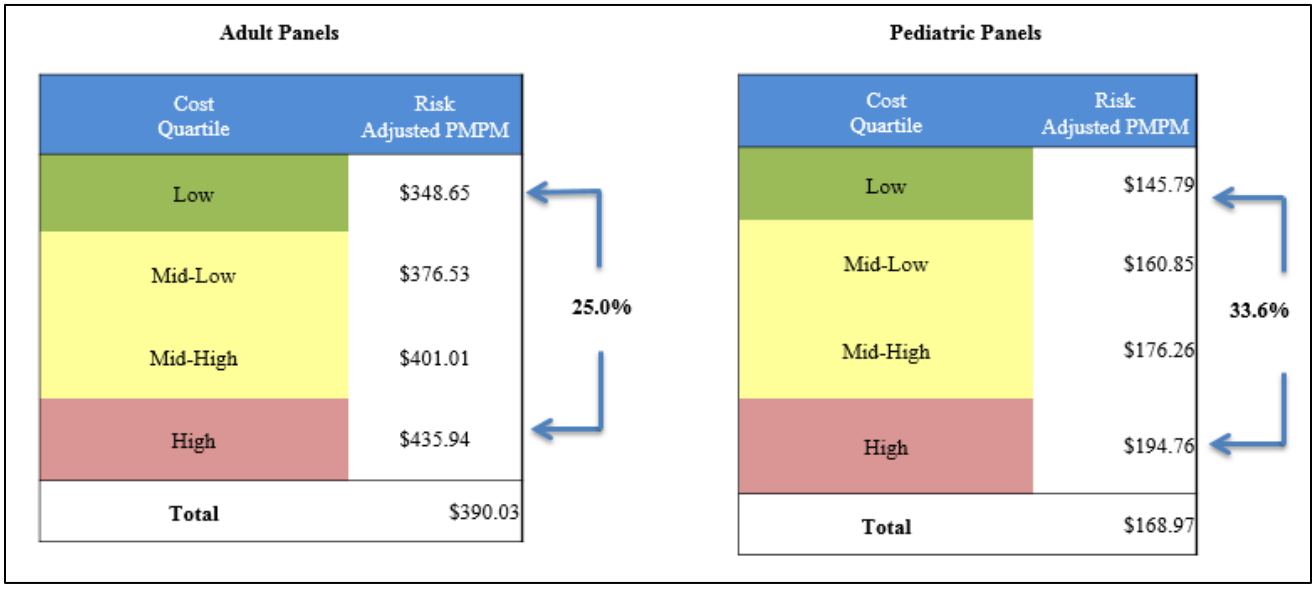
**Wide Differences in Results Across Panels Emerge**

With five years of experience now complete, patterns relating to the consistency of results can be seen. The Program has an abiding interest in finding top performing Panels of PCPs who have performed at high levels of efficiency and quality over an extended period of time. The Program considers a longitudinal, three-year record sufficient to make judgments about which Panels are doing better than others.

Accordingly, the experience of all Panels with at least three years of experience is gathered and compared to other Panels with similar duration of experience on a rolling three-year basis. Panels are ranked from lowest to highest cost PMPM on a risk adjusted (global PMPM) basis. Additionally, their Quality Scores over the three years are calculated and the rate of rise or decline in their aggregate care costs and Quality Scores is also determined.

This results in a ranking of Panels by quartiles – with the lowest cost/highest quality performers placed in the first quartile (High Performers) and the highest cost performers/lowest quality performers in the fourth quartile (Lowest Performers). The uniformity in program design and data definitions/measurement enables such comparisons to be validly made. This would not be possible if each Panel were doing its own version of Care Coordination and medical home program. These rankings are shown in **Figure 20**.

**Figure 20: Variation In Cost Among PCMH Panels[7]**
**2016 Results**




In looking at the reasons for better performance, it appears that the single most important factors are where Panels refer their Members for specialty care and whether they are part of large, integrated delivery systems. Large health systems Panels and large multi-panel practices heavily populate the high cost quartile while independent, community-based Panels generally perform better and heavily populate the low-cost quartiles. See **Figure 21**.

[7] *Source: CareFirst HealthCare Analytics – 2016 Data for Panels Participating in PCMH.*

**Figure 21: Variation In Cost Among PCMH Panel Types[8]**

| Cost Quartile | Health System Panels | Virtual Panels | Single Panel Independent | Multi-Panel Independent |
|---|---|---|---|---|
| Low | 13% | 39% | 27% | 12% |
| Mid-Low | 23% | 28% | 35% | 15% |
| Mid-High | 30% | 19% | 27% | 25% |
| High | 34% | 13% | 29% | 37% |
| **Total** | 100% | 100% | 100% | 100% |

It is noteworthy that the best performers in the top quartiles take on Members that are sicker based on their average Illness Burden Scores and maintain Quality Scores that are comparable to the Panels in the other quartiles who have higher PMPM care costs. That is, it does not appear that higher costs result in higher quality of care or that lower costs result in lower quality of care.

**Improvements in Engagement and Quality Scores have been Strong**

As the Program matures, Panels have become increasingly engaged in both the Care Coordination and practice transformation aspects of the Program. A key measure of Engagement is the PCPs participation in Care Coordination of Members with multiple chronic conditions. This involves identifying Members who would most benefit from Care Coordination, introducing the Program to Members, and working with the LCCs on coordination activities and Member follow-up.

There were more than 3,000 PCPs who had at least one Member in a Care Plan in 2016. This is nearly seven times the number of PCPs with a Member in a Care Plan in 2011 (approximately 390) and almost triple the number of PCPs with a Member in a Care Plan in 2012 (approximately 900). Of the PCPs who have had at least one Member in a Care Plan, 49 percent have had at least five Members and 29 percent have had 10 or more.

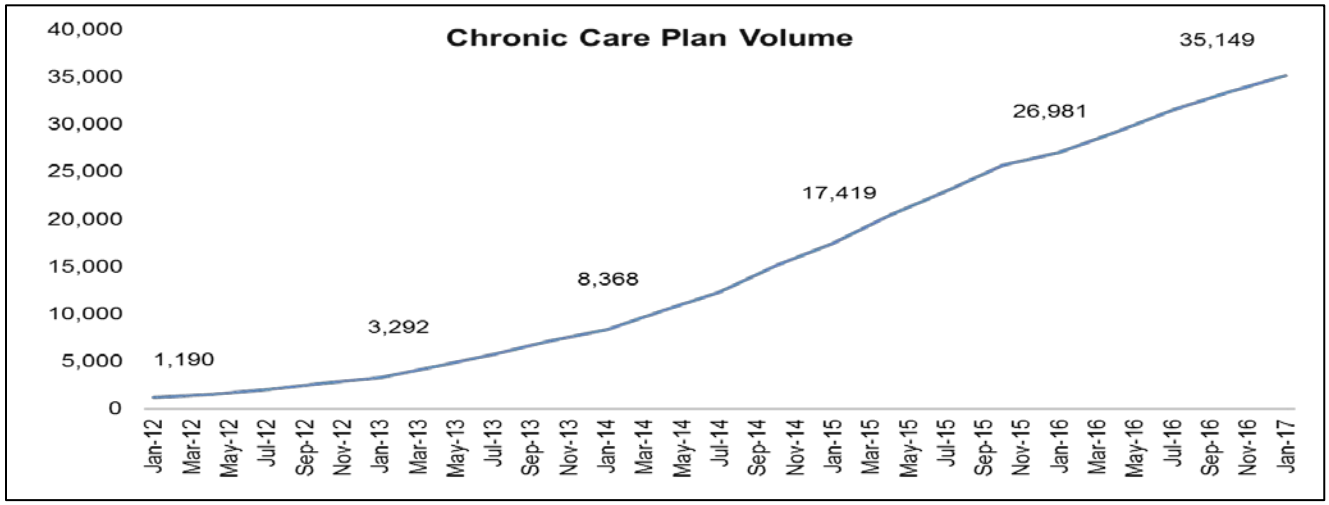
The standard for Panel achievement of a minimum Engagement Score has increased from an average of two Care Plans activated by 60 percent of Panel PCPs to an average of five Care Plans activated by 90 percent of Panel PCPs. With the growth in Care Plan volume, there has been a growth in the number of nurse Care Coordinators operating in the field. In 2017, there are 250 such nurses working with Panel PCPs.

Once a PCP has a Member in a Care Plan and establishes a relationship with a Care Coordinator, he or she has a better understanding of the support resources and data and analytic tools available to manage his or her population and is inclined to do more Care Plans. This seems to be the key to opening up understanding of the Program and to increased receptivity on the part of PCPs to the Program's incentive structure and goals.

The growth of Care Plans volume is shown in **Figure 22** on the next page.

[8] *Source: CareFirst HealthCare Analytics – 2016 Data for Panels Participating in PCMH.*

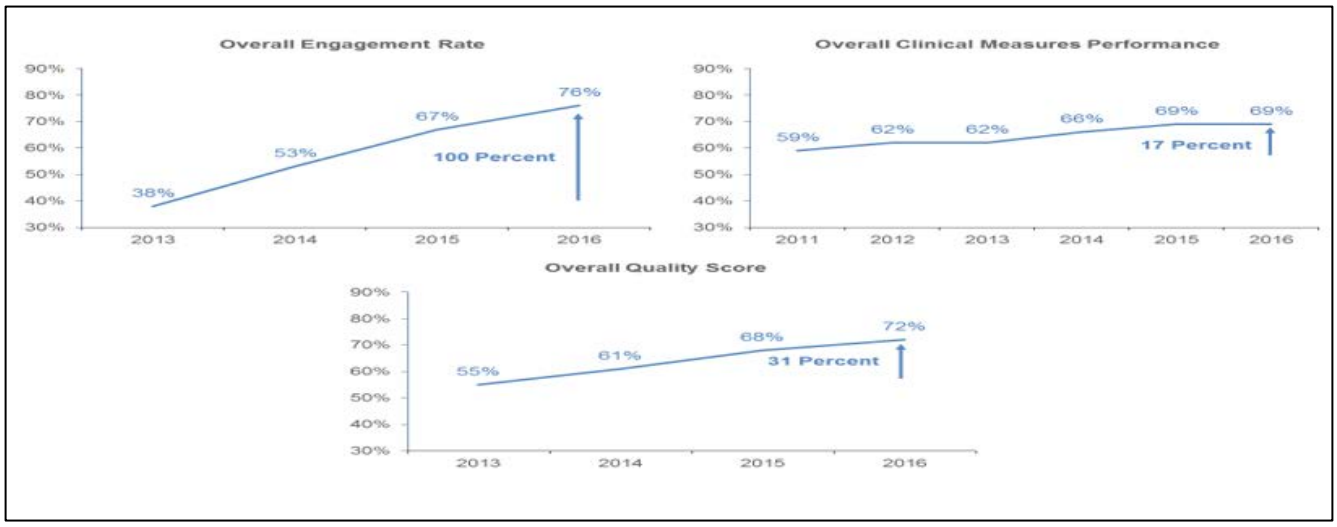
**Figure 22: Chronic Care Plan Volume By Month 2012-2017** [9]




The rise in Engagement among PCPs is evident not only in the Care Plan totals, but also in the consistent rise in Quality Scores among Panels. The Overall Quality Score is an equally weighted average based on the value of the Engagement and Clinical Quality. Over the last four years of the Program Panels have increased their overall Quality Scores by 31 percent. Much of this increase is due to a material increase in the Engagement levels of PCPs over time. Clinical measures have also risen but at a less dramatic rate, increasing 17 percent since the inception of the Program in 2011.

It is worth noting that Engagement was not scored in **Performance Year #1 (2011)** and only 25 percent of Panels received an Engagement Score in 2012. Therefore, these two Performance Years' Engagement scores cannot be equitably compared to the panel averages for later years. Beginning in 2013 all Panels were scored on Engagement and since then, Engagement Score rates across all Panels have continued to improve on average by 12.5 percent each year. **Figure 23** below displays this increase in quality over time.

**Figure 23: Average Quality Score Improvement Over Time**




[9] *Source: CareFirst HealthCare Analytics – Chronic Care Plan Volume by Month through February 1, 2017*

While CareFirst updates the clinical measures in the Score Card to maintain alignment with industry standards (i.e. Healthcare Effectiveness Data and Information Set ("HEDIS")), several clinical measures have persisted throughout, with Adult measures being consistently scored since the inception of PCMH in 2011 and the addition of many more Pediatric measures in 2013. Most of these are preventive measures: cancer screenings for adults and immunization and well-visits for children. See **Figure 24**. With one exception, Lower Back Pain, all clinical health-based measures have made material improvements since they were first rated in the PCMH Score Card. With this level of quality, CareFirst expects that the rise in quality scores will being to tapper and maintain current rates.

Not only did the average clinical quality improve year-over-year, but Members attributed to a PCMH PCP outperformed Non-PCMH Members on every clinical measure on the Scorecard. On average, PCMH Panels performed 13 percentage points higher than Non-PCMH Panels on the same measures. **Figure 24** below displays each measure and the score of both populations of Members.

**Figure 24: PCMH vs. Non-PCMH Clinical Quality**

| | PCMH Clinical Quality Score Card | Non-PCMH Quality Scores |
|---|---|---|
| ***Adult - Preventive Health Measures*** | **2016** | **2016** |
| Breast Cancer Screening | 76.20% | 59.28% |
| Cervical Cancer Screening | 73.60% | 63.49% |
| Colon Cancer Screening | 62.70% | 48.39% |
| ***Adult - Other Health Measures*** | | |
| Patients with Low Back Pain | 72.90% | 70.24% |
| Diabetes - HbA1c Screening | 87.00% | 81.28% |
| Diabetes - Retinal exam | 39.50% | 26.79% |
| Diabetes - Medical Attention for Nephropathy | 80.00% | 76.25% |
| ***Pediatric - Preventive Health Measures*** | | |
| *Childhood Immunizations / Well Visits* | | |
| Diphtheria, Tetanus, and Pertussis Vaccine (DTaP) | 74.00% | 53.32% |
| Inactivated Poliovirus Vaccine (IPV) | 80.70% | 59.01% |
| Measles, Mumps, & Rubella Vaccine (MMR) | 93.20% | 77.58% |
| Haemophilus Influenzae Type B Vaccine (HiB) | 84.10% | 63.63% |
| Hepatitis B Vaccine (Hep B) | 24.70% | 23.56% |
| Varicella-Zoster-Virus Vaccine (VZV) | 92.60% | 76.42% |
| Pneumococcal Conjugate Vaccine (PCV) | 74.60% | 53.36% |
| Hepatitis A Vaccine (HepA) | 90.00% | 72.99% |
| Rotavirus Vaccine (RV) | 74.00% | 51.03% |
| Influenza Vaccine (Influenza) | 60.10% | 48.68% |
| Well-Child Exams Ages 0-15 Months | 76.20% | 39.60% |
| *Adolescent Immunizations / Well Visits* | | |
| Meningococcal | 83.40% | 56.35% |
| Diphtheria and Tetanus Toxoids (Tdap/Td) | 85.50% | 62.09% |
| Human Papillomavirus Vaccine (HPV) for Females | 17.40% | 10.25% |
| Well-Child Exams Ages 3-6 Years | 82.20% | 41.72% |
| ***Pediatric - Other Health Measures*** | | |
| Children with Viral Upper Respiratory Infections | 92.60% | 86.17% |
| Children with Pharyngitis | 94.30% | 83.81% |
| **Total Average** | **73.81%** | **57.72%** |

Each year CareFirst audits hundreds of cases of Members in active or recently closed Care Plans. In so doing, CareFirst reviews and analyzes detailed clinical outcomes from claims, the Member's Health Record, Care Plan and Care Coordinator progress notes to determine clinical outcomes of the PCMH and TCCI interventions. These findings have been encouraging.

For example, in 2016, the audit looked for improvement of A1c in Care Plan Members with diabetes. Testing A1c gives a picture of a Member's average blood glucose control for the past two to three months. Even a slight decline has a material impact on the health of a Member. Just a one percentage point decrease in A1c produces a 40-45 percent decreased risk of cardiovascular death and risk of microvascular complications such as kidney diseases, eye diseases, and neuropathies. Members in Care Plans experienced an average decrease in A1c of 3.6 percent upon completion of a Care Plan. Similarly, the audit found that Members with obesity as a condition decreased their Body Mass Index ("BMI") by 6.8 points.

## Future Program Direction

In the Program's seventh Performance Year, the direction from here is to:

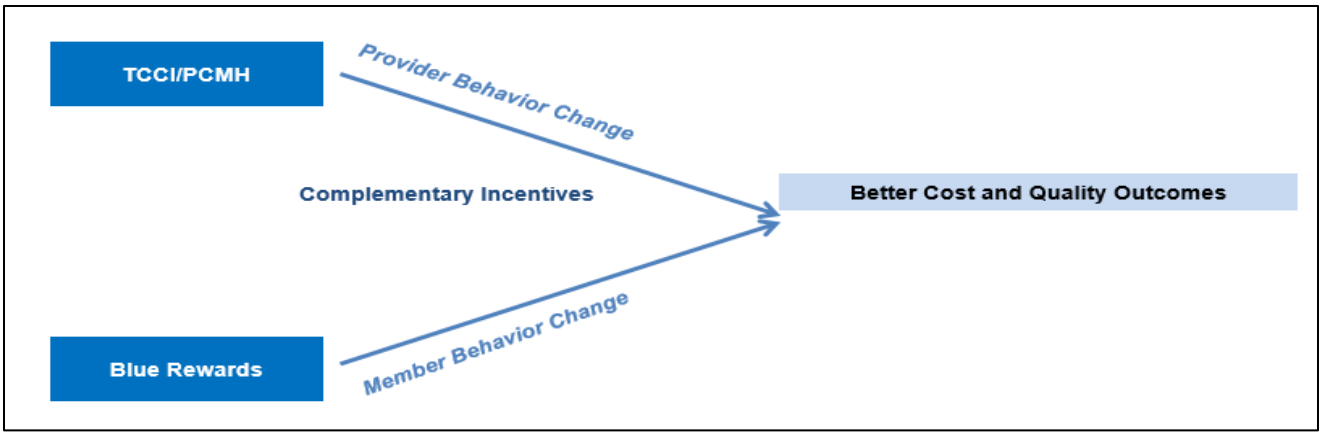
- continue to strengthen and scale up the supports provided in the TCCI Program Array;
- deepen understanding among PCPs regarding how the incentives in the Program work in the context of global budgets and performance targets;
- encourage Panels to focus on the five key categories of action in the HealthCheck Scorecard (especially referrals and intra-Panel consistency of performance among PCPs); and
- strengthen the intra- and inter-Panel comparisons that spur competition among providers in the Program toward higher levels of performance as teams, which become higher performance units.

In the end, the model at the core of the PCMH Program is a free market, competitive model in which PCPs pursue self-interest by serving their Member's interest more effectively. The goal is to reward those who intervene in the health risks of their Members early, coordinate care of the multi-chronic Member with attentiveness and most of all, "buy" or "arrange" expensive specialty services with great attention to cost and quality outcomes (in which the PCP has a stake as well as the Member).

**Benefit Designs that Assist Higher Quality and Cost Control**

The PCMH Program is designed to work in concert with CareFirst products that align Member incentives. While the CareFirst PCMH Program rewards PCPs for ensuring low-cost, high-quality care delivery, CareFirst products reward Members for taking control of their health and being careful how they access health care services. Incentives woven into CareFirst health benefit plans encourage Members to strive to achieve the same goals that the PCMH Program rewards providers to meet.

**Figure 25: Aligning Provider And Member Incentives To Shape Behavior Change**




Through the Blue Rewards Program benefit plan coverage and cost-sharing changes, CareFirst has introduced benefit designs that encourage Member selection of high-performing PCPs, awareness of health status/roles, achievement of improved health outcomes and increased consideration when selecting to the most cost-effective setting of care. These benefit designs are pervasive among all premium-based individual and small group plans as well as with large group self-insured designs – whether these are HMO or PPO in nature.

Additionally, CareFirst's benefit plans include the ability to waive cost-sharing requirements when a Member is placed in a Care Plan under the direction of their PCP. This is based on the observation that even minor cost sharing amounts discourage compliance with a Care Plan or in gaining the Member's consent to enter into a Care Plan in the first place. The waiver of cost sharing is, however, conditioned on the Member's continuing compliance with the elements of the plan. This aligns the interests of all involved – PCP, Member and nurse coordinator.

The PCMH Program helps PCPs steer Members away from expensive hospital-based services, unless they cannot be provided effectively in a non-hospital setting. To support this effort, Blue Rewards and other CareFirst benefit design reflect differential cost-sharing to encourage Members to access care in the most appropriate and cost-effective setting. As illustrated in **Figure 26**, Members who access care in higher cost settings may be subject to higher out-of-pocket costs, (e.g., deductible and/or higher co-pay).

**Figure 26: Members Are Induced To Seek Most Efficient Care Settings[10]**

| Service | Freestanding | Hospital Setting |
|---|---|---|
| Labs | $15 co-pay | Deductible, then $30 co-pay |
| X-rays | $30 co-pay | Deductible, then $60 co-pay |
| Imaging | $200 co-pay | Deductible, then $400 co-pay |
| Urgent/Emergency Care | $50 co-pay | Deductible, then $250 co-pay |
| Outpatient Surgery | $200 co-pay | Deductible, then $300 co-pay |

Additional incentives include waiving some of the deductible when a Member takes an annual health assessment and consents to share the results with the Member's PCP. The Program also rewards a Member for reducing their known risk factors – usually through diet, exercise and smoking cessation. These rewards typically take the form of a reduction in the Member's cost share (through a credit) against their deductible or as a credit on a medical expense debit card.

Perhaps the most significant of all is an incentive for a Member to pick a PCP within a high-performing Panel as part of the PCMH Plus Program. Special additional rewards – in the form of a credit against a deductible or a credit on a medical expense debit card – are offered to Members who select top performing PCPs in Panels with strong, proven performance over a three-year period as described above (i.e., top tercile or top two terciles). These PCPs constitute a select PCMH network in the CareFirst provider directory to ease Member choice. The PCMH Plus incentives are not available for Maryland risk coverage plans in the individual and small group markets due to constraints in Maryland law, but are available for all coverage plans in the District of Columbia and Virginia as well as all self-insured groups everywhere in the CareFirst Service Region.

The desire of Members to select such top performing PCPs is high due to the considerably greater cost sharing (in the form of higher deductibles and out-of-pocket expense) built into ACA benefit plan designs – particularly on the Silver and Bronze levels.

Encouraging Members to choose PCPs in top performing Panels who, in turn, direct specialty care referrals to their own selected specialists (and hospitals) is a key goal of benefit designs. It appears – based on the first six months of 2016, that these designs increase the market share of high performing Panels and the specialists while re-directing referral traffic away from other specialists and hospitals.

In these ways, the Program uses market forces to reward strong performers and place pressure on lower overall value performers to improve. In the long term, Panels that receive substantial supplemental/earned income based on their performance should be in the best place to recruit and retain new PCPs in order to sustain and grow their enrollment and revenue.

[10] *Examples of cost-sharing in BlueChoice Advantage Gold 1000, 2016*

## Summary Of Key Insights To Date

Five years of experience provides a practical perspective on the elements of greatest importance in the CareFirst PCMH Program and the TCCI Programs. Five design features, thought to be important at the outset, have proven to be every bit as critical as originally believed. These are:

### PCP Scope of PCP Accountability Needs to be Global

It has turned out to be essential that PCPs in Panels are accountable for all care outcomes and all costs for all the Members in their Panel. Only six percent of all the care costs that CareFirst pays for its membership are for primary care services while all other costs are driven by specialists, hospitals or ancillary providers (including pharmacy). Yet, having a direct economic interest in the downstream implications of their own referral decisions and in unplanned care by Members creates a focus and attentiveness in PCPs to the whole care experience of Members that is essential to cost control and quality outcomes alike.

### Nature of Incentives Have to be Tied to Population Health Outcomes at a Panel Level

Population health management, when coupled with a Member-centric approach, requires a strong PCP interest in the ultimate outcome for an individual as well as for the whole population of Members in a Panel. Therefore, reward under the Program comes when the sum of individual results contributes to improved outcomes for the whole membership of a Panel in a way that can be seen and measured as well as compared across all Panels in a consistent way. This is the essential goal of the "population health" approach that is at the heart of the Program.

OIAs in the CareFirst PCMH Program are just what their name implies – rewards for better outcomes on both quality and cost effectiveness for the whole membership of each Panel. These awards are always at the Panel level and mirror the scope of accountability of PCPs. And, for each Panel, the OIAs are not dependent on the whole Program's results – but, instead, determined Panel by Panel where no Panel's award is dependent on what other Panels do or on how the whole Program performs. It is each Panel's results that dictate awards.

This greatly focuses PCP attention on what each Panel, itself, has to do. So, if one or more Panel PCPs in the Panel are not performing, it becomes a matter of great interest to the other Panel Members who can – and do - place peer pressure on the poorer performers in close quarters (given the small size of Panels).

### Consistency in Incentive Design is Essential

It takes considerable time and experience to win over skeptical PCPs who have become deeply convinced that payers undervalue their service and underpay them. It is critical that they come to believe that changes in their income based on value-based payment tied to better outcomes will actually be fairly measured and rewarded. A Program with changing rules, moving goal posts, changes in measurement processes or too many requirements undermines trust and, with it, the will it takes to change established ways of practicing.

One other point here: Incentives are essential, not large risk shifts and penalties. Placing global insurance risk on a PCP who is not able to bear that risk is not fair and undermines the whole purpose of incentives, creating distrust and behavior that undermines the purpose of the Program – to serve Members more effectively. It certainly appears, based on six years of experience, that incentives, and the risk of losing them, are a sufficient motivator when constructed soundly.

### Self-Chosen Teams with Wide Specialty Physician Choices are Critical to PCP Acceptance of Accountability

We have learned that it is critical that PCPs be able to pick their own Panel teams and change the membership of these teams if need be. While there has been modest change in Panel composition during the first five years, we expect more "tuning" to occur in teams as maturity in experience and understanding deepens.

An equally important point is that Panel "teams" are just now beginning to extend their focus to preferred specialists underscoring how difficult it is to make substantial, sustained changes in health care delivery modes. These changes in referral patterns will be strongly encouraged and watched closely as the Program continues to mature.

**Data Must Be a Click Away**

As in so many fields, the importance of understanding patterns cannot be overstated. Without comprehensive views of patterns matched with the ability to drill down into the details behind them (to the Member and service level), there seems to be inattentiveness on the part of primaries to feedback. The more available, the more complete and the more drillable the data, the more it is used in decision making by PCPs. This is essentially what SearchLight and HealthCheck analytics capabilities provide to Panels.

## Conclusion

With all of this said, the overwhelming impression after six years of experience with the TCCI/PCMH Programs, on a large scale, is that making progress toward better outcomes is hard to achieve, but possible, even if it seems slow. Changing the perspective and context for PCPs – away from the treadmill of visit-based reimbursement to Member-centric population management - is also very hard to do, but possible. But, FFS cannot – and should not – be removed as a basis of payment. It should be held in check.

Getting PCP "buy in" to all the elements of the PCMH Program and TCCI Program Array requires persistence and a credible partnership between payer and provider after years during which this was not present. This means scrupulous attention to detail, to honest, respectful relationships and to follow through on support and making good on OIA's actually earned.

The challenge, therefore, is not in the doing of one or two things better or differently, but, rather, in the doing of dozens of things differently and consistently as part of a coherent whole. This is at the heart of the purposeful, integrated design of the PCMH and TCCI Programs and the Member benefit plan designs that dovetail with them.

Several remaining elements of the infrastructure to support the PCMH/TCCI Programs are still being put in place even though an enormous amount has already been constructed. As of January 1, 2017, there were approximately 75 HTC nurses stationed in area hospitals, another 85 case management nurses and yet another 250 nurses in local communities working with Panels and their Members every day. This latter number is expected to increase in the coming years. There were also 25 data experts – Practice Consultants – working full time with Panels to help them see and react to the patterns that are most telling. This number, too, is expected to increase. And, the Program is expected to engage Members in over 900,000 interventions 2017 that are needed for their health and wellbeing.

Gradually, Panels learn the Program, how the incentives work and how to effectively work with nurses assigned to them. They learn how to do a Care Plan and how to interpret and use the data. They learn to trust Program rules and the staff that carries them out.

Were it not for the blend of global capitation and FFS features of the model, there would be little usable data and little in the way of disciplined, comparative information. This is very likely one of the most critical learnings. FFS payment not only preserves and builds a comprehensive data base, it easily accommodates the ever changing and the complex patterns of service to Members. The challenge is not to replace FFS, but to check its volume inducing tendency through global capitation-like features.

In the end, quality – particularly for the multi-chronic, resource intensive Member– is best achieved by an attentive PCP able to see data well outside their own practice who is supported by a nurse led team able to function across all care settings in constructing and following up on a Care Plan. To make this happen requires a great deal more than incentives to the PCP. All of the programs that make up the TCCI Program Array are operated and arranged by CareFirst with this end in mind, as is the administration of all data and incentives in the PCHM Program. There is no charge to Panels for these supports.

When taken together in a unified Program structure – as is described in great detail in the Program Description and Guidelines that follow - the opportunity for real improvement is enabled.

To realize this improvement, however, a different perspective and mindset among PCPs is the single most important need that must be met before attention to total outcome for a Member or a cohort of Members can be achieved and sustained.

CareFirst expects the Program to continue to mature as measured by broader, deeper and consistent PCP understanding of all Program elements - resulting in their significant behavioral change. Progress, so far, towards this goal is well underway.

Independent analyses are now ongoing to assess all aspects of the Programs' impacts. These analyses have resulted and will result in published papers as experience develops in the Program. So far, there are strong reasons to be encouraged and press on.

CareFirst
Family of health care plans

# VOLUME I

## THE CAREFIRST PATIENT-CENTERED MEDICAL HOME (PCMH)

## (Parts I-V)



Q4 2017

# Part I: The Problem And The Challenge

## Preface

Nothing so threatens the American public's access to health care services or the quality of these services as the cost of the services themselves. Cost is to health care what carbon dioxide is to global warming: it is the up-swelling ingredient that, if left unchecked, is the undoing of the whole system.

There is a long history of awareness in the country of this problem and an equally long history of ineffective attempts to deal with it. This is because there are forces at play that make steadily rising costs extremely difficult to hold in check. These include Americans' lifestyle choices and the consequent rise of chronic disease often resulting from these choices. The CareFirst service region is no different.

This, in turn, unleashes demand forces for health care services that meet a system of health care financing that thrives on volume. More units of service mean more revenue for providers who rationally act to meet the demand forces with higher volume – particularly of hospital-based services. The CareFirst region is especially remarkable in this respect.

Additionally, the fragmentation of the health care system through which Members must navigate leads to inevitable breakdowns, lack of coordination, duplication and miscues. Yet the freedom to choose from a vast array of providers is a cherished American value. Indeed, the HMO movement – once seen as the answer – has been limited in its growth by the unwillingness of the public to subordinate their free choice of provider to a single, organized, integrated system of care that they appear not to fully trust even when it provides high quality services.

Payer intrusion into the care giving process through medical review and preauthorization of services or through the creation of a maze of rules that thwart, confuse and block access has been unable to stem the rise, and instead has frustrated the public, providers and government officials alike.

The move toward shifting far more cost to individuals through high deductible plans – a move that has accelerated as a result of requirements of the Affordable Care (ACA) – has thwarted access to needed care and services – leading over the long term to breakdowns that become costly to address downstream.

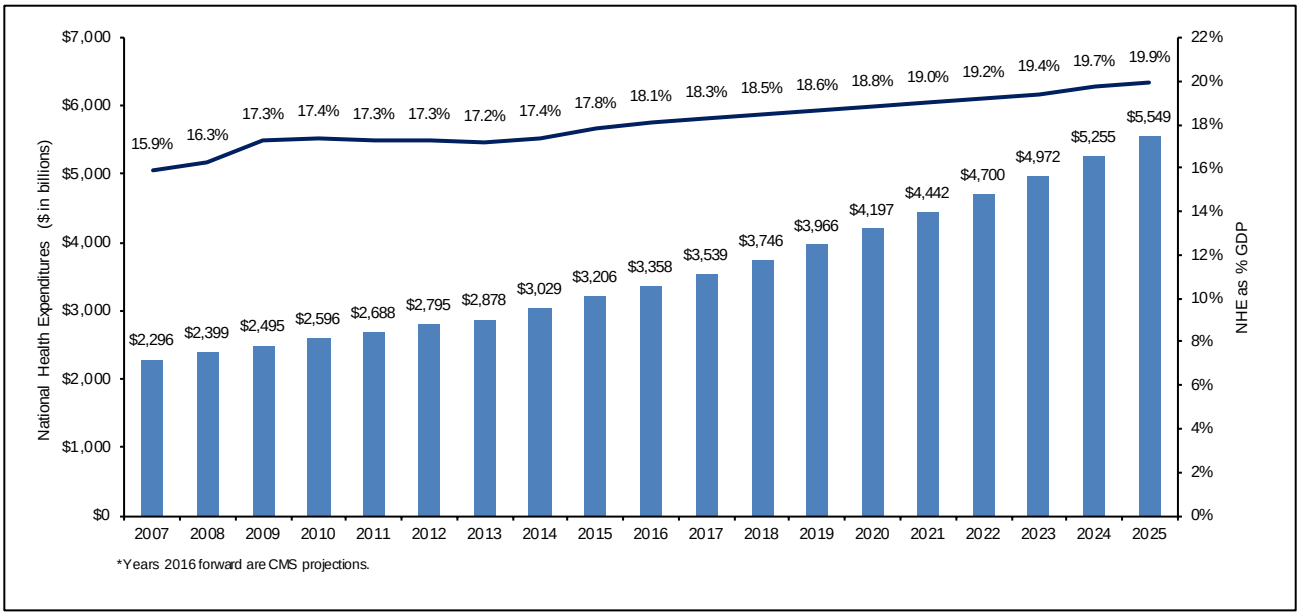
So, it is clear that the problem and challenge of controlling the rise in health care costs is daunting. Yet, failure to do so threatens the whole system. What one does to address the challenge is based very heavily on how the challenge itself is diagnosed and understood. This **Part I** presents CareFirst's analysis of the challenge and of previous attempts – including its own – to deal with this challenge. The PCMH and TCCI Programs derive their content and structure from this analysis.

## Cost Is The Problem – Key Facts And Trends – National And Regional

The high cost of health care is the single greatest threat to access. If unabated, it threatens to place needed services out of reach for more and more people. It threatens the quality of services. And, it threatens the viability of providers.

As a percentage of the Gross Domestic Product (GDP), health care expenditures have risen from 15.9 percent in 2007 to 17.4 percent in 2010, and are on course to reach well over 19 percent by 2025 as shown in **Figure 1** below**.**

**Part I, Figure 1: National Health Expenditure (NHE) Total Cost And Share Of GDP, 2007-2025**[1]




Nationally, the rise in health care expenditures is expected to grow at an average rate of 5.6 percent per year if no effective actions are taken to abate it **(Figure 2).** Although some slowing in trend has been observed over the past few years, more recently trend is showing signs of being on the rise again. Health costs are likely to outstrip the expected rise in wages and general inflation by a considerable margin.

The cost of coverage for an average family of four covered by CareFirst for the most common Preferred Provider Organization (PPO) benefit plan is now about $1,700 per month. If one reflects on the fact that costs are projected to rise over the next eight years at the pace shown, who then will be able to afford coverage if costs reach $2,500 per month or more? What, then, will be the concerns with access to quality health care services?

As can be seen in **Figure 2** on the next page, the yearly rate of rise in health care spending is expected to proceed at a steady pace over the next several years. There are some factors that many believe might cause it to rise more quickly – such as the aging of the population and pent up need for care from the newly insured, less healthy population who have been able to obtain coverage as a result of ACA. Even at the pace shown, health expenditures will rise nearly 60 percent in the next eight years if the trends materialize as depicted. This will almost certainly place full health coverage out of the reach of most people in the CareFirst region, assuming wages rise at even half the rate of health care costs.

When the rise in health care costs is shown in relation to the rise in wages and general inflation, the full cumulative impact can be seen clearly as shown in **Figure 3.**

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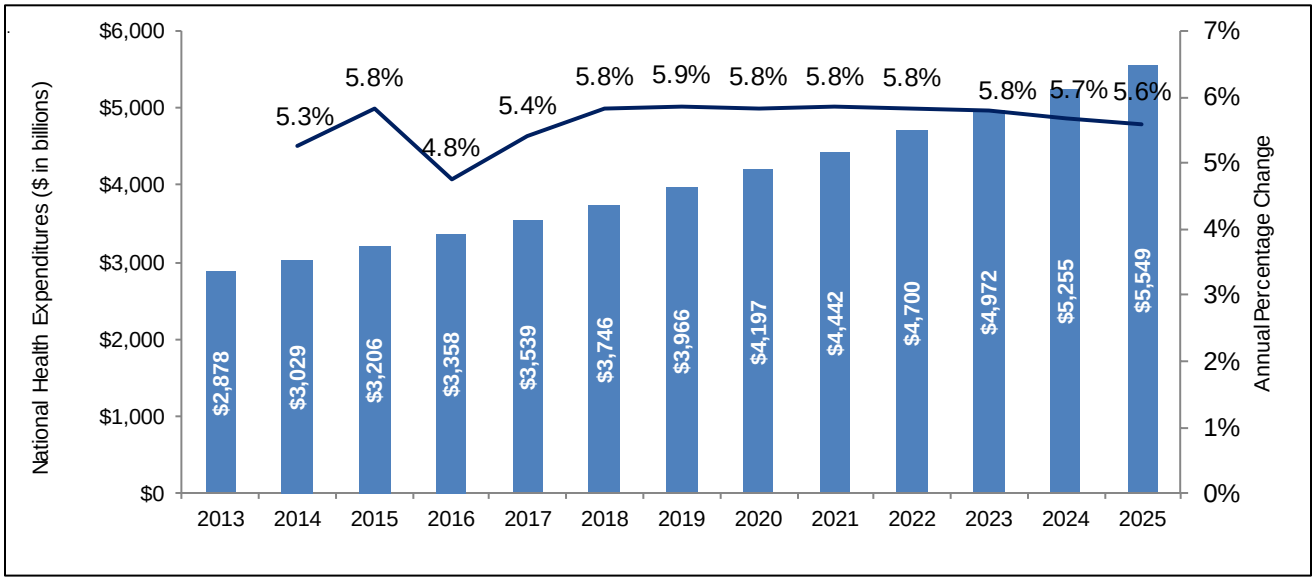
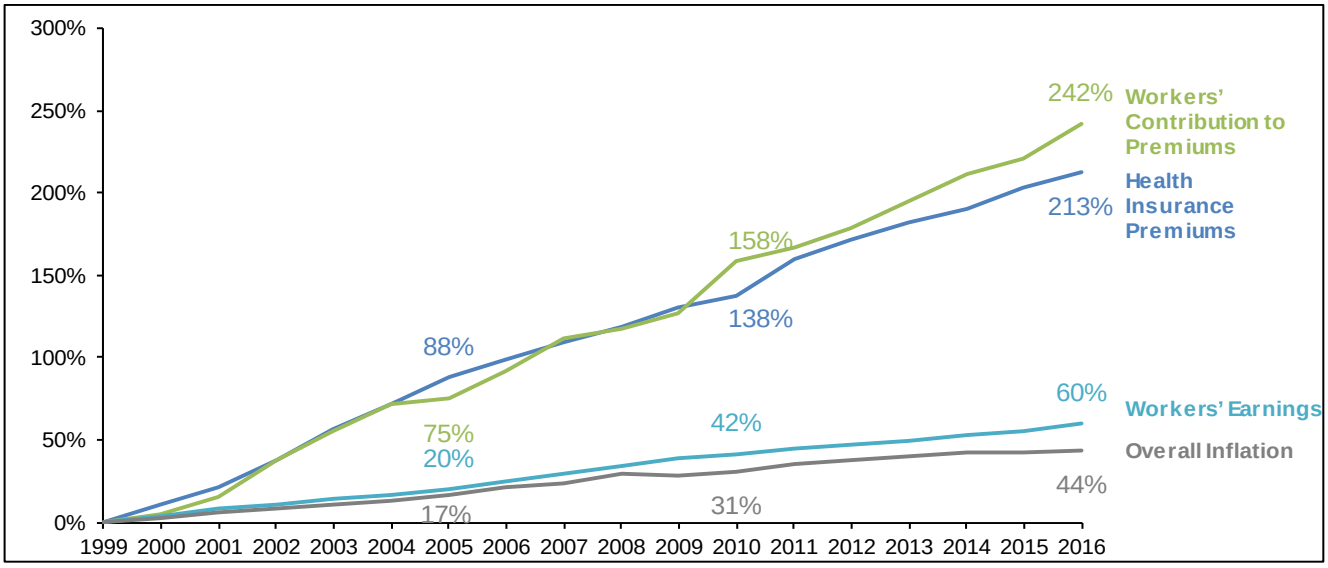
[1] *Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, March 2017.*

**Part I, Figure 2: Projected National Health Expenditure (NHE), Calendar Years 2013-2025**[2]




**Part I, Figure 3: Cumulative Increases In Health Insurance Premiums, Workers' Earnings And Inflation, 1999-2016**[3]




[2] *Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, March 2017.*

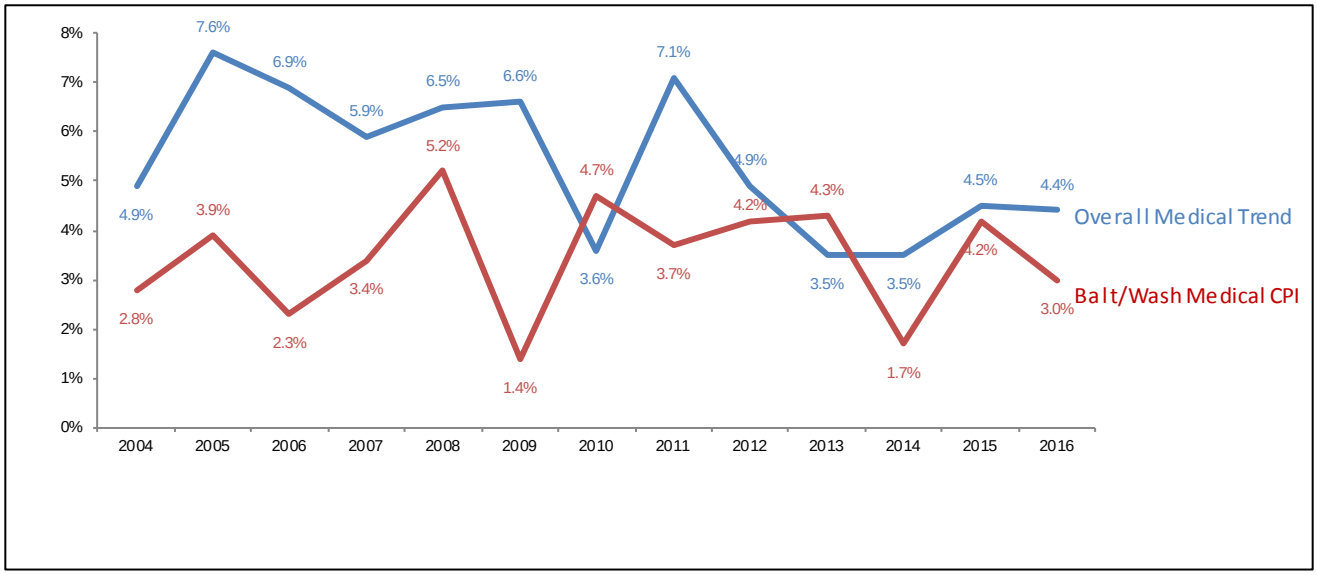
[3] *Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment StatisticsSurvey,1999-2016 (April to April).*

It is important to understand that Medical Consumer Price Index (CPI) in the CareFirst region has closely tracked the rate of increase in national Medical CPI. Medical CPI reflects the movement in unit prices of medical services such as the price of particular services, tests and equipment.

A better measure is Overall Medical Trend (OMT) (see **Appendix F** for more on OMT) that measures both the change in unit prices (fees, rates) as well as the changes in use and mix of services. It is a more complete measure of the change in overall medical costs. Since Medical CPI assumes change in neither the number of services or in the mix of services, it has historically been lower than OMT.

As will be discussed throughout these Program Guidelines, use of health care services has been rising steadily, driven largely by demographics, expansion of coverage to previously uninsured individuals as a result of ACA, increased use of new technologies and the rise of chronic disease in the general population often reflective of American lifestyles. This is the key cause of the difference between OMT and Medical CPI shown in **Figure 4** below.

**Part I, Figure 4: Historical CareFirst Overall Medical Trend (OMT) And Baltimore/Washington Medical Consumer Price Index (CPI)**[4]




At the present time, the region served by CareFirst experiences per capita health care expenditures that are among the highest in the nation. These expenditures have been rising on pace with national trends.

The underlying reasons for cost growth must be understood and dealt with if there is to be any hope of avoiding the looming crisis. This will require changes to American lifestyles as well as in the way health care services are organized, financed and supported.

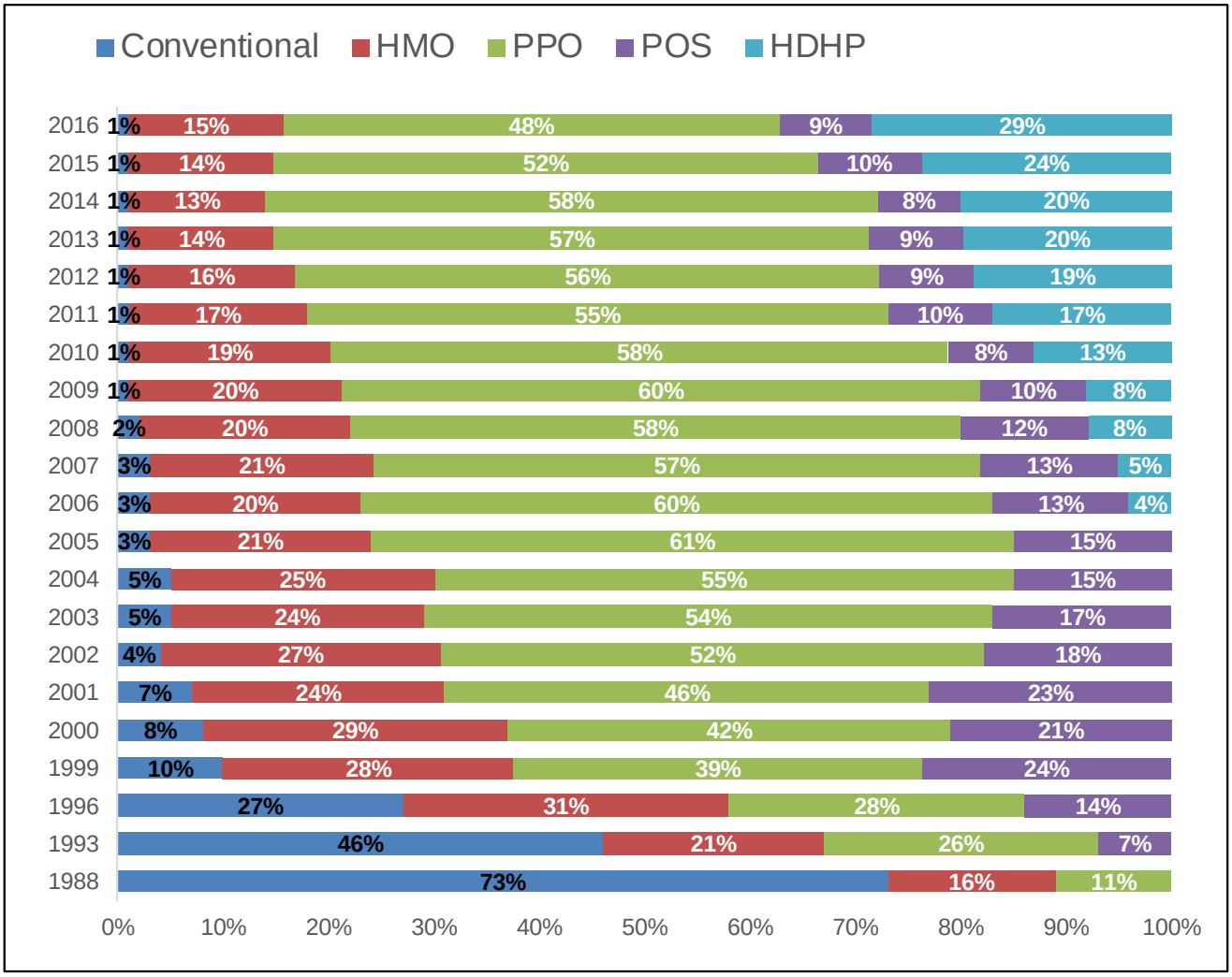
The idea that health insurance reform under the Affordable Care Act – by itself – is enough to deal with the problem of escalating costs is rejected here. In fact, implementation of the centerpiece of federal health care reform in 2014 – guaranteed issue coverage plans coupled with an individual mandate and supported by low income premium and cost sharing subsidies for a large part of the population –is showing evidence of inducing further unaffordable demands on a system of health care financing that is fundamentally not conducive to cost control as it presently exists.

[4] *Source: Bureau of Labor Statistics, Consumer Price Index (CPI), 2004-2016; CareFirst Actuarial Department, 2016.*

## Benefit Design/Plan Coverage Changes Are Not Enough

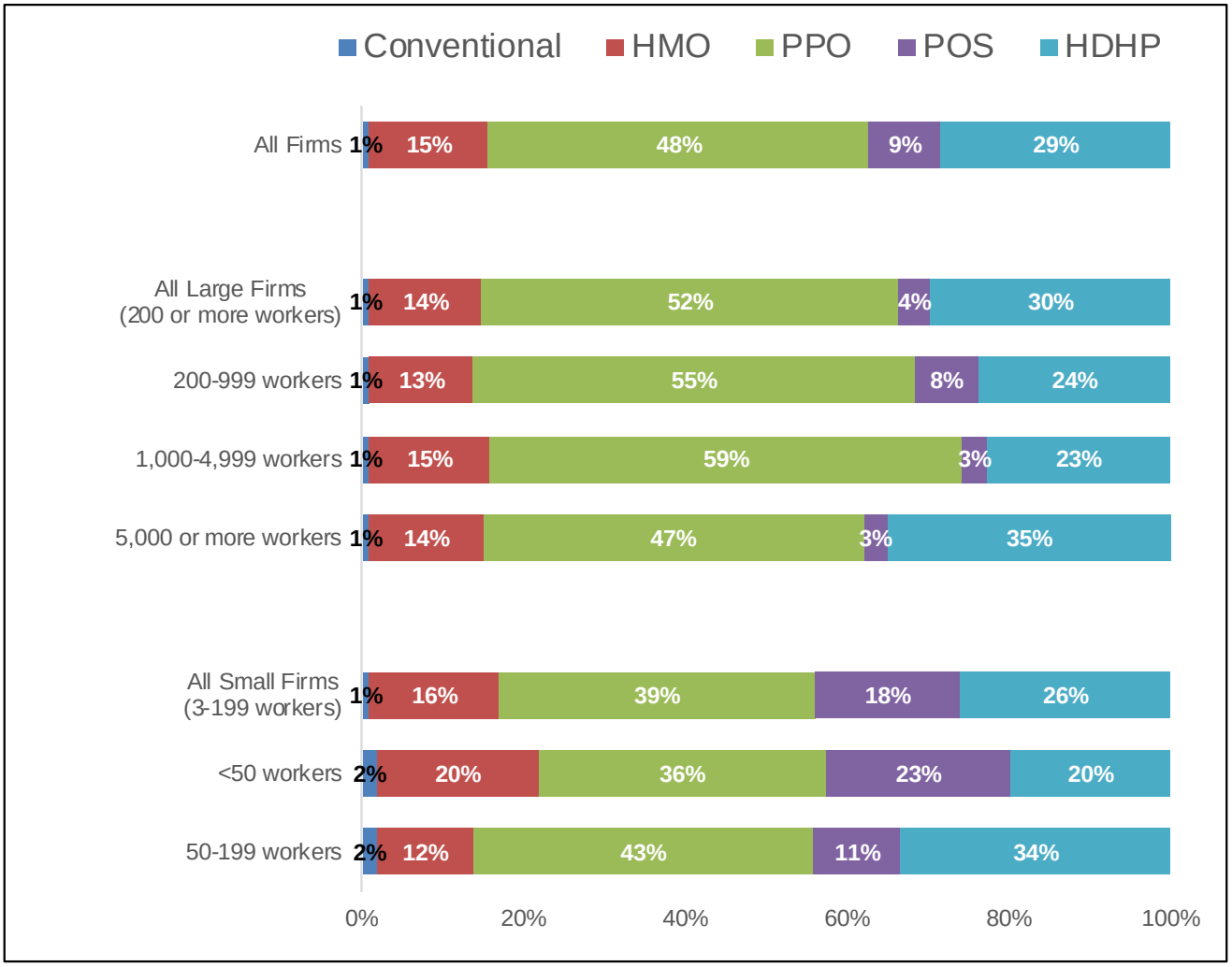
To underscore the point that plan coverage changes by themselves are not enough, consider the fact that new coverage designs aimed at controlling costs were massively introduced into the CareFirst service region over the latter half of the last decade with the launch and rapid market adoption of high deductible health plans (HDHPs). While the political world focuses on the ACA and the yet to be determined version of the AHCA/BCRA, changes have been occurring for the many more who get their health insurance through their employers – about 150 million Americans. Employer groups have broadly embraced HDHPs to control their premium (if fully-insured) or medical care costs (if self-insured) expenditures.

**Part I, Figure 5: Distribution Of Health Plan Enrollment For Covered Workers By Plan Type, 1988-2016** [5]




[5] *Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2016; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.*

**Part I, Figure 6: Distribution Of Health Plan Enrollment For Covered Workers By Plan Type And Firm Size, 2016** [6]




High deductible health plans have become even more prevalent with the requirement that all ACA Qualified Health Plans in the Individual and Small Group markets must meet specific actuarial values as defined for the metal levels that dictate Member cost-sharing. Bronze and Silver plans typically have deductibles of several thousand dollars or more.

High deductible designs are often accompanied by a Health Reimbursement Account (HRA) or a Health Savings Account (HSA). But, experience has shown that only two-thirds of HSA accounts are funded by employers and that primary care services are subject to substantial deductibles, except for preventive services.

Health savings accounts (HSA) plans are intended to provide incentive for consumers to manage their own health care costs. This is accomplished through coupling a tax-favored savings account with a high-deductible health plan (HDHP) to pay medical expenses. Since 2005, there has been a steady increase of enrollment in HSA/HDHP plans (see **Figure 7**).

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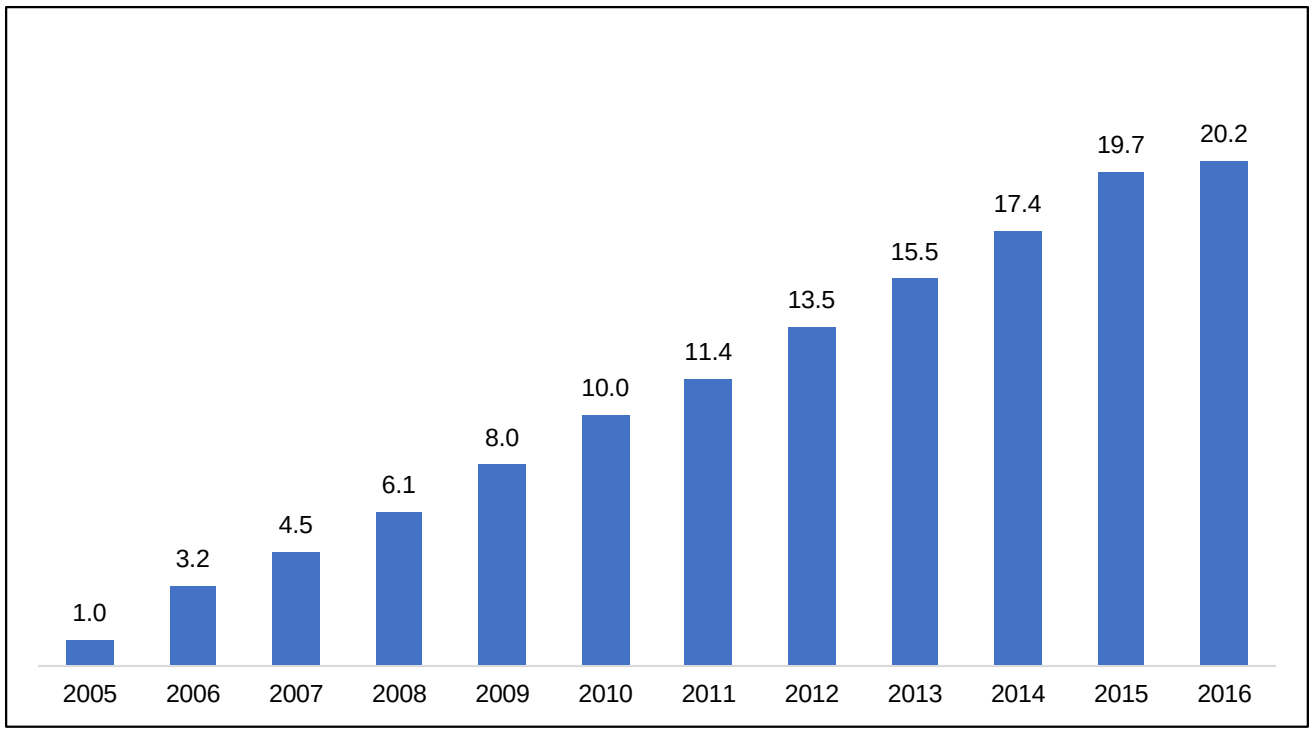
[6] *Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016.*

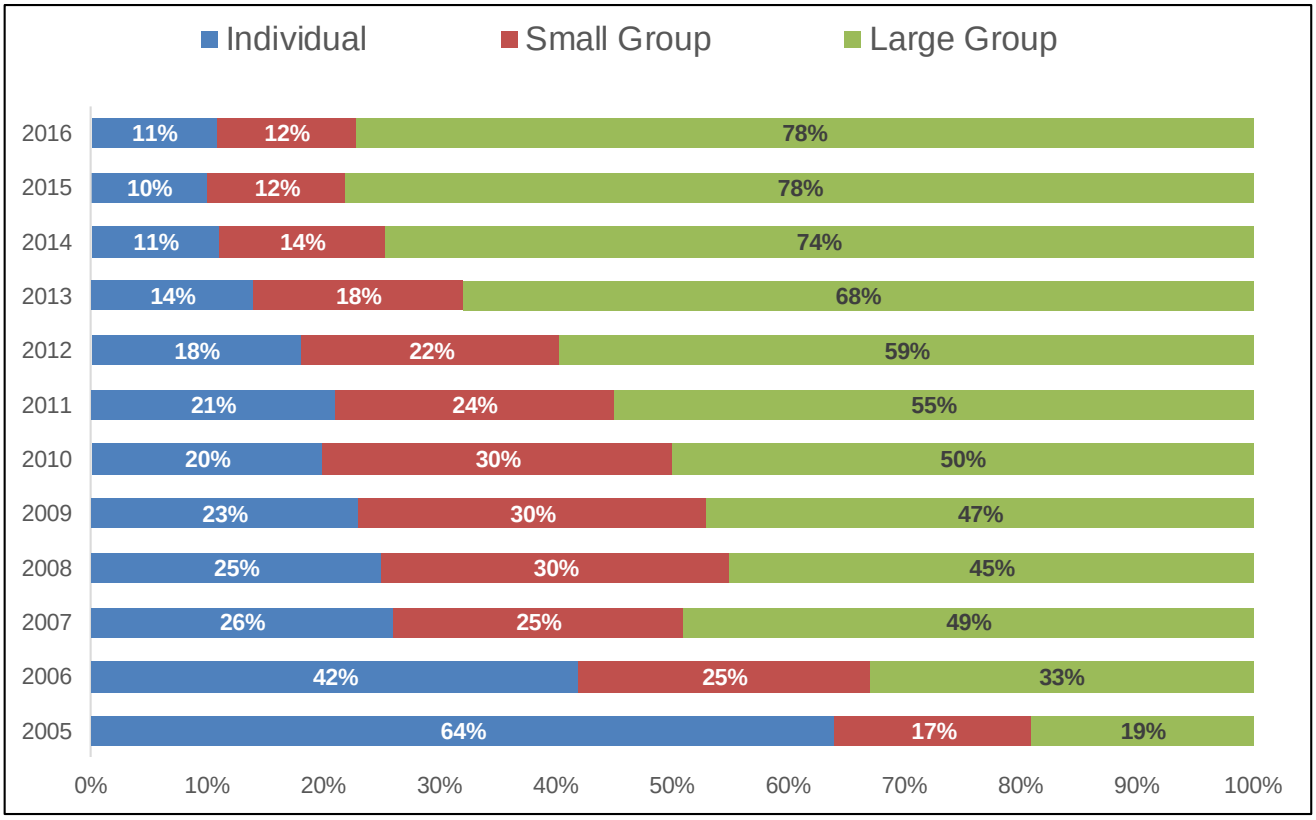
**Part I, Figure 7: HSA-Qualified High-Deductible Health Plan Enrollment, 2005-2016 (Millions)**[7]




Many enrollees in HSA/HDHP plans are in the large group market, with all remaining enrollees about evenly split between the small group and individual markets. Since 2005, the proportion of HSA/HDHP enrollees in the large group market has been steadily increasing to about three-fourths of total HSA/HDHP enrollment (see **Figure 8**).

[7] *Source: America's Health Insurance Plans (AHIP). 2016 Survey of Health Savings Account – High Deductible Health Plans, 2016.*

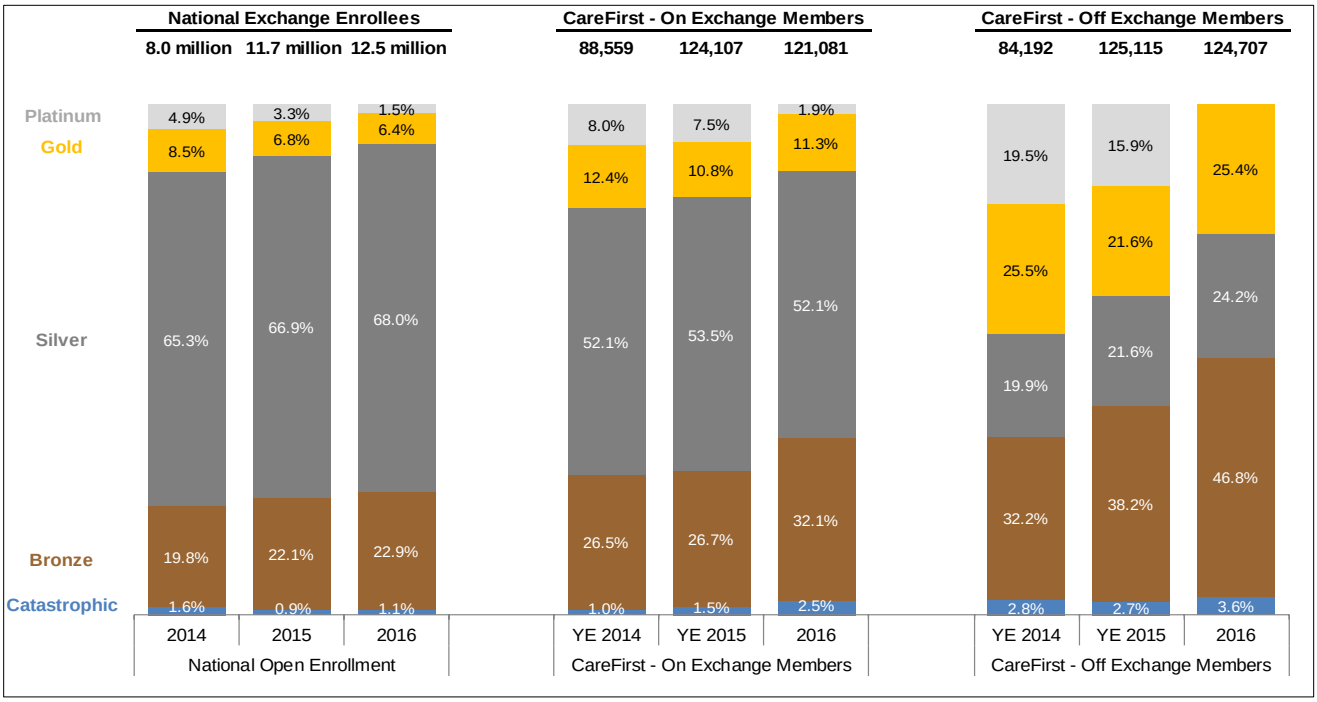
**Part I, Figure 8: Commercial Health Insurance Coverage By An HSA-Qualified High-Deductible Health Plan By Market Type, 2005-2016[8]**




[8] *Source: America's Health Insurance Plans (AHIP). 2016 Survey of Health Savings Account – High Deductible Health Plans, 2016.*

Nationally, over 90 percent of 2016 ACA Exchange enrollees were in bronze or silver plans – resulting in high cost sharing – through higher deductibles and out-of-pocket expenses. The proportion of Individuals buying these high cost-sharing health plans has increased (see **Figure 9**). CareFirst members have a similar experience to what has occurred nationally. Any proposal to repeal and replace the ACA is likely to promote high-deductible health plans and increase consumer cost-sharing.

**Part I, Figure 9: ACA Metal Level Distribution**[9]




If people have modest means and coverage is expensive, they will buy health plans with lower premiums – and high deductibles and cost-sharing. High deductible plans are not for everyone. They can be a good option for people who are in relatively good health, but they can expose people who have more modest incomes and chronic health needs to out-of-pocket costs that can be a barrier to care. The cost trends emerging from these high deductible coverage plan designs show how difficult it is to control cost growth using changes in coverage plans as the only strategy.

Many plan designs required by ACA have very substantial cost-sharing provisions. For example, Bronze and Silver metal level plans contain 40 percent and 30 percent Member cost-sharing, respectively, which translates into $1,350 to $6,550 in deductibles and out-of-pocket expense limits of $6,850 per year per person in 2016. Of all the Individual Members who enrolled in ACA coverage plans, over 70 percent enrolled in plans on these metal levels. The consequences are likely to be dire in terms of discouraging access to needed primary care and other services when illness strikes, particularly for those Members whose household incomes are not low enough to receive subsidies.

All of this has been driven by a single factor – cost.

One final word about high deductible plans: Since a large percentage of total medical costs in any year are associated with a small number of people with acute or chronic illnesses who run up enormous health care bills, these costs typically far exceed even the highest deductible and other out-of-pocket cost limits that are included in high deductible plans. Therefore, a large share of the medical costs incurred by people covered by high deductible plans occurs after they have exceeded the out-of-pocket limits that are set by these plans. Further, this care involves complex tests, procedures and drug regimens that they are in no position to question or "shop" for best prices.

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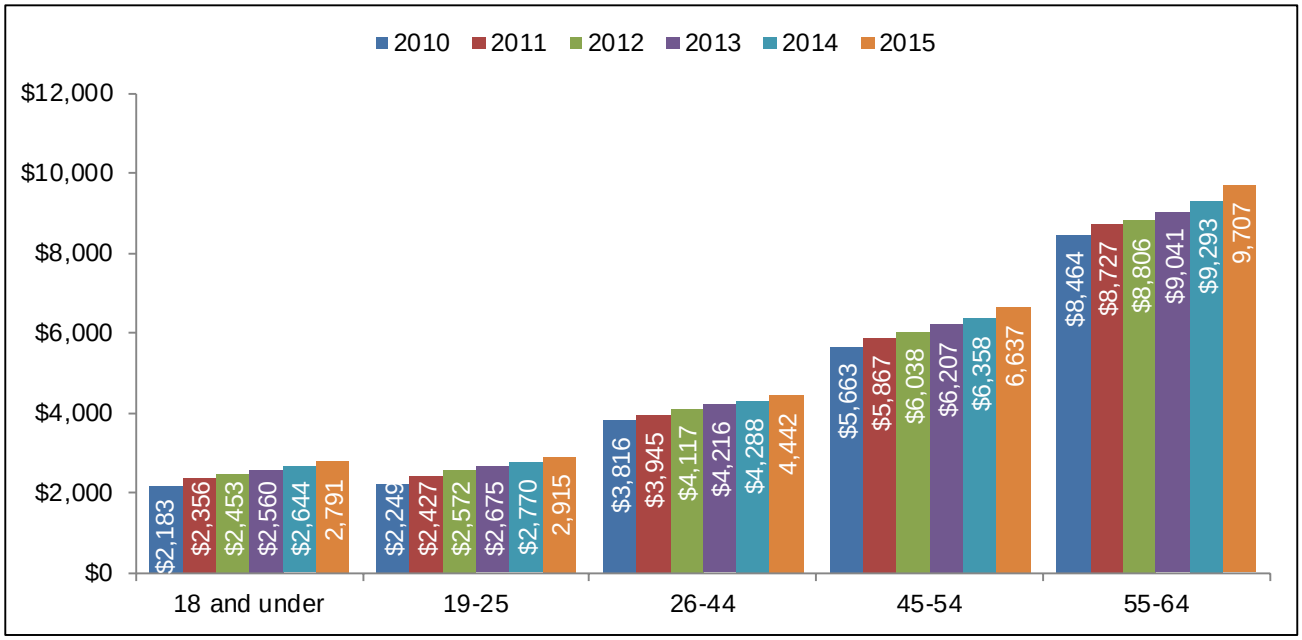
9 *Sources: ASPE Issue Briefs, 2014, 2015 and 2016 Health Insurance Marketplace: Summary Enrollment Report. CareFirst data as of April 12, 2016.*

That is, even if those covered by these plans had an ongoing interest in their medical expenses, it is questionable whether persons who are gravely ill have the ability to purchase care on a cost-effective basis for themselves. Hence, these plans are not likely to represent – by themselves – the path forward toward more effective cost control.

## Demographics Are A Leading Cause Of Cost Growth

Meanwhile, demographics of an aging population are a leading cause of cost growth. As the population ages, higher health care costs are inevitable, as seen on **Figure 10** below. This is a virtual demographic certainty.

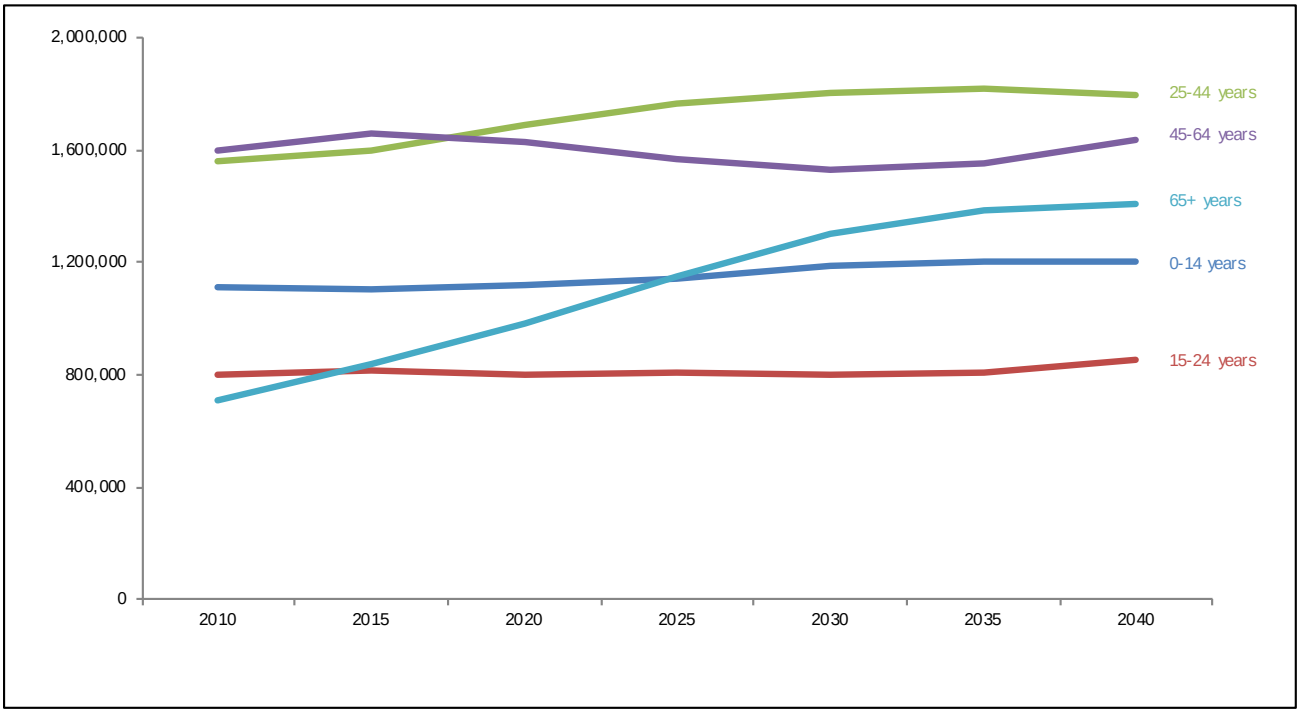
**Part I, Figure 10: Per Capita Health Expenditures By Age, 2010 vs. 2015**[10]




Total population growth in the CareFirst service area from 2010 to 2040 is projected to increase by more than 800,000, with over 70 percent of the growth coming from the 65+ group as depicted in **Figure 11** on the next page. Absent any lifestyle influences, health care costs would be expected to increase by virtue of absolute population growth and aging alone. These forces – in combination – drive increases of about one to two percent per year.

[10] *Source: Health Care Cost Institute, Health Care Cost and Utilization Report, 2015.*

**Part I, Figure 11: Resident Population, Maryland By Age (For Selected Years)**[11]

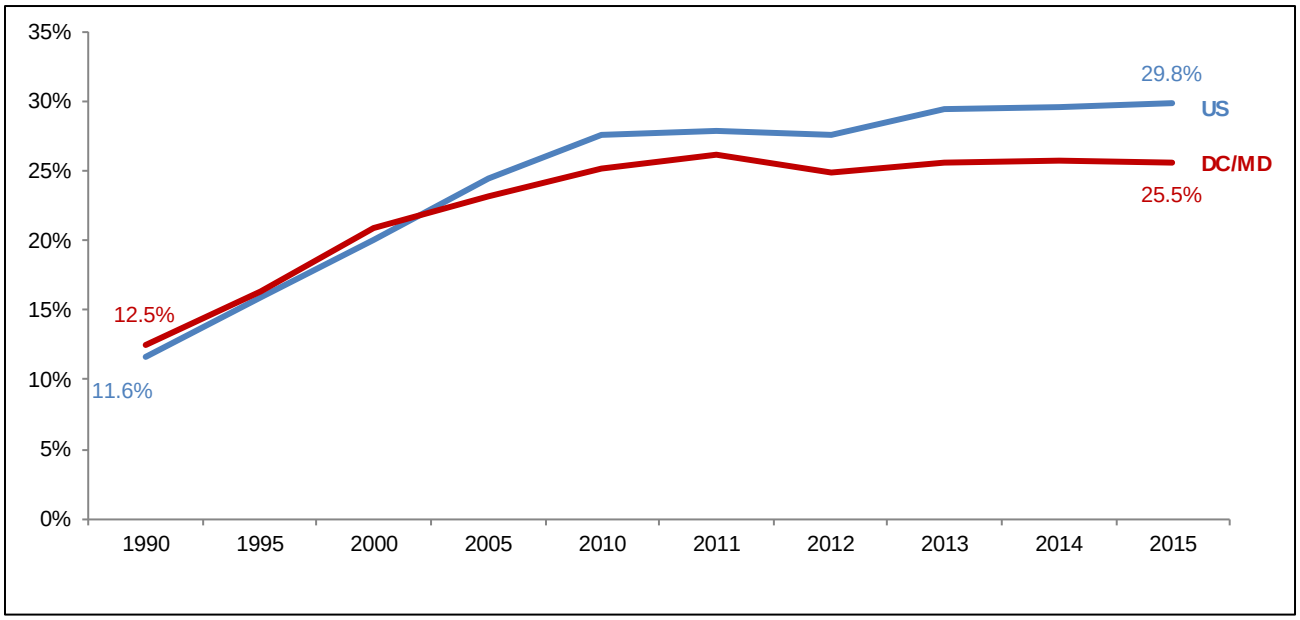



[11] *Source: Maryland State Department of Planning. 2014 Total Population Projections by Age. Revised January 2015.*

## Lifestyle Has Exacerbated Demographic Trends Toward Higher Health Care Use

The impact on rising health care costs has been further accelerated by the consequences of American lifestyles and habits. Obesity has become the central pervasive problem. The prevalence of obesity in the CareFirst region has increased over 120 percent since 1990 (see **Figure 12)** and has brought with it all the related maladies of cardiovascular disease, diabetes, stroke risk, etc. This mirrors the national experience.

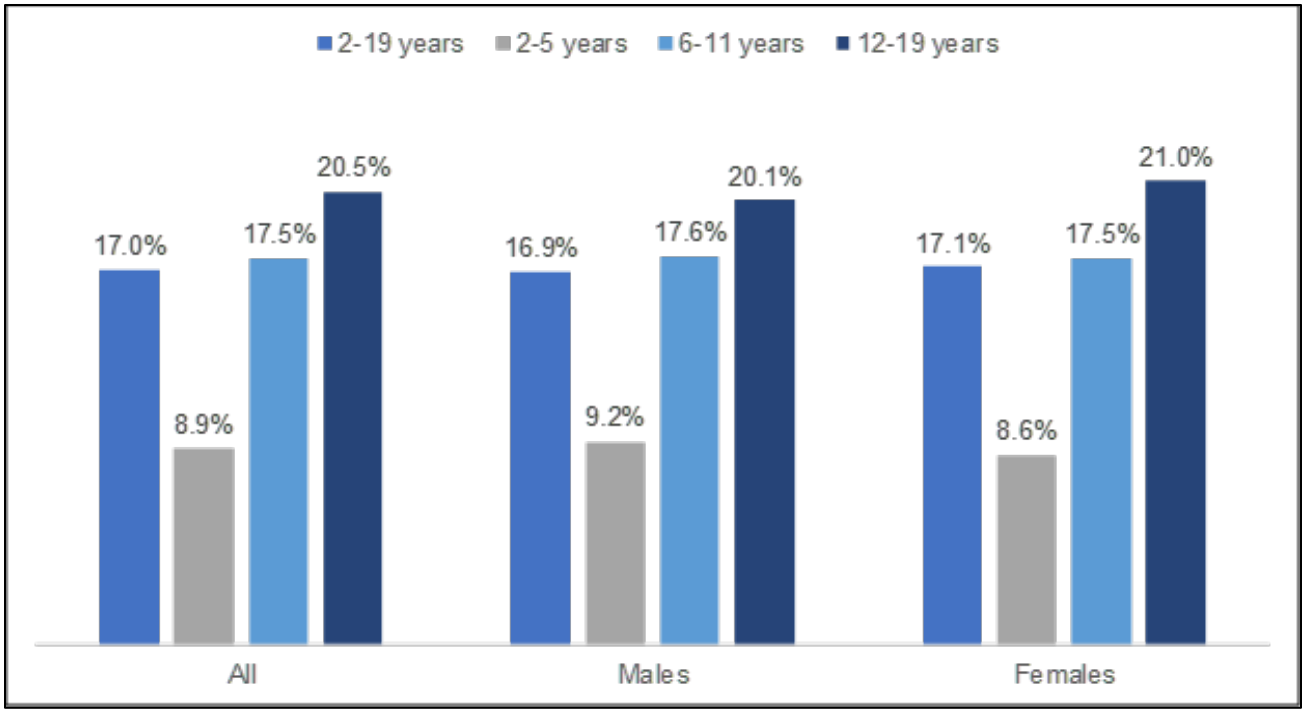
**Part I, Figure 12: Prevalence of Obesity, U.S. vs. DC/MD Region (For Selected Years)**[12]




Nearly 1 in 5 children struggle with obesity. Young children with obesity tend to maintain extra weight into adulthood. The percentage of children in these categories has been rising over the past three decades (with some recent slowing). The prevalence of obesity among U.S. youth was 17.0 percent in 2011–2014. Overall, the prevalence of obesity among preschool-aged children (2–5 years) (8.9 percent) was lower than among school-aged children (6–11 years) (17.5 percent) and adolescents (12–19 years) (20.5 percent). The same pattern was seen in both males and females (see **Figure 13**). This brings with it the likelihood of a long list of maladies that cluster around obesity, including high blood pressure, diabetes, cardiovascular disease and more.

[12] *Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System Survey Data.*

**Part I, Figure 13: Prevalence of Obesity Among Youth Aged 2-19 Years, By Sex And Age 2011-2014**[13]



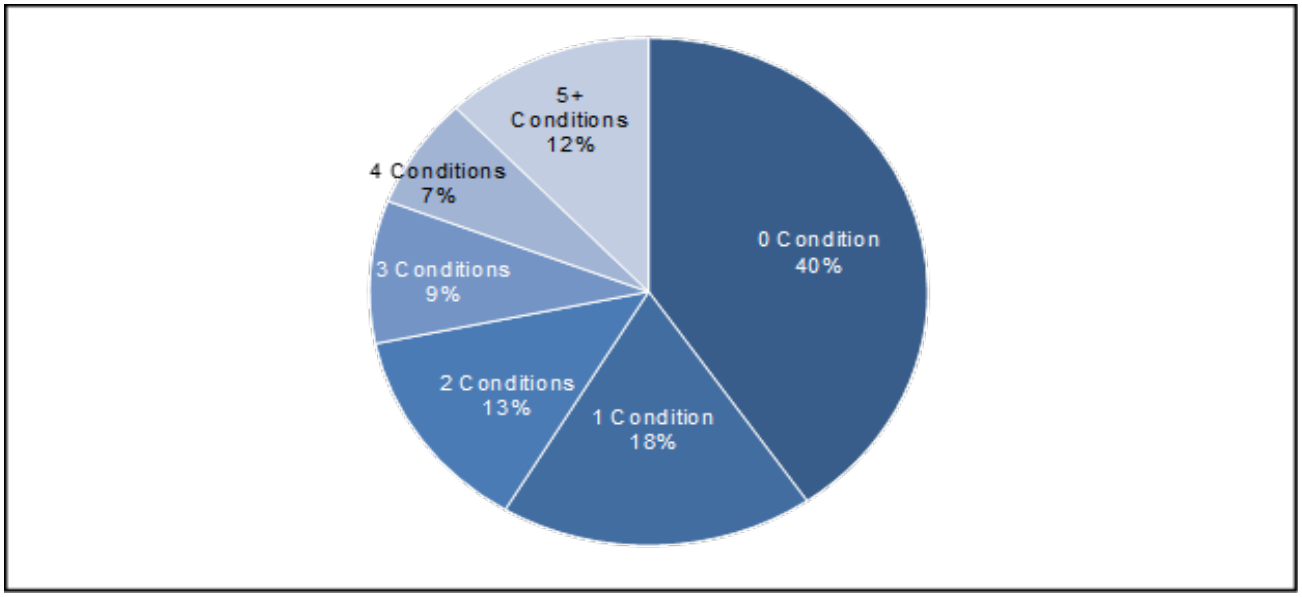

The prevalence of chronic disease in the nation can be seen in **Figure 14** on the next page. Six in ten of the adult population had at least one chronic condition. Since these people with more chronic conditions require more healthcare services, this drives up current and future costs. Those with five or more chronic conditions made up 12 percent of the population but accounted for 41 percent of total healthcare spending in 2014[14].

*Note: Clinically distinct chronic conditions include hypertension, congestive heart failure, coronary heart disease, cardiac arrhythmias, hyperlipidemia, stroke, arthritis, autism spectrum disorder, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia (including Alzheimer's and other senile dementias, depression, diabetes, hepatitis, human immunodeficiency virus (HIV), osteoporosis, schizophrenia, and substance abuse disorders (drug and alcohol).*

[13] *Source: CDC/NCHS, National Health and Nutrition Examination Survey, 2011–2014.*

[14] *Buttorff, Christine, Teague Ruder and Melissa Bauman. Multiple Chronic Conditions in the United States. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/tools/TL221.html.*

**Part I, Figure 14: Prevalence Of Chronic Conditions Among Adults, 2014**[15]




As the population of the United States continues to age, the prevalence of chronic conditions will continue to rise. While having one chronic condition increases the chances of an individual having higher medical expenses, having more than one generally has a multiplicative effect on functioning and the need for health care.

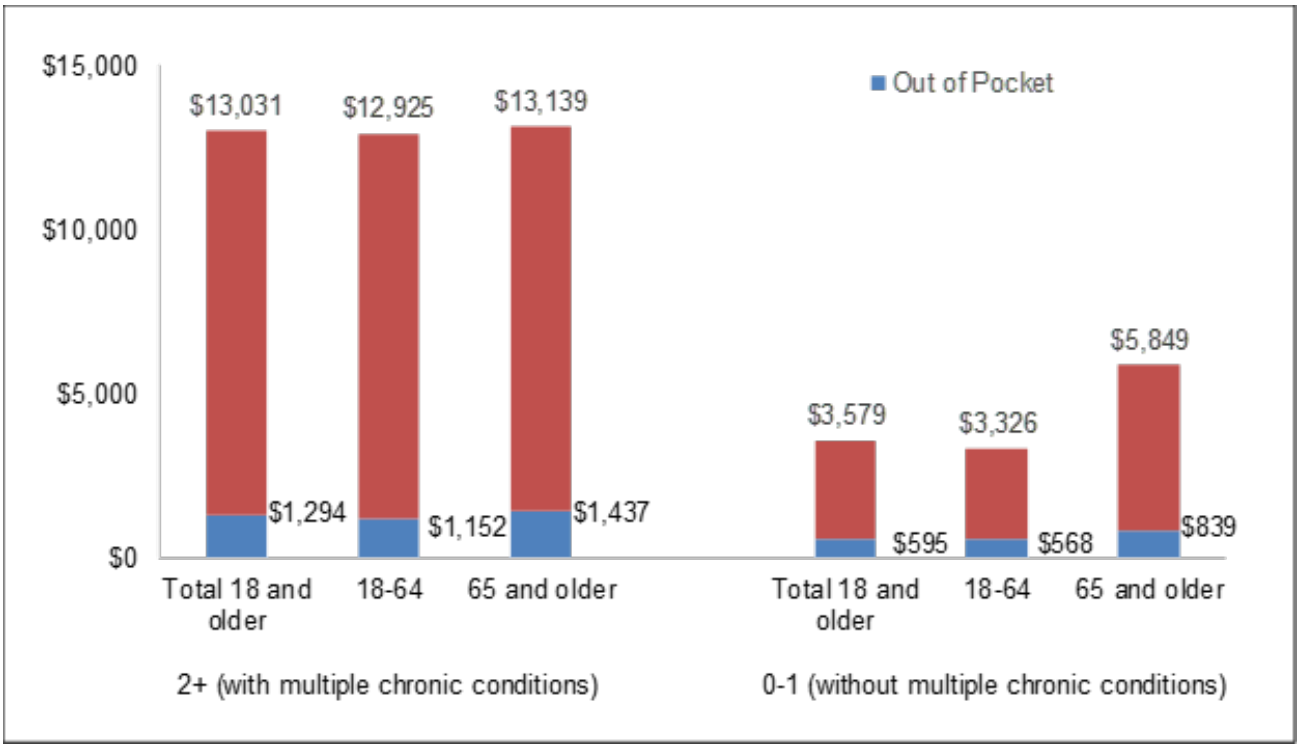
In 2014, adults who had expenses for medical care associated with multiple chronic conditions had more than three times higher total treatment expenses compared to those who had no or one chronic condition ($13,031 versus $3,579) (see **Figure 15**). Per person out-of-pocket expenditures for adults with multiple chronic conditions were more than twice as high as those for adults who had one or no chronic condition ($1,294 versus $595).

Out-of-pocket expenditures for elderly adults with multiple chronic conditions were higher than for non-elderly adults with multiple chronic conditions ($1,437 versus $1,152). Out-of-pocket expenditures for elderly adults with multiple chronic conditions were also higher compared with adults of the same age who had one or no chronic conditions ($1,437 versus $839). Among non-elderly adults, those with multiple chronic conditions reported double the out-of-pocket expenditures of those who had one or no chronic conditions ($1,152 versus $568).

*Note: Clinically distinct chronic conditions include hypertension, congestive heart failure, coronary heart disease, cardiac arrhythmias, hyperlipidemia, stroke, arthritis, autism spectrum disorder, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia (including Alzheimer's and other senile dementias, depression, diabetes, hepatitis, human immunodeficiency virus (HIV), osteoporosis, schizophrenia, and substance abuse disorders (drug and alcohol).*

[15] *Buttorff, Christine, Teague Ruder and Melissa Bauman. Multiple Chronic Conditions in the United States. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/tools/TL221.html.*

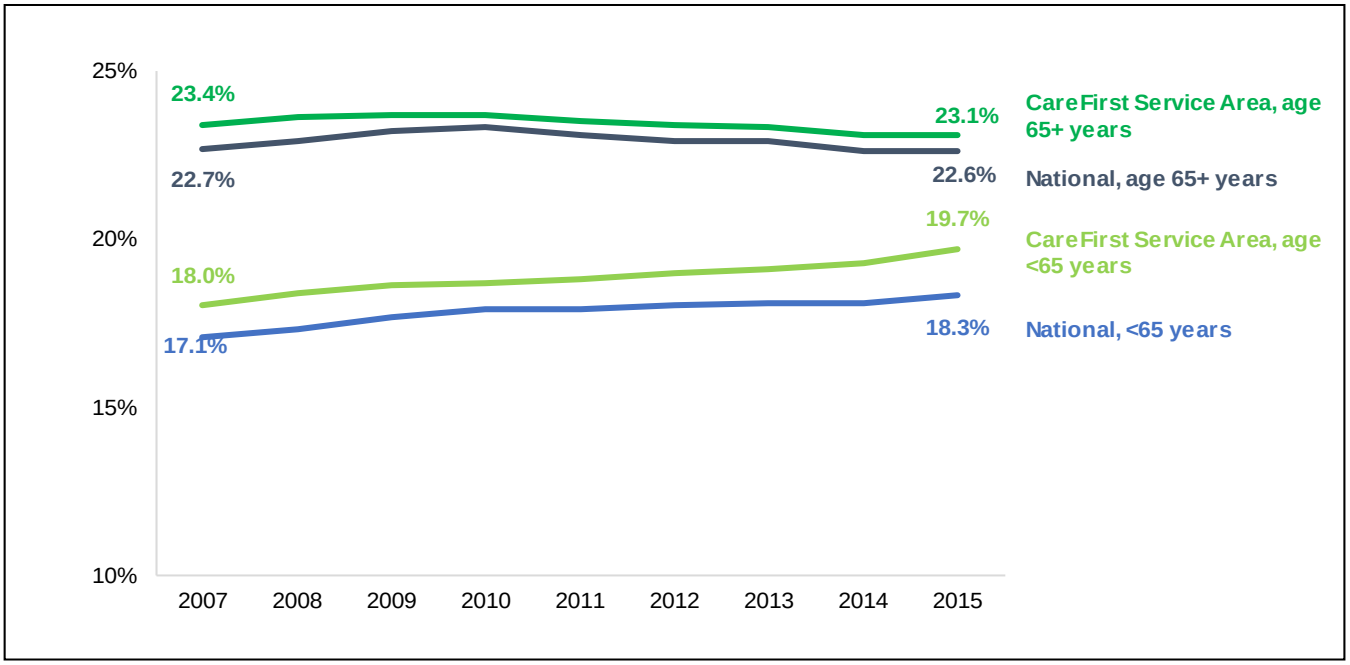
**Part I, Figure 15: Average Per Person Expenditures (Total and Out-of-Pocket) For Adults By Number of Chronic Conditions, 2014[16]**




Nearly one-quarter of Medicare beneficiaries in the CareFirst region age 65 and older, and one-fifth of Medicare beneficiaries under age 65, had two or more chronic conditions in 2015 (see **Figure 16**). Of note, in the CareFirst service area, individual Medicare beneficiaries with two or more chronic conditions trend a bit higher than the national experience.

[16] *Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Household Component, 2014*

**Part I, Figure 16: Prevalence Of Two Or More Chronic Conditions Among Medicare Beneficiaries, 2007-2015[17]**




Many people react to the consequences of chronic disease with a "fix me" attitude. That is, these people see medical intervention – not change in lifestyle – as the answer. The thought is that a lifestyle based on inexpensive, processed fast food consumed in supersized portions together with sedentary habits need not be changed if a drug or medical intervention can remedy or mitigate the health downsides. Indeed, the impact of better medical technology and knowledge has been to facilitate just this thought process and to keep people with multiple chronic diseases alive and functioning longer – at persistently higher cost – with ongoing and cumulative health problems.

## Huge Unmet Need Remains

The amount of unsatisfied demand for health services is huge because much chronic disease goes untreated or undertreated. There is also compelling evidence that even those in treatment often do not comply with their medical or pharmaceutical treatment protocols. Indeed, a number of studies have shown that compliance is as low as 30 to 50 percent with prescription medication – let alone more extensive Care Plans.

Additionally, gaps in care for the portion of the population with chronic disease(s) are exceedingly common due to the fragmented nature of the health care system itself. The treatment of chronic disease – particularly multiple chronic diseases in a single Member – often involves multiple specialists and other caregivers over an extended period of time. Often, Members fend for themselves in trying to access and coordinate the services they need. Understandably, they do this very imperfectly. Care sporadically obtained in an uncoordinated way over long periods of time sub-optimizes outcomes. Yet, this is the norm.

Studies performed by the RAND Corporation[18] have shown that Americans receive only about 50 percent of the "appropriate" care they should get – according to well-documented and broadly endorsed clinical guidelines – for a range of common

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[17] *Source: Centers for Medicare & Medicaid Services, Multiple Chronic Conditions Prevalence State/County Tables: All Fee-for-Service Beneficiaries by Age, 2007-2015.*

[18] *Landmark Study Finds American Adults Often Fail to Get Recommended Care, Posing "Serious Threats" to Health, The RAND Corporation, 25 June 2003, http://www.rand.org/news/press/2003/06/25.html.*

conditions. Thus, even though there is much evidence of significant overuse of tests, procedures and other types of care, there are also large areas of clinical practice where more care of an appropriate nature is needed.

## Illness Burden And The Illness Burden Pyramid Of Costs

To put the impact of chronic disease in perspective, CareFirst continually analyzes its claims experience and finds that a small percentage of its Members – those with advanced manifestations of multiple chronic diseases – consume approximately half of all of the Company's health care spending in the region. This mirrors the national experience. There can be no moderation in health care cost increases without recognizing this problem and squarely dealing with it.

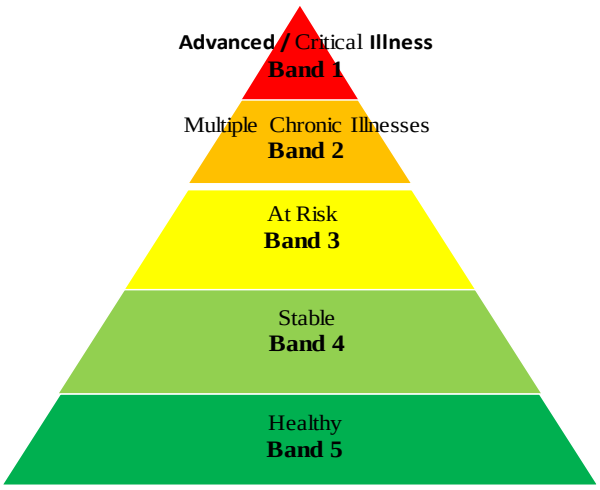
CareFirst calculates an Illness Burden Score for each Member it serves every month based on the Member's unique claims history using the trailing 12 months of claims experience for each Member. This score shows not only the relative current illness level of the Member, but is useful in determining which cohorts of Members are most likely to have high future costs. When Members with "like" illnesses are pooled together, in bands, such as those shown in the pyramid below, one gains a perspective on how the Illness Burden – the degree of illness or the risk for future illness – influences cost patterns in a population of people.

This is vividly illustrated by the "Illness Burden Pyramid" that is familiar to anyone with experience in the health insurance field. As can be seen in **Figure 17** below, the top three percent of CareFirst Members – typically those with acute, catastrophic or end-of-life conditions – accounted for 33 percent of total medical care payments by CareFirst based on 2016 data.

The next nine percent of Members – typically those with multiple chronic diseases in advanced stages – account for another 28 percent of total medical care payments. It is noteworthy that the bottom 43 percent of Members account for only four percent of total medical care spending. This pyramid is consistent in all age 65 and under populations in all markets in the United States.

It is stunning to consider that the cost PMPM of those in Band 1 is more than 100 times higher than for those in Band 5. Band 1 Members have Illness Burden Scores that range from five to 50 times the average in the community as a whole while Band 5 Members have one-fifth the average Illness Burden of the community average.

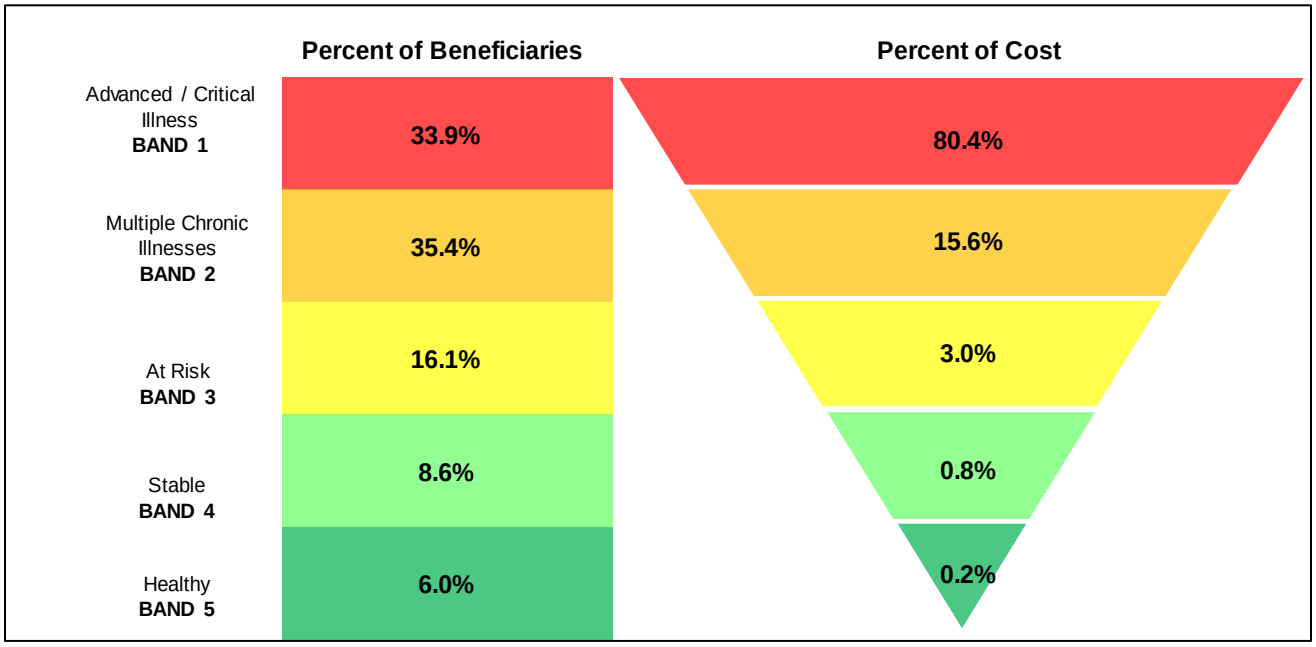
**Part I, Figure 17: CareFirst Illness Burden Pyramid, 2016**[19]




| | Percent of Population | Percent of Cost | Cost PMPM |
|---|---|---|---|
| **Illness Burden (5.00 and Above)** Extremely heavy health care users with significant advanced / critical illness. | 2.6% | 32.5% | $4,659 |
| **Illness Burden (2.00 - 4.99)** Heavy users of health care system, mostly for more than one chronic disease. | 8.9% | 27.8% | $1,151 |
| **Illness Burden (1.00 - 1.99)** Fairly heavy users of health care system who are at risk of becoming more ill. | 13.2% | 18.3% | $512 |
| **Illness Burden (0.25 - 0.99)** Generally healthy, with light use of health care services. | 32.6% | 16.9% | $195 |
| **Illness Burden (0 - 0.24)** Generally healthy, often not using health system. | 42.6% | 4.4% | $44 |

[19] *Source: CareFirst HealthCare Analytics – Incurred in 2016 and paid through April 2017 – CareFirst Book of Business, excluding Medicare Primary Members.*

**Part I, Figure 18: Medicare Fee-For-Service (FFS) Illness Burden Pyramid, 2015**[20]




## Defensive Medicine Plays A Role In Cost Patterns

To understand costs more fully, one must add to this pattern in any population, the cost impacts of defensive medicine and the concern that PCPs feel that their failure to order or conduct extensive testing may subject them to malpractice risk. If confronted with something out of the ordinary, most PCPs refer to specialists who then often become the most critical medical decision maker for the Member on only the particular aspect of the Member's condition that is within the scope of their practice. A holistic view of the Member is often not gained.

Members frequently demand testing beyond what may be necessary to be sure of a diagnosis or to rule out certain conditions and diagnoses. Members also often demand prescription medications to treat conditions that the PCP believes may be better addressed through other approaches. PCPs are placed in a difficult position if they resist this pressure.

All of these forces persistently push up demand for service with no sign of abatement. As far as one can see into the future, it appears that greater demand is coming. Indeed, as already noted, if one looks to younger generations, there is nothing encouraging in the data about lifestyle and its coming consequences.

## Disturbing Conclusion

Here is the disturbing conclusion: CareFirst, as a payer, and we, as a society, face a tsunami of demand just as benefits are being curtailed due to lack of affordability. The market shift to high deductible plans is the first manifestation of this and has been accelerated by ACA. The plan designs offered under the Affordable Care Act on each of the various metal levels – particularly on the Bronze and Silver levels – have very large amounts of cost-sharing in them, as already noted. Even Members with premium subsidies are left with considerable cost-sharing. What behaviors will this cause? Are we headed to a solution? Not by ACA insurance reforms alone.

[20] *Source: HealthCare Analytics - incurred in 2015 and paid thru March-2016 using CMMI Grant data for Medicare Beneficiaries.*

## Powerful Demand Meets A Fee-For-Service (FFS) System That Rewards Volume

If all of this were not enough, the system of health care financing in this region – like most of the nation – is based on an inherently inflationary model since it relies almost exclusively on a FFS method of payment. This system builds in powerful forces for growth in the volume of service. It is no surprise that when one pays by unit, one gets more units.

The vast majority of providers are paid in this way – by government Programs (e.g., Medicare) as well as private insurance carriers, such as CareFirst. This includes payments to physicians, hospitals, pharmacies, physical therapists and virtually all other providers.

This has led to a determined payer focus on trying to limit fee levels (unit price) with Medicare setting the framework and benchmarks. Unit price has been the object of a large consultant community that pores over the relative fees paid by different carriers. As payers try to control unit fees through contracted provider networks, the volume of service rises steadily – at least, in part, to compensate for fee/rate restraints.

It is now clear that federal health care reform depends on major Medicare savings in the form of fee and rate restraints to providers in order to cover the costs of increased coverage to millions more Americans and the subsidies this entails.

While hospital charges in Maryland are controlled by State regulation, the one-third of all health care costs that are driven by professional fees (two-thirds of which, in turn, are for physician services) are not currently regulated and never have been. Therefore, control rests with the private contracting efforts of payers who develop – as CareFirst has – networks of providers who accept less than their billed charges as full payment. If this were not true, payments to physicians would be two to three times higher than their current levels – and premiums would be substantially higher as well.

It is elemental to realize that efforts focused only on fee levels fail to address the key inflator – the high use of services driven by high demand – which is, in turn, driven by lifestyle and aging, and a financing system that rewards volume. A central reason why the CareFirst region experiences among the highest health care costs per capita of any region in the U.S. is the direct result of high use levels. The region has among the highest rates of hospital admissions, one day stays, readmissions and professional service use levels in the nation.

Why this is so is not well understood. There are no known, unique risk factors in the region driving this higher use level. But a number of experts believe that it was the reimbursement system itself – with its historical emphasis on volume based rewards – that induced higher use. The new all payer system of hospital reimbursement is designed to contain and reverse this under Maryland's new Medicare waiver that went into effect on January 1, 2014.

Under Phase 1 of the new waiver, Maryland has transitioned to a population-based model where hospital revenue is no longer impacted as directly by volumes, but is adjusted based on population and demographic factors. An expected outcome of the new waiver is that hospital admission/readmission and utilization rates should come down to national norms. This will not happen overnight and is likely to take the full five years allowed under the waiver to reach national averages. Results to date have been mixed.

Despite the challenges and volume inducing aspects of FFS payment, many believe that PCPs are substantially underpaid in the aggregate, while specialists, particularly hospital-based specialists, are overpaid relative to PCPs. It is believed that this is leading to imbalances and shortages in the availability of primary care services – the key to accessibility.

Nevertheless, there is little evidence that the region served by CareFirst has a greater undersupply of physicians or a greater shortage of PCPs than other regions of the country.

The need to generate income from the FFS system has led many PCPs to pass Members through their offices at high rates of speed – often at 35 or more Members a day. This has led to Member encounters of ten minutes or less with quick handoffs to specialists when anything beyond the routine is found – as noted above. Quite simply, there is little financial reason for a PCP to take the time and risk or bear the consequences with more complicated Members in his/her office.

This forced, rapid-fire style of practice is often not what the PCP wants. Most would prefer to work more closely and extensively with those of their Members who have multiple conditions to manage. This simply is not possible in a fee-based

system that pays solely based on visits, not on outcome or Member need. (It should be noted that Phase 2 of the new Maryland Medicare waiver – to begin in 2019, if approved – would include non-hospital costs, i.e., Medicare Part B).

## Fragmentation, Gaps And Breakdowns Result From Fee-For-Service (FFS) System

Not surprisingly, as is evident to any user of health care services, the health care system that has been built by the FFS financing system is highly fragmented with silos of independent specialists and other practitioners. In such a system, coordinated care and shared information – the keys to better outcomes for people with chronic disease – are hard, if not impossible, to achieve.

To make matters worse, a person with multiple chronic diseases typically visits a number of specialists who have no connection to each other. Each focus on his/her specialty. The busy PCP is often not aware (or, at least not aware timely) of the outcome of these visits or of a subsequent hospital admission. Each provider cannot see or may not trust what the other has done and may repeat what the other did. No longitudinal Member record exists that displays all the services (and results) provided by the fragmented health care system to a particular Member.

Too often, real coordination of care does not occur. Indeed, many small primary care groups lack the capacity for Care Coordination because of limited resources and systems. And, nearly three-quarters of PCPs in the CareFirst service area practice in solo offices or in groups of fewer than three physicians.

## No Holistic Picture Or Understanding Of Chronic Disease Members

The bottom line: one of the things most essential to the care of Members with chronic disease – a complete running understanding and record of their evolving condition and treatment – has been most lacking. Thus, there is no holistic focus on outcome and results over time across providers, care settings and services.

Further, providers in the current FFS System of financing are not incented/rewarded to overcome this. Nor do providers typically see, understand or come to grips with the aggregate cost of services that the fragmented FFS system generates for such Members. This is a central problem that must be squarely dealt with if care cost trends are to be moderated.

## Emergence Of Integrated Health Care Systems – Hope And Concern

It should be noted that a marked trend toward integrated systems of care is emerging in this country and region. These systems are almost always hospital-centric. In this region, we have seen the merger and/or affiliation of smaller community hospitals into larger academically-centered systems as has been true elsewhere. Increasingly, these large systems are employing physicians who were formerly in private practice as well as those just entering practice. Smaller, independent systems are in decline and may be largely gone by the end of this decade.

Two contradictory observations can be made about this: on the one hand, these large health systems offer the hope that badly needed integration will bring a pathway to help solve some of the problems of fragmentation. On the other, many experts are becoming increasingly concerned – as is CareFirst – that these consolidations represent oligopolies or monopolies that will breed a virulent new form of cost growth and unchecked negotiating power.

Additionally, massive capital investments made by hospitals in the last fifteen years now cause an equally massive urgency to secure Member flow and volume. Almost without exception, the compensation systems used by integrated health care systems for newly employed physicians reward the generation of billings and little else.

It is almost perfectly true that the larger the integrated system, the higher the unit fees/rates they are paid. This reflects little more than the respective leverage of the parties involved and raises the legitimate concern that the larger these systems become, the higher their reimbursement becomes.

In this environment, an employed PCP is seen by an integrated health care delivery system as an inlet valve – most useful for revenue preservation or enhancement through referrals to specialists in the larger system. Thus, the congealing health system generates its own demands that converge with the rising demands in the population and the demands prompted by FFS medicine and malpractice fears. This is a “witch’s brew” for a society concerned with the continued rise in health costs.

## Current Forces Work Against Cost Control

Given all of this, should we be concerned about future health care cost increases? Can there be a doubt of the answer? It is a resounding "yes." As a society, we have catalyzed potent forces that drive costs ever upward.

The ACA and the "repeal and replace" alternative legislation do not focus on curtailing these forces anywhere near as much as they do on insurance reform. ACA did, however, spawned efforts to innovate and find new payment incentive and accountability models. Indeed, this feature of ACA led to the Innovation Award CareFirst received to bring Medicare FFS Beneficiaries into the PCMH/TCCI Program.

## Long List Of Previous Approaches – Some Lessons Learned

Looking back over the past four decades, one is struck by the fact that substantial continuing efforts to curtail costs have been made – without substantial effect. What have we learned from these efforts that might guide us now?

To start, one needs only to recall the power of the movement that led to the creation of Health Maintenance Organizations (HMOs) that were the original hope for a more efficient care model to focus on prevention, wellness, holistic Member view, and Care Coordination. This hope was largely rooted in the belief that attention to the "whole" enrollee was needed. This was certainly not wrong. Yet, pure HMOs are a far smaller force today than were originally envisioned and have had generally less success and market appeal than was expected. Their typically closed or limited practice model has left a large percentage of the population looking for more choice.

A far different approach – aggressive payer intrusion into the care-giving process through stringent pre-authorization review processes before payment (with accompanying denials of coverage) has yielded small savings at the price of widespread dissatisfaction that is the very essence of why people distrust and dislike health insurance and managed care companies. This approach provided the grist for strong political invective in the health care debate as well as the political leverage to pass ACA legislation. In short, it is what made insurance companies and payers even more unpopular and provided the foil for insurance reforms which, while needed, are not nearly the whole answer as pointed out above.

A third approach – the shift of risk to individual providers and whole provider systems through capitated arrangements – was the rage in the 1990s with provider sponsored networks and appears to be coming into favor again by federal policy makers. It is useful to keep in mind that in the 90's, this approach resulted in well documented disasters and failures because the shift of risk was carried out in an inaccurate or unfair way that provider systems misunderstood and misjudged.

And, it turned out that providers, themselves, were not in a position to do what really needed to be done – to manage aggregate cost and demand and to coordinate the many steps needed to truly manage chronic care Members over a prolonged period of time. Many were hopelessly conflicted. How can hospitals afford to cut use levels? Should they fill their beds or try to reduce bed days? Should physicians be rewarded for cutting use of services, including testing and ancillary services or even admissions? Or, should they be rewarded for billing maximization?

The recent resurgence of interest in global capitation and in "bundled" payments for certain discrete services ("mini-capitations" or episode by episode capitations) is intended to foster better communication, stronger focus on outcomes and enhance accountability to achieve desired results. These approaches seek to include some provider "skin in the game" as a way of fostering these goals.

This is the essential idea behind the current interest at the federal level in Accountable Care Organizations (ACOs) which represent a renewal of the provider-sponsored network idea of the 1990s in a somewhat updated form. An ACO can include one or more hospitals, PCPs, specialty care providers and potentially other medical professionals and, as a system, would be paid a global, capitated amount for individual Members under its care. An ACO is based on a shared savings model within a global or partial capitation where some or all risk is shifted to the provider system.

Because ACOs are held accountable for aggregate cost and quality outcomes, they will presumably seek efficiencies and other ways to improve quality. Whether this approach will succeed this time is all in the details. What will be done differently? No one can yet say.

It will likely be the case, however, that ACO status may be achievable only by the same large, integrated health care systems referenced above whose unit rates and fees are invariably higher than the community average. Will these higher amounts be captured and preserved – in effect, be used as a base for capitated payments – in the bundled payments to come? Then, what will be achieved in making health care services more affordable?

It is certainly the case that, in the first six years of experience with the PCMH and TCCI Programs (**Performance Years #1-6, 2011-2016**), the systemically higher PMPM costs of Medical Panels that are part of large health care delivery systems was remarkably evident as discussed in the **Background, History and Results (2011-2016)** at the beginning of these Guidelines.

## Wellness – Right Direction, But Weak Results So Far

Recently, there has been great interest among employers in offering wellness Programs to their employees in an attempt to encourage healthy lifestyles. A substantial "wellness" industry has evolved to support these initiatives. There is, as yet, no compelling evidence that these Programs work across a broad spectrum of the population – especially among those whose unhealthy lifestyles are most engrained and most conducive to multiple chronic disease.

If such Programs appeal only to those most inclined to a healthy diet, fitness and general well-being, then little impact will be seen relative to those who are in the top 10 percent of the Illness Burden Pyramid where so much use and spending is located – or, in those who are headed there.

Yet, there is no doubt that attention to wellness and risk mitigation must be Elements in any successful drive to hold down cost growth. But, to become more impactful they must be based on stronger incentives of a financial nature to Members and providers alike. We believe they must also become the centerpiece of engagement between Members and PCPs rather than only between payers/employers and Members.

## Conclusion – No One Idea Works – A New "Weave" Of Ideas Is Necessary

CareFirst operates in the midst of all the forces outlined above. It has been involved in all of the various approaches that have been tried so far and has had direct experience with all of their consequences. The company feels the pressures from all parties. In developing the PCMH and TCCI Programs, this collection of experiences has been carefully weighed as has the experience of others outside of our region.

As a not-for-profit payer, CareFirst operates essentially at cost with razor thin underwriting margins (0.2 percent of annual premium/revenue, on average, over nine years). Any positive bottom line from operations is placed in company reserves for the protection of subscribers or for future rate moderation. Thus, over time, CareFirst premium increases directly reflect increases in health care costs and little else. On average, 83 to 85 percent of premium costs are for claims expenses.

In an attempt to control costs on behalf of its customers and subscribers, CareFirst relies on an extensive network of contracted providers which represents approximately 90 percent of all providers in the region, with a goal to keep networks as broad as possible. CareFirst offers an array of wellness Programs. Yet, premiums reflecting the actual care costs of Members continued to rise at alarming rates through 2011, but have slowed since. It is clear that what was done through the first decade of the 21st century (2000-2010) was not enough. The second decade has seen innovation – including the PCMH and TCCI Programs that are the subject of these Guidelines – with some encouraging results.

One only has to be in the payer role a short while to realize that the forces shaping the landscape are powerful, difficult to change, slow acting, and mighty in their impacts. Simply stated, health costs are rising as a result of tectonic forces that seem to be gathering strength. So called "solutions" cannot deal around the margin and expect to have an impact. There is a distinct need to change the incentives in the system that act on the Member and on the physician – starting with the PCP – in such a way as to counteract these forces. This is an exceedingly complex and extensive undertaking.

There is also a distinct sense that CareFirst as a payer and we as a society are at a pivotal point: individuals and employers are concluding that they can afford neither the premiums they are charged nor the out-of-pocket costs they incur at the point of service. This undermines access to care and, in the long term, the quality of the services received.

Contracted provider networks – on which coverage plans depend – seem threatened by increasingly intense disputes over reimbursement levels and legislative action. The individual consumer is coming to perceive that the value of his/her coverage is being eroded by high deductible plans and increasingly strident payer interventions, and is worried about less provider choice – all distinctly unattractive tracks to pursue – and all as costs continue to become more unsupportable. This is a toxic combination.

ACA rules governing health benefit plan designs – with their heavy cost-sharing and rigid rules – are making innovation more difficult. It is difficult to build incentives for risk mitigation and healthy lifestyles into these designs due to actuarial rules and other requirements. Ideally, one would want to provide incentives to Members to access care through more efficient and effective providers, to mitigate their health risks, to achieve better outcomes/results in dealing with these risks and to comply with Care Plans when they are sick. CareFirst has managed do so with some of its newer benefit plan designs, but is greatly constrained by ACA rules.

With all of this said, what can be done? Since no one thing has caused the problem, no one thing can "fix" it. Since the forces causing it are slow acting and powerful, the strategy to hold back cost growth or "bend the cost curve" cannot be expected to produce instant results. This makes a solution tough to conceive and even more challenging to implement.

This, then, is the context for the combined PCMH/TCCI Programs.

It is the specific intent of these Programs to steadily improve quality of care and outcomes over time. The improvement of quality outcomes will almost surely have a positive impact on cost results over time. Quality matters. Higher quality matters more. The highest quality matters most. The results in the years 2011-2016 are encouraging on both cost and quality measures.

In the pages that follow, the key results, goals and Design Elements of the PCMH Program – and their intended interaction – are presented and explained.

# Part II: PCMH: The Core Economic And Accountability Model

## Preface

The core Patient-Centered Medical Home Program ("PCMH"), which is supported by the Total Care and Cost Improvement Program ("TCCI"), is based on a number of beliefs, assumptions and theories about what must be done to transform the health care system in the CareFirst region – and, by extension, the American health care system.

These beliefs, theories and assumptions are rooted in common every day experience and common sense. They are based on essentially simple and straightforward ideas that have been around a long time. They find expression at the intersection of financing, structure and accountability in the health care system. They build on the old-fashioned idea of the central and inescapable role of the Primary Care Provider ("PCP"). But, they weave this idea and a number of others together in a way that has not been tried before in an attempt to create a model on a region wide scale that could become a model on a national scale.

As important as they are, the PCP, alone, cannot credibly be a PCMH. A team is needed that is composed of PCPs together with other health care professionals. The Program takes the view that small performance teams of PCPs – called Medical Panels – are the essential building blocks.

While the days of the solo PCP are ending, the centrality of their role endures and even ascends in value. The PCMH Program sees a path forward that represents an alternative to the employment of PCPs by large health systems (a direction taking place in the CareFirst region just as it is all over the U.S.). Their continued independence as part of viable small teams is seen as central to cost control and increased value.

A powerful outcome oriented incentive tied to the actual results achieved by a Panel (which is a performance unit) for the whole cohort of Members it collectively treats is seen as central to transformation. This incentive is not tied to process measures or to the delivery of primary care alone, but, rather, to global improved quality and cost outcomes for the whole cohort of Members cared for by the Panel. All design considerations and financing features flow from this – including how accountability is fixed, how information is gathered and displayed, how supports are arranged (through TCCI) and how the role of the network administrator (CareFirst) is defined and carried out.

Recognition of the importance of the micro local nature of health care is seen as central as well. High-touch for those Members with multiple chronic diseases – through high engagement with the PCP and team leveraging the best local health care assets – is among the greatest areas of emphasis.

So, on the belief that any system of health financing can be beaten, the PCMH Program takes the view that the "secret" is to design a system that when beaten, is beaten in a socially productive way. The beliefs, assumptions and theories behind the PCMH Program shape a system that is meant to be beaten – but, one that can only be beaten by improved quality and cost restraint over time – and, by actual achievement of strong outcomes, not simply well intentioned process oriented attempts to do so.

In effect, the core to the whole PCMH design is to build a market-driven model in which the pursuit of informed self-interest by PCPs drives the whole system to better outcomes. This fosters focus on the Members at the top of the Illness Burden Pyramid and on other "at risk" Members who might otherwise move up in the Illness Burden Pyramid were it not for more attentiveness to them and their risks.

In effect, the model reinforces and adds impetus to the very reason why most PCPs went into their chosen field to begin with – to take care of these kinds of Members. The difference is that it gives them a tangible, substantial reward to do so.

Incentives are the key to change. There are no penalties, no risk shifts, and no complicated mazes of rules that are the active ingredients in this new model.

The primary care team with the PCP at the center, becomes not only the essential provider, but the essential "buyer and arranger" of specialty services for Members. This causes specialists to become responsive to a marketplace of informed PCP "buyers" or lose ground in the struggle for referrals. These buyers are incented to seek cost-effective results. No Member can perform this "buying" function better for themselves.

Indeed, the Program takes the view that a collective market composed of informed and motivated PCPs is in the best position to productively influence specialist behavior – and with it, hospital behavior. The independence of primaries to do so is seen as central.

Therefore, the hospital in this marketplace is not seen as the central player around which to organize. Indeed, it is the shrinkage of the hospital as the central player that is the consequence of this model. Stabilization of Members at home and in their community – through avoidance of unnecessary or preventable admission, re-admission and emergency room use as well as avoidance of over medication, is seen as central to long-term savings. In short, it is the savings derived from care provided in more appropriate settings that leads to avoided inpatient and outpatient hospital use and pays for the incentives and redirection that must occur.

The rules of financing in the PCMH Program fulfill the beliefs, theories and assumptions as outlined in this **Part II**. These ideas are universal, apply to all payers and are scalable without limit. There is not a single brick and no mortar. There is, however, extensive online integration of Program elements, extensive use of online data transparency and a blended capitation and FFS financing model in which it is essential that global capitation be fused with FFS payments.

The execution of the underlying beliefs and theories, therefore, requires an online infrastructure that is the essential scaffold upon which the beliefs find expression and come to life. A network administrator who is also an information supplier and connector – with the breadth to reach all settings, all providers, all services anywhere as well as the broader purchasing marketplace – is seen as the essential scaffold builder and maintainer as well as the strategic partner to the PCP and Medical Panel. This is the role CareFirst plays.

This **Part II**, therefore, sets the stage for all that follows in subsequent **Parts** and establishes the core goals of the PCMH Program that the larger TCCI Program seeks to support and enable.

## Basic Principles And Core Ideas For Providers And Members

The aspirations that guide CareFirst's approach to improving cost and quality outcomes are rooted in five core ideas. Before setting forth the specifics of the PCMH Program, which is the heart of the larger TCCI Program, it is worth noting these core ideas – all of which are aligned with the Triple Aim of improving the Member experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

### Five Core Ideas Relating to Providers – Especially PCPs

There are five key ideas that shape the PCMH Program. They are:

**First,** the best approach is to build on incentives that foster partnership and greater accountability as well as reward changes in behavior. Nothing in the PCMH Program is predicated on penalties or the shift of insurance risk to providers. Therefore, there is nothing in payment methodology that could negatively disrupt or influence provider judgment in caring for Members;

**Second,** quality of care measures must be built in from the beginning to assure that any drive toward cost control does not result in suboptimal quality. The single most critical component of quality is the degree of engagement among the Member, the PCP, the specialist, and other health care professionals involved in the Member's treatment, all of whom comprise the Care Coordination Team. This is never more necessary than for the chronic care Member with multiple conditions/diseases that persist over time and that are treated in multiple settings through multiple providers;

**Third,** PCPs must be better rewarded for seeking and actively pursuing the best outcome for their Members over time and across all care settings – not just in their own offices. Further, the PCP must be better compensated for taking more time with certain chronic care Members at the point of care to reach a considered judgment about their needs and to more fully follow-up on their care over time;

**Fourth,** the FFS System is useful in some essential ways that simply cannot be pushed aside or discarded. Among these are documentation of services actually rendered and the accurate "capturing" of the enormous variation in services often required to treat Members with different circumstances, conditions and diagnoses. The benefits of FFS payment should not be tossed aside in the dash to a new "bundled" approach to financing health services.

However, the virtues of capitation – such as stronger focus on outcome and results – must be brought to bear. The best path is not to rely wholly on one approach or the other. That is, the key to a new payment approach lies in a blend of the two methods that rewards both cost control and high-quality outcomes over time while harnessing the benefits of FFS. This also eases implementation for all parties; and

**Fifth,** the power of real-time, web-based online connectivity must be brought to bear on the problem of sharing information about Members with and among their care givers more completely and easily – especially in creating and maintaining a longitudinal Member record. This alone improves the chances for attaining better outcomes and is less about Electronic Medical Record (EMR) Systems within provider offices and more about the connectivity between and among providers and payers who will always be on disparate systems.

**Five Core Ideas Relating to CareFirst Members**

There are five core ideas that relate to Members. These ideas relate to how Members can play a constructive role in curtailing health care cost growth. It is, after all, their health status that is the principal and sustaining driver of improved health care service use.

**First,** a baseline health assessment at the yearly enrollment of each Member is a starting point in focusing Member attention on lifestyle consequences and emerging health risks. Such an assessment is designed to engage the Member in working with his/her PCP for better health outcomes. The assessment itself is composed of two parts: A questionnaire and Biometric Screening. If conducted in the workplace, apart from the PCP, the results of both parts should be shared with the PCP (with the Member's consent);

**Second,** there should be no cost barrier in the form of deductibles and/or copayments that prevent Member access to primary care services (for sick care), preventive screenings and prescription drugs necessary for the management of chronic disease;

**Third,** there should be meaningful incentives for Members to form a strong, lasting relationship with the PCP of their choice – regardless of their health status. But, this should come with the freedom to access care around the PCP if the Member feels this is appropriate so that no "lock-in" occurs. At present, nearly one-sixth of CareFirst Members do not have a PCP– particularly young, healthy people who do not think they need health care services or those whose conditions/illnesses cause them to be already in the care of specialists. Moreover, the right of Members to switch PCPs at any time should be preserved. The Program imposes no limit on the ability of Members to choose their PCP or to change their PCP at any time;

**Fourth,** there should be meaningful financial incentives for Members with chronic disease – especially those with multiple chronic diseases – to comply with Care Plans developed by their PCP and to take steps to reduce their health risks. This is probably best done by taking a page from the high deductible health plan playbook in the form of subjecting higher cost specialty and hospital-based services to deductibles and copayments, but then waiving these in whole or part when Members comply with their Care Plans thereby reducing their risks for future health care expenditures;

**Fifth,** Members should be covered by a complete benefit plan, including coordinated/integrated prescription drug and mental health coverage as part of a purposeful design. No "savings" should be achieved by curtailing or creating holes in coverage that become traps for the Member or inhibitors to Care Plan implementation. No "carve outs" of services should occur causing a difficulty in coordinating services or obtaining complete data on a Member. In particular, no design should foster hidden rules, gaps, cost-sharing or conditions that create surprises when access to service is sought by the Member or when a Member tries to comply with Care Plan directives.

However, here again, the ACA establishes rules for benefit plans that cause them to include considerable cost-sharing. These rules may inhibit the achievement of this objective in the individual and small group market segments, in particular, where ACA rules and benefit plan requirements are most felt.

**The Combination of the Provider and Member Ideas – in Full Alignment – is the Foundation of the CareFirst Strategy**

The two sets of five core ideas for Providers and Members described above shape the design of the PCMH Program and the Blue Rewards product portfolio which is presented more fully in **Part V**. Blue Rewards is an amalgam of HMO, PPO and high deductible design ideas – itself, a new "weave" – with a purposeful point of view: To induce more health risk awareness in the Member, reward health risk reduction, and foster guided, coordinated care when the Member needs it. The five ideas behind the provider model are also an amalgam of proven techniques in a "new weave". Put together, they are intended to induce better overall outcomes in cost and quality for Members.

Thus, the core concepts underlying these Guidelines are diffused through the entire CareFirst product portfolio and provider network design.

## Key Beliefs Underlying The PCMH And TCCI Programs

**PCMH is More Than a PCP**

PCPs, by themselves, generally are not set up in the current environment to provide appropriate Care Coordination for Members with multiple chronic conditions. A typical comprehensive Care Plan involves multiple services in multiple settings over an extended period of time, with labs, prescriptions and diagnostic services associated with each. Multiple follow-ups are often required. Specialists are extensively used.

The complete picture of the Member's health status that emerges from all of the interactions involved must be monitored, continually interpreted through ongoing interaction with the Member and the Member's various care givers, and then acted upon effectively. This is difficult to do and is not done well or at all in many cases. The lack of financing for these coordinating services inhibits their doing.

To have a hope of realizing better coordination over time, the most immediate challenge facing most PCPs is the lack of a clinical support team. This must be overcome. Therefore, key to the Program is a clinical support team – which is referred to in these Program Description and Guidelines as a Care Coordination Team that includes the PCP, the PCP's Group, all participants on the PCP's Medical Panel, other treating providers and health care professionals who provide PCMH services to the Medical Panel and/or CareFirst's Members.

The Care Coordination Team is led by a Regional Care Director ("RCD") who is supported by a number of Local Care Coordinators ("LCCs"), all of whom are Registered Nurses. These nurses are in the best position to provide ongoing Care Coordination – especially for Members with multiple chronic diseases – under the direction of the PCP.

It is this fulcrum between PCP and the support team that improves the chances for stronger Member outcomes. It is precisely this fulcrum that is lacking in so many primary care practices, especially the small ones that predominate since they do not have the resources.

A support team, in turn, goes beyond the RCD and LCC. It often includes other health professionals, such as nutritionists, health educators, physical therapists, pharmacists and mental health professionals, among others. It is critical that these support services be locally based and well-woven into the community where the PCP is located and the Member lives. And, the home may be the best setting for the provision of these services – a place where few services are provided today. Home care services account for less than three percent of CareFirst's current spending.

Accessible primary care services – including extended service hours and telemedicine – are also critical to high-quality outcomes. This is necessary for the avoidance or reduction in ER visits and preventable hospital readmissions. But, the availability of many PCPs is limited to regular office hours with little or no back-up and coverage. After-hours coverage is often provided by the local hospital ER.

It is apparent that the elements listed above – while generally seen as desirable – are often missing, given the way in which PCPs practice. PCPs in solo practice or in small practices are simply not in a position to offer extended access or to provide continuity of services through Care Coordinators and other allied health professionals within their practices. Without overcoming this, no real change can occur.

## The Goals Of The PCMH Program

There are three goals of the PCMH Program:

**First,** the Program seeks to encourage all CareFirst Members to select and use a PCP regardless of benefit coverage plan (e.g., PPO or HMO). Adoption of Blue Rewards features is, of course, strongly encouraged.

**Second,** with the PCP in the role of quarterback, the Program seeks to have the PCP differentially and persistently focus on resource intensive Members. The Core Target lists identifies Members who may be most appropriate for care coordination.

Care Plans are generally developed for Members whose Illness Burden Score (IBS) is significantly greater than the average in the PCMH Program. The PCP is the key to intelligent, informed guidance and assistance to the Member who needs to make changes in lifestyle or comply with the requirements of a treatment regimen/plan.

In support of this, the Program seeks to provide PCPs with additional dedicated Care Coordination Team Members, including allied health professionals who are charged with active Care Plan follow-up over time to minimize care gaps or breakdowns and to promote healthier lifestyles.

In other words, the PCMH Program seeks to enable PCPs to disproportionately focus on the health outcomes, treatment patterns, and plans of their Members most in need of enhanced support – across all settings – and not just the small portion of services that relate to primary care. To do this, PCPs must have connection to and engagement with the other participants on the Care Coordination Team in a way that does not cost the PCP– or a "Panel" – up-front dollars to create and maintain. This is exactly what the TCCI Program provides. Over 400 nurses are involved in these Programs in the CareFirst area as part of the PCMH and TCCI Programs.

**Third,** the Program seeks to enable the PCP to better see and understand the downstream costs and quality implications of his/her referrals and to take a continuous interest in this through informed specialist selection and collaboration. That is, the Program seeks to encourage the PCP to wisely select providers of specialty services with a considered eye toward both the cost and quality of outcome which the Member may be unable to effectively do on his/her own.

Simply stated, the Program seeks to foster a greater connection and engagement between the PCP and the specialists that serve his/her Members by focusing his/her attention on **both cost and quality outcomes** achieved for his/her Members over time across all settings. This is accomplished through a combination of technical support, the development of networks of local Care Coordination Teams and direct, substantial financial incentives to the PCPs to become concerned with the downstream consequences for their Members resulting from their Care Plans and referral decisions.

In the PCMH Program, high-quality, coordinated and anticipatory service across PCP and specialist is seen as the key to cost-effective results. That is, high-quality works for cost control – not against it.

## An Important Key Is PCP And Member Engagement

To achieve these goals, a high level of engagement by PCPs with their Members in the top three illness bands or on the Core Target lists is essential. This means that the PCP must be deeply involved in the Care Plan and implementation process for their eligible Members. Each Care Plan must, in effect, constitute a "contract" between PCP and Member if it is to be effective. Care Plan development and maintenance in the PCMH Program cannot be relegated by a PCP to someone else.

Since engagement between the PCP and the various specialists involved in a Member's Care Plan is also essential, the Program design seeks to foster strong communication between the PCP and specialists in weighing the options and various courses of treatment for a Member. It does not seek to have PCPs second guess the judgments of specialists or attempt to do the job of the specialist. Rather, it seeks to focus PCP attention on the "when" and "where" decisions regarding specialty care and to truly engage the specialist in shared, ongoing decision making – that is, true consultation around the need of each Member in a Care Plan.

This means obtaining the considered judgment of both the PCP and the specialist about a Member's course of action – with the Member involved as much as possible. This "considered judgment" then guides the Care Plan and all modifications of it over time. It is in this environment that the RCD, LCC and support team carry out their role, monitor Member progress and provide feedback on results to the PCP.

## Incentives For Members To Select PCPs In The Most Effective Panels

CareFirst believes it is important to encourage Members to choose PCPs in cost-effective, high-quality Panels through reductions in their cost-sharing. CareFirst has built an incentive to do this into its product portfolio based on the track record that has emerged from Panel performance. This new Program – called PCMH Plus – identifies high performing Panels with at least three full years of experience in the Program.

As of January1, 2016, a new version of Blue Rewards became available that encourages access to these high performing PCMH Plus Panels. By choosing PCPs in these high performing Panels, CareFirst Members are able to gain access to more affordable, high-quality health care while the PCPs in Panels have an opportunity to gain Members as a direct result of their strong performance. This new Program is described more fully at the end of **Part III** of the Guidelines.

## Summary Of The Key Beliefs Underlying The CareFirst PCMH Program

With all that has been said above, it now becomes evident that the CareFirst PCMH Program is predicated on a number of underlying core beliefs and theories. These beliefs and theories find expression throughout the 10 Design Elements of the PCMH Program and 20 Program elements of the TCCI Program. The core beliefs and theories are summarized below.

### 1. PCP Accountability For Global Target Budgets Is Essential

**The Program assumes that the PCP should be the central player/quarterback and "arranger" of care across all settings and is in the best position to influence global health care spending for his/her Members, not just the small portion of spending provided in the PCP's office.**

Therefore, the accountability of the PCP in the PCMH Program is global – for all costs in all settings and for the aggregate cost and quality outcomes for Members attributed to the PCP.

**The Program design assumes that the organization of PCPs into small teams is essential for backup and coverage and that the pooling of experience across the multiple PCPs on a team is needed to establish actuarially stable target budgets and to provide statistically meaningful reports designed to identify significant differences in cost and utilization patterns.**

This is intended to promote effective, self-interested, highly focused peer review. Thus, in order to be eligible to join the PCMH Program, the PCPs are required by CareFirst to form "Medical Panels" even though this is unnatural for many in active practice today.

**The right of Members to change PCPs and refer themselves for specialty care is viewed as a key counterbalance to any ability or inclination that the PCPs might otherwise have to under-provide care or stint on appropriate referrals to specialists.**

Although Members are attributed to PCPs in Medical Panels, they retain the same "freedom of choice" rights to change PCPs and to refer themselves for specialty care that are embedded in their underlying benefit packages.

**The main challenge in achieving sustained and focused care management is not limited to setting up of the PCP in his/her office to be a PCMH, but rather, enabling of PCPs to coordinate care and see patterns of care and cost beyond their office, across all settings, and over time for their Members**.

As noted earlier, the Program causes PCPs to take accountability for the overall cost and quality of services provided to their Members in any and all settings.

This requires additional capabilities that PCPs do not typically have – and, cannot reasonably be expected to obtain in many cases. These include Care Coordination capabilities that are well outside the PCP's office, including nurses who serve as LCCs; and a common Member Health Record (MHR) across all settings, with highly accurate information on services actually rendered to the PCP's Members in all settings (hence, the importance of FFS). These capabilities are, therefore, supplied by CareFirst as the administrator of the PCMH and TCCI Programs.

**Simply paying PCPs more through a PMPM mechanism will not – by itself – produce results. Rather, the Program assumes that it takes two parties to achieve meaningful, sustained results toward better outcome and cost control over time: The PCP and the PCMH Program administrator/payer who spans the entire network and healthcare system – well beyond the reach of the PCP**.

Administrative capabilities provided by this central administrator/payer – a role played by CareFirst – must include ubiquitous web connectivity, information feedback on Member care patterns over time across all settings, and the ability to offer support capabilities. Member rosters stratified by Illness Burden and episode profiling (to better see patterns of care) are critical capabilities well beyond the reach of most PCPs to develop on their own. All of these capabilities are provided to PCPs by CareFirst.

**Large hospital-based integrated care systems such as those fostered by risk-based ACO models should not be made the central players in global budget target models. Rather, global budget target models should be built around the PCP as the central player.**

Systems built on hospital-centric cores will likely create conflicting goals and may not be the best chassis for long-term cost control. Indeed, they may very well be antithetical to it. Specifically, hospital-centric systems have business models that are volume-driven. Specialists and hospitals – whose volumes are most vulnerable to a Program designed to root out inappropriate use – are financially, organizationally and philosophically not well-positioned to be early and aggressive adopters of the kinds of changes in medical practice that are sought by the Program.

## 2. Financial Incentives To PCPs Must Be Substantial

**Offering strong financial incentives to PCPs to reward them for differentially focusing on the needs of Members with chronic disease or those at high-risk for chronic disease is critical to bending the cost curve and improving overall quality for defined populations of Members**.

The most powerful incentive offered in the Program is a very substantial upside-only "gain share" opportunity in which Medical Panels that perform well on quality metrics and beat overall budget targets receive additional large increases in their compensation levels. These additional/supplemental fee payments can be in the 20 to 50 percent range. The "target budgets" given to Panels are set by trending the historical, risk adjusted experience of each Panel's attributed Member population from a base year. The Program uses a shared savings approach to reward and offer incentives to PCPs to work together towards better overall quality and cost outcomes for the cohort of Members in their Panel.

**The shared savings method used in the PCMH Program – which pays incentives in the form of FFS supplements to PCPs– enables these incentives to be applicable to all lines of commercial business, including insured and ASO accounts.**

This broad inclusivity of all types of coverage is essential to broad market adoption – which, in turn, is essential to assuring the Program is significant enough in size to induce PCP attention to the Program's objectives.

**FFS as a payment method should not – and cannot – be wholly replaced in the foreseeable future, but its volume-inducing effect can be mitigated by global health care budget targets for Medical Panel Member populations.**

The essential benefit of FFS payment – the tie between specific services actually rendered and payment – must be maintained. This is critical to data completeness, transparency, and accuracy which enable the Program's quality measurements and information analyses and reports to be generated. This will be further enhanced with the adoption of HIPAA 5010 and ICD-10 standards.

**The FFS basis of payment to PCPs is conducive to motivating the PCPs to continue (or increase) their rendering of primary and preventive services to Members.**

There is little concern for overuse of primary care services because these services are currently underprovided in many instances and account for so little of overall health care costs.

**Shared savings incentives to PCPs can be relied upon to drive much more effective use of specialty and hospital services.**

The Program assumes these incentives will change behavior and that PCPs will become more attentive to when and where they refer and to the cost and quality outcomes resulting from these referrals. In effect, the Program gives PCPs a direct stake in Member outcome over time for services they did not render themselves but, in fact, are essential for their Members.

**No individual PCP or group of PCPs is in a position to take on risk for the total costs of their population of Members.**

As previously noted, PCP incomes account for only five to six percent of total health care spend. PCPs cannot feasibly underwrite even small overruns in total medical cost budgets.

Therefore, the PCMH Program's system of global accountability and rewards is based solely on incentives. These incentives are tied to total population outcomes regarding total cost savings and are conditioned on achievement of quality standards. The key assumption is that the Program's incentives are powerful enough to work even when they operate without risk – and that these incentives are powerful enough to change behavior in the directions desired.

**Once formed, a Panel's base experience for all the health costs of its Members is adjusted for changes in the illness burden of its Members over time. Once these costs are further adjusted for Overall Medical Trend they are re-based only under certain specific circumstances relating to large changes in the PCP composition of a Panel.**

In effect, the incentive is to beat trend in cost growth year after year after changes in the illness level among Members in a Panel is normalized – and to do so by improving overall performance for the cohort of Members in each Panel. The Panel that beats trend attains a reward in shared savings that becomes greater when done consistently year over year. Multiple Panels beating trend, bends trend. This leads to systemic cost control and improvement in care quality.

## 3. Improving Quality Outcomes Is Essential To Cost Control

**Quality improvement and cost control are seen as inextricable – they go hand in hand and are mutually reinforcing**.

The most important cost control and quality improvement action is to actively coordinate care for the multi-chronic Member across time and multiple settings/providers and to closely monitor high-risk Members before they break down – that is, to fill in gaps in care effectively. This requires capabilities beyond the reach of the PCP alone.

OIAs to Panels are based on degree of savings achieved against budget targets, but they are adjusted up or down based on Panel performance against a substantial list of industry proven quality measures. This makes quality performance an integral part of outcome performance assessment.

**Engagement among PCP, Member and LCC is the single most essential element in obtaining quality outcomes and is the driving force of the Program toward quality improvement.**

Engagement means paying attention to the needs of certain Members more closely over time due to their conditions or illnesses and working actively with them as well as with a nurse-led care team in coordinating their care across time and care settings.

Engagement and aligned incentives induce coordinated, focused actions around the dual purposes of cost control and quality improvement over time with the Member at the center.

## 4. Reporting/Informatics On Demand Is Critical

**Information feedback to PCPs on their Panel's total cost and care patterns – including PCP knowledge of the cost of specialty referrals by episode – is critical to causing productive behavioral change.**

This information enables the PCP to make prospective decisions on when and where he/she refers Members for specialty care and to make informed decisions about Member "slotting" into different programmatic or clinical tracks outside the PCP's office.

It is a core premise of the Program that judicious decisions about when to refer, and to whom to refer, are more important keys to cost control and outcome than anything the PCP does in his/her office.

**Exposing and highlighting differences in quality and cost outcomes within and across Medical Panels will encourage individual PCPs and Medical Panels to examine their own performance and their opportunities to improve care and their own incomes. This information is essential to motivating and sustaining behavioral change.**

Cost and quality data gathered and reported in a disciplined, common way across the PCMH network for all care in all settings by all providers is essential to behavioral change since it creates a fair and uniform yardstick of performance.

To do this, detailed claims data is needed. Only the administrator/payer is capable of providing this information and CareFirst provides it to the PCMHs through a sophisticated package of online, regularly updated SearchLight Reports and other information**.** Much of this data is derived from claims – a key and essential byproduct of the FFS system that must be maintained.

**The Program attempts to create a viable health care market by providing Medical Panels with information and financial incentives that make them informed "buyers" of specialty based services who are able effectively to represent the interests of their attributed Members.**

The interests of the Medical Panels and their attributed Members are aligned because Members want timely, high-quality, cost-effective medical care and Medical Panels are the most likely to retain Members and earn incentive awards as those providing this kind of medical care. Equally important, the PCPs become the "buyers" and arrangers of specialty care services for their CareFirst Members and make key decisions about when and where to refer Members. The outcomes achieved by Members rest heavily on these decisions.

## 5. Care Management Supports Are Essential To PCP Success

**Locally based nursing support in the development and maintenance of Care Plans is essential** to the coordination of care for Members who have multiple chronic diseases. This support must be made available in a manner which does not place the entire expense of nursing support on the PCP.

**Hospital transition of care nursing support and case management services for critically ill Members of PCPs is essential** to overall cost control and improved outcomes that are typically beyond the reach of most PCPs.

**Pharmacy consultation for Members with multiple medication/prescriptions** is essential to stabilization of the multi-chronic Member and should be performed in cooperation with local pharmacists.

**Behavioral health services are essential to a high percentage of Care Plan Members** and must be made easily accessible to PCPs and local nurses as a continuing part of any overall Program of Care Coordination.

**Home-Based Services ("HBS") and home assessments are essential** to stabilizing Members with multiple chronic diseases and must be readily available as a resource for PCPs in Care Plan development and maintenance.

## The CareFirst PCMH Program Can Be Seen As A Market Driven Model

In sum, the CareFirst PCMH Program seeks behavioral change on the part of PCPs that is driven by their pursuit of enlightened self-interest through incentives to improve quality and cost in the aggregate for their defined population of attributed Members. These incentives are intended to fuel the desire on the part of PCPs to work as a part of a small team-driven approach in which performance and reward are tightly linked. Team performance and cooperation are assumed to be atypical for many PCPs and must be induced to occur by the Program's rules, structure and incentives.

The role of the Program Administrator (CareFirst) is seen as essential as the role of the PCP, but this role is supportive and enabling, not controlling. Rather, the incentives, accountability model, and information feedback loops in the Program are deliberately intended to create an etiology of productive change in behavior centered on the PCP and his or her decision-making on behalf of Members that cuts across all settings and aspects of care.

Thus, in a deliberate way, the PCMH Program design is intended to be self-fulfilling, self-policing, and uses the pursuit of self-interest to achieve a larger public policy purpose. In this sense, it is a market-driven model. Little intrusion through traditional means of cost control (preauthorization, medical necessity reviews, etc.) is present. The dual goals of higher quality outcomes and more moderate cost trends are the intended result. Stated alternatively, the Program uses incentives and accountability to create a market driven dynamic in which PCPs "shop" for specialty and other services on behalf of their Members and focus on the Members that need them the most across time and settings of care. This is something the Member cannot do as well for himself or herself.

Indeed, the Outcome Incentive Award ("OIA"), explained in **Part III**, **Design Element #9** that follows, is the method used by CareFirst to calculate the level of financial reward that is distributed to the Medical Panels. Medical Panels that achieve at least a minimum level of Member Engagement and beat their target budgets earn an OIA. That is, the Panels that achieve savings for their whole cohort of Members receive incentive payments which are paid in the form of increases to their fees in subsequent periods. These awards, in turn, are tied to the percentage level of savings the Panels generate in their target budgets and their relative performance on a set of defined quality measures. The level of OIA is ratcheted up and down to reflect the relative quality and consistency of performance of each Medical Panel.

This gives the Medical Panels strong motivation to both save on costs and improve quality. Medical Panels that improve quality without saving costs do not receive incentive payments on the grounds that total healthcare costs (at nearly 18 percent of GDP) are already at the breaking point of affordability and funding payment for higher quality alone without also improving efficiency is no longer feasible.

Quality improvement and cost control are seen as inextricable. Cost control without quality improvement is impossible over the long term. PCPs cannot achieve improvements in quality and cost control by themselves. Indeed, they must catalyze these improvements by effective, informed relationships with specialists. The Program gives them the tools to do so and incentive to use them in this regard.

In short, the PCMH and TCCI Programs assume that any system can be beaten. The PCMH and TCCI Programs set up a system that is designed to be beaten but, when beaten, is beaten in a socially productive way.

# Part III: Building Blocks Of The PCMH: The Ten Essential Design Elements

## Preface

To meet the goals of the Patient-Centered Medical Home Program ("PCMH"), there are 10 Design Elements that are intended to work together as a whole to produce the desired results.

There is no attempt in the PCMH Program to go for a quick fix in "bending the cost curve." It has been expected from the beginning that a slow, steady shaping of behavior will occur as a re-orientation takes place in reaction by Primary Care Providers ("PCPs") to the Program's framework and incentives.

At its core, the Program seeks to encourage what is best for Members and to reward PCPs for achieving this. The 10 key Elements are listed below and are explained in detail subsequently:

**Design Element #1: Medical Panels – The Central Building Blocks And Performance Units**

**Design Element #2: Member Attribution – The Assignment Of Members To Each Panel**

**Design Element #3: Calculating Member Illness Burden Scores ("IBS") – Enabling Population Health Management**

**Design Element #4: Establishing Global Expected Care Costs For Each Panel – Patient Care Accounts ("PCAs")**

**Design Element #5: Deciding And Making Referrals – The Key Decisions**

**Design Element #6: Enhanced Focus On The Chronic Member – Care Plans And Care Teams**

**Design Element #7: Online Member Health Record – Information "Home Base"**

**Design Element #8: Measuring Quality Of Care – The Single Most Essential Ingredient**

**Design Element #9: Reward For Strong Performance –Outcome Incentive Awards ("OIAs")**

**Design Element#10: Signing On And Complying With Program Rules**

As already noted, the Program seeks to encourage/induce a mindset shift in PCPs toward greater focus on global outcome for their whole population of Members. This is intended to enable PCPs to do what many were called to do when they first started to practice: To focus on those who need them the most and to help others reduce or mitigate their risks.

At its core, the PCMH Program design is Member centric as well as focused on enabling overall population health. Incentives are intended to foster this and to reward PCPs who achieve better overall cost and quality outcomes than targeted.

**PCMH Plus**

On January 1, 2016, CareFirst launched the PCMH Plus Network which is comprised of Panels that have attained - over a three-year period - the most cost-effective results. These Panels are attractive to Members who receive a deductible credit or credit on a medical expense debit card under the Blue Rewards feature of CareFirst benefit designs if they select a PCMH Plus PCP. This Program is available to all Members except those in individual or small group policies in Maryland (due to statutory and regulatory constraints).

## Design Element #1: Medical Panels – The Central Building Blocks And Performance Units

One of the central precepts of the PCMH Program is that small units or groupings of PCPs should be the basic organizational building blocks of the PCMH Program. These units or groupings are called Medical Panels or simply "Panels." A Panel may be formed by an existing group practice or be composed of a number of solo practitioners and/or small independent group practices that agree to voluntarily work together to achieve Program goals.

The Program starts with the recognition that most PCPs in the CareFirst region practice in solo practice settings or in groups of fewer than three physicians. PCPs must be part of a Panel in order to participate in the PCMH Program.

Panels must contain no fewer than five PCPs and no greater than 15 PCPs. There are five reasons for this requirement:

**First,** no one PCP has enough Members to pool experience necessary to see patterns and trends of care costs for an entire cohort of Members and to account for the randomness of illness in Member populations. For example, while a cohort of 3,000 Members may be reasonably sufficient to mitigate the randomness in the "luck of the draw" of Members, no individual PCP can attain this level just with CareFirst Members. This is also true with measures of quality, which can be reasonably evaluated with some degree of confidence based on composite scores from relatively small populations, but cannot be accurately assessed in the context of a single physician in a solo or small practice for a single payer's Members.

Since the PCMH Program offers incentives for improved cost and quality outcomes, there must be enough experience to reach sound conclusions regarding these outcomes. Too small a membership base is not fully credible because the smaller the number of Members, the less credible the result.

**Second,** solo practitioners cannot reasonably be expected to provide substantially expanded office access and continuous coverage for their Members by themselves. Larger practices or coordinated practices are better able to do this. Since a key goal of the PCMH Program is to provide maximum access to primary care services, grouping PCPs into Medical Panels is a way of better answering backup and coverage needs.

**Third,** Medical Panels have greater potential to coordinate care with a Clinical Care Coordinator Team led by a Regional Care Director ("RCD") – in the development and carrying out of Care Plans for individual Members. When smaller practices become part of a Medical Panel, they can take advantage of this opportunity to share other clinical team resources. This makes it more likely that they can effectively produce better results for their Members over time.

**Fourth,** there is a greater prospect for peer consultation across and among practices. This can promote discussion of different courses of treatment and specialist choices for particular conditions, diagnoses or treatments. The PCMH Program encourages the discussion of particular courses of action and peer review of emerging results within a Medical Panel.

**Fifth,** shared savings are calculated at the Panel level. These powerful, potential rewards place the participants of a Panel in common interest with each other – causing the actions of each to affect the others. The Panel – as performance unit – brings incentives as close as possible to each participant's behavior in full view of other Panel participants who have a stake in the results of the whole Panel.

It is these considerations that make the Medical Panel the basic organizational building block of the PCMH Program. All data, incentives and accountability provisions in the Program – as explained below – work best at the ideal Medical Panel size: Between 10 and 15 PCPs. At this size, Medical Panels are big enough to accumulate a credible cohort of CareFirst Members, but small enough for the contribution of each PCP to be seen and have an impact that matters to all Panel participants.

It is for these reasons that a Panel is best understood to be the basic performance unit or building block of the PCMH Program. It forms a team where a team otherwise did not exist. With this as the foundation, there are four types of Panels:

**Panel Type 1: Virtual Panel**

A Virtual Panel is formed by PCPs in solo practice or in small, independent group practices who voluntarily agree to form a single Panel for the purposes and goals of the PCMH Program. This Panel type is called "Virtual" because the PCPs do not become part of a single legal entity. Rather, they agree to contractually become part of a Panel that they freely choose while maintaining their own practice independence. In so doing, these PCPs agree to share information about Members in their care, use each other for backup and coverage and perform as a team or unit for the purpose of improving outcomes for the combined CareFirst population of Members in their care. When they do so as a Panel, they are more likely to earn an OIA.

Hence, a Virtual Panel formed in this way is not a legal entity (i.e., a professional corporation or other legal form). Rather, it is a voluntary association of practices consisting of five to 15 PCPs formed by contract with CareFirst. The PCPs in the Panel agree to sign a contract Addendum (see **Appendix A**) and individually and collectively agree to work together to provide services to CareFirst Members in the PCMH Program.

CareFirst's recognition of "Virtual" Panels places great emphasis on ensuring that the PCPs in these Panels practice within a reasonably proximate geographic distance from each other so as to ensure accessible service to Members who live in that locality.

**Panel Type 2: 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.

**Panel Type 3: Multi-Panel Independent Group Practice**

A Multi-Panel Independent Group Practice refers to a practice with more than 15 PCPs that is not under the control of or employed by an academic or multi-hospital health system.

All such Practices are required to identify segments that constitute logical parts of the larger practice. These segments of five to 15 PCPs become Panels in their own right. All incentives, metrics and OIAs are based on the performance of the segments that serve as Panels. Division of a larger group into two or more Panels is based on practice identification of subgroups that constitute logical parts of the group – typically by specialty (pediatrics, family practice, etc.) or location. CareFirst must agree with the division of the group practice into constituent Panels in order for the Panels to be recognized and become part of the PCMH Program.

**Panel Type 4: Multi-Panel Health System**

A Multi-Panel Health System is under common ownership or control of a hospital or health system and consists of more than 15 PCPs segmented into Panels of five to 15 PCPs for the purpose of tracking performance (Debits and Credits in a PCA at the Panel level) and pooling experience at the Panel level, thereby enabling the calculation of an OIA at the Panel level.

**Figure 1** on the next page shows the number of Panels by Panel type, the number of PCPs in them, and the total number of Members attributed to each Panel type for the PCMH Program as a whole.

**Only Medical Doctors ("MDs"), Nurse Practitioners ("NPs") and Doctors of Osteopathic Medicine ("Dos") are Invited to Form Panels**

Only practitioners in the traditional primary care categories of adult internal medicine, pediatrics, family practice, general practice, and geriatrics are invited to form Panels. This includes MDs, NPs and DOs. To qualify, practitioners in these categories must be full-time with active, unrestricted licenses to practice in their discipline and be in good standing in both the CareFirst BlueChoice Participating Provider Network ("HMO") and the CareFirst Regional Participating Preferred Network ("RPN").

**Part III, Figure 1: Panel Characteristics By Panel Type As Of January, 2017[1]**

| Panel Type | Panels | PCPs | PCPs/ Panels | Members | Members/ Panel |
|---|---|---|---|---|---|
| **Virtual Panel** | 155 | 1,388 | 8.9 | 356,726 | 2,301 |
| **Independent Group Practice Panel** | 81 | 680 | 8.3 | 186,438 | 2,302 |
| **Multi-Panel Independent Group Practice** | 110 | 1,086 | 9.8 | 269,479 | 2,450 |
| **Multi-Panel Health System** | 127 | 1,243 | 9.7 | 328,249 | 2,585 |
| **January 2017** | **447** | **4,397** | **9.2** | **1,140,892** | **2,552** |

Multi-specialty groups may also join the Program, but for the purposes of Panel formation and enhanced payments, only the PCPs in such practices qualify.

Whether Panels are formed by existing, established practices or "virtually" by voluntary association of solo/small practices, the goal of this organizational approach is to ensure that Panels are 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 seen and understood by all PCPs in the Panel. The idea is to tie rewards as directly as possible to individual PCP performance while providing enough of an experience base to support sound conclusions about performance overall for each Panel.

There are two ways that a NP may participate in PCMH:

1. NPs who function as a PCP may bill professional services in their own right and have Members attributed to them. These Members will be reflected in the roster and SearchLight Reports in the same way as with any other PCP.

2. NPs who function as a true PCP but bill "incident to" a physician in the practice will also be considered a full-fledged Member of a Panel. However, without claims data in their name, the NP will not have any attributed Members in the roster or SearchLight data. Members will appear under the name of the physician under whom the NP is billing. However, the *ad hoc* attribution process in which an RCD can individually assign a Member to the NP for Care Coordination purposes enables Engagement Scores to be handled appropriately under the NP's name.

NPs who function as physician extenders and not as true PCPs are not included in a Panel's PCP count. These NPs are not counted as a Panel Member for any purpose other than as a physician extender, and therefore, have no Members attributed to them.

NPs who currently serve as a PCP count toward meeting the minimum of five PCPs to form a Panel. NPs may also form a Panel of their own, independent of physicians. If the removal of a NP who is serving as a PCP causes the Panel membership to fall below five, the Panel must recruit other PCPs to meet the required Panel size of five to 15. However, there may be an exception granted for those Panels with fewer than five PCPs who have an attributed Member population greater than 2,500, achieved by use of physician extenders, as this is a credibly sized population upon which to judge Panel performance.

NPs must comply with all statutory and regulatory obligations to collaborate with or be under the supervision of a physician pursuant to applicable state and local laws. NPs who function under #1 and #2 above may complete and maintain Care Plans as part of the Program.

[1] *Source: HealthCare Analytics – July 2015. Member counts include the "NA" Panels for multi-Panel entities (except Hopkins). These Members are attributed to an active practice within the entity, but do not have attribution to an active PCP (required for assignment to a specific Panel).*

No partial group practices are accepted into the PCMH Program. All PCPs in a group practice must join the Program or none in the practice will be accepted. This assures there is no internal practice conflict once the commitment of the practice to follow Program rules or pursue Program goals has been made. 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.

**Concierge Practices and Rules Relating to Voluntary Supplementary Fees Charged to Members**

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 Medical Panel will be subject to immediate termination from the Program and will forfeit any additional reimbursements or incentives they may otherwise be entitled to.

**Rules Regarding Changes in the Composition of Panels**

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 and/or termination, and/or allow PCPs to leave and join other Panels. However, certain rules govern these changes in the interest of preserving the Program's goals of higher quality and better overall cost results as outlined below:

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 one year, the Panel will be terminated from the Program. There may be an exception granted for those Panels with fewer than five PCPs who through the use of physician extenders are able to maintain an attributed Member population greater than 2,500, as this is a credibly sized population upon which to judge Panel performance.

2. A Panel may request an exception to the limit of 15 PCPs in writing. For an exception to be granted, the Panel must demonstrate that the Panel practices as a cohesive unit, works in close geographic proximity and must provide compelling justification as to why the Panel should be larger than the standard Program limit as well as 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 whose OIA was calculated and paid at the entity wide tax identification number (TIN) level for the 2012 Performance Year had a choice for OIA to be calculated at the Panel level for the 2013 Performance Year. For the 2014 Performance Year forward, all OIAs are calculated at the Panel level as a Program requirement. Nevertheless, Multi-Panel Independent Group Practices may

choose to be paid at the entity level or at the Panel level. 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.

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). A new PCP joining an existing Practice will only be considered to be a member of the Panel on a prospective basis.

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 Fee 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.

Virtual Panels are subject to the following rules as well:

1. If a new PCP joins a Practice in a Virtual Panel, the new PCP will immediately assume the level of OIA incentives (if any) being received by the other PCPs in the Panel.

2. Any practice that joins a Virtual Panel is required to be an active PCMH participant of that Virtual 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 Virtual Panel after July 1, that Practice is excluded from the OIA for that Performance Year.

3. 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, not any OIA that may have been earned for that same year by the Practice's new Panel.

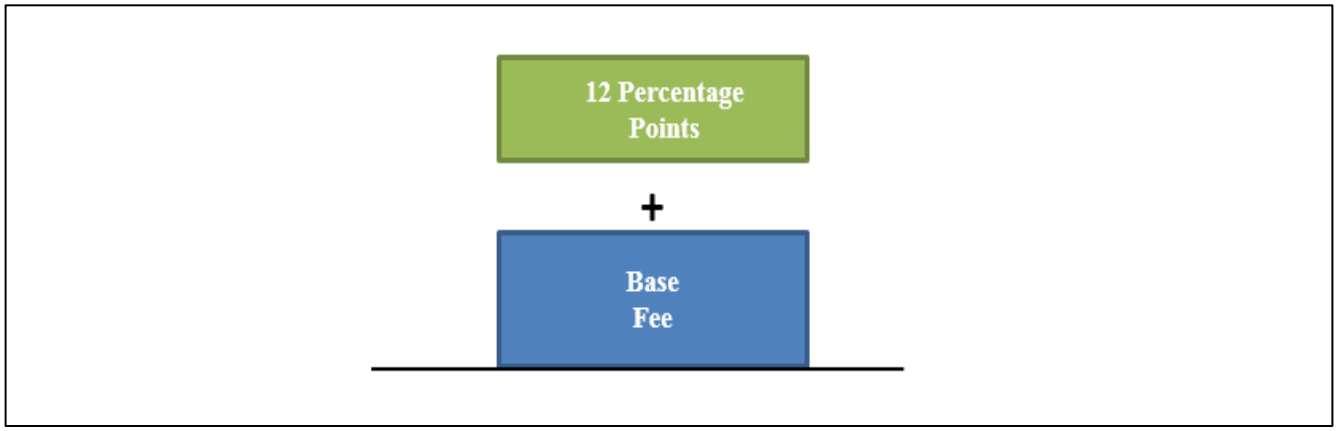
**When Panels Become a PCMH, their PCPs Receive a Participation Fee and are Eligible for OIAs**

A Panel becomes effective as a PCMH on the first day of the second month following CareFirst's receipt of a complete PCMH application from the Panel. Enrollment with a retroactive date is not allowed. Panels are then eligible for Program incentives and rewards, as explained in the following sections.

Once effective as a PCMH, CareFirst professional fees will be supplemented by 12 percentage points for all Practices in each Panel. This add-on is termed the "Participation Fee" which continues for as long as PCPs in the Panel remain in good standing in the Program. Participation Fee and OIA increases (if any) do not apply to time-based anesthesia, supplies and injectable drug fees/billings. In order for a Panel to continue to receive the Participation Fee, the Panel must achieve a minimum level of Engagement and overall Quality Score as described in **Design Element #8**.

An Illustrative Example is shown in on the following page:

**Part III, Figure 2: Illustration Of Base And Participation Fee**




Should a PCP in a Panel leave the PCMH Program, their CareFirst reimbursement will return to its former level and any Participation Fee or OIA which they were receiving while participating will be removed.

It should be noted that all PCPs, regardless of Panel Type, must bill CareFirst in their usual way for all services they render through the submittal of claims in the normal course of practice operations. The Program does not require any sharing of administrative, office or billing processes of practices within Virtual Panels.

## Design Element #2: Member Attribution – The Assignment Of Members To Each Panel

During each month of the Program, CareFirst will attribute each CareFirst Member to the PCP who the Member has either selected or actually uses for primary care services according to the following step by step process:

**First**, all Members who have self-selected a PCP within the last six months will be attributed to that PCP.

**Second**, those Members not attributed in the first step will be attributed to the PCP or Practice that they have visited most frequently for primary care services in the last 12 months based on CareFirst claims experience. If there is a tie between Practices with the most visits, the Member will be attributed to the PCP or Practice seen most recently.

**Third**, if a Member has not visited a PCP or Practice in the last 12 months, CareFirst will review the Member's claims history for the prior 12 months (months 13-24). The Member will be attributed to the PCP or Practice most frequently visited during that more extended time period. If there is a tie between Practices in this longer period, the Member will be attributed to the PCP or Practice seen most recently.

**Fourth**, if CareFirst records show that a Member has not selected a PCP and has no claims experience in a 24-month period, no Member attribution to a PCP will be made.

**Fifth**, if a PCP finds that a Member is missing from his/her attribution, the RCD with oversight responsibility for the region will add the Member to the PCP's attribution and override the system generated attribution that is described above. The RCD typically may not remove the Member from the PCP attribution unless the Member is attributable to a different PCP that participates in the PCMH Program. However, there are two rare instances when the Member can be removed completely from attribution: If the Member moves a substantial distance of at least 75 miles away from the PCP or if the Member has self-selected a PCP of the wrong specialty (i.e., an adult has self-selected a Pediatrician or a child has self-selected an Internal Medicine provider.).

**Sixth**, any Member in a Care Plan will remain attributed to the PCP who initiated a Care Plan for them until their Care Plan is closed. This overrides any step above. After the Care Plan is closed, the attribution reverts back to the methodology described above, unless overridden by the RCD with oversight responsibility.

The vast majority of all attributions are systems generated. To accomplish systems generated attribution, CareFirst analyzes the claims history (as described above) for all CareFirst Members monthly and identifies those Members who have actually received services from participating PCPs in the PCMH Program during the last two years. The attribution algorithm that CareFirst uses is based on a nationally accepted method of performing attribution. For most Members, it is their actual use of a PCP, not simply their identification of a PCP upon enrollment, that drives attribution, especially for Members covered by non-HMO benefit plans. See **Appendix G** for more information on how the Member attribution process works.

Since the attribution process is run monthly by CareFirst, a new or departing attributed Member of a PCP will be detected and reflected in the Panel's membership.

**SOP for Removing a Member from Panel Attribution**

There are some rare instances where a Member may be removed completely from attribution. There are only two scenarios where it is permissible to remove a Member from attribution:

1. The Member has moved more than 75 miles away from the CareFirst Service Area

2. The Member has a self-selected a PCP that is the wrong specialty, i.e. an adult has self-selected a Pediatrician or a child has self-selected an Internal Medicine provider.

Only an RCD may submit a request to remove a Member from attribution, and it must be approved by the Senior Director and Senior Vice President. If one of these cases presents, the RCD will document the issue and submit to the Senior Director and Senior Vice President for approval via email.

Once approved via email, the RCD will log the request into OneStop, where it will be approved and routed to D&I for completion of the removal. The job aide to complete these steps can be found here.

Ongoing monitoring and auditing will review all Members who have been removed from attribution to ensure compliance with these guidelines.

There are no other cases where a Member may be removed from attribution, including Members who are only seeing specialists or have been "fired" from a practice. The PCP will need to do their best to outreach to a Member who is not actively being seen or wait for the Member's attribution to expire (24 months of no claims and no self-selection).

**iCentric Support to Panels in Making Best Use of Attributed Panel Membership Rosters**

Thus, the membership of each Panel is the sum of all Member attributions made to particular PCPs who make up each Panel. The result is a Panel-specific Member roster that includes the name and the IBS of each Member attributed each month. CareFirst provides a web-based system (called iCentric) that is available 24/7 via the internet through the CareFirst Provider Portal, that includes the following five online services:

1. A Member Roster that displays all of the attributed Members of each Panel, including each Member's Illness Burden Score and an identification of Members who should be considered for Care Plans as part of the Core Target population. This Member Roster represents a disease registry as well as a total population health management data source. Each attributed Member in the Panel Roster is color coded, reflecting the Illness Burden Band they are in as shown in the Illness Burden Pyramid.

2. A Member Health Record for every attributed Member including relevant data obtained by CareFirst regarding the Member as well as any Care Plan prepared for the Member.

3. Election to Participate form for a Member's participation in a Care Plan.

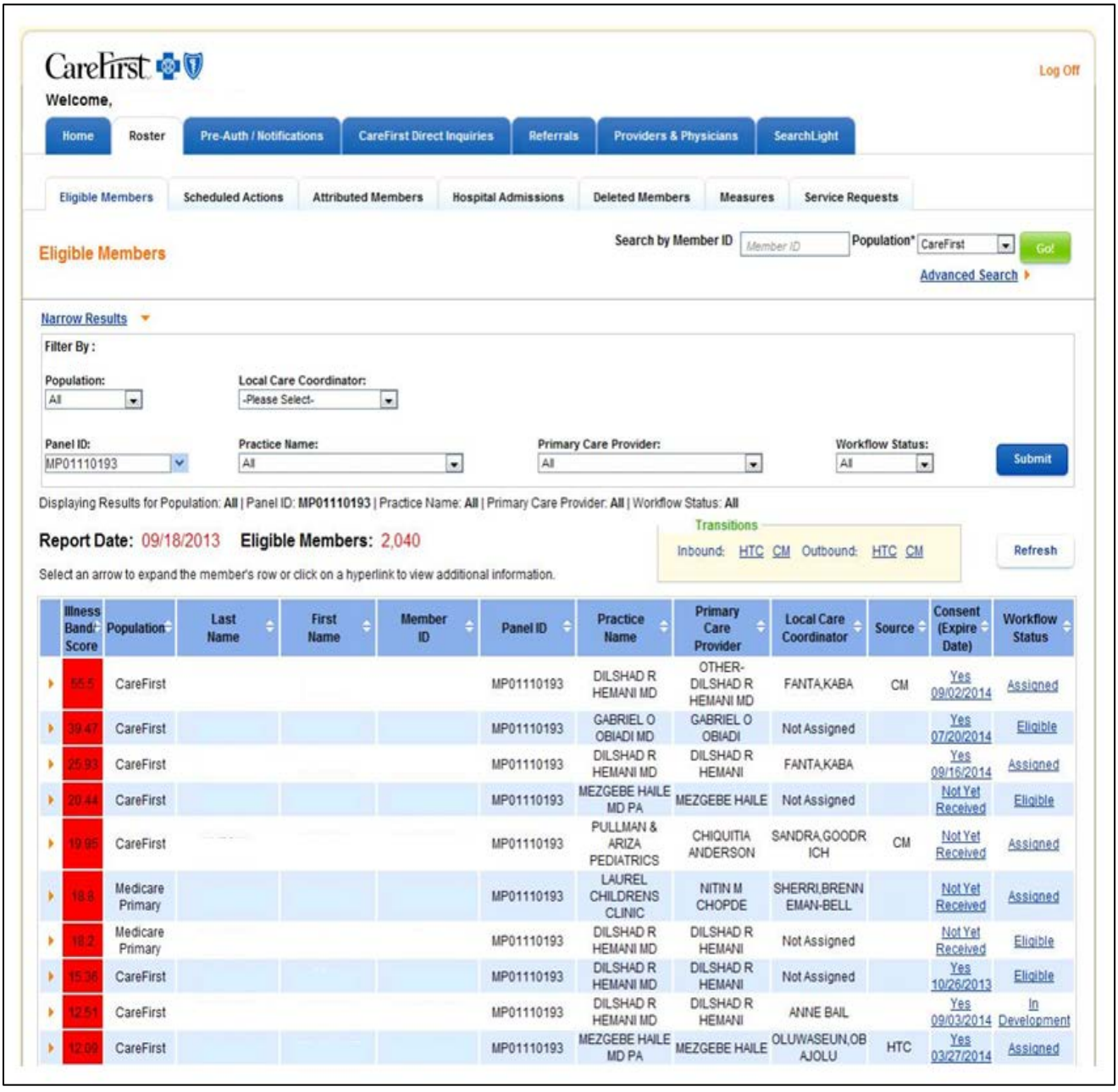
4. A PCA for each Panel showing cumulative Credit and Debit totals (as explained in **Design Element #4**).

5. A SearchLight Report that displays the detailed claims for each Member in the Panel to provide insight into the patterns that matter the most, so that the PCP and Panel can increase its understanding of its own cost and quality results and maximize its chance of earning an Outcome Incentive Award.

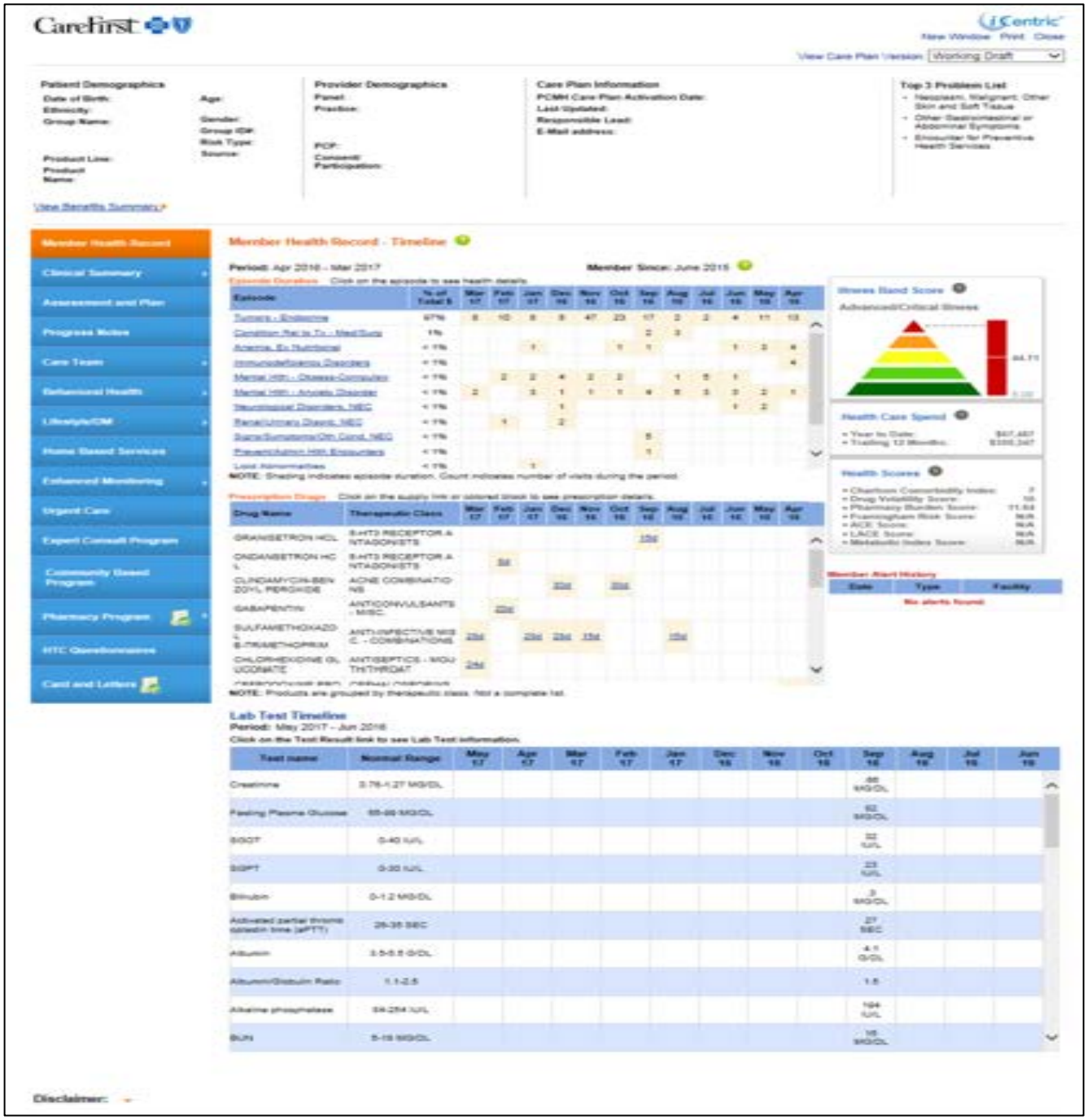
Following acceptance and recognition into the PCMH Program, Panels are required to use these online capabilities which require only broadband access to the internet and a web browser. No software or other cost is required of any Practice.

A depiction of a typical Panel Member Roster is shown in **Figure 3** and the depiction of a typical Member Health Record is shown in **Figure 4.**

## Part III, Figure 3: Member Roster



**Part III, Figure 4: Member Health Record**




Approximately, 75 percent of CareFirst's 2.6 million locally residing Members can be attributed to a PCP in accordance with the process above.

The gap between this number and the total CareFirst Member base of 3.3 million is composed of those Members who are not attributable because they have not seen an eligible PCP in a two-year period, have not designated a PCP, are only seeing specialists for their care, or live out of area. Closing this attribution gap to the greatest extent possible is a key goal of the PCMH Program.

**Attribution is Independent of the Member's Coverage Plan**

The attribution of a Member to the PCP they have actually been seeing does not change any of the benefit/coverage rules contained in the Member's benefit plan. This means that any copayments, deductibles, limits or other rules governing scope of coverage continue to apply, including those applicable to high-deductible plans. For example, a PPO Member is not converted to HMO or Blue Rewards coverage by being attributed to a PCP in a Panel. The attribution merely recognizes an already established relationship between a Member and the PCP of their choice that they have actually seen.

## Design Element #3: Calculating Member Illness Burden Scores – Enabling Population Health Management

Once each Panel's membership is attributed through the Member Attribution methodology, CareFirst will calculate – based on the same historical claims data used in the attribution from the prior 12 months – the Illness Burden Score of each Member attributed to each Panel. To do this, a software "rules" engine is used that "scores" each Member based on his/her unique claims history.

The software used to review each Member's claim history has been independently developed through third party research over many years and is widely used in the health care payer industry. This is described more fully in **Appendix I**. This software uses the Diagnostic Cost Grouper ("DxCG") classification model which has been researched and refined over 20 years. The DxCG model relies on diagnosis and demographic information to assess the level of illness of a Member. ICD-9-CM diagnostic codes in claims are grouped into Condition Categories that have a hierarchy and a numerical weight for relative importance.

Thus, DxCG groupings are based on diagnosis codes, not procedure codes. These groupings describe morbidity, or illness level, not treatment or cost patterns. The DxCG groupings are not affected by the type or intensity of health care services delivered. They are less sensitive to variations in local practice styles or health system configuration (e.g., Urgent Care Centers, rehabilitation facilities).

Therefore, the Illness Burden Score is not affected by the services or procedures used to treat a condition or diagnosis or the cost of the care delivered. Pharmacy claims are not included in calculating the Illness Burden Score because there is no associated diagnosis in the pharmacy claim, and one cannot reliably assign a diagnosis based on the medication alone (as few medications are specific to a single condition or illness).

The resulting Illness Burden Score for each Member shows the relative sickness or wellness of each Member. This is also calculated for whole cohorts of Members who are assigned to a particular illness band within a Panel's membership. The scoring algorithm is particularly cognizant of the presence of chronic disease and clusters of chronic conditions/diseases since these are powerful predictors of current and future health care use. The average Illness Burden Score for the Panel's membership shows whether a particular Panel's Members are sicker or healthier than another Panel (or the system-wide average). Since all are calculated identically, the comparison takes on greater validity.

By way of example, consider the case of a middle-aged man with a history of heart disease, hypertension and diabetes. Such a Member would receive a far higher score than someone at the same age with none of these conditions. The score in this situation is not simply additive of the individual condition scores, but is multiplicative to reflect the compounding effect of multiple conditions/illnesses and diagnoses.

Although there is considerable rigor in the statistical modeling underlying the scoring process, it is not possible to accurately predict in advance what any one Member will need or use in health services in a future period. But, by taking into account what is already known for each Member and pooling this information with other Members of like illness/diagnosis characteristics, one can gain a much better understanding of the actual illnesses a Panel's membership may have and of what may lie ahead.

**Illness Bands are Used to See Patterns/Degree of Illness in Panel Populations**

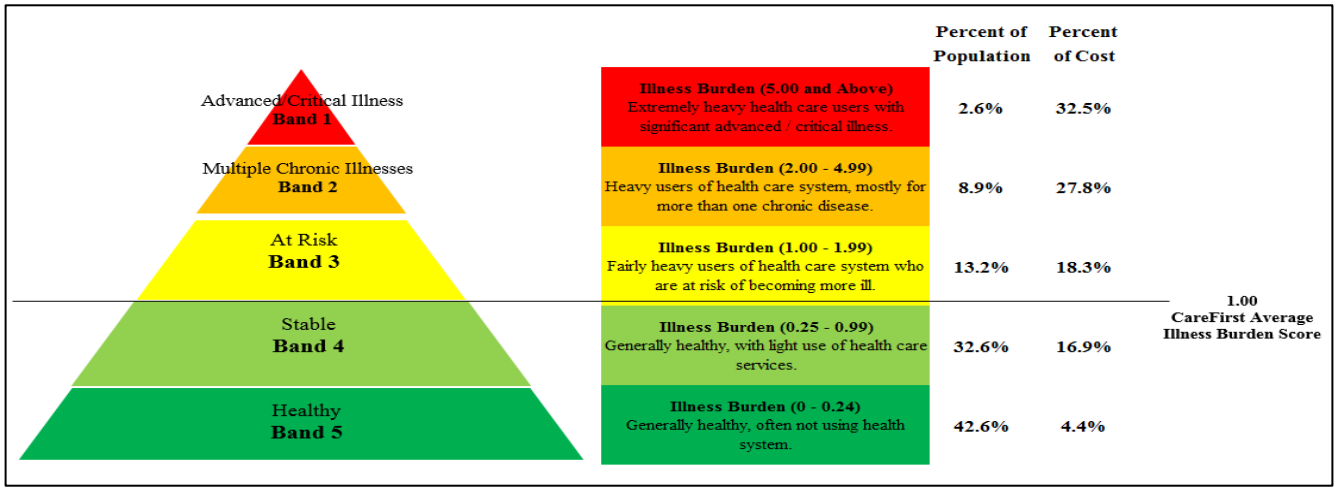
This analytic process works best at a Panel level where pooled Member experience is available and can be used to discern reliable patterns of illness. The identification of patterns of illness that can be effectively focused on by PCPs underscores the importance of forming Panels with reasonably credible Members populations. The average Panel in the PCMH Program has a population of Members in the 2,500 to 3,000 Member range – enough to obtain sufficiently "credible" results and reliably see patterns – a key objective of the Panel process.

The overall result of this type of Illness Burden Score analysis is depicted in on the following page for all CareFirst Members. Several observations can immediately be made when CareFirst-wide scores are compared to the scores that are shown for a specific hypothetical Panel as shown in **Figure 5B** also on the following page.

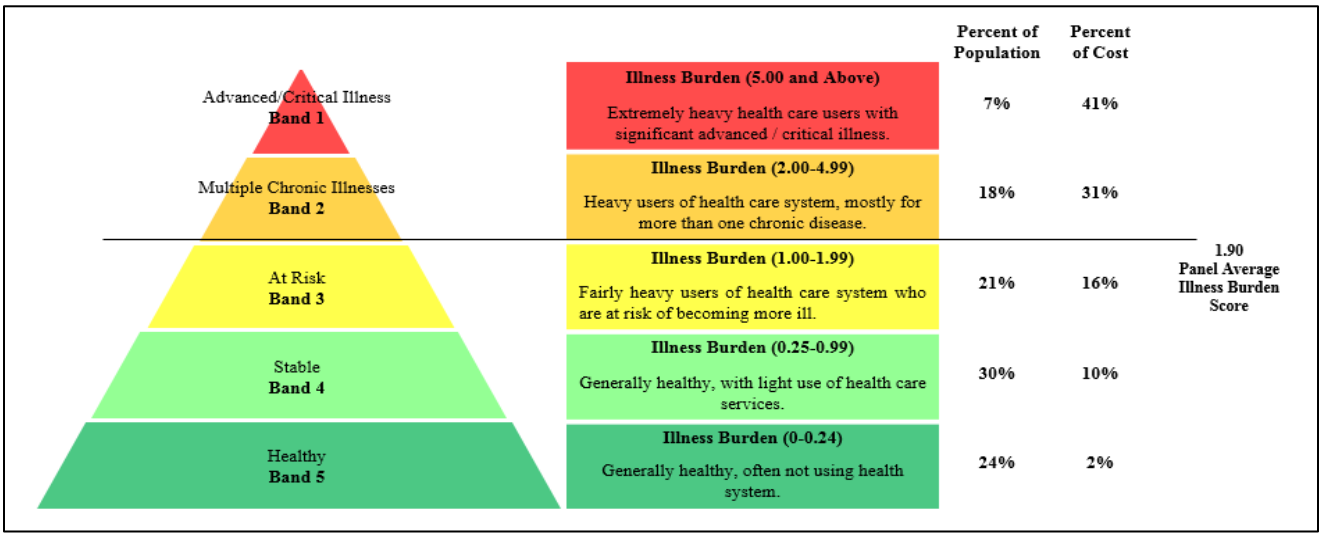
One can see in **Figure 5A** below that the average score for the CareFirst membership as a whole is set at "1". In contrast, as shown in **Figure 5B** below, the IBS for a particular Panel may be higher or lower than this. For example, the IBS for the hypothetical Panel shown is 1.90. This means that the Panel has an Illness Burden Score that is 90 percent higher than the overall CareFirst average. The stratification of risks/illness across the bands within the Illness Burden Pyramid is also somewhat different for the two populations.

A continually updated (monthly) Illness Burden Pyramid for each Panel assists each Panel to focus the attention of its PCPs on the Members with the greatest needs and risks – as well as costs.

**Part III, Figure 5A: CareFirst Population: Illness Burden Pyramid, 2016**[2]




**Part III, Figure 5B: Hypothetical Panel: Illness Burden Profile**[3]




[2] *Source: HealthCare Analytics - incurred in 2015 and paid thru Mar-2016 CareFirst Book of Business, excluding Medicare Primary Members*

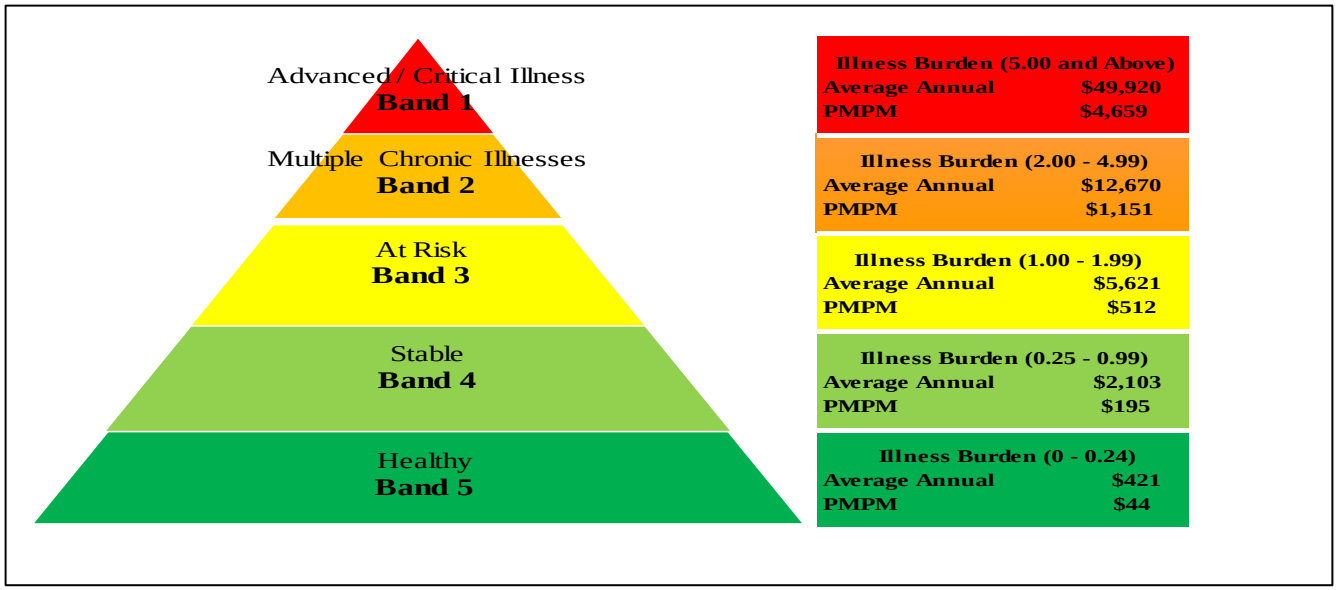
[3] *Source: HealthCare Analytics.*

It is remarkable that despite the fact that the Diagnostic Cost Grouper considers only diagnoses and conditions, age, and gender in Illness Burden Scoring, it produces highly reliable bands of Members within each Panel and across the PCMH Program as a whole that have like resource demands. Hence, health cost/spending levels are directly related/correlated to IBS Scores. This greatly aids Panels in where to focus their attention.

**Figure 6** below shows the actual annual costs in 2016 for the Members in each band across the entire CareFirst membership population. This reveals that the Members in the uppermost bands are much more ill and nearly 100 times more resource intensive than Members in Band 5, as can be readily seen. The yearly and Per Member Per Month ("PMPM") cost descends rapidly as one goes downward through the bands. Those in Band 2 often have multiple chronic diseases in a full-blown stage that predict future health costs. Those in Band 3 often have incipient chronic disease and are heading upward if their risks are not effectively managed.

**Figure 6,** therefore, presents direct and compelling statistical and analytical evidence of the need to offer coordinated care and to perform Care Planning for those in the upper reaches of the pyramid – both to manage what is already occurring and to minimize additional cost that lies down the road for those at high risk.

**Part III, Figure 6: CareFirst Average Annual Costs And Per Member Per Month (PMPM) Costs By Band, 2016**[4]




The value of this data is obvious. With this information, one does not have to scatter effort across the entire membership base to know where to focus. In fact, an intense focus on a small percentage of Members is what is required. Such data is typically never seen by PCPs, yet it is central to knowing where to direct their actions. And it brings to light what it means to gain a view of an entire population of Members associated with each Panel and the Program as a whole. In addition to the Illness Burden Score, a "Core Target" list is continually created, as described in **Appendix E**, that further identifies Members most in need of additional focus and possible Care Coordination at any point in time.

PCPs usually have only informal or partial knowledge of the "downstream" actions and judgments of specialists who treat their Members. Their view is often incomplete. However, the data that is available to them through the PCMH Program shows this far more readily and clearly. It is this ability to see and understand what the cohort of Members looks like – over time and across all medical services and specialties – that gives PCPs in the Panel the ability to channel their attention to where it might do the most good.

[4] *Source: HealthCare Analytics - incurred in 2016 and paid thru Apr-2017.CareFirst Book of Business, excluding Medicare Primary Members.*

CareFirst calculates an Illness Burden Score for each Member at the end of each month for each Panel's total membership so that the change in the score can be seen by the PCP. A final Illness Burden Score for each Member and for Panel membership as a whole is calculated at the end of each Performance Year (calendar year) after three months of claims run out. As discussed more fully below, changes in Illness Burden Scores are built into the PCA settlement process on which incentive fees are calculated.

One final point is worth noting: All the information on which the scoring depends is gathered from claims data. Without claims data, this process could not be executed. Since claims data is scrubbed and checked for accuracy before payment, it is highly – although not perfectly – accurate.

In this connection, it is also worth noting that the entire industry is held to a higher level of data specificity with the implementation of ICD-10 standards for coding of claims that took effect on October 1, 2015. This will explode the detail in claims data tremendously – greatly enriching the data for analytics purposes.

All of this data is potentially lost or degraded in capitated or bundled payment systems because providers do not have to submit detailed bills) unless such systems have full access to Electronic Medical Record ("EMR") data. Even then, EMR data is usually not presented in a way that can readily delineate all services rendered for a particular Member. In a Fee-For-Service ("FFS") System, the rigor of the data and the discipline that comes from its association to payment preserves its timeliness, accuracy and completeness in a very useful way for the Program.

This connection between data and FFS claims is harnessed deliberately to support online data that is used in the SearchLight Reporting and analytics tool available 24/7 to all Panels as shown and described in **Part VII**.

When the day comes – at some distant point in the future – when data can be universally obtained directly and uniformly from EMRs and practice management systems – then reliance on claims data can be supplemented, but likely never eliminated. In the meantime, claims data remains the best possible source.

## Design Element #4: Establishing Global Expected Care Costs For Each Panel – Patient Care Accounts (PCAs)

With the first three Elements in place, the next Element in the Program Design can be added: Establishing the expected total cost of care for all of the Members in each Panel. This is accomplished through a five-step methodology.

**Step 1: Establish the Base Year for Each Panel**

Using the Member attribution process described in **Design Element #2**, CareFirst collects all the claims for every Member in each Panel during a Base Year. For Panels of 2,000 or more attributed Members, the year of experience prior to the year the Panel was formed represents the Base Year. If a Panel has less than 2,000 attributed Members in December of the year the Panel formed, two years of prior experience are used to represent the Base Year. This is intended to provide a base experience as credible as possible in establishing baseline costs for each Panel. The data used for this purpose is the same data used for attribution and risk scoring as described in **Design Elements #2 and #3**.

**Step 2: Gather/Count all Member Months in Each Panel**

Each month that a Member is attributed to a PCP in a Panel, a "Member Month" is counted. For Members who are attributed to a Panel PCP for a full year, a total of 12 Member Months are counted. If a Member of a Panel in the Base Year was in the Panel for less than a full 12 months of the Base Year, this fact will be taken into account. For example, a Member might not have joined a CareFirst health plan until part way through the Base Year. Alternatively, a Member might have changed his/her PCP (and, thereby, his/her associated Panel) during the course of the Base Year. These will be accounted for in the identification of Member attributions to PCPs that is run each month.

Thus, for each Member of a Panel in the Base Year(s), CareFirst will calculate the specific months (e.g., August, September, and October) that the Member was attributed to a particular PCP. This is the Member's "Term" with that PCP (and with their Panel). These calculations are important because, in allocating responsibility for the care costs of the attributed Member, it is critical to know when the costs were incurred so that they can be assigned to the PCP who was responsible for the Member. The number of Member Months assigned to the PCP (and his/her Panel) is the number of months included in the Member's Term with the PCP.

If a Member is attributed to different PCPs in different Panels over the course of the Base Year, the Member will be considered an attributed Member of Panel "A" and an attributed Member of Panel "B" for the respective length of time the Member spent in each Panel. The Member's Terms in Panel "A" and Panel "B" will not overlap. For example, if a Member was attributed to Panel "A" for the first four months of the Base Year and incurred costs of $4,000 during that period and was attributed to Panel "B" for the remaining eight months and incurred costs of $1,500 during that period, the two Panels would be assigned their respective months and associated costs in the Base Year calculation.

**Step 3: Gather All Care Costs of Members in Each Panel**

Once the Member Months are counted, CareFirst gathers and sums all the historical claims expenditures for each Member during their Term in the Panel. This historical claims' experience shows all claims in all settings by all providers and for all services that each attributed Member consumed during the specific months he or she was an attributed Member of the Panel. This amount is the "aggregate cost" of the Member for the Panel to which he or she was attributed in the Base Year.

In this way, the data from the Base Year reflects the historical cost patterns that existed for each Panel and its attributed Members. The data reflects all historical patterns of relevance, including, among other things, the location of the PCPs who make up the Panel. If a Panel's Members have a higher or lower Illness Burden, it will show up in the data. The costs associated with the particular array of specialists, hospitals, and other providers used by Members in the Panel will also show up in the data. If certain inefficiencies are present because the Member population of the Panel has not been "managed" or "guided," this, too, will show up in the data.

The total cost of care for Members of each Panel represents all care costs paid by CareFirst, plus any out-of-pocket payments due from the Members. This "all-in" cost per Member reflects the full "allowed" amounts in the form of fees or rates actually paid by CareFirst (plus the out-of-pocket payments that were due from the Members) for each Member's covered services. It is important to note that these allowed amounts are substantially lower than the actual billed charges of providers, because

institutional allowed amounts for hospitals are either the rates approved by the HSCRC in Maryland or the CareFirst negotiated rates in DC and Northern Virginia, and professional provider discounts are negotiated across the CareFirst region. Thus, Panels receive the benefit of CareFirst negotiated and contracted rates and fees for all provider services.

Member cost-sharing amounts such as deductibles, copayments, and coinsurance amounts are included in the allowed amounts so that changes in benefit levels (e.g., increases or decreases in Member cost-sharing requirements) will not distort the computation of allowed costs over time**.**

There is one exclusion for the aggregation of costs with respect to newborn babies. The parent of the newborn baby may select a Pediatrician at birth resulting in the baby being attributed to this Pediatrician, but the Pediatrician will not have yet seen the baby and until they do, has no ability to influence how the baby's care is managed. Because of this, any costs associated with a hospital admission within 14 days of the child's birth will be excluded.

To put this aggregation of costs by Panel in perspective, it is useful to note that a Panel with 3,000 CareFirst Members in the Base Year would be expected to have approximately $10 to $12 million in annual total costs of care covering some 60,000 distinct services/events reported on claims. This calculation is essentially the same as determining the experience of an employer group of a similar size – something CareFirst has a great deal of experience in doing.

So, all costs – gathered in this manner – are pulled together for each Panel to establish Base Year costs. This means that each Panel will have its own unique, distinct historical Base Year cost experience that will reflect what actually happened in that year to the attributed Members of the Panel before any impact from the PCMH Program was felt. For Members where CareFirst has pharmacy data, CareFirst also calculates Base Year pharmacy costs separately. This ensures that year over year changes in the number of Members with pharmacy data are properly accounted for.

It should be noted that each Panel (and all of its PCPs) is required to have an electronic connection with CareFirst for all claims and Health Insurance Portability and Accountability Act ("HIPAA") transactions through one of several CareFirst preferred Electronic Data Interchange ("EDI") clearinghouses. This is intended to assure prompt, accurate, and timely completion of claims transactions which, in turn, assures more rapid claims "completion" factors. This keeps Panel experience as up to date as possible.

**Step 4: Calculate Base Year PMPM for Each Panel**

Base Year costs for each Panel are computed on a PMPM basis. This is calculated by dividing the total Member Months into total Base Year costs, resulting in a total overall PMPM cost for each Panel, unique to its Members' history.

For example, suppose that the XYZ Family Practice Group as a Panel had aggregate costs of $6,899,031 and 25,203 Member Months in the Base Year. In this case, the Panel's Base Year PMPM would be $273.74, calculated as follows:

$6,899,031 ÷ 25,203 = $273.74

It is, of course, possible that for Panels with small enrollment or with rapidly changing enrollment, a particular year may not represent a fair Base Year PMPM. So, as noted earlier, to reduce the chance that a single Base Year is not representative of the practice patterns for small Panels, two years of baseline experience are used to determine the PMPM for smaller enrollment Panels (i.e., for those Panels with fewer than 2,000 attributed Members).

**Change in Panel PCP Membership**

The PCP membership of a Panel changes over time as some providers are added while some depart. With these additions and deletions, there are changes in the Members attributed to Panel PCPs. A new PCP brings new Members with them, and a departing PCP is often followed by departures of some of the Members attributed to them. To illustrate the impact of changes in the PCP membership of Panels, consider Panel ABC which is comprised of Providers A, B, and C in Year 1. Panel ABC's Base Year PMPM is computed with the Base Year experience of A, B, and C. Between Year 1 and Year 3, Providers B and C depart while Providers D and E join. As the Panel composition changes, the Base Year PMPM becomes less and less representative of current reality. The solution to this is to re-compute the Base Year PMPM with the experience of Providers D and E included and B and C excluded.

For all Panels, a re-determination of Base Year PMPM is triggered when a "Substantial Change" in Panel composition occurs. A "Substantial Change" occurs when two conditions are simultaneously met:

- First, a certain threshold of Panel PCP change must have occurred. This threshold is a change of greater than 50 percent of the Panel's PCPs at the end of the current Performance Year compared with the PCPs in the Panel at the end of the Performance Year two years prior. If the change in PCP composition is greater than 50 percent in a Panel on a cumulative basis, the Panel meets the definition of "Substantial Change." For example, this criterion would be triggered if more than 50 percent of the PCPs from two years ago have left the Panel, or if more than 50 percent of the current PCPs have joined the Panel in the last two years.

- Second, the Panel's recomputed PMPM is greater than five percent different than the Panel's current PMPM Rate, after adjusting for illness burden changes and trending forward to the same period.

Thus, if a change in Panel membership is more than 50 percent over the past two years and its recomputed PMPM is more than five percent different than its current PMPM, the Panel is considered to have undergone a "Substantial Change" which causes its PMPM rate to be adjusted to the changed circumstances of the Panel.

If a rebase is triggered due to a "Substantial Change," the Performance Year prior to the Performance Year in which the "Substantial Change" occurred will be used as the new Base Year. This change in Base Year will be applied prospectively to the following Performance Year. For example, if a rebase is triggered at the end of Performance Year 2016, then 2015 will become the new Base Year, and the 2015 Base Year will be applied prospectively to the 2017 Performance Year.

Base Year data is compiled at the individual PCP level for Panels who have undergone "Substantial Change." Hence, for an individual PCP participating in the PCMH Program, the relevant debits and member months for this PCP will be used in the calculation of PMPMs for a new Base Year. For providers exiting the Panel, their debit and member month history will be excluded from a new Base Year. If the history of a new PCP in the new Base Year is not available, the Panel average is used as a proxy.

Otherwise, all Panels will be rebased once the Base Year is seven years old. This recognizes the dynamic nature of the healthcare landscape, including changing market conditions, new medical technologies, new drug approvals, and other healthcare system changes that result in shifts in the amounts and relative distribution of healthcare spending over time. Under these conditions, a Base Year that is more than seven years old is likely to no longer accurately form a basis for a Panel's performance, unduly causing benefit or harm to the Panel.

Hence, once a Panel's Base Year is seven years old, the Panel's Base Year will move up one year, each year. That is, no Panel's Base Year is permitted to be more than seven years old. The new Base Period will reflect the PCP membership as it existed during that period. A smaller Panel that has a combined two-year Base Period will have its older year dropped (i.e., a small Panel with a 2009/2010 Base Period will move to a 2010/2011 Base Period for the 2017 Performance Year). A larger Panel with a Base Year of 2010 will also move up to a 2011 Base Year in the 2018 Performance Year.

This result will be trended forward to the Performance Year using the Overall Medical Trend ("OMT") applicable to each year following the Base Year and will be risk adjusted as outlined in Step 5.

**Step 5: Trend Costs from the Base Year to the Performance Year and Risk Adjust – Target Budget**

The Base Year PMPM cost of each Panel is then trended using the OMT, which represents the expected or actual change in all healthcare costs in the years following the Base Year (see **Appendix F** for further explanation of how the OMT is calculated). In so doing, the Base Year PMPM cost is projected into the current year known as the "Performance Year."

In subsequent Performance Years, the expected costs for the Panel will be derived by again trending the Base Year PMPM. By trending the Base Year PMPM costs (using OMT), the Program allows Panels to continue to benefit from the cost savings that they have achieved in previous years moving forward year to year, for up to seven years.

After seven years, the Base Year only moves forward one year, each year, as long as the physician complement in a Panel remains mostly unchanged. In effect, Panels are challenged to perform within their trended (OMT) Base Year PMPM from one Performance Year to the next.

For example, let us continue with our fictitious XYZ Family Practice Group and assume that the OMT factor for the Performance Year is seven percent. As shown above, the Base Year PMPM of the XYZ Family Practice Group is $273.74. Therefore, the XYZ Family Practice Group's first Performance Year PMPM would be $292.90 (i.e., the Base Year PMPM increased by seven percent) as computed below:

$273.74 x 1.07 = $292.90

If we assume that the following Performance Year OMT factor is six percent, the XYZ Family Practice Group's second Performance Year PMPM would be $310.47, which is the Panel's PMPM of $292.90 from the first Performance Year increased by an additional six percent, as shown below:

$292.90 x 1.06 = $310.47

Medical and pharmacy OMT factors were the same in the years 2011-2014. However, in 2015, there was a sharp difference in the OMT for pharmacy and medical costs. A separate OMT was calculated and applied for pharmacy and medical costs in that year to address this. CareFirst will continue to analyze trends and will determine in subsequent years whether separate/distinct OMT for medical and pharmacy costs are appropriate.

While each Panel's Base Year PMPM reflects the actual claims experience of the attributed Members of the Panel, the OMT that will be applied reflects the CareFirst region as a whole. Thus, the OMT adjustment to the Base Year's PMPM is not specific to any one Panel's experience, but rather, reflects the overall healthcare cost trends for the entire region. In this way, Panels that outperform the OMT will continue to benefit from their superior performance if their total costs go up less than trend over time. In the process of doing so, they will "bend" the increase in the cost curve when enough Panels beat trend to slow its rise.

**Illness Burden Adjustment**

Each Panel's target PMPM is adjusted each year to take into account the relative change in Illness Burden Scores for all of the attributed Members in the Panel from the Base Year to the Performance Year. For example, if the average Illness Burden Score increased from 1.73 in the Base Year to 1.78 in the second Performance Year, then the target PMPM would be increased by 102.9 percent (1.78 / 1.73), as follows:

$310.47 x 1.029 = $319.48

**Targeted PMPM Global Budget**

This trended and Illness Burden adjusted PMPM target becomes the "expected" or care cost of the Panel that is expressed as a PMPM and is posted in the PCA of a Panel as a "Credit" for each attributed Member. When the Base Year PMPM of each Panel is trended into the Performance Year and multiplied by the current year's Member Months, the result is the Panel's "Target Budget" for the Performance Year.

So, to carry on with our example, in its second Performance Year, the XYZ Family Practice Group had a PMPM rate of $319.48 (trended forward two years and Illness Burden adjusted) and 20,641 Member Months in the Performance Year. Therefore, its Performance Year Aggregate Target Budget is $6,594,344, which is the product of its target PMPM of $319.48 multiplied by its final 20,641 Member Months:

$319.48 x 20,641 = $6,594,344

**Posting PMPM Credits to the PCA of Each Panel**

The Target PMPM for each Panel – as calculated per the method described above – is attributed every month to each attributed Member's Panel as a "Credit." The Target Budget for a Panel in a Performance Year is the sum of all Credits attributed to each Panel. This Credit is posted to the PCA that is established for each Panel.

The sum of all the Credits will accumulate month by month until the end of each calendar year. Panels receive monthly updates of their Member Roster and PMPM Credits. These are posted to the PCA established for each Panel (as explained more fully below).

Every Performance Year is a calendar year. For example, Calendar Year 2017 is **Performance Year #7**. And, a full run out of experience through March of the year following each Performance Year is used to assure completeness of the data before the experience of a Performance Year is determined (i.e., March of 2018 for Calendar Year 2017).

The postings of Monthly Credits to the Performance Year PCA of the XYZ Family Practice Group are accounting tabulations only (rather than actual payments into bank accounts) which are used to determine the performance of the Panel. A target PCMH Credit can also be thought of as a global capitation for each Member in the Panel.

It is important to keep in mind that the sum of all Credits will not be fully known until after the end of the Performance Year, because the Term of Members and their final Illness Burden Score will not be known until three months after the end of the Performance Year (allowing for claims run out).

Thus, the sum of the Credits for the attributed Members of each Panel represents the expected costs of care for all attributed Members of the Panel in the Performance Year for the portion of the year each Member spent in the care of a PCP in a particular Panel. In the aggregate, these "Credits" constitute the Panel's Target Global Budget. They reflect the history, level, location, practice style, specialty referral and hospitalization patterns, and size of the Panel trended into the Performance Year for each Panel as a whole. Hence, they are designed to present as fair a target as possible with regard to expected overall care costs.

**Figure 7** below and **Figure 8** on the next page display the way in which the Credits associated with Member Mary Smith would flow into the PCA of the XYZ Family Practice Group. These would be posted every month in the Performance Year that Mary Smith is a Member of XYZ Family Practice Group. The difference in the annual credits of Mary as a Member reflect the time she was attributed to the XYZ Panel and any changes in her IBS.

In short, by following the five steps above, the PCMH Program establishes and posts "Credits" to the PCA for each Panel so that the Target Budget of the Panel can be determined and posted. As noted, the goal is to present as fair a target as possible for each Panel and to make it sensitive to changes in the number of Members the Panel serves during a Performance Year as well as changes in the Illness Burden of the Members in the Panel.

**Part III, Figure 7: Illustration Of A Scorekeeping System For Panels[5]**

**Patient Care Account**

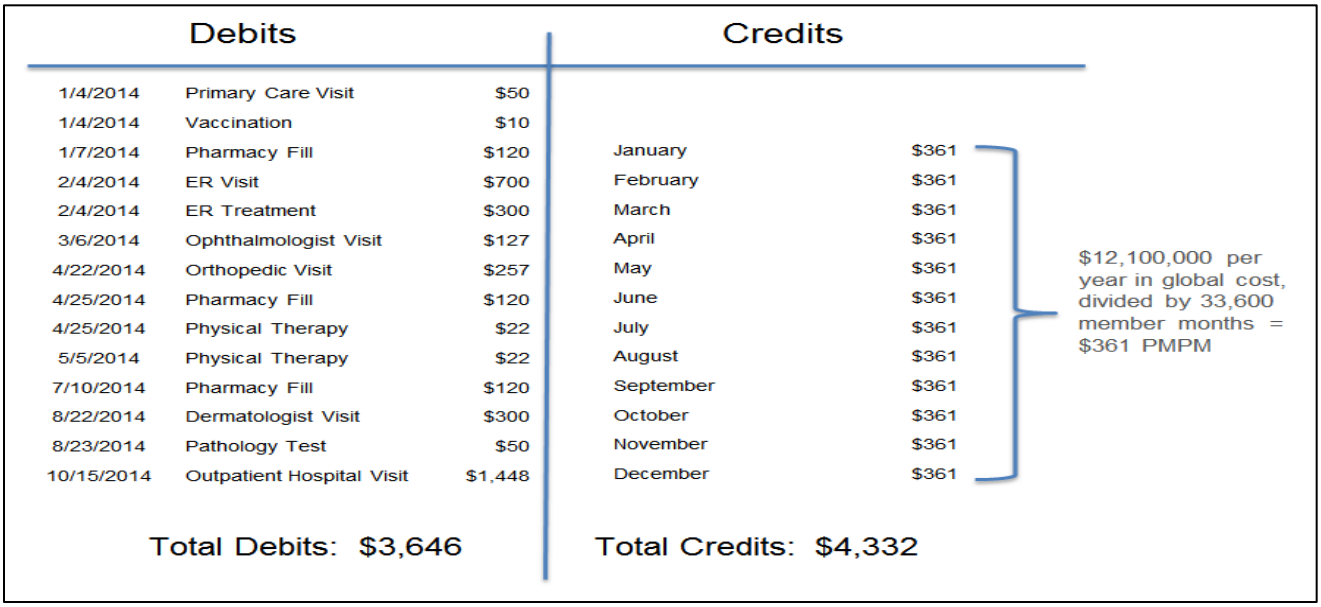
| Debits (PMPM) | Credits (PMPM) |
|---|---|
| All services paid (Allowed Amount) | Global projected care costs expressed as a PMPM |

**Panel Targets (Credits) are calculated as follows:**

| | |
|---|---|
| $9.0M | Base Year Costs (2010); 1.26 IB Score for 3,000 Members |
| x 1.34 | Overall Medical Trend over 6 years at 7.5%, 6.5%, 5.5%, 3.5%, 3.5%, 3.5% |
| x 1.079 | Illness Burden Adjustment 2016 vs. 2010 (1.36/1.26) |
| $13.0M | Performance Year Target (2016) |
| ÷ 36,000 | Member Months for 3,000 Members |
| $361 | Target PMPM Care Costs |

[5] *In any Panel, month to month fluctuations in Membership occur. Member Month counts shown reflect this.*

**Part III, Figure 8: Illustration Of Debits And Credits[6]**




**Care Costs are "Debited" to Each Panel's Patient Care Account (PCA) Monthly**

We are now ready to see how XYZ Practice Group performed against its Target Global Budget.

During the Performance Year, as care is rendered to the attributed Members of each Panel, the claims for this care are submitted to CareFirst by the various providers (i.e., PCPs, specialists, hospitals, etc.) who treated these Members. These claims are paid in accordance with the contracted fee allowances (i.e., "Allowed" amounts) that CareFirst has established by contract with all providers in its regional networks inclusive of all covered services to Members. Thus, FFS payments are used as the cash flow mechanism for providers during the course of each Performance Year.

Also, included in the Debits are fees associated with Care Coordination and additional Clinical Programs under the Total Care and Cost Improvement Program Array ("TCCI"). A detailed delineation of these fees is provided in the SearchLight Report for each Panel and explained in **Appendix N**.

In this way, all fees and rates reflected in allowed claim amounts for any Member in any Panel during the Performance Year will be counted as "Debits" against the PCA of the Member's Panel including the costs of TCCI Care Coordination Programs. These Debits will accumulate through the Performance Year and through the run-out period described above in order to gain a complete picture of all service costs and services for each Member.

The Debits for a specific Member (or for a Panel as a whole) reveal, in detail, the care patterns, services rendered and decisions of all providers who have cared for the Member. In this way, Debits are the running record of services actually rendered to the Members of each Panel as well as the economic cost of these services. They provide – after extensive scrubbing and checking by CareFirst at a detailed line level on all claims to ensure payment and data accuracy – a robust and comprehensive service and cost record for each Member and for each Panel as a whole. This record is a rich analytical data source for examining practice patterns regarding the efficacy, cost, and quality of services and is the basis for all SearchLight Reporting.

**Figure 9** on the next page illustrates an example of the details of how Debits would appear in the PCA of XYZ Panel and how these Debits would be compared to the Credit side of the ledger.

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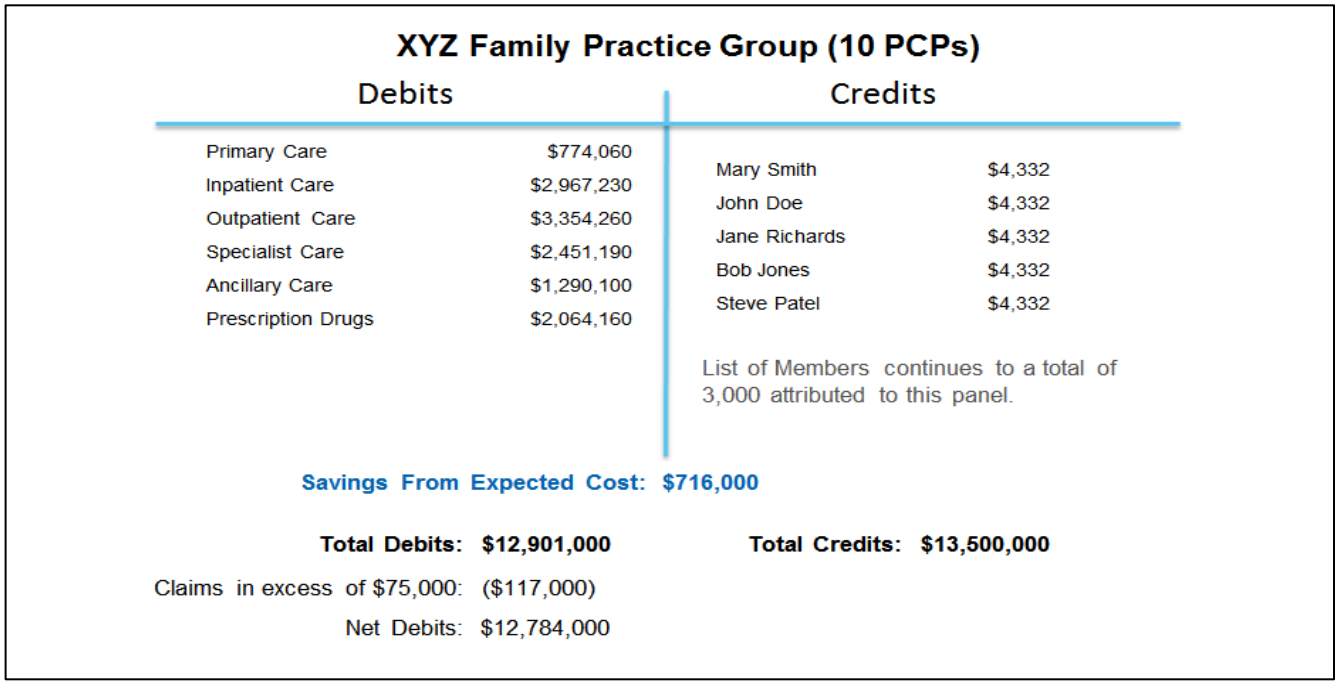
[6] *In any Panel, month to month fluctuations in Membership occur. Member Month counts shown reflect this.*

**Part III, Figure 9: Illustration Of One Panel For One Year**[7]




**Comparing Credits and Debits at the End of Each Performance Year**

At the end of the run-out period for each Performance Year (March 31 of the next year), the sum of all Credits is compared to the sum of all Debits, and a settlement is calculated for each Panel's PCA.

It is essential to understand that all covered claims are paid to all providers – including Panel providers – by CareFirst even if the Debits exceed the Credits. Thus, there is no risk to PCPs in any Panel based on the performance of their Panel. CareFirst takes this risk for Panels – a key aspect of Panel protection. There is also no risk to any other provider that served the Members of each Panel during the course of the Performance Year. All providers are paid for their services at CareFirst contracted fee levels for services actually rendered, regardless of whether a Panel exceeds its credits or not.

**Minimum Size for Panel Viability**

In order for the PCA results to be meaningful, a Panel must have a minimum level of attributed Members over the course of the Performance Year. This is considered the point at which a Panel is considered "viable" for an OIA.

Accordingly, beginning with **Performance Year #5 (2015)** and extending into **Performance Year #6 (2016),** all Panels must have had at least 12,000 Member Months in order for the results to be considered credible enough to qualify the Panel for eligibility for an OIA. For a Panel with a minimum complement of five PCPs and, this would equate to having approximately 200 CareFirst Members (attributed via claims or Member selection) per PCP. If this threshold is not met, then the Panel will be considered as not "viable" for an OIA in the Performance Year during which the threshold is not met.

The threshold increased in **Performance Year #7 (2017)** to 15,000 Member Months and will increase to 18,000 Member Months in **Performance Year #8 (2018)**.

[7] *In any Panel, month to month fluctuations in Membership occur. Member Month counts shown reflect this.*

There may be some instances when Panels are not able to reach the number of attributed Members needed to be considered viable 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 to add additional PCPs, with the approval of CareFirst, exceeding the 15 PCP maximum, to achieve a viable Panel size.

**Stop Loss Protection for High Cost Claims**

All Panels are protected against "shock claims" for extremely high cost 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 ("PMPY") against these types of claims with respect to amounts shown as Debits in each Panel's PCA.

For **Performance Year #6 (2016)**, the ISL was set at $85,000 PMPY. Only 20 percent of any costs above $85,000 in the calendar year are debited against the PCA of a Panel (although all Debits are shown for analytical purposes). The ongoing 20 percent Debit is designed to keep PCPs actively interested in their most complex Members, especially for the purposes of managing and arranging the care needed by their Members during the acute and/or rehabilitative stages of their illness.

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. For **Performance Year #7 (2017)**, the ISL remains set at $85,000 PMPY.

## Design Element #5: Deciding And Making Referrals – The Key Decisions

As pointed out in **Part I**, the two most common – yet value laden – decisions made by PCPs involve judgments about when to refer a Member to a specialist and, then, which specialist. These "when" and "where" decisions dictate everything that follows – including confirmation of diagnoses, course of treatment and location of subsequent services/hospitalizations. In so doing, they account for 94 percent of all costs paid by CareFirst.

While the PCP is the key to these "when" and "where" decisions regarding specialty services, they have historically never had information on the cost of their decisions or feedback about the results with regard to either quality or costs. Accordingly, the PCMH Program treats these decisions as a central matter of concern and attempts to overcome these failings.

All costs – expressed as Debits – that specialists drive are posted to the PCA for each Member attributed to the Panel – as are all other costs such as lab fees, drugs and hospital costs. In doing so, they drive the vast majority of Debits in each Panel's PCA. So, it pays the PCP in each Panel to be careful when and where they refer. The variability for any episode of care in terms of cost and outcome can be huge.

It is not hard to illustrate this by using the variability in the costs of any surgical procedure that might be advised by or recommended by a PCP. The cost of a total hip replacement can be used as an example. Costs include physician fees, which typically account for 15 percent of total cost, as well as hospital and all other ancillary fees, which typically account for 85 percent of the total cost for the procedure. PCPs play a key role in making care decisions and recommendations for their Members.

Since decisions on when and where to refer a Member for tests or to a specialist directly affect the subsequent quality and cost of care, both the surgeon, and very importantly, the hospital, need to be considered when determining the best choice for the Member, from both a quality and cost perspective. The variability in the cost and volume of these procedures by surgeon is shown in **Figure 10** below.

**Part III, Figure 10: Average Cost By Surgeon For Total Hip Replacement (Includes Professional Allowed Amount)**[8]

| Surgeon | Total Cases | Average Allowed Amount |
|---|---|---|
| Surgeon 1 | 68 | $21,606 |
| Surgeon 2 | 59 | $35,639 |
| Surgeon 3 | 50 | $25,329 |
| Surgeon 4 | 49 | $30,045 |
| Surgeon 5 | 41 | $27,048 |
| Surgeon 6 | 37 | $23,304 |
| Surgeon 7 | 33 | $22,103 |
| Surgeon 8 | 27 | $40,891 |
| Surgeon 9 | 26 | $33,103 |
| Surgeon 10 | 24 | $25,278 |
| All Other Surgeons | 991 | $34,620 |
| **Total** | **1,405** | **$32,663** |

There are over 260 surgeons in the CareFirst region who perform hip replacement surgery – virtually all of whom are Board certified and fully credentialed as a condition of being in the HMO and RPN networks. Currently, there is little information

[8] *Source: CareFirst Network Management Department.*

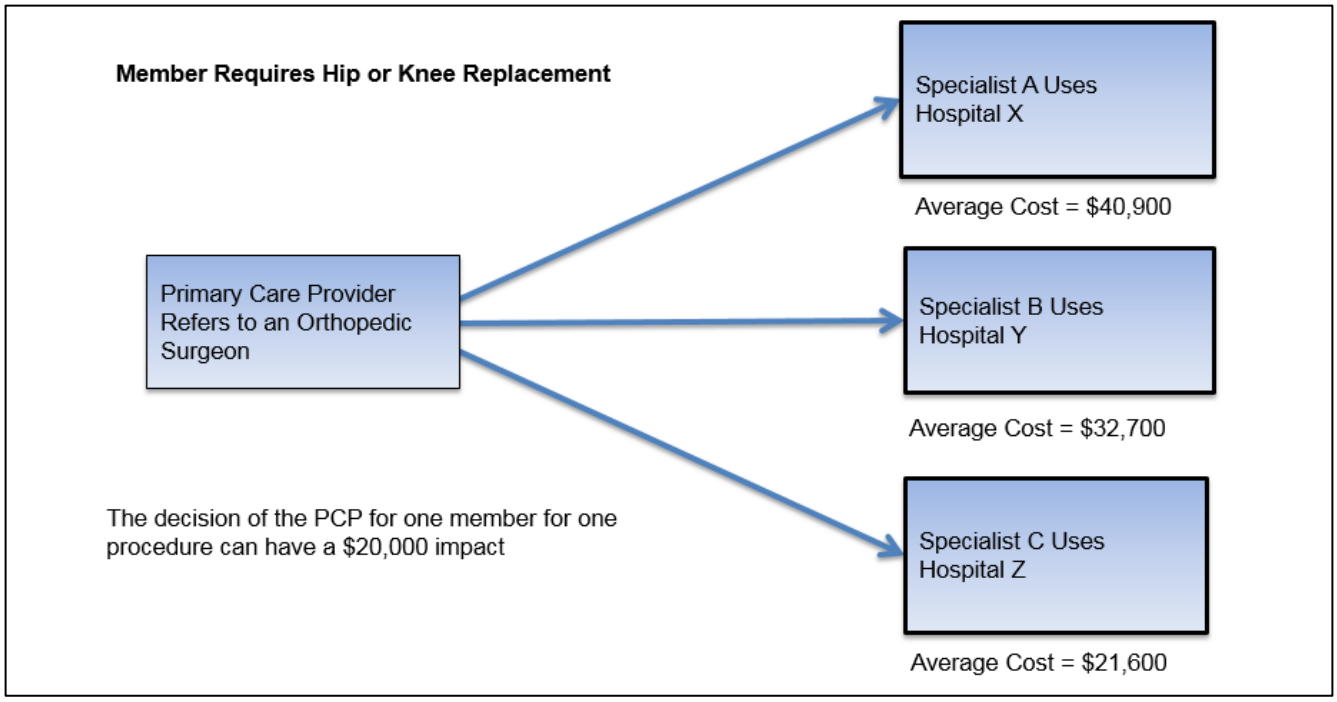
available that allows differentiation among these surgeons with respect to quality. It is generally accepted that surgeons with greater experience (higher volume) have better outcomes, although this is not universally true.

There is a growing body of knowledge about quality outcomes in institutions for selected high volume, high cost procedures. External entities certify institutions that achieve better outcomes including lower in-hospital and follow on mortality rates, lower complication and readmission rates, composition and adequacy of the team to provide care throughout the hospital experience, pre-operative education of the Member with shared decision making, focused discharge planning, and follow-up procedures.

For example, the American Society of Bariatric Surgeons provides a designation for centers that meet these kinds of standards. The BlueCross and BlueShield Association, in collaboration with national medical and surgical specialty groups, collects this information on applicant hospitals, and makes available a Blue Distinction Center designation in the areas of cardiovascular surgery, hip and knee surgery, spine surgery, bariatric surgery and certain complex cancer surgeries. This sets up the TCCI Centers of Distinction Program.

The impact of specialist decision making can be seen in **Figure 11** below. When a PCP decides to send a Member to a specialist, it matters greatly who they send the Member to – both in what it costs and what outcomes are attained. All the costs come back as Debits to the PCA shared by the PCPs in each Panel.

**Part III, Figure 11: High Cost Variation Among Specialists**




The PCMH Program recognizes the essential role that the PCP plays in the specialty "buying" decisions for CareFirst Members and seeks to give PCPs both the data and the financial motivation to be judicious in these decisions.

Data on such cost differences is available to PCPs in a number of ways:

- By episode (both surgical and medical)
- By specialty group (both surgical and medical)
- By hospital
- By individual specialist

This data is presented in the SearchLight Report of each Panel through the iCentric Portal with a few clicks online, so that it can be used by PCPs in deciding on a referral before it is actually made.

To facilitate decision making by PCPs, specialty providers are listed in one of four cost categories for easy, quick reference. The various views in each Panel's SearchLight Report are updated monthly and show whether the referral pattern of a Panel is predominately oriented to High, High-Mid, Low-Mid, or Low-cost specialists or hospitals.

It must be stressed that cost appears to be mostly independent of quality and that cost is only one consideration for the PCP in making a referral. The PCMH Program leaves to the PCP any judgment on quality. The data in the iCentric System and the SearchLight Reports is designed to help the PCP make critical decisions on referrals. Indeed, the PCMH Program seeks to introduce cost as a consideration into the act of deciding on a referral by a PCP– something that has typically never been done before. This is intended to make the role of the PCP as "buyer" or "arranger" of specialty services more effective.

**PCPs May Create Their Own Specialty Partners**

In its mature expression, the goal of the Program is for each Panel to carefully select its own specialist partners to work with on an ongoing basis in meeting the needs of its Members. In support of the judgments regarding cost and quality, the Program seeks to focus attention on full communication and data sharing between PCP and specialist. This gets at the central goal of having PCPs and their chosen specialist partners work with one another in reaching shared "considered judgments" about how to proceed with the course of treatment of each Member.

The Program encourages PCPs to engage in discussion with specialists about how they will work together to optimize care for the Member. The understanding reached between them defines the roles and responsibilities of each physician, both in the course of care itself, as well as in scope and nature of communication with each other and with the Member. This enhanced level of communication for the chronic care Member (those most likely to be in Care Plans) is an essential element in achieving greater engagement between the Member, the PCP and the specialist.

And, it must be stressed that the PCMH Program makes the extremely large network of CareFirst providers fully available to PCPs – maximizing the universe of specialist choices from which they can select. It is the care taken in these choices as to value, cost effectiveness and outcome that is a central focal point of the Program and is a central purpose, therefore, of the data analytics in SearchLight that supports these choices.

**Referrals Over the Web Made Easy – A Key Element of Control**

The secure, web-based, online iCentric capability that is made available to PCPs in the PCMH Program is composed of two parts: Deciding a referral and making a referral.

To enable a PCP to decide a referral, a drop-down list of specialists, specialty groups and hospitals ranked into High, High-Mid, Low-Mid, and Low-cost strata is presented. Once decided, making a referral using this online capability can be done at any time on a 24/7 basis by entering a few basic data elements into the referral portion of the PCMH website that conforms to standard state requirements for referrals.

Referrals are generally not required by most benefit plan designs, but this online referral capability is an essential tool of the PCP. The referral capability in iCentric better assures that if the PCP came to a considered judgment about a referral that it is actually carried out as they intended. Although the vast majority of Members do not have referral requirements in their benefit plan designs, it is CareFirst's experience that Members overwhelmingly follow the referral advice of the PCP. The online iCentric capability makes it easy to do.

Any online referral can be printed at the PCP's office and given to the Member. This is intended to better ensure that the referral choice of the PCP is carried out. It also can be seen and followed by the Care Coordination Team in carrying out the direction of the PCP. In other words, referrals are a key instrument in Care Plan implementation.

Hence, the PCMH online system that is available to Panels enables them to both decide referrals and make referrals with ease. It also better assures that care is carried out as they intend it to be. It must be emphasized that all such decision making in the PCMH Program is between a Member and his/her PCP without payer involvement. CareFirst never specifies referral targets or requires that certain PCP referrals go to certain specialists. However, the PCMH Program incents PCPs to be careful in the referral decision making to search out and find the best value in specialty care for the Members of their Panel.

In short, while referrals are not required if the Member's benefit plan does not otherwise require them, it is good practice to use the referral feature to assure greater chance the Member will go to the specialist or other provider the PCP is recommending.

The following information must be included as specified on the referral form in accordance with State regulatory standards:

- The Member's name, date of birth and Member identification number.
    - The PCP name, phone number and CareFirst provider identification number.
    - The specialist's name and CareFirst provider identification number.
    - The date the referral is issued and the "valid until date".
    - The diagnosis or chief compliant (stating "follow-up" or "evaluation" is not sufficient).
    - The number of visits allowed, limited to a maximum of three visits.

If a Member is covered by a BlueChoice benefit plan, specialists may only perform services as indicated on the referral form. All other services require additional approval from the PCP. Additionally, if three visits or 120 days is to be exceeded, the Member must obtain another referral from the PCP (with an exception for long-standing referrals).

## Design Element #6: Enhanced Focus On The Chronic Member – Care Plans And Care Teams

With the first five Elements in the PCMH design in place, it is now possible to add another Element that is central to the Program: Care Coordination for those most in need of Care Coordination or for those most likely headed upward in the Illness Pyramid in the future.

To start, one must return to the key observations made in **Part I** regarding the Illness Pyramid. Those at the very pinnacle – the top two to three percent – are already in the hands of specialists or super-specialists. It is not likely that the PCP can play a central role with these Members. But, they must stay involved because many acutely ill Members return home to deal with ongoing chronic conditions.

This top cohort includes complex, end-stage metastatic cancers, end-stage renal disease, neonatal Intensive Care Unit ("ICU") cases and major trauma. These Members may need assistance with complex coordination of care, home health services, and effective use of their medical benefits. CareFirst Complex Case Management ("CCM") services are available to serve these Members, and knowledge of this is available to the PCP through online access to the Member Health Record.

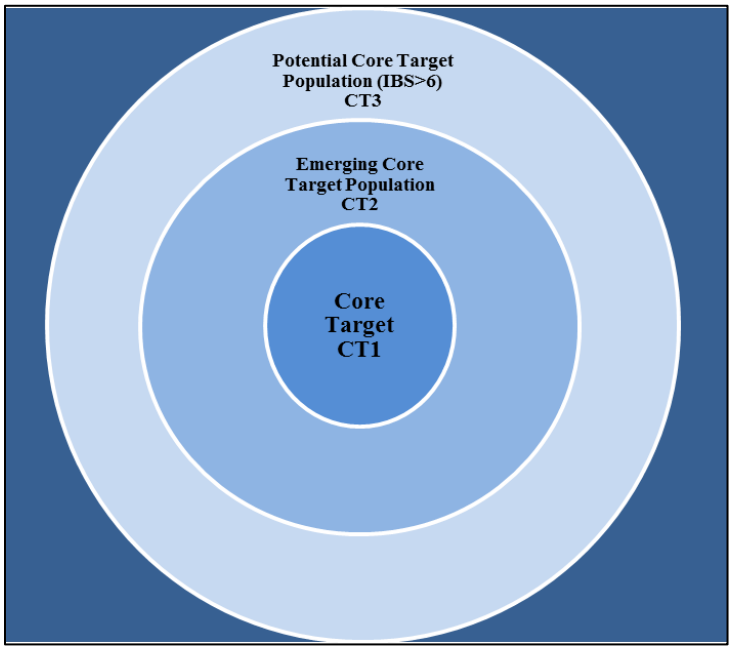
The Members who may be appropriate for care coordination are identified as being in one of three groups, and are depicted in the three concentric rings shown below. These Members – collectively - are considered to be in the "Core Target" population most in need of coordinated care due to their level of illness and vulnerability for breakdown.

The highest priority Members for Care Coordination are the Members in the Core Target Population in the inner ring. These Members are reviewed before all others under consideration for Care Coordination.

After all the Members in the inner ring have been assessed (CT1), the second level of priority for Care Coordination is given to Members who are classified in the middle ring as the Emerging Core Target Population (CT2). These are Members who have serious emerging conditions or diagnoses that may have recently or suddenly appeared and are not yet reflected in their IBS but, without intervention, are likely to experience breakdown and incur high levels of medical cost.

The third level of priority for Care Coordination are Members in the outer ring with an IBS greater than six (CT3). These are Members who, while not as ill as those in the Core Target Population, should be assessed to make sure they are not headed toward a costly breakdown in their health. Each of these populations is shown in **Figure 12** below.

**Part III, Figure 12: Identifying Members In Need Of Care Plans**



### *The Core Target Population (CT1)*

The Core Target Population is comprised of between 45,000-50,000 CareFirst Members in any given month who have been identified through specific criteria that are characterized as having high costs, high hospital utilization, and health instability. These costly, unstable Members are the top priority to assess for Care Coordination needs. There are five routes to being identified as a Core Target Member:

- Members who were flagged on hospital admission by an HTC as "High Cost" Level 1 admissions in the last 12-months and/or members assigned a LACE score between 11 and 19 following admission.
- Members with known high readmission rates for any reason within 30-days of a previous discharge in the last twelve months.
- Members with consistent high cost over six or more months at $5,000 or more per month in medical spend in the last twelve months.
- Members in Band 1: Acute - Return to Chronic category who have an Illness Burden Score between 10.00-24.99.
- Members with multiple high-risk indicators of progressive disease or instability in the last 12 months. These indicators include Overall PMPM cost, Hospital Use, Multiple Comorbidities, Specialty Rx PMPM cost, Advanced Chronic Kidney Disease ("CKD"), and a Drug Volatility Score ("DVS") of at least eight (on a scale of 1-10).

The Core Target list is updated on a monthly basis. Members who have Medicare as the primary insurer are excluded from the Core Target Population.

### *Emerging Core Target Population (CT2)*

The second priority group of Members that are assessed for Care Coordination is comprised of Members who do not yet meet the criteria for inclusion on the Core Target Population but have been identified by the PCP, in collaboration with the LCC, as needing Care Coordination. These Members have come to the attention of the PCP and LCC through alternative means, as opposed to being included on the Core Target or the Top 10-50 lists.

These Members have significant and often sudden complexity in their health care treatment regimen. For Members with an IBS less than six who are unstable or prone to break down and whose condition is expected to worsen, documentation is necessary to support this conclusion. Examples include Members with seriously aberrant laboratory values and Members with significant behavioral health and psychosocial barriers in addition to other co-morbid medical conditions that, if not addressed, will likely lead to costly breakdowns.

The PCP often finds Members in this category through scheduled office visits. Members may be new to CareFirst and have not yet accrued sufficient evidence for inclusion on the Core Target List. Along similar lines, the Member may have neglected to follow through on prescribed care, resulting in a lack of data by which to evaluate the Member. The PCP, however, recognizes the warning signs of impending breakdown and identifies the Member as in need of Care Coordination.

The PCP or LCC may also find Members who have shown physiologic deterioration over time. For example, a Member's hemoglobin A1c might have risen significantly in three months in addition to evidence of hypertension. The Member might also be exhibiting early signs of renal failure, a symptom not present three months ago. This deterioration signals to the PCP and LCC that the Member will need intensive coordination and support to ensure an emergency department visit, a hospitalization, or irreparable loss of function is prevented.

The PCP, with assistance from the LCC, determines if the Member could benefit from Care Coordination by determining that the Member is close to or obviously headed for significant clinical breakdown. Signals of an impending breakdown may

include emergency department visits, multiple PCP and specialist visits, and/or concerning physiologic indicators of health decline. The PCP reviews these factors and makes the considered judgment that the Member's condition warrants Care Coordination.

### *Potential Core Target Population (IBS > 6) (CT3)*

Once all the Emerging Core Target Members have been assessed, the PCP and LCC evaluate Members who have the potential to enter the Core Target Population.

These Members, who have an IBS greater than six, may be identified through Top 10 to 50 SearchLight reports or through office visits or declining physiological or behavioral health indicators. If the PCP identifies a Member as being appropriate for Care Coordination, the LCC then begins the process of Care Coordination with the Member.

### *Clinical Status Review*

Each LCC reviews the Core Target Population with the Member's PCP on a monthly basis to assess Care Coordination needs. The LCC discusses the Core Target Members with the PCP during the weekly visits to the PCP's office and during the regularly scheduled monthly face-to-face meetings. The PCP and LCC must perform this function together, incorporating clinical judgment throughout the process.

The purpose of this review is to reach a considered judgment on the Member's clinical status and assure the Member receives the appropriate services necessary to stabilize the Member. The review must consider all aspects of the Member's health and social/psychological situation, thereby making an informed decision about the Member's care needs the central objective. Additional information about completing the Clinical Status Review and documenting an Assessment Outcome can be found in **Appendix E**.

**Reaching a "Considered Judgment"**

The PCP of a Member identified as needing a Care Plan is expected to cooperate with the LCC assigned to help develop and carry out the Plan. This requires the PCP to take considerable time to understand the whole set of facts and circumstances surrounding the Member. This may involve additional tests, images and consults with specialists. Often, these Members have multiple prescriptions that need to be assessed for efficacy and drug interaction/side effects. The proper development of a Care Plan certainly cannot be accomplished in the usual five- to 10-minute Member visit with a PCP.

Thus, the PCMH Program seeks to have the PCP take a differentially longer amount of time with Members who make good candidates for Care Plans. This is necessary for the PCP to reach a "considered judgment" about what each such Member needs. This judgment is documented in the Care Plan on the iCentric Online System – as part of the Member Health Record – by the LCC assigned to each PCP. Each Care Plan developed in this way is maintained online and can be retrieved in real time with a secure inquiry over the web on a 24/7 basis by any treating provider. The Care Plan can, therefore, be shared with all treating providers involved in the Member's care, including those outside the Panel.

Since each PCP is supported by an LCC who lives and works in the community where the Member lives and where the Panel is located, a close, continuous coordination in developing and carrying out Care Plans is sought. The LCC is supported by allied professionals such as pharmacists, therapists, and behavioral health professionals who can be called upon as appropriate in a team oriented approach to meet the needs of a particular Member.

The LCC is expected to make frequent contact with the PCP including visits to his/her office to discuss Care Plans and Member progress or lack thereof. This approach is explicitly meant to overcome a severe shortcoming in the current capability of small PCP practices – namely, that they typically cannot afford to hire such allied professionals, nor do they have the time or expertise to develop, monitor and implement Care Plans by themselves. These capabilities are, therefore, provided through the PCMH and TCCI Programs.

The PCMH Program requires that all Care Plan notes, directives, follow-ups, etc., be entered on a timely basis into the online Care Plan template made available over the web in iCentric. This results in a running, longitudinal record – with commentary by the various providers and LCC involved – on how the Member is progressing. This does not obviate or replace the

physician's own medical record for the Member, but is in addition to it. The Care Coordination standard procedures set forth timeliness and completeness requirements regarding Care Plan data and documentation that applies to all caregivers associated with each Care Plan.

**LCC Nurses Are a Critical Resource**

It cannot be emphasized enough that the task of documenting and carrying out a Care Plan is critical. This role is performed by the LCC and the local support team with input and guidance from the PCP. This approach minimizes the work effort required from the PCP. Notes and observations made by the PCP– or by the LCC with the approval of the PCP– are essential in interpreting why certain courses of action and decisions are made. Since it is expected that the LCC will be the principle maintainer of the longitudinal Care Plan record under the guidance of the PCP, a strong communication between the LCC and the PCP is essential. This full engagement between PCP and LCC is one of the most important parts of the "Engagement" process envisioned by the Program.

Therefore, as a critical Program requirement, the PCP must participate in and approve each Care Plan developed for one of their attributed Members and must see to it that the Care Plan is carried out, modified and updated under his/her watchful, informed eye. Most importantly, the PCP must be truly engaged with the Member and be seen by the Member as the key decision maker. This is essential to success and to taking the payer (CareFirst) out of the equation to the maximum extent possible.

This is also why the PCMH Program makes this level of engagement a fundamental condition for earning OIAs. Such "Engagement" is the most essential and important aspect of quality assessment in the Program as explained in **Design Element #8** and is measured continuously in a rigorous way in accordance with the Care Coordination standard procedures presented in **Appendix E**.

**Special Fees for Care Plan Development and Maintenance by PCPs**

In order to compensate PCPs for the additional/differential time and attention devoted to Care Plan development and maintenance, two special billing codes (CPT "S" codes) are used that provide additional reimbursement to the engaged PCP for the time they take to develop and maintain Care Plans in concert with their LCC. This additional reimbursement is unique to the PCMH Program and is not available to PCPs who are not in the Program.

These Care Plan development and maintenance fees are in addition to fees that PCPs bill for comprehensive office visits, so that the total compensation to the PCP adequately reflects the differential amount of time consumed on behalf of chronic care Members in Care Plans. The Care Plan fees are $200 for initial Care Plan development and $100 for maintenance at periodic review visits. These should be billed in conjunction with an office visit or telemedicine visit.

In the instance of a Member who is identified for a Care Plan who has recently seen their PCP, it is unnecessary to bring the Member back for an additional visit. In these instances, the Care Plan may be billed, as long as the activation date is within 90 days of the service date of the office visit. In all cases, the LCC will activate the Care Plan within three days of obtaining the Member's Election to Participate.

For complex visits, there are several different Evaluation and Management ("E&M") codes that a PCP may use for billing depending on the individual Member's situation. Regardless of which codes fit best, development and maintenance fee supplements are added when a Care Plan for a Member is being set up or updated.

Medical services rendered by any provider in carrying out a Care Plan are billable on a FFS basis in the normal manner pursuant to CareFirst contracted rates for these services with these providers. All payments for these services appear as Debits in the PCA of the Panel involved, including Care Plan development and maintenance fees.

The goal is clear: Cause a differential level of PCP and allied professional focus on those Members in the Core Target population – not only in the Care Plan development process, but also in continuous, persistent follow-up to assure progress is made. In reinforcement of this, and as explained more fully in **Part V**, benefit designs offered by CareFirst, including Blue Rewards, increasingly permit the waiving of cost-sharing in whole or part for those Members who comply with their Care Plans and show progress as a result. In this way, these benefit designs are intended to reinforce the Care Planning and implementation process.

## Design Element #7: Online Member Health Record – Information "Home Base"

As was pointed out in **Part I**, one of the greatest stumbling blocks to better Care Coordination and improved cost/quality outcomes is the lack of a single, longitudinal record for each Member. Ideally, such a record would give a holistic view of all services in all settings provided to treat a Member and all services provided to coordinate, assess, and monitor the care of a Member. It would also show the Care Plan of a Member if they are in one (or ever were in one) as well as any other services rendered through any of the supporting TCCI Programs that are integrated with the PCMH Program.

To satisfy this need, CareFirst maintains just such an online Member Health Record for each of its Members. The Member Health Record is available to every PCP as well as all treating providers of a Member and all Care Coordinators.

The Member Health Record contains the following information for each Member:

- Detailed claims information showing service type, date, and the provider name captured during claims adjudication by CareFirst across all settings, providers, and services both in and out of network (updated monthly);

- All information included in a Care Plan. This includes all orders, notes, referrals, and other information entered into the record by a Member of the Care Coordination Team – including the Member, PCP, and any specialist – as a part of the Care Planning or care giving process. This is available immediately as new information is added to the Care Plan;

- All clinical information on laboratory, pathology, imaging, prescription drug or other results obtained in furtherance of the Care Plan of a Member as this is documented by the LCC;

- All health risk appraisal and biometric information that is available about a Member; and

- The Member's Illness Band Score and trailing 12 months' claims expenses as well as LACE and Drug Volatility Scores (if applicable and available).

This information is maintained by CareFirst in its secure data/analytics warehouse and is kept continuously up to date. The SearchLight Reporting Package that is discussed and displayed in **Part VII** offers a wide range of views of Panel and Member specific patterns of disease, use, cost and other data about Panel Members while enabling a drill down to Member-specific information to better see the underlying particular circumstances of a Member. Many different summary views/displays of the data are made available to ensure that the shear mass of the data is not overwhelming.

**The Member Health Record is Available to Providers**

The existence of this Member Health Record and access to it requires no investment on the part of any PCP, Panel, or other provider. Its accessibility over the web requires no special software or hardware on the part of any provider. A browser and high-speed internet connectivity is all that is required. The Member Health Record is available through an online query via the iCentric Portal or as a drill-down view as part of SearchLight Reporting capability. Security is maintained through password and other protections (such as encryption).

It is important to stress that the Member Health Record is not meant to replace the electronic or paper medical record maintained by the PCP, or other providers, for a specific Member. The Member Health Record is consistent with industry-wide interoperability standards, so that automated information exchange with all common EMR or Practice Management Systems (PMSs) vendor applications can be achieved via an HL7 or other suitable interface.

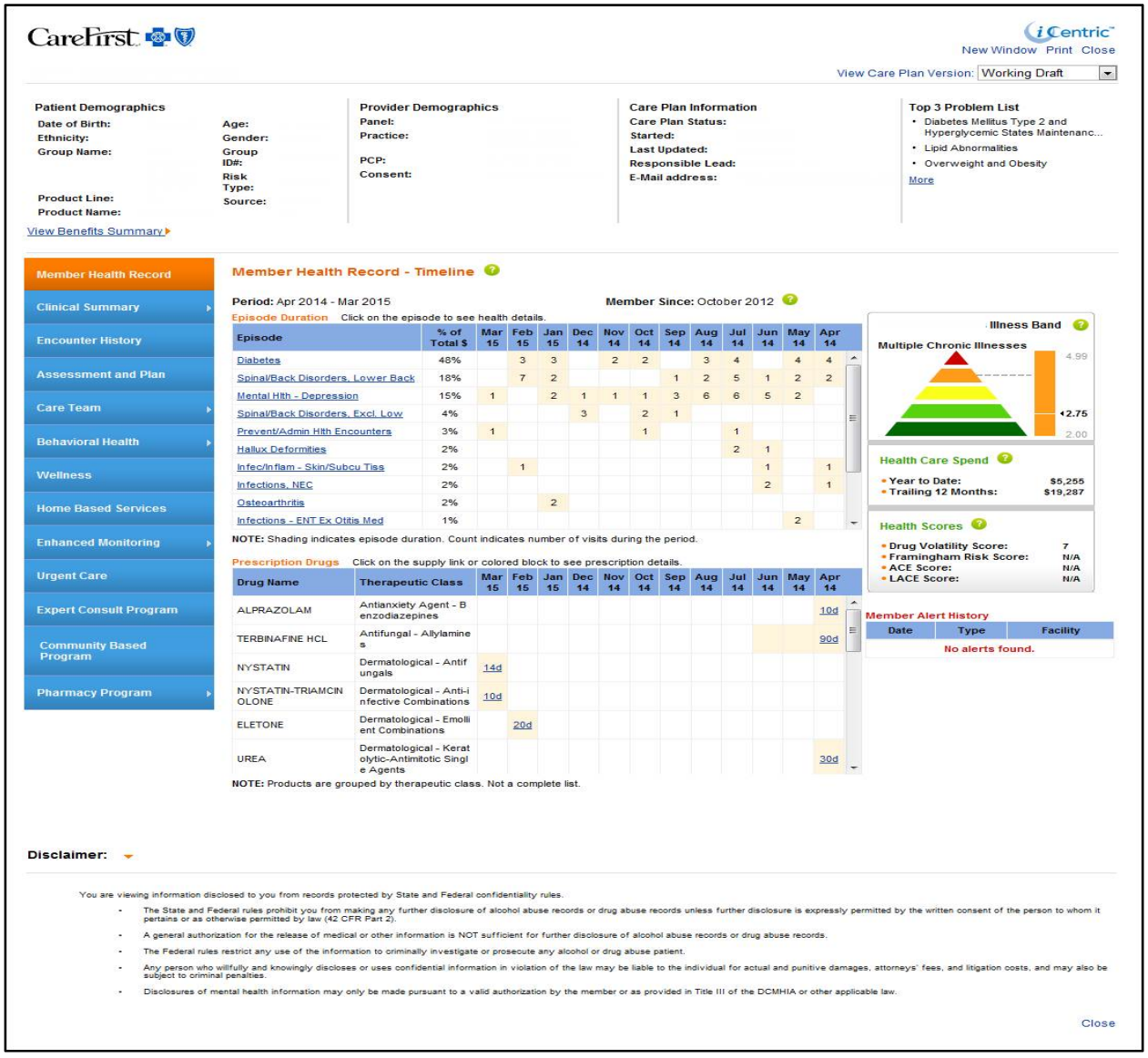
The major advantage of the Member Health Record is that it is far wider in scope than most provider medical records. It stores and displays information about a specific Member from many disparate providers, settings and services longitudinally over time. It is, therefore, intended to present a global picture of each Member in a way that is quickly and easily understood. And, it shows the record of services and Members actually received as well as their economic value/cost.

As Health Information Exchange ("HIE") standards and capabilities improve throughout the industry over the next decade – thereby increasing the availability of clinical findings and results – these will be posted to the Member Health Record to the

extent feasible and permitted by law. In this way, the information in the Member Health Record will be enriched as the clinical information exchange capabilities in the industry increase.

**Figure 13** below shows a summary view of the Member Health Record. More information on the Member Health Record is contained in **Part VIII** of these Guidelines.

**Part III, Figure 13: Member Health Record**



## Design Element #8: Measuring Quality Of Care – The Single Most Essential Ingredient

## Quality Scorecard In 2016

Beginning in **Performance Year #6 (2016)**, the Quality Score for each Panel has consisted of two equally weighted parts: a Clinical Score and an Engagement Score. Each is worth 50 points. The Clinical Score uses the CMS core clinical measures (i.e., the "Consensus Measures") while the Engagement Score uses a set of other measures as explained more fully below. Both parts are calculated and rolled up for the performance of each PCP for each Panel as a whole to derive an overall Panel Quality Score.

In order to be eligible for an OIA in **Performance Year #6 (2016)**, Panels must have scored at least 35 out of 50 Engagement points and attain an average of five Care Plans per PCP with at least 90 percent of all PCPs in the Panel having at least one care plan. Both Chronic Care Coordination and Behavioral Health Care Plans count towards the minimum. Failure to meet these minimums disqualified a Panel from receiving an OIA in 2016, even when cost savings were achieved and other quality measures are met.

**Section X** of **Appendix E** fully outlines, in great detail, all of the steps currently involved to obtain, review and report on all categories of quality measurement for the vast majority of Panels. However, there are certain, special circumstances in which the standard approach does not apply as explained immediately below.

A **"Pediatric Alternative Method"** to measure the Engagement of pediatric Panels was adopted for **Performance Year #6 (2016)** as follows:

- Any pediatric Panel or any pediatricians in a mixed Panel may be considered fully engaged in the Care Plan process and eligible to earn an OIA if savings are achieved in the Performance Year and if the Panel reviews and assesses each child specifically for their case management, Behavior Health Care Coordination and CCC needs. To qualify under the Alternative Method, the PCP must make an assessment of the very sick (IBS) those with an Illness Burden Score greater than 10) for CCM needs. Children with an Illness Burden Score of six to 10 must be individually assessed for chronic care needs and those with an Illness Burden Score of less than six - but greater than four - must be assessed to make a determination if the child was sufficiently managed. All children across all illness bands must be considered for behavioral health needs.

- When a child is in need of a Care Plan, a Care Plan must be developed with Care Coordination beginning shortly thereafter. If it is determined that a child is not in need of Care Coordination, the reason for this must be documented. This process is meant to be continuous with the results reviewed by the RCD to ensure timeliness and completeness on a quarterly basis. If this exercise is not completed each quarter by the last day of the quarter, the Panel is considered not fully engaged in the Care Plan process.

- A viable Panel that is primarily comprised of pediatric Members that accounts for all children with an IBS greater than 4.0 per above is considered engaged in the Care Plan process if it uses this Alternative Method, and the Panel will receive full points for Care Coordination. For viable Panels that have a mix of adult and pediatric Members, the pediatric portion of the Panel is deemed engaged in the Care Plan process for its portion of Panel performance if it conforms to the pediatric **"Alternative Method"** described above.

An **"Adult Alternative Method"** for **Performance Year #6 (2016)** follows a virtually identical path.

If a viable adult medicine Panel, or an individual PCP within such Panel, has too few Members with an IBS greater than six or too few Core Target Members to have met the Care Plan requirements above, an exception may be granted if the facts provide justification for an exception. To satisfy the **"Adult Alternative Method",** the following must occur:

- Each PCP in the Panel must review and assess each adult Member for their Care Coordination needs. The PCP must make a full assessment of the very sick (those with an Illness Burden Score greater than 10) for CCM needs. Members with an Illness Burden Score of six to 10 must be assessed for chronic care needs and those with an Illness Burden Score of less than six - but greater than four - must be assessed to make a determination if any

such Member needs any coordination or supportive services. All Members across all Illness Bands must be considered for behavioral health needs.

- Each PCP must complete this review with his or her LCC each quarter. When a Member is in need of a Care Plan, a Care Plan must be developed with Care Coordination beginning shortly thereafter. If it is determined that a Member is not in need of Care Coordination, the reason for this must be documented. This must be completed and documented by the last day of each quarter of the year. This process is meant to be continuous with the results reviewed by the RCD to ensure timeliness and completeness on a quarterly basis. If this exercise is not completed each quarter, the Panel is considered not fully engaged in the Care Plan process.

- Each Panel seeking to use the **"Adult Alternative Method"** will be reviewed for the timeliness and completion of the steps in the Alternative Method with a final year-end review by the RCD not later than February 15, following
  the end of the Performance Year. If an exception for use of the Alternative Method is approved for the PCPs with too few Care Plan Eligible ("CPE") or Core Target Members, and the balance of PCPs in the Panel meet the Care Plan requirement, the Panel will be considered fully engaged in the Care Coordination process and receive full Engagement points for Care Coordination.

With the initiation of the Core Target requirement, these alternative methods ended in Performance Year #6 (2016). Some Quality Measures were also revised, starting in July 2017. The Engagement portion of the Panel Quality Scorecard is shown below in **Figure 14**.

## Quality Scorecard In 2017

Beginning in **Performance Year #7 (2017)**, Panels must achieve the following in order to be eligible for an OIA:

1. Attain a minimum score of at least 35 points out of 50 possible Engagement points.

2. Complete a Clinical Status Review each month of all Members in the Core Target (CT1), Emerging Core Target (CT2) and Potential Core Target (CT3) population in the Panel, as described in **Appendix E**. When a Member is in need of a Care Plan, a Care Plan must be developed with Care Coordination beginning shortly thereafter.

3. All results of the Clinical Status Review for each Member must be documented as an Assessment Outcome. The process for conducting, completing and documenting the Assessment Outcome is described in **Appendix E**.

4. A three-month grace period (January, February and March) is granted in 2017 in order to allow Panels to become familiar with the current review of their Core Target lists. The requirement for April, May and June is that 80 percent of Core Target population (CT1, CT2, and CT3) is reviewed and an Assessment Outcome documented. Starting July 1, 2017, all Members in the Core Target population (CT1, CT2, and CT3) must be assessed and documented each month.

5. It is expected that approximately one-third of the Members in the Core Target (CT1) population and 25 percent of Members in the Potential Core Target (CT3) population need Care Coordination. It is also expected that virtually all Emerging Core Target (CT2) Members will need Care Coordination.

Failure to meet these requirements disqualifies a Panel from receiving an OIA in 2017, even when cost savings are achieved and other quality measures are met. With the implementation of the Clinical Status Review of the Core Target population and an Assessment Outcome for each such Member, there are no longer pre-established targets for the number of Care Plans that must be completed by each Panel and PCP, nor any alternative methods for meeting Care Coordination goals.

Instead, the review, assessment, documentation and Care Coordination of all Members identified in Core Target lists satisfies the requirement. Members in need of Care Coordination, as revealed by the Clinical Status Review must be approached by the PCP to whom they are attributed for a Care Plan or other appropriate TCCI Program.

All PCPs in Panels are required to timely complete Clinical Status Reviews and record – with the help of their assigned LCC – Assessment Outcomes on all of the attributed Members as well as to actively seek the consent of Members in need of a Care Plan. Failure to do so will result in disqualification for an OIA.

**Figures 14** below shows the composition of the Engagement portion of the Panel Quality Scorecard in 2017.

**Part III, Figure 14: Panel Quality Scorecard: Composition of Panel Quality Score**

| Engagement Scorecard Questions | 1st Half 2017 | Engagement Scorecard Questions | 2nd Half 2017 |
|---|---|---|---|
| **I. Engagement with and Knowledge of PCMH and TCCI Programs** | **12.5** | **I. Engagement with and Knowledge of PCMH and TCCI Programs** | **15.0** |
| Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end. | 2.5 | Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end. | 2.5 |
| PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. | 2.5 | PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. | 2.5 |
| PCP attends and actively/constructively participates in PCMH Panel meetings. | 2.5 | PCP attends and actively/constructively participates in PCMH Panel meetings. | 2.5 |
| PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel. | 2.5 | PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel. | 2.5 |
| PCP uses the categories in HealthCheck to take action that leads to better cost and quality outcomes. | 2.5 | PCP takes due care to review a Member's needs for CMRs and Drug Therapy Recommendations and responds as needed. | 2.5 |
| | | PCP takes due care to review a Member's needs for all other TCCI Program Elements, including Home-Based, Enhanced Monitoring and Expert Consult services. | 2.5 |
| **II. PCP Engagement with Care Plan** | **15.0** | **II. PCP Engagement with Care Plan** | **12.5** |
| PCP actively and constructively reviews top 50 and other target lists on a timely basis to identify appropriate Care Plan Eligible Members. | 2.5 | PCP timely and constructively completes a Clinical Status Review of all Members on the Core Target (CT1) list on a monthly basis to identify appropriate Care Plan Eligible Members. | 2.5 |

**Part III, Figure 14: Panel Quality Scorecard: Composition of Panel Quality Score (continued)**

| Engagement Scorecard Questions | 1st Half 2017 | Engagement Scorecard Questions | 2nd Half 2017 |
|---|---|---|---|
| **I. Engagement with and Knowledge of → PCMH and TCCI Programs** | **12.5** | **I. Engagement with and Knowledge of → PCMH and TCCI Programs** | **15.0** |
| PCP actively seeks to work with the LCC to schedule Members appropriate for Care Plans. | 2.5 | PCP timely identifies Members who may have emerging needs (CT2) and reviews Members on the Potential Core Target (CT3) list who may be appropriate for Care Coordination. | 2.5 |
| PCP clearly and effectively explains to Care Plan Eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and targeted "State of Being" for Care Plan Members. | 2.5 | PCP clearly and effectively explains to Care Plan Eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and a targeted "State-of-Being" for each Care Plan Members. | 2.5 |
| PCP is responsive to requests of LCC when consultation about a Member is needed and works actively on Care Plan compliance with Members. | 2.5 | PCP reaches an appropriate and timely Assessment Outcome for each Member on the Core Target list on a monthly basis. | 2.5 |
| PCP takes due care to review a Member's medication list and cooperates with the LCC and pharmacist as part of CMRs. | 2.5 | PCP is collaborative with the LCC, ensuring that the LCC has access to needed clinical information, completing Care Plans on a timely basis, providing consultation about Member status changes as needed, and works actively with Members to better ensure Care Plan compliance. | 2.5 |
| PCP ensures LCC has access to needed clinical information to identify a Member that is appropriate for a Care Plan and collaborates with the LCC to complete the Care Plan on a timely basis. | 2.5 | | |
| **III. Practice Transformation** | **22.5** | **III. Practice Transformation** | **22.5** |
| PCP identifies and refers to cost-efficient specialists in the top specialty categories. | 10.0 | PCP identifies and refers to cost-efficient specialists in the top specialty categories. | 10.0 |
| PCP has an effective plan for after-hours care, including active use of telemedicine and nurse hotline capabilities to enhance Member access and avoid unnecessary ER visits or breakdowns. | 5.0 | PCP has an effective plan for after-hours care, including offering Members the opportunity to speak with a clinician after hours, to avoid unnecessary ER visits or breakdowns. | 5.0 |

**Part III, Figure 14: Panel Quality Scorecard: Composition of Panel Quality Score (continued)**

| Engagement Scorecard Questions | 1st Half 2017 | Engagement Scorecard Questions | 2nd Half 2017 |
|---|---|---|---|
| **I. Engagement with and Knowledge of PCMH and TCCI Programs** | **12.5** | **I. Engagement with and Knowledge of PCMH and TCCI Programs** | **15.0** |
| PCP actively refers Members to TCCI Program Elements through LCCs assigned to Panel. | 5.0 | PCP (or designated practice staff for all Panel providers) is meaningfully engaged with the CareFirst Practice Consultant between quarterly Panel meetings to implement practice transformation recommendations as indicated by the HealthCheck data. | 5.0 |
| PCP actively collaborates with hospitalists on Members prior to and after admission. | 2.5 | PCP offers and uses Video Visits to improve convenience and access for CareFirst Members after hours or when follow-up visits are not required to be in-person. | 2.5 |
| **Total Points** | **50.0** | **Total Points** | **50.0** |

## Measurement of Degree of Engagement (50 points of Quality Score)

The process for assessing the degree of Engagement of PCPs and completing the Quality Scorecard for Engagement in 2016 and 2017 is carried out as follows:

- Each LCC conducts a quarterly assessment of each PCPs Engagement, with oversight from the RCD.
- The Program Consultant assigned to each Panel also provides a quarterly assessment of the Panel's Engagement with oversight from the RCD.
- Each PCP receives an overall score for each question. The Panel scores are then calculated as the average of the PCP scores.

Engagement for a new PCP is not measured for the first three months of enrollment in PCMH to allow time for the PCP to become established and to meet Members of the Care Coordination Team as well as to schedule Care Plan appointments. If a PCP is within the first three months of enrollment at the end of the year, the PCP will not be included in the measurement of the Panel's Engagement.

If a PCP goes on an extended leave of absence for 12 weeks or more, the PCP may request to be removed from Engagement Scoring during the period of their leave. The PCP's Engagement Scores will be suspended (not measured) during any quarter that the PCP is on leave for the majority of the quarter. The Panel must continue to complete a Clinical Review of the Core Target list of any PCP on leave and document the Assessment Outcomes on their behalf in order to meet the Engagement requirements to be eligible for an OIA.

Any PCP intending to go on leave must provide written notice to CareFirst of the dates of the leave of absence prior to or as soon as possible after the commencement of the leave and make clear that the leave prevents the involvement of the PCP in the practice's daily Member care activities. Once the leave period is completed, the PCP Engagement Score results will be measured and included in the Panel's Engagement Score.

Additional, more detailed information about Engagement Scoring can be found in **Section X** of **Appendix E**. As already noted, the Program's core clinical measures align with the CMS core clinical measures so as to eliminate any inconsistency in what PCPs and Panels must accomplish regarding quality for Medicare beneficiaries and CareFirst commercial Members. These are sometimes referred to as the "Consensus Measures." The CareFirst clinical quality score aligns with these CMS

measures, and the detailed technical specifications for the measures are defined by NCQA. The technical specifications may be updated on an annual basis, to reflect current clinical practice and guidelines. For the purposes of the quality scorecard, any changes to the specifications will be applied on a prospective basis to the following Performance Year.

These technical specifications determine which Members are included in a measure, which Members may be excluded from a measure and what qualifies as compliance. There are also NCQA definitions of minimum thresholds that are required in order to be scored. For some Panels, there may be certain measures that do not have enough data to meet the threshold to be measured due to a small number of Members meeting the criteria. In these instances, the measure will not be included in the average rates, so that they will not contribute to the Panel score.

There are four categories of measures within the Clinical Scorecard as shown in **Figure 15** below.

**Part III, Figure 15: Quality Scorecard Clinical Categories And Points**

| Clinical Category and Measure | Adult/Mixed Panel Points | Pediatric Panel Points |
|---|---|---|
| Care Coordination/Member Safety | 12.5 points | 40 points |
| At-Risk Population | 12.5 points | |
| Preventive Health | 12.5 points | |
| Member, Caregiver Experience of Care | 12.5 points | 10 points |
| **Total** | **50 points** | **50 points** |

The first three categories in the Clinical Scorecard above are based on claims data. Beginning in April of each Performance Year, a Panel rate is calculated each month for each measure and reflects year-to-date paid claims. The Panel's Quality Score is based on a full year of claims data, with a three-month run out period through March 31, following the end of a Performance Year.

To determine a Panel's points for the Quality Score for adult and mixed Panels, the Panel achievement rate is averaged across all measures in a category. For any measure that does not include enough data to meet the threshold warrant being evaluated, the measure is not included in the calculation. The average achievement rate by the Panel for the measures within a category is applied to the total number of possible points available for each category to determine the Panel points for the quality score. The achievement rate for each PCP within the Panel is displayed in SearchLight. The achievement rate of a Panel as a whole is used to calculate points for the Quality Score. The Quality Score is calculated in the same manner for adult, mixed and pediatric Panels, except that for Pediatric Panels, the achievement rates are averaged across all the claims-based measures for all categories.

For example, the Preventive Health category for an adult Panel includes five measures and is worth 12.5 points. The rate of compliance with the recommended screening or assessment for each measure for all Members attributed to the Panel is calculated. After the Performance Year completes (with three additional months of claims run out), the average of the three measures in this example is calculated to be 85.0 percent, which is applied to the total possible points 12.5, for a Panel score of 10.6 points for Preventive Health. This is shown in **Figure 16** on the next page.

**Part III, Figure 16: Quality Scorecard Sample Calculation Of Rates**

| Preventive Health | Eligible Members | Members Who Met Goal | Achievement Rate |
|---|---|---|---|
| Breast Cancer Screening | 1,000 | 900 | 90.0% |
| Colorectal Cancer Screening | 1,500 | 1,200 | 80.0% |
| Cervical Cancer Screening | 800 | 680 | 85.0% |
| **Panel Rate** | | | **85.0%** |

Panel Rate 85.0% x 12.5 Possible Points = 10.6 Points for Preventive Health

For measures that are "composite," the average of all the sub-measures is calculated first, and the composite achievement rate is used for any further calculations. For example, the diabetes composite rate will reflect the average rate of the following three sub-measures: eye exam, Hemoglobin A1c testing, and medical attention for nephropathy. The composite rate is then averaged with the other measures in the At-Risk Population Category. In addition to diabetes, there are also composite measures for children prescribed ADHD medication and children and adolescents on antipsychotics.

The claims-based categories and measures are described below for adult and pediatric Panels. For mixed Panels, all measures are included in the scorecard. Full technical specifications for these measures can be found in the SearchLight Appendix within the iCentric portal. However, a brief summary is provided below and in the following pages.

## Care Coordination/Member Safety Adult

- **All-Cause Readmissions** - For Members 18 to 64 years of age, the number of acute in stays during the measurement year that were not followed by an unplanned acute readmission for any diagnosis within 30 days.

- **Use of Imaging Studies for Low Back Pain** - The percentage of Members 18 to 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

- **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis** - Assesses the percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic medication. (Requires pharmacy enrollment.)

## Pediatric

- **Appropriate Treatment for Children with Upper Respiratory Infection** - Assesses the percentage of children three months to 18 years of age who were given a diagnosis of Upper Respiratory Infection ("URI") and were not dispensed an antibiotic prescription on or three days after the Episode Start Date ("ESD"). (Requires pharmacy enrollment.)

- **Appropriate Testing for Children with Pharyngitis** - Assesses the percentage of children two to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic medication and received a group A streptococcus (strep) test for the episode. (Requires pharmacy enrollment.)

## At-Risk Population Adult

- **Persistent Beta Blocker Treatment After a Heart Attack** - Assesses the percentage of Members 18 years of age and older during the measurement year who were hospitalized and discharged alive from six months prior to the

beginning of the measurement year through the six months after the beginning of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge. (Requires pharmacy enrollment.)

## Diabetes Composite

- **Diabetes: Eye Exam** - Assesses the percentage of Members 18 to 75 years of age with diabetes (Type 1 and Type 2) who had an eye exam (retinal) performed.

- **Diabetes: Hemoglobin A1c Testing** - Assesses the percentage of Members 18 to 75 years of age with diabetes (Type 1 and Type 2) who received an HbA1c test.

- **Diabetes: Medical Attention for Nephropathy** - Assesses the percentage of Members 18 to 75 years of age with diabetes (Type 1 and Type 2) who received a nephropathy screening test or had evidence of nephropathy.

- **Medication Management for People with Asthma** - Assesses the percentage of Members five to 85 years during the measurement year who were identified as having persistent asthma and were dispensed an asthma controller medication that they remained on for at least 75 percent of their treatment period. (Requires pharmacy enrollment.)

## Pediatric

- **Medication Management for Children with Asthma** - Assesses the percentage of Members five to 85 years of age during the measurement year who were identified as having persistent asthma and who were dispensed an asthma controller medication that they remained on for at least 75 percent of their treatment period. (Requires pharmacy enrollment.)

## Follow Up Care for Children Prescribed ADHD Medication Composite

- **Initiation Phase** - Assesses the percentage of Members six to 12 years of age as of the Index Prescription Start Date ("IPSD") with an ambulatory prescription dispensed for Attention-Deficit/Hyperactivity Disorder ("ADHD") medication who remained on the medication for at least 210 days.

- **Continuation and Maintenance Phase** - Assesses the percentage of Members six to 12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended. (Requires pharmacy enrollment.)

- **Antipsychotics in Children and Adolescents Composite:**

    - **Use of Multiple Concurrent Antipsychotics in Children and Adolescents** - Assesses the percentage of children and adolescents one to 17 years of age who were not concurrently on two or more antipsychotic medications. (Requires pharmacy enrollment.)

    - **Metabolic Monitoring for Children and Adolescents on Antipsychotics** - Assesses the percentage of children and adolescents one to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Requires pharmacy enrollment.)

## Preventive Health Adult

- **Breast Cancer Screening** - Assesses the percentage of women 50 to 74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

- **Colorectal Cancer Screening** - Assesses the percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test; flexible sigmoidoscopy every five years; or colonoscopy every ten years.

- **Cervical Cancer Screening** – Assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: Women age 21 to 64 who had cervical cytology performed every three years or women age 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

## Pediatric

- **Well-Child Visits in the First 15 Months of Life** - Assesses the percentage of Members who turned 15 months old during the measurement year and who had six well-child visits with a PCP during their first 15 months of life.

- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life** - Assesses the percentage of Members three to six years of age who had one or more well-child visits with a PCP during the measurement year.

- **Adolescent Well-Care Visits** – Assesses the percentage of enrolled Members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.

- **Childhood Immunization Status (Combo 10)** - Assesses the percentage of children who turn two years of age during the measurement year who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotaviruses and two influenzas by their second birthday.

- **Immunizations for Adolescents** - Assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine; one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td); and three doses of the Human Papillomavirus Vaccine ("HPV") by their 13th birthday.

The final category within the Clinical Scorecard is based on survey data for the PCMH Member Survey and CAHPS.

## Member, Caregiver Experience of Care

- **The PCMH Member Survey** - Is intended to gauge the degree to which the Member is aware of, engaged in and receiving benefit from their Care Plan. There are five questions and each one is scored on a scale of one to five, as described in **Appendix E**. All scores for all Members in an active Care Plan are averaged to create a Panel Score each quarter. Each Member who has an active Care Plan and does not answer the survey is counted in the average as a zero score. The Panel average is converted to a rate and applied to the 2.5 points available each quarter. Each quarter's score is summed to a total of 10 possible points in the Performance Year.

- **CAHPS** - Is scored for the Health Plan on an annual basis and is based on the average result of the following categories. Technical specifications for these measures can be found in the SearchLight Appendix within iCentric.

    - Getting timely care, appointments, and information
    - How well your providers communicate
    - Members' rating of provider
    - Access to specialists
    - Health promotion and education

- Shared decision making
- Health status/functional status
- Stewardship of Member resources

**Figures 17** and **18** shown in the following two pages present all clinical categories and measures as well as their relative weights for both adult and pediatric Panels that are used in 2016. Every PCP, as well as every Panel as a whole, is subject to these measures. All scoring is at a Panel level, but each PCP's individual score contributes to the overall Panel score. A Panel must work together to improve its scores and pay attention to its poorest performers.

**Part III, Figure 17: Adult Panel Clinical Categories And Measures For 2016 And 2017**

| Adult Panel Clinical Category and Measure | Points |
|---|---|
| **Care Coordination / Member Safety** | **12.5** |
| All-Cause Readmissions | **i** |
| Use of Imaging Studies for Low Back Pain | |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | |
| **At-Risk Population** | **12.5** |
| Persistent Beta Blocker Treatment After a Heart Attack | **i** |
| Diabetes Composite | |
| ☐ Diabetes: Eye Exam | |
| ☐ Diabetes: Hemoglobin A1c Testing | |
| ☐ Diabetes: Medical Attention for Nephropathy | |
| Medication Management for People with Asthma | |
| **Preventive Health** | **12.5** |
| Breast Cancer Screening | **i** |
| Colorectal Cancer Screening | |
| Cervical Cancer Screening | |
| **Member, Caregiver Experience of Care** | **12.5** |
| PCMH Member Survey | **i** |
| CAHPS: Getting timely care, appointments, and information | |
| CAHPS: How well your providers communicate | |
| CAHPS: Members' rating of provider | |
| CAHPS: Access to specialists | |
| CAHPS: Health promotion and education | |
| CAHPS: Shared decision making | |
| CAHPS: Health status/functional status | |
| CAHPS: Stewardship of Member resources | |
| **Total** | **50** |

**Part III, Figure 18: Pediatric Panel Clinical Categories And Measures For 2016 And 2017**

| Pediatric Panel Clinical Category and Measure Title | Points |
|---|---|
| **Care Coordination / Member Safety** | **40 points** |
| Appropriate Treatment for Children With Upper Respiratory Infection | |
| Appropriate Testing for Children With Pharyngitis | |
| **At-Risk Population** | |
| Medication Management for People with Asthma | |
| Follow-Up Care for Children Prescribed ADHD Medication Composite | |
| ☐ ADHD Initiation Phase | |
| ☐ ADHD Continuation and Maintenance Phase | |
| Antipsychotics in Children and Adolescents Composite | |
| ☐Use of Multiple Concurrent Antipsychotics in Children and Adolescents | |
| ☐Metabolic Monitoring for Children and Adolescents on Antipsychotics | |
| **Preventive Health** | |
| Well-Child Visits in the First 15 Months of Life | |
| Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | |
| Adolescent Well-Care Visits | |
| Childhood Immunization Status | |
| Immunizations for Adolescents | |
| Human Papillomavirus Vaccine for Female Adolescents | |
| **Member and Caregiver Experience of Care** | **10 points** |
| PCMH Member Survey | |
| **Total** | **50 points** |

PCPs have the opportunity to attest for those of their Members who have met a measure. PCPs may attest to the fact that some Members met their goal or should be excluded from a measure based on a review of the Member's medical chart whether or not this was captured in CareFirst claims data. This process is available through the PCMH iCentric online portal and is an entirely voluntary process. PCPs are required to upload a copy of a test/screening result to which they have attested and are subject to CareFirst audit verification for any and all attestations.

## Overall Quality Profile Score is Calculated for Each Panel

Based on the results obtained on the Engagement measures and clinical measures, a composite Quality Profile Score is calculated for each Panel throughout the year on a monthly basis and, finally, by the end of the run out period (i.e., March 31, 2018 for **Performance Year #7 2017**). A separate weight is assigned to each of these categories that contribute to the total score as seen in **Figure 19** on the next page.

**Part III, Figure 19: Composite Panel Quality Profile Score**

| | Category | Possible Points for Adult Panels | Possible Points for Pediatric Panels |
|---|---|---|---|
| **Engagement Measures** | Engagement with and knowledge of the Program | 12.5 | 12.5 |
| | Engagement with the Care Plan | 15.0 | 15.0 |
| | Practice Transformation | 22.5 | 22.5 |
| **Clinical Measures** | Care Coordination / Member Safety | 12.5 | 40.0 |
| | At-Risk Population | 12.5 | |
| | Preventive Health | 12.5 | |
| | Member / Caregiver Experience | 12.5 | 10.0 |
| **Total Quality Score** | | **100 points** | **100 points** |

## Consequences of Failure to Engage

Beginning in **Performance Year #7 (2017)**, failure to achieve the Engagement point threshold for two consecutive years will cause a Panel's Participation Fee to decrease from 12 percentage points to six points in the next Performance Year, in addition to being disqualified from receiving an OIA in the current Performance Year. If a Panel fails to achieve threshold Engagement points for three consecutive years, the Panel will no longer receive a Participation Fee or OIA.

To be more specific, a Panel that fails to achieve the Engagement point threshold in **Performance Year #7 (2017)**, will be identified and notified by the RCD in which the Panel is situsued. If such Panel fails to achieve the Engagement threshold again in **Performance Year #8 (2018)**, the Panel's participation fee will decrease to six percentage points, starting August 1, 2019. If such Panel, again fails to achieve the Engagement point threshold a third time in **Performance Year #9 (2019)**, it will have zero participation fee, starting August 1, 2020.

Any subsequent failure by a Panel to achieve the Engagement threshold after three consecutive years of failure to achieve the threshold Engagement Score, will result in the Panel being terminated from the PCMH Program. However, if the Panel achieves the engagement threshold for a full Performance Year prior to termination from the Program, the Panel will return to a 12% participation fee, effective on August 1 of the year following the Performance Year in which it obtained the necessary Engagement threshold.

Safety Net providers will not be held to this requirement, due to the low attribution of commercial Members and will be allowed to maintain their Participation Fee for as long as they remain in the PCMH Program.

## Concluding Perspective on Quality Score

It is important, as a matter of perspective, to understand that all PCPs who are in the CareFirst RPN and HMO networks have been fully credentialed and are in good standing. Fully credentialed status is a baseline requirement for entry into the Program. Thus, there is no known quality issue with any of the PCPs in these networks who may become participants in the PCMH Program.

Starting with the baseline level of quality that existed in **Performance Year #1**, the goal of the PCMH Program is to raise quality by integrating the Quality Profile Score into the OIA for each Panel. By doing so, a Panel's OIA is influenced up or down depending on their relative Quality Profile Score. This is explained more fully in **Design Element #9**. In short, the way for a Panel to maximize its incentive payments is to maximize its overall Quality Profile Score and its cost savings at the same time.

It is the specific intent of the PCMH Program to steadily improve and refine the measures of quality that are used over time in close coordination with the advancement of national standards. As previously noted, the improvement of quality outcomes will almost surely have a positive impact on cost results over time. Quality matters. Higher quality matters more. The highest quality matters most.

As with the rest of the PCMH Program design, there are no quality performance penalties and all Panels that show meaningful Engagement (i.e., attain the minimum threshold score of 35/50 points) are eligible for OIAs as long as they have produced savings in their PCA and achieved the minimum quality points as described in this **Design Element #8**. However, a Panel's Quality Score has a direct effect on its overall OIA by ratcheting up or down the award, assuming that the minimal number of points on Engagement have been earned by the Panel.

One final note: Consistency of performance within Panels on quality measures is a key objective. While Quality Scores are calculated at the Panel level, the data on quality used to build the Panel's Quality Score is specific to each PCP. This level of specificity is shared with each Panel PCP so that all can consider what actions may be appropriate to improve the score of individual PCPs. This internal Panel peer review process is seen as essential to steady improvement in quality.

## Design Element #9: Reward For Strong Performance – Outcome Incentive Awards (OIAs)

In fulfillment of all that has been said with regard to the first eight Elements, the PCMH Program pays substantial incentives to those Panels that achieve favorable outcomes for their Members on both cost control and quality. These incentives are called OIAs. All such incentives are expressed as add-ons to the professional fees paid to PCPs who make up "winning Panels". This section explains the way these incentives are calculated.

All quality and cost results of each Panel's performance are taken into account in the OIA. In simplest terms, the OIA seeks to determine the degree to which each Panel achieved a cost savings within its total PCA and achieved quality results for its Panel's Members as well.

All Panels could qualify for an OIA in **2016 (Performance Year #6)** by meeting the conditions related to savings and quality outcomes. To be eligible for an OIA, the Panel must meet the following criteria:

1. The Panel must had joined the Program on or before July 1st of the Performance Year. If the Panel joins after this date, it will be eligible for an OIA the following year.

2. The Panel must have had a cost savings in their PCA (i.e., Credits must exceed Debits).

3. The Panel must have achieved 35 out of 50 points on the Engagement measures and attained an average of five Care Plans per PCP with at least 90 percent of all PCPs in the Panel contributing to this average or have qualified for an Alternative Method.

4. The Panel must have complied with minimal Panel participation requirements.

5. The Panel must be "Viable" by having achieved at least 12,000 Member Months in **Performance Year #6**.

All Panels may qualify for an OIA in **2017 (Performance Year #7)** by meeting the conditions related to savings and quality outcomes. To be eligible for an OIA, the Panel must meet the following criteria:

1. The Panel must have joined the Program on or before July 1st of the Performance Year. If the Panel joins after this date, it will be eligible for an OIA after the following Performance Year.

2. The Panel must have a cost savings in their PCA (i.e., Credits must exceed Debits).

3. The Panel must achieve 35 out of 50 points on the Engagement measures and complete a Clinical Status Review each month of all Members in the Core Target (CT1), the Emerging Core Target (CT2), and Potential Core Target (CT3) population in the Panel, as described in **Appendix E**.

4. All results of the Clinical Status Review for each Member must be documented as an Assessment Outcome. The process for conducting, completing and documenting the Assessment Outcome is described in **Appendix E**.

5. The Panel must be "Viable" by having at least 15,000 Member Months in Performance Year 2017.

Before discussing the calculation of the OIA, it is important to recall, as stated earlier, that the randomness of illness in any population plays a role in Panel results that cannot be wholly removed. A small number of large claims – "shock claims" – can distort results even with the ISL feature of the Program in place. Small Member populations exhibit greater volatility than larger populations simply because larger population numbers mute the impact of randomness. This is a fundamental tenet of insurance and it comes into play in calculating OIAs. The requirement that Panels include at least five PCPs is designed to help Panels attain more credible results through pooling of larger Member populations.

It is the intent of the Program to reward Panels as strongly as possible for the results they achieve on cost savings and quality improvements. While OIAs are calculated in accordance with the step-by-step process below, there is an upper limit of 100 percentage points on the size of an OIA award a Panel may earn for one Performance Year. The upper limit is set prior to applying a persistency award (if any).

This generous cap is meant to guard against the effects – sometimes dramatic – of large fluctuations in Panel membership because of growth or shrinkage or other changes not related to the actual performance of the Panel. It also recognizes the critical point that fluctuations in random illness patterns are not entirely removable.

Since the Program seeks to reward performance – especially consistent performance over an extended period of time – the upper award limit establishes an outer boundary in awards so that random fluctuations and other "external" changes do not cause unjustified windfalls in awards. But the limit is generous enough to allow all but a few outlier Panels to receive their full awards.

**Calculating a Panel's OIA – Five Steps**

There are five distinct steps in calculating Panel OIAs. All OIAs are expressed as a percentage point supplement to the professional service fees paid to PCPs in the Program. All OIAs are Panel specific. All are added on top of the Base Fee and Participation Fee of each PCP in a "winning Panel".

The five steps are as follows:

**Step 1: Determine Degree of Savings and Annual Quality Score –** For those Panels that have met the criteria above, the degree of care cost savings actually achieved by each Panel against its Target Budget (i.e., the sum of the Credits less the sum of Debits) is determined as is the Panel's Composite Quality Profile Score. These are determined and located in the grid below after three months of claims run out in the year following the Performance Year.

**Step 2: Determine Panel Size –** The next step in the Annual Settlement process is to determine the size of each "winning" Panel's membership. Each Panel is sorted into one of the following three size tiers that reflect the Panel's average membership during the Performance Year.

Due to the enhanced credibility that accompanies larger Member population size, the OIA percentages for Panels increase with larger membership sizes. The size tiers are shown in **Figure 20** below. Panels with membership smaller than Tier 3 are not large enough (credible enough) to earn an OIA and are, for this purpose, considered "non-viable".

**Part III, Figure 20: Size Of Panel Membership Influences Size Of Outcome Incentive Award (OIA) Percentage**

| Size Band | Member Membership |
|---|---|
| **Tier 1** | ≥ 3,000 |
| **Tier 2** | 2,000-2,999 |
| **Tier 3** | 1,000-1,999[9] |

**Step 3: Calculate Award as Intersection of Savings and Quality –** Once a qualifying Panel's results are entered into the grid, an OIA is calculated by taking into account the degree of savings actually achieved by the Panel as well as its Quality Score (assuming at least 35 out of 50 points in **Performance Year #6 and #7)**. This is shown in **Figure 21** on the next page:

[9] *This applies to **Performance Year #6 (2016)**. A 1,250-minimum membership for Tier 3 applies to **Performance Year #7 (#2017)**.*

**Part III, Figure 21: Grid To Determine Outcome Incentive Award's (OIA) Degree Of Savings**[10]

| QUALITY SCORE | PCP PERCENTAGE POINT FEE INCREASE: YEAR 1* | | | | |
|---|---|---|---|---|---|
| | SAVINGS LEVELS | | | | |
| | **10%** | **8%** | **6%** | **4%** | **2%** |
| 80 | 67 | 53 | 40 | 27 | 13 |
| 60 | 56 | 45 | 34 | 23 | 11 |
| 40 | 46 | 37 | 28 | 18 | 9 |

The horizontal or "x" axis depicts the percentage level of savings achieved by a particular Panel in its PCA and the vertical or "y" axis depicts the Panel Quality Profile Score earned by a particular Panel. The grid illustrates OIAs for a set of selected outcomes rather than for all possible outcomes. The fee incentive payment formula is computed so that higher savings and quality always produce higher awards, and lower savings and quality always produce lower awards.

In this manner, a PCMH's Quality Score and the degree of its cost savings are simultaneously taken into account. That is, the boxes on the upper left provide the greatest reward in fee incentives and the ones on the lower right provide the least reward in fee incentives. This fulfills the Program's goals of giving the greatest rewards for maximizing both cost effectiveness and quality of care results at the same time.

**Step 4: Determine Persistency/Consistency of Performance -** The Program's central purpose is to reward consistently strong performance over time. Thus, for a Panel that earns incentives for two years in a row, the fee reward for second year performance is increased by 10 percent over the corresponding award that would have been applicable for the same performance in the first year. If a Panel earned incentives three years in a row, the award is increased further – by 20 percent – and stays at this higher level until the string of "win" years is broken.

In order to be eligible for this persistency award the Panel must not have undergone a "Substantial Change" during the consecutive years of its "win" years and must meet the definition of "viable" Panel.

This additional reward for consistency is not only meant to recognize strong continuing performance, it is also intended to provide added incentive to Panels not to under serve Members in any given year since any breakdowns in the health status of such Members – accompanied by higher health care costs – will become future Debits to the Panel's PCA and possibly threaten a future incentive award. **Figure 22** on the following page shows how size and consistency in performance over a multi-year period influences OIAs.

[10] *Example for Panels with greater than 3,000 Members.*

**Part III, Figure 22: Multi-Year Impact Of Persistency/Consistency Of Performance**

**Tier 1 with Over 3,000 Attributed Members**

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 1 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 72 | 57 | 43 | 29 | 14 |
| 80 | 67 | 53 | 40 | 27 | 13 |
| 70 | 61 | 49 | 37 | 25 | 12 |

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 2 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 79 | 63 | 47 | 32 | 16 |
| 80 | 73 | 59 | 44 | 29 | 15 |
| 70 | 68 | 54 | 41 | 27 | 14 |

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 3 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 86 | 69 | 52 | 34 | 17 |
| 80 | 80 | 64 | 48 | 32 | 16 |
| 70 | 74 | 59 | 44 | 29 | 15 |

**Tier 2 with 2,000 to 2,999 Attributed Members**

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 1 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 60 | 48 | 36 | 24 | 12 |
| 80 | 56 | 45 | 34 | 22 | 11 |
| 70 | 52 | 41 | 31 | 21 | 10 |

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 2 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 67 | 53 | 40 | 27 | 13 |
| 80 | 62 | 49 | 37 | 25 | 12 |
| 70 | 57 | 46 | 34 | 23 | 11 |

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 3 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 73 | 58 | 44 | 29 | 15 |
| 80 | 67 | 54 | 40 | 27 | 13 |
| 70 | 62 | 50 | 37 | 25 | 12 |

**Tier 3 with 1,250 to 1,999 Attributed Members**

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 1 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 54 | 43 | 32 | 22 | 11 |
| 80 | 50 | 40 | 30 | 20 | 10 |
| 70 | 46 | 37 | 28 | 18 | 9 |

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 2 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 59 | 47 | 35 | 24 | 12 |
| 80 | 55 | 44 | 33 | 22 | 11 |
| 70 | 51 | 41 | 30 | 20 | 10 |

| PCP PERCENTAGE POINT FEE INCREASE: YEAR 3 | | | | | |
|---|---|---|---|---|---|
| QUALITY SCORE | SAVINGS LEVELS | | | | |
| | 10% | 8% | 6% | 4% | 2% |
| 90 | 65 | 52 | 39 | 26 | 13 |
| 80 | 60 | 48 | 36 | 24 | 12 |
| 70 | 55 | 44 | 33 | 22 | 11 |

**Step 5: Determine the OIA Percentage Fee Add-On for One Year.**

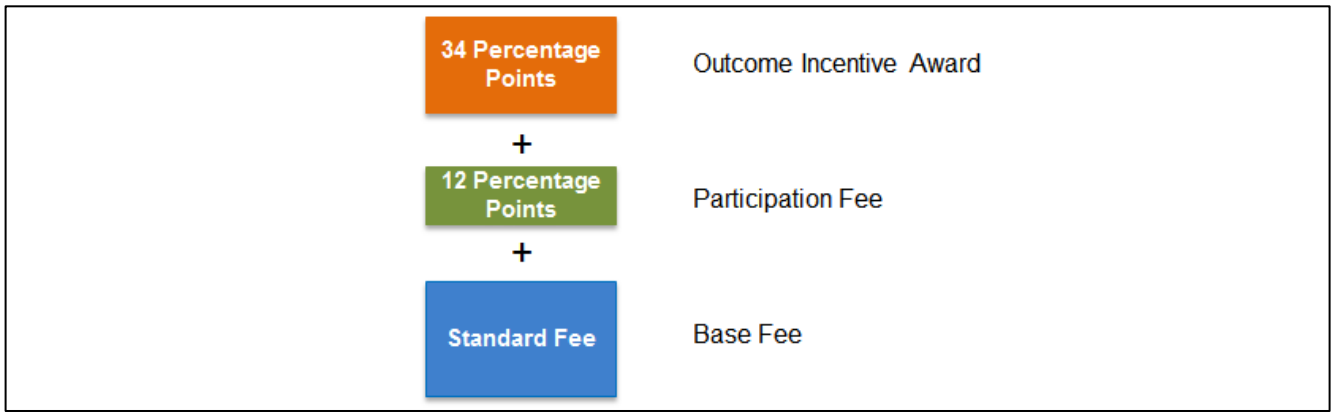
All earned OIAs are implemented by adding the earned OIA to the fees paid for all primary care services provided by PCPs in the Panel.

The OIA is rounded to the nearest whole percentage point. Those greater than zero and less than one are rounded up to one percentage point. Time-based anesthesia, supplies and injectable drug fees/billings are excluded from OIA supplementation.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2018 for **Performance Year #7 - 2017**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2017.).

All OIAs earned by each Panel are added on top of Base Fees and Participation Fees as shown in **Figure 23** below:

**Part III, Figure 23: Example Of Outcome Incentive Award (OIA) Fee Supplement**




For a Panel that joins the Program within the first six months of the Performance Year, the OIA will be prorated based on effective date of Panel entry into the Program as shown in **Figure 24** below.

**Part III, Figure 24: Proration Of Outcome Incentive Award (OIA)**

| Effective Date | Prorated Percentage |
|---|---|
| | |
| 2/1 | 92 |
| 3/1 | |
| 4/1 | 75 |
| 5/1 | |
| 6/1 | 58 |
| 7/1 | |

It is important to keep in mind that these OIAs are just that – incentives – not permanent additions to fees. Thus, if no OIA is earned for a given Performance Year or is lower than in a previous Performance Year, Panel fee levels may drop just as they may increase. However, in no event, would the fees for PCPs in good standing in the Program be lower than the CareFirst contracted fees plus the 12-percentage points Participation Fee.

Thus, OIA payouts are best seen for what they are – bonus payments for value added by the Panel in attaining better quality and cost outcomes for Members in the Panel in a particular Performance Year or consecutive string of years.

An appeals process is available for Panels and/or PCPs to request review of possible errors in OIA calculations if they believe this has occurred. CareFirst will make corrections in Panel PCAs that are presented on appeal to correct data errors. In carrying out corrections, CareFirst may provide a correction on a prospective basis or on a retrospective basis, depending on the circumstance of a particular case.

CareFirst will automatically correct data errors in PCAs and protect PCMHs from other data anomalies if they become evident. In carrying out corrections, CareFirst may provide a correction on a prospective basis or on a retrospective basis, depending on the circumstance of a particular case.

**Alternative Method for Calculating Awards for Highly Cost-Effective Panels**

An Alternative Method is used to determine the OIA for certain high performing Panels. If a Panel achieves a risk adjusted PMPM cost result for the full Performance Year that is within the top quartile of all Panels (based on their risk adjusted cost PMPM as shown in the Panel's SearchLight Report) and achieves a total Quality Score of at least 70 points, then its OIA is determined by applying the greater of the following:

- Its calculated OIA score per the step by step method above.
- The average OIA award earned by all winning Panels on a Credit weighted basis.

This assures that these high performing Panels receive an OIA that is commensurate with the excellence of their results. The top quartile is calculated for each of three categories of Panels: Adult medicine, pediatrics and mixed (adult and pediatric) Panels.

## Design Element #10: Signing On And Complying With Program Rules

### Key Conditions and Expectations

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.

The Program's expectation for the PCPs and group practices that elect to participate is that they carry out the intended purposes of the Program and abide by the processes and rules of the Program as described in this *Program Description and Guidelines*.

As a starting point, only fully credentialed PCPs in good standing that are either directly contracted with, or employed by, a medical practice that is contracted with CareFirst for both its HMO and RPN networks are eligible to join the Program. PCPs not in these networks that wish to join the Program may concurrently join these networks and the Program. However, each PCP must be fully credentialed, according to CareFirst's credentialing standards, before acceptance into these networks or the Program. A description of the Credentialing process CareFirst follows as well as the standards used can be found on the CareFirst Provider portal under Providers & Physicians → Resources → Administrative → Manuals & Guides →Professional Provider Manual → Administrative Functions → Medical Credentialing.

Each PCP (or the practice to which they belong) will be required to sign an Addendum to its CareFirst RPN and HMO Participation Agreements. This is contained in **Appendix A**.

If a PCP applying for participation in the Program is in an established large group practice that contains more than 15 PCPs and is already contracted with CareFirst for HMO and RPN network participation, then prior to the effective date of Program participation, the practice and CareFirst will agree on the way the practice will be divided into Panels, for Program purposes only, so that the performance of each Panel can be tracked and an OIA determined.

If a PCP applicant is in solo practice or is in a small practice (four or less PCPs) and wishes to participate in the Program by joining another Panel(s) or practice(s) as part of a Virtual Panel, as described in Element #1, 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.

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.

### Program Requirements of PCPs

When volunteering to participate in a Panel, PCPs agree to put forth good faith efforts to meet Program requirements, goals and expectations. This means that each PCP in a Panel agrees to:

1. Obtain and maintain valid Member consent and authorization for the Member's participation in the PCMH Program including the sharing of medical information between CareFirst and the PCMH, including the PCMH Care Coordination Team.

2. Actively engage with Members identified in need of care management, including the development, maintenance and oversight of Care Plans for such Members.

3. Communicate timely and cooperate with the PCMH Care Coordination Team and other involved providers in furtherance of Care Plans and Member health risk mitigation efforts.

4. Use only other provider participants in CareFirst's HMO and RPN networks as referral targets.

5. Electronically submit all HIPAA administrative transactions through CareFirst's approved EDI clearinghouse(s).

    - Use best efforts to adopt other web-based electronic information and related information exchanges offered by CareFirst in support of the PCMH Program.

    - Use CareFirst's web portal capabilities for referrals, Care Plan development (including Care Plan templates) and monitoring and retrieval of the Member Health Record.

    - Use provider self-service functionality for demographic and practice composition updates and electronic submittal of credentialing information through Council for Affordable Quality Healthcare ("CAQH") (unless credentialing has been delegated).

6. Cooperate with other physician Members in their Medical Panel in arranging health care service coverage for each other's Members and in sharing information about Members in their Medical Panel upon receipt of appropriate consent.

7. Deliver high quality and medically appropriate care in a cost-efficient manner.

8. Cooperate with CareFirst in its efforts to carry out Program rules and requirements as set forth in this Addendum and the *Program Description and Guidelines*.

9. Not withhold, deny, delay, or provide any underutilization of medically necessary care, and not selectively choose or de-select Members.

PCPs must be accessible to all CareFirst Members. However, there are times when PCP Practices or an individual PCP is closed 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.

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 and satisfying the basic requirements therein. For continued participation, the CareFirst PCMH Certification Program requires that a Practice meet all requirements within 12 months of participation (with the exception of e-prescribing, which must be in place within 24 months of participation). Failure to meet these requirements in a Performance Year will disqualify a practice from receiving an OIA. Repeat failure to meet these requirements in the subsequent year will disqualify a practice from PCMH Program participation entirely.

The provider's responsibilities also include a commitment to accept the PCPCC Joint Principles of the Medical Home (see **Appendix D**) to transform the practice into a PCMH and to participate in CareFirst's PCMH Education Program.

**Participant Qualifications**

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
- General Practice
- Pediatrics
- Geriatrics

- Family Practice/Geriatric Medicine
- Doctors of Osteopathy – Primary Care
- Nurse Practitioners – Primary Care

However, PCPs who condition their services to CareFirst Members based on private fees of any kind or require CareFirst Members to participate in a private practice specific Program for which a fee is charged to these Members that is neither a CareFirst benefit nor a charge reimbursed by CareFirst, do not qualify for participation in the PCMH Program. If such a Program or requirement is initiated by a practice after having been recognized in the PCMH Program, it will result in immediate disqualification[11].

Multi-specialty group practices may join the Program, but only the PCPs that predominantly provide primary care services in the practice will be counted for Panel purposes. If a PCP that is part of multi-specialty group practice seeks to join the Program, all qualifying PCPs in primary care within the practice must agree to join in order to qualify for Program participation.

A practice may not participate in another PCMH Program during the time they participate with the CareFirst PCMH Program if both Programs would provide fees and/or incentives to the practice for care rendered to a CareFirst Member. However, a practice may participate in another Program for CareFirst Members if participation is mutually exclusive.

**Incentive to Join and Agree to Program Rules on an Ongoing Basis**

Once recognized in the Program, PCPs in each Panel are paid an additional 12 percentage point Participation Fee that is added on top of the PCP's HMO and CareFirst PPO Base Fees for all primary care professional services, except time-based anesthesia, supplies, and injectable drugs. The Participation Fee will continue in effect for as long as the PCP remains in good standing in the Program. This additional percentage point add-on to the Base Fee is intended to recognize the additional work PCPs take on in voluntarily joining the Program and agreeing to cooperate and coordinate care.

One note to be clear: The 12-percentage point Participation Fee is added to Base Fees, not multiplied against them.

NPs that function as a PCP are considered full participants in any Panel they join.

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 and to meet the expected increased demand for access to primary care services that will come under the Affordable Care Act. NPs count toward the minimum five PCPs required to comprise a Panel. Panels, including Virtual Panels, may be comprised of any combination of PCPs. Physicians collaborating with NPs participating in the Program must also participate in the PCMH Program.

Formal Program acceptance and the additional 12 percentage point Participation Fee will become effective on the first day of the second month following submission of a complete application to become a Panel.

The Participation Fee and any OIAs are treated as incentives only and are contingent upon continued participation in good standing in the PCMH Program. These incentive awards 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 Fee.

Otherwise, the Participation Fee will continue in effect for as long as each practice remains in good standing in a recognized Panel, and each Panel will have the opportunity to earn an OIA based on its performance under the Program in each Performance Year.

[11] *This restriction does not prohibit PCPs from offering such services to patients who are not covered by a CareFirst policy.*

**Qualification and Pay Out of OIAs**

In order to qualify for an OIA in any Performance Year, Panels must participate in the Program for at least two full calendar quarters during the Performance Year. For a Panel that joins the Program within the first six months of a Performance Year, the OIA will be prorated based on their effective date as shown previously in **Part III, Figure 24**. Additional details regarding eligibility are described in "Rules Regarding Changes in the Composition of Panels" earlier in **Part III**.

Multi-Panel Independent Group Practices and Multi-Panel Health System Panels whose OIA was calculated and paid at the entity wide level (TIN) for the 2012 Performance Year had a choice to be paid at the Panel level for the 2013 Performance Year. For the 2014 Performance Year forward, all OIAs are calculated at the Panel level. However, the sum of the OIA for each Panel will be the basis for an overall result that will be used to determine on an entity wide level what the OIA adjustment will be. The entity may elect to be paid this aggregate OIA amount on all its claim billings or be paid a different OIA for the claims associated with each winning Panel.

Beginning in 2013 (**Performance Year #3**), practices that join an existing Virtual Panel are required to be active PCMH participants during the last two complete quarters of the Performance Year to be OIA-eligible for that Performance Year. 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 Virtual Panel after July 1 or terminates its participation in the Program, it will be excluded from the Panel OIA results for that Performance Year.

In order to be paid an OIA, the practice must participate in the PCMH Program during the incentive pay out period (August 1st - July 31st) following each Performance Year. The OIA fees and the Participation Fees will cease to any practice immediately upon termination of a practice's participation in the Program and/or termination of the Panel from the Program.

Finally, a non-viable Panel as defined earlier in these Guidelines is not eligible to receive an OIA regardless of its results during a Performance Year.

**Termination and Changes in PCP Membership**

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, and become eligible for the PCMH OIA fees then in effect for the new Panel, including the 12-percentage point Participation Fee per the rules described above. This requires the acceptance of the Panel as evidenced by their unanimous agreement, communicated in writing to CareFirst by the Panel's DPR.

A Practice may terminate its participation in the Program upon ninety (90) calendar day's prior written notice to CareFirst for any reason. If this termination causes a Medical Panel to fall below minimum participation requirements, the Panel will have up to one year to restore itself to the minimum participation level and avoid the termination of the entire Medical Panel from the Program. However, any Medical Panel that falls below the minimum participation requirements for at least one calendar quarter in the Performance Year is not eligible for an OIA in the next calendar year.

A Medical 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 Medical Panel from the Program unless they join another Medical Panel. If a PCP in the 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 Medical Panel may change its self-selected team of PCPs at any time as long as it continues to meet the minimum size requirements of the Program and notifies CareFirst. No Practice(s) may be removed from a Virtual Medical Panel without the consent of at least three-fifths (3/5) of the PCPs in the Virtual Medical Panel.

CareFirst may immediately terminate the practice, PCP and/or a Medical 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 days prior written notice:

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

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

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

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

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 RCD, who is the PCMH Program lead for physician Engagement, 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 by certified mail with a copy to the other Panel PCP Members. This letter identifies the termination date if Engagement does not occur. If the PCP or practice is still unwilling to engage in the Care Coordination components of the Program 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, 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 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 Medical Panel's termination from the Program regardless of the reason for termination.

The payment of all incentives will immediately terminate upon the effective date of the PCP's, Group's or Medical 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, 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.

**Participation in Multiple Medical Home Programs for CareFirst Members**

In the event that a practice in the PCMH Program (or a practice location that is part of a larger practice) chooses to join another medical home Program through which to provide services to CareFirst Members, the practice (or specific practice location) must provide immediate notice to CareFirst and its participation in the CareFirst Program will terminate on the effective date of its participation in the alternative Program.

**Online Connectivity and Systems Requirements for PCPs**

The PCMH Program is designed to empower PCPs or and their LCC Team(s) with the tools and data to effectively manage the care of their Members without placing a technology burden on the practice. The PCMH online iCentric System is available 24 hours a day/seven days a week via the Internet through CareFirst's provider website. There are five core online services available in support of the Program:

- A Member Roster including the Panel's attributed Members and each Member's Illness Burden Score.
- A Member Health Record for each Member including all relevant data regarding the Member as well as any Care Plan prepared for the Member.
- A PCA report for each Panel showing cumulative Credit and Debit totals with drill down capability and pre-established pattern recognition views, as well as the complete SearchLight Reporting Package.
- A Care Plan housing all aspects of a Member's Care Plan and related services.
- SearchLight Reports that provide insight into patterns underlying the Panel's cost and quality.

To access the CareFirst Provider Portal, a valid User ID/Password is required and a computer meeting the following requirements is necessary:

- Windows XP SP2 or higher
- Intel or AMD processor – Dual-Core 3.0 GHz or higher
- 2GB of RAM
- USB 2.0
- Minimum Broadband Speed of 1.5Mbps upload and download
- Internet Browser such as Internet Explorer 7.0 or higher – free download
- Browser plug-ins (e.g. Java, Flash, etc.) – free downloads
- Adobe Reader 9.0 or higher – free download

Participation in telemedicine with video capability requires the addition of a web camera with auto light adjustment, 720p resolution, and auto focus along with Windows-compatible speakers, microphone, and/or headset.

**Appeal of OIA Calculations**

A Panel as a whole – or any PCP within a Panel – 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, through a provider representative, will then 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 Panel and/or PCP of its response in writing within 90 days of the receipt of complete information from the Panel and/or PCP.

## Special Provisions For Safety Net Clinics In The PCMH Program

Safety Net Clinics serve a critical role in caring for underserved populations. Their comprehensive services and deep understanding of the medical and social challenges facing the uninsured and underinsured establish them as a vital resource in the health care system. CareFirst values the contribution of Safety Net Clinics and recognizes the need for supports that enable these centers to keep pace with health care trends and remain responsive to the evolving profile of the area's medically disadvantaged.

### Safety Nets and the PCMH Program

Through the PCMH Program, CareFirst seeks to continue its efforts to enhance the capability of Safety Net Clinics to coordinate the care of those they serve. CareFirst's support to these providers began with their inclusion in its commercial PCMH Program. Through the CareFirst Commitment Community Giving Program, the Company also provided a seven million multi-year grant to these clinics to bolster their ability to serve and coordinate care for chronic Members.

The PCMH Program provides ongoing clinical and analytical support to Safety Net Clinics centers enrolled in PCMH, regardless of viability and OIA eligibility. The goal is to improve health outcomes through clinical practice of Safety Net providers supported by optimal utilization of CareFirst's PCMH tools, programming, and services.

### Features of the Safety Net Supports Available from the PCMH Program

Jointly implemented by CareFirst's commercial PCMH and Community Affairs teams, the PCMH Program offers all Safety Net Clinics, regardless of viability or Panel size, the following:

- The Regional Field Team will provide support as needed at the Panel's request.
- The full Participation Fee (12 percent) and Care Coordination incentives ($200 and $100).
- An OIA for all viable Safety Net Panels.
- An assessment of Engagement in the fourth quarter of each year.
- An assessment of quality measure performance according to the Program Description and Guidelines.
- Monthly Care Coordinators' roundtable webinars to foster a learning community comprised of commercial and Safety Net Care Coordinators.
- In-person meeting/workshop held between commercial and Safety Net Care Coordinators on emerging issues in caring for the underserved, as needed.

Safety Net Clinics that meet the definition of viability are treated with the same rules as all other Panels in the PCMH Program and are required to meet Engagement requirements in order to be eligible for the OIA.

## PCMH Plus Program

CareFirst has analyzed results from its multiple years of experience with the PCMH Program and has created a special Program to recognize and further reward "high value" Panels who have performed exceptionally well over a three-year period. This Program – called PCMH Plus – became effective January 1, 2016. Qualifying Panels are invited to participate in the PCMH Plus Program based on their achievement of certain milestones. Such Panels receive enhanced compensation in exchange for differentially greater achievement of both global cost and quality outcomes. As with the entire PCMH Program, participation in the PCMH Plus Program is voluntary on the part of the invited Panels.

### Two Purposes of the PCMH Plus Program

The two core purposes of PCMH Plus can be summarized as follows:

**First,** to encourage higher levels of quality and cost control achievement by Panels through increased rewards for doing so; and

**Second,** to encourage selection of high performing Panels by Members in lieu of narrowed or tiered networks that constrain access.

### The Need

Virtually all employers and individuals who buy policies seek less costly premiums and look for less out of pocket expenses in the coverage they buy. To this end, many bid requests being issued by consultants on behalf of large employers seek high performing provider networks from carriers.

Increasingly, these networks constrain Member choice to "narrow networks" that have a limited number of hospitals, specialists and other providers. The larger and more sophisticated the employer, the more likely this kind of requirement appears in the bid process. Narrow networks are also a key strategy used by carriers to control costs for the newly covered population gaining access under the ACA through public and private health care exchanges.

The drive in this direction is gaining momentum due to the continuing high cost of health care services and the mandates imposed by the Affordable Care Act. While recognizing the motivation that drives this interest, CareFirst does not support the idea of narrow networks that artificially constrain Member choice. Accordingly, the PCMH Plus Program is not a narrow network and does not affect CareFirst's larger provider networks or Members' access to providers in CareFirst's networks.

### The Fact Pattern that has Emerged

The multi-year experience that CareFirst now has with PCMH Panels reveals that some Panels are able to achieve – on a sustained basis - lower global cost outcomes for Members while meeting the quality standards of care in the Program. In fact, Panels that obtain more cost-effective results often do so with Members who have a higher average illness level. These Panels also obtain Quality Scores in the PCMH Program that are comparable to or better than Panels that produce higher overall costs.

These observations derive from the experience of all Panels that have had at least three consecutive years in the PCMH Program with a sufficient attributed membership from which to reliably discern results and that have been engaged in the PCMH Program at a sufficiently rigorous level of Engagement to produce a track record.

### A Different View

CareFirst rejects the idea that individual PCPs or whole Panels can be accurately assessed based only on a portion or sampling of their cost or quality results. Partial measures do not reveal the whole story and are often misleading. Currently, fragmentary quality and cost measures are all that exist in most of the healthcare insurance marketplace to measure the value impact of PCP services. In contrast, the PCMH Program's OIA offers a far more complete view of the overall population health cost and quality outcomes actually achieved by Panels in the Program.

The results that Panels have actually achieved over time – as teams – for the population of Members who have selected them reveals that within each of the 20 geographic sub-regions contained in the CareFirst service area, there is significant variation in overall (Illness Burden adjusted) cost, while quality appears to vary less. These global cost and quality outcomes can be compared in an entirely consistent way due to the uniformity in Program rules, data definitions and Program Elements.

This enables CareFirst to distinguish the better performing Panels from those not performing as well in each sub-region over a three-year period. As noted, this is best seen on an Illness Burden adjusted basis in order to permit a fair comparison of results.

**Invitation to Join PCMH Plus**

Higher performing Panels are invited – as integrated teams – to increase their collaboration with CareFirst and their Members by committing to enhanced Care Coordination efforts that support further improvement in care, quality and cost results. Panels in the PCMH Plus Program retain their current access to all participating practitioners in the CareFirst Regional PPO and HMO networks.

As with the larger PCMH Program, PCP participation in the PCMH Plus Program is open to all PCPs within a qualifying Panel. Practices in PCMH Plus execute an addendum to their provider agreement that includes the need to achieve a higher level of Program Engagement in exchange for certain enhancements in their compensation.

The PCMH Plus Program is composed only of PCPs in Panels that join as a whole. No partial Panels are accepted. This is because qualification is based on Panel performance as a whole – not on the performance of individual PCPs. This fulfills a core concept in the PCMH Program - that Panel results are measured as a whole on a team-by-team basis.

Nevertheless, each Practice must sign the PCMH Plus Addendum to their current PCMH agreement in order to join the Program as part of their Panel. All other terms and conditions applicable to the PCMH Program continue to apply.

**Incentive to Members to Choose PCMH Plus PCPs**

All PCMH Plus PCPs will be designated separately in the CareFirst provider directory. Under the Blue Rewards Program as presented in **Part V**, Members may earn enhanced coverage for selection of a PCMH Plus PCP in the form of an additional financial credit against their deductible or an additional credit on a medical expense debit card.

**Qualifications for Panels to Receive an Invitation to Join the PCMH Plus Program**

In order to participate in the PCMH Plus Program, a PCP must be in good standing in the PCMH Program, his/her Panel must have been in the PCMH Program for the last three consecutive years and the PCP must be in a Panel that – as a Panel - meets the qualifying conditions below:

**Condition #1 -** The Panel must have met the definition of Viability as described in **Part III** of the Guidelines;

**Condition #2 -** The Panel must not have undergone a "Substantial Change" in PCP membership during the last three years as defined in **Part III** of the Guidelines;

**Condition #3 -** The Panel must have maintained eligibility for an OIA based on its quality performance as described in **Part III** of the Guidelines (even if no actual award was achieved) during each of these three years; and

**Condition #4** - The Panel must have produced an Illness Burden adjusted aggregate medical cost PMPM over the three-year period that is in the upper third of all Panels in the same peer group (adult, pediatric and mixed) in its geographic sub-region (as sub-region is described in **Program #4, Part VI** of the Guidelines).

All quality and Engagement measures for the PCMH Plus Program remain the same as in the larger PCMH Program, but to remain qualified, PCMH Plus Panels must achieve and maintain higher levels of compliance with these measures as explained below.

**Methodology Used for Determining Which Panels are Invited to Join the PCMH Plus Program**

For those Panels that have met qualifying Conditions #1 through #3 above, two different tests are used to determine whether the Panel meets Condition #4. The detail of this is described in **Appendix P,** but a brief description is provided below. An otherwise qualifying Panel must meet one of these two tests.

The first test calculates the cumulative Illness Burden adjusted PMPM cost for each Panel over the most recent three years of its experience in the PMCH Program. This is expressed as a single cumulative PMPM dollar amount (e.g., $300 PMPM) for the full three-year period. Different weights are assigned to each of the three years in calculating this amount as follows:

| | |
|---|---|
| Most recent year | 50 percent |
| Next most recent year | 30 percent |
| Oldest year | 20 percent |

This step is completed for all Panels within each peer group (adult, pediatric and mixed) in each of the 20 sub-regions in the PCMH Program. Panels that have performed in the upper third of all their peer Panels in their sub-region meet the qualifying condition on cost effectiveness specified by Condition #4.

An alternative test for Condition #4 is to calculate the average cost attained over the last three years by all Panels within each one point of the Illness Burden Score (e.g., from 0 to 1 Illness Burden Score, 1 to 2 Illness Burden Score and so on) with adult and pediatric Members calculated separately. The result becomes an "expected" or benchmark cost for each one-point level of illness for all adult and pediatric Members. This calculation is done for each of these Panel types (adult, pediatric and mixed).

Each Panel's actual Member Months are then determined for each of these one-point Illness Burden Score intervals and multiplied by the respective "expected" cost for each interval. Then, each Panel's total actual costs are compared to the "expected" costs for every Illness Burden Score one-point interval to determine whether a Panel's actual costs are higher or lower than expected. Panels who performed at least two percent better than expected on an overall basis for their entire attributed Member population meet the alternative test for qualifying under Condition #4.

Panels that meet one or both tests are deemed to have qualified under Condition #4.

CareFirst updates this analysis each year, dropping the oldest year and adding the next year of completed experience after the settlement process is complete for each Performance Year.

**Timing of Acceptance and Duration of Participation in the PCMH Plus Network**

Invitations to join the PCMH Plus Program are offered in October of each calendar year. Practices must execute the PCMH Plus Addendum by December 1. If acceptance does not occur by this time or the entire qualifying Panel does not agree to participate, none of the PCPs who make up the invited Panel will be included in the PCMH Plus Program for the upcoming Performance Year and will need to re-qualify the following year.

Should a Panel fail to carry out its obligations under the PCMH Plus Addendum in the Performance Year during its participation in the PCMH Plus Program, the Panel will return to its regular status in the larger PCMH Program at the start of the next Performance Year. If the Panel was receiving a guaranteed OIA in the PCMH Plus Program, it will continue to receive this through July 31 of the year subsequent to when its participation in the PCMH Plus Program ended. The Panel will then revert back to the standard OIA method on August 1**.**

**Additional Obligations to Remain in the PCMH Plus Program**

All PCPs in Panels that participate in the PCMH Plus Program must:

- Maintain the capacity to accept and timely see new Members.

- Establish by January 1 of each Performance Year and maintain throughout the term of the PCMH Plus Addendum, a list of designated specialists and specialty groups in the top 10 specialist types to whom Panel PCPs generally refer and with whom the Panel PCPs develop referral relationships that promote an enhanced level of Care Coordination. The list must be certified as existing and being used by the Panel's assigned Practice Consultant each year.

- Complete a Clinical Status Review and document an Assessment Outcome for all Members on the Core Target Lists, as described in **Appendix E**, on a monthly basis.

- Achieve and maintain at least 70 percent of the available points in the overall Engagement and Quality of Care categories that measure the level of Panel performance in these aspects of the PCMH Program requirements.

Panel performance regarding the fulfillment of these requirements will be monitored by CareFirst on an ongoing monthly basis and the insights resulting from this monitoring will be used to facilitate ongoing monthly Panel discussions. Any material non-compliance with these requirements will result in the Panel's termination from the PCMH Plus Program at the end of the then current Performance Year.

Once included in the PCMH Plus Program, a Panel may remain in the Program for each Performance Year thereafter based on its continued strong performance as measured by continuing to meet the qualifying Conditions #1 through #4 for each Performance Year as well as fulfilling the additional obligations on Engagement and quality.

In order to maintain continuity for Members who are incented to select a PCMH Plus provider, a Panel may remain in PCMH Plus without meeting Condition #4 if one or more of the scenarios applies.

- The Panel's growth in Illness Burden adjusted global PMPM is less than or equal to 75 percent of the OMT applicable to the entire PCMH Program.

- The Panel is within 1.5 percent of the highest permissible three-year Illness Burden PMPM for the top third of all Panels in its geographic sub-Region.

- The Panel is within 0.5 percent of the lowest permissible savings rate for the top third of all Panels in its geographic sub-region, and the Panel has costs below expected.

**Enhanced Compensation for PCMH Plus PCPs**

Commencing on January 1 of each Performance Year, CareFirst will pay a PCMH Plus Practice a 15-percentage point Participation Fee to a participating PCP instead of the standard PCMH 12 percentage point Participation Fee. For each subsequent consecutive year of a Panel's participation in the PCMH Plus Program, a participating Panel will receive an additional one percentage point increase over and above this enhanced 15 percentage point Participation Fee.

Additionally, effective August 1 of each year, CareFirst will pay the greater of the OIA actually earned by a PCMH Plus Panel or the average OIA earned by all PCMH Plus Panels. This places a guaranteed floor under the OIA Award of PCMH Plus Panels. The higher of the Panel's earned OIA or the guaranteed floor will be paid in the next Performance Year pursuant to the rules provided in these Guidelines governing the pay out of OIAs.

**Demonstrable Differences in Aggregate Performance**

The actual difference in the total three-year cost performance (PMPM) of the qualifying Panels who have met Condition #4 versus those that have not is approximately 10 percent.

The average Quality Scores of the Panels meeting qualifying Condition #4 are virtually the same as those of Panels in the PCMH Program as a whole. The Illness Burden Scores of those Panels meeting Condition #4 are approximately three percent lower than those of all other Panels who did not qualify for PCMH Plus.

So, the most noteworthy difference in the three-year performance of Panels that are invited into the PCMH Plus Program is that they have achieved their results at considerably lower overall cost without sacrificing quality.

# Part IV: Medicare Fee-For-Service (FFS) Beneficiaries In PCMH/TCCI: Expanding The Program's Reach Via The "Common Model"

## Preface

While CareFirst is the largest commercial health care payer in the Mid-Atlantic region when considering the number of people it serves, the single most significant payer in the region is Medicare when measured by the size of health care reimbursements it accounts for. Virtually all Medical Care Panels in the Patient-Centered Medical Home Program ("PCMH") that offer adult medicine and all mixed Panels (pediatric and adult medicine combined) receive a substantial portion of their reimbursement from the Medicare Program.

The presence of chronic disease in the Medicare population is far higher than in the general under age 65 population, leading to a Medicare per capita spending level that is four times higher than that for CareFirst membership. Per capita Medicare expenditures in the CareFirst region are among the highest in the nation.

The CareFirst region also experiences a higher percentage of Medicare beneficiaries enrolled in Traditional Medicare (i.e., Medicare Fee-For-Service ("FFS")). This reflects the fact that Medicare Advantage Plans have not penetrated the CareFirst region to the same extent as in the rest of the nation, leaving the vast majority of the Medicare population in the region with little or no Care Coordination.

In total, there are just over one million Medicare FFS beneficiaries living in the CareFirst service area. CareFirst provides Medicare Supplementary products to a small portion of this population (serving approximately 65,000 beneficiaries), most of whom purchase Plan F – the most complete Medigap coverage plan available.

In fulfilling its mission to provide affordable health care coverage to as many people as possible in its service region, CareFirst sought to determine whether the capabilities in place with the PCMH Program and Total Care and Cost Improvement Program Array ("TCCI") could be effectively applied to the large unmanaged Medicare FFS population. It is clear that indeed they could – and in so doing, contribute to more effective cost control and quality enhancement for CareFirst Members as well.

To this end, CareFirst operated, a pilot program under a Health Care Innovation Award ("Innovation Award") from the Centers for Medicare and Medicaid Services ("CMS") between the years of 2012 and 2015. This was named the "Common Model" and constituted the side-by-side application of the PCMH and TCCI Programs for both CareFirst and Medicare FFS beneficiaries. The Innovation Award was completed on December 31, 2015 and its final results were made available in July 2016. This "Common Model" is described in the pages that follow.

Following the completion of the Innovation Award, CareFirst provided a Mission-related grant to support the carrying out of the Common Model through December 2016 while efforts proceeded with CMS and other stakeholders to find a Federal or State funding service. Unfortunately, this could not be done, and the Common Model Pilot was ended in December 31, 2016.

Nevertheless, its results were impressive, and this **Part IV** describes these results as well as the underpinnings of the Model.

**Common Model**

The core idea behind the "Common Model" is to apply all the elements present in the PCMH and TCCI Programs to both Medicare FFS beneficiaries and CareFirst Members.

Such a common approach, provides "heft" for a more powerful transformation of the health care delivery system since a large portion of health care spending (approximately 50 percent) would be impacted and be subject to the incentives and accountability structure built into the PCMH/TCCI Programs. The inclusion of the Traditional Medicare population into the PCMH/TCCI Programs would provide a single model that is Member and primary care centric, as well as population based with a common underlying accountability and financial incentive system that is at the core of these Programs.

Indeed, a Common Model used by the region's largest private and public payers – with common incentive rules, common infrastructure, common data sharing and transparency as well as common accountability – could create a powerful effect on the approach taken by Primary Care Providers ("PCPs") in caring for their Members – to the potential benefit of the whole community. This, in turn, would likely influence the referral patterns to high value specialists used by these PCPs and could profoundly affect the level, nature, and extent of hospital-based use (i.e., admissions, readmissions, Emergency Room ("ER") visits) in the region, which, as noted, is among the highest in the nation and the central health care challenge the region faces.

The theory of action behind the Common Model is that when the shared savings concept is broadened to include both the Medicare and CareFirst populations, there will be a far more powerful financial reason for the PCPs to pay attention to total outcomes. As the PCPs become more involved in and committed to the care management activities that are encouraged and supported by the PCMH/TCCI Programs, their effects will grow, accelerate and spread throughout the health care system.

As noted, on a combined basis, Traditional Medicare (Parts A & B) and CareFirst reimbursements account for approximately half of all health care spending in the region. If placed under a single, common global incentive and accountability model focused on the chronic and multi-chronically ill sub-populations these payers serve (as well as those at greatest risk for chronic illness), a major impact could potentially be achieved in reducing hospital admissions, readmissions, and over medication (and the complications that flow from this) – thereby better restraining the rise in health care spending while improving care outcomes for all.

The knowledge gained by Medical Care Panels over the first five years of the PCMH Program involving CareFirst Members and "tuning" of the Program in this period produced a network of PCPs armed with experience and knowledge of the tools that enables them to select and coordinate the care of the multi chronic Member – or those at high risk for chronic conditions. In short, their private sector experience with the PCMH and TCCI Programs enabled PCPs to be well set up to deal with the greater challenges of Care Coordination required with the Traditional Medicare FFS population.

**CMMI Innovation Award**

It was with these thoughts in mind that CareFirst applied to CMMI for a Health Care Innovation Award in early 2012. The purpose was to create a new model Pilot Program in which the Traditional Medicare FFS beneficiaries already being served by PCPs in the CareFirst PCMH network would be brought within the PCMH/TCCI Program framework.

The Innovation Award that supported the Common Model Pilot (the "Pilot") involved 140 PCPs in 14 teams ("Panels") of PCPs with 60,000 attributed CareFirst Members, and over 40,000 attributed Medicare Primary FFS beneficiaries. These Panels were selected to be representative (in structure and geography) of the larger PCMH Program CareFirst operates in its service area involving over 4,300 PCPs in over 440 PCP Panels. The Pilot began to serve Medicare beneficiaries in July 2013 and concluded on December 31, 2016 – a time span of three and a half years. For the entire period of the Pilot, Panels assumed responsibility for total cost and quality outcomes for their attributed Medicare FFS and CareFirst patient populations.

In essence, the Pilot tested whether a common incentive-based system built around PCPs with strong Care Coordination features could create a new form of public-private partnership. If extended further, this partnership model could ultimately help both CareFirst and CMS achieve better health care outcomes and smarter spending.

The Common Model is inherently scalable and can be extended virtually without limit to other geographic areas and other Member segments such as beneficiaries eligible for both Medicare and Medicaid. Unlike many Accountable Care

Organizations under the Medicare Shared Savings Program ("ACOs"), CareFirst's Innovation Award was with PCPs, was patient-centric, and was not tied to a specific hospital or health care delivery system.

**What Follows in this Part**

This section, **Part IV**, describes the rules and methods that applied to the Common Model Pilot. Since providers and Panels could not be in multiple incentive Programs which cover the same Medicare beneficiaries simultaneously, providers and Panels voluntarily agreed to participate only in the Common Model Pilot and not in any other ACO.

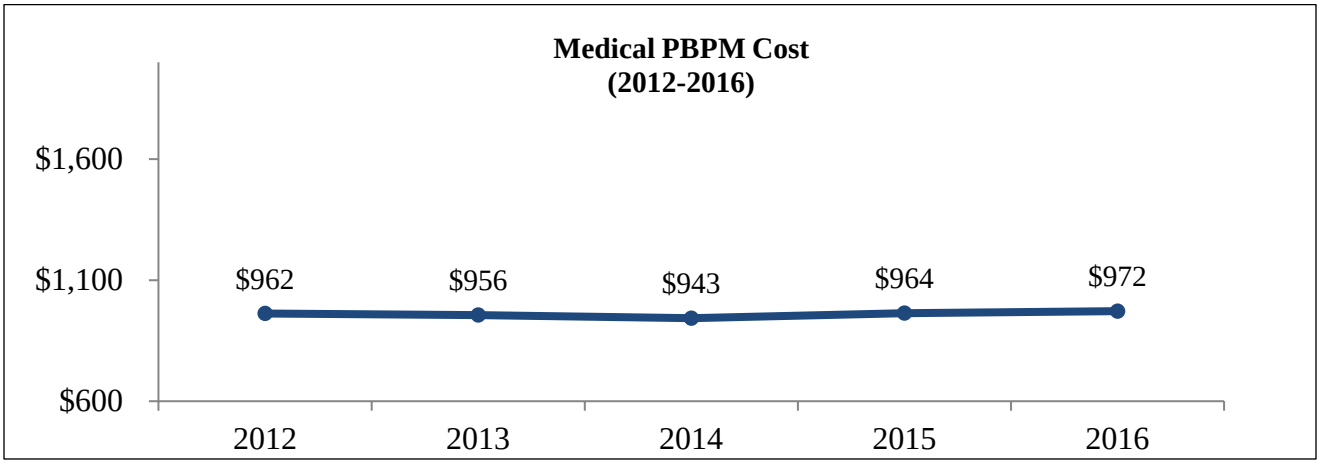
The CareFirst PCMH and TCCI Programs that are the foundation of the Common Model contain highly detailed and specific rules which establish provider accountability, responsibility and incentives for cost and quality outcomes for CareFirst Members. The Innovation Award enabled these very specific elements, incentives and rules to be applied to the Medicare FFS beneficiary population in the selected Panels.

The driving assumption was that when the same rules, incentives, infrastructure, and types of data are shared with experienced primary care Panels who treat both Medicare beneficiaries and CareFirst Members (which, on a combined basis, account for approximately 50 percent or more of the dollar flow in these Panels), these commonalities would accelerate and deepen the impact on behavior change among the providers in these Panels. This, in turn, would motivate deeper change and accelerate progress towards the achievement of better cost and quality outcomes as well as improve the health of the Medicare and CareFirst populations in these Panels.

**Results Were Extremely Promising**

Given that CareFirst was three years into the PCMH and TCCI Programs at the start of the Pilot there was high confidence that when the features and rules and incentives of these Programs were applied to the Traditional Medicare population, they would produce productive change. This indeed proved to be the case. PCP Engagement levels increased materially while costly hospital utilization decreased and, as seen in **Figure 1** below, overall cost of care remained flat.

**Part IV, Figure 1: Overall Medicare Per Member Per Month (PMPM) Costs For Common Model Panels (2012-2016)[1]**



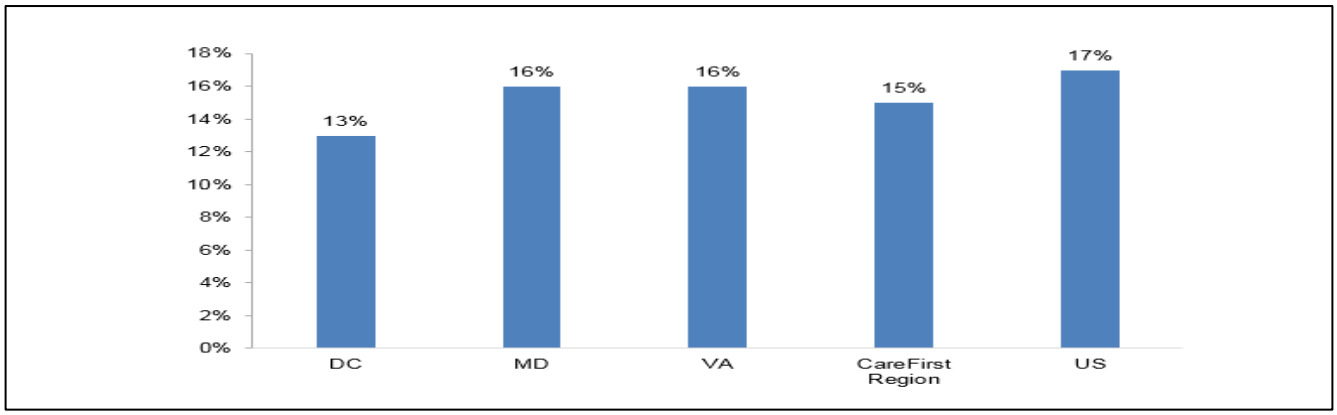

For the first two years of the Pilot there were 14 Panels with more than 125 PCPs and approximately 40,000 Medicare beneficiaries. This membership held steady through the Pilot period with the exception of 2016 when only 13 Panels participated in the Pilot. The illness level in the Medicare population in the participating Panels also held steady or slightly increased during the period of the Award.

[1] *Trend is for Common Model Medicare Beneficiaries paid claims.: HealthCare Analytics – Includes data through December 2016, paid thru March 2017.*

## The Key Facts That Shape The Challenge

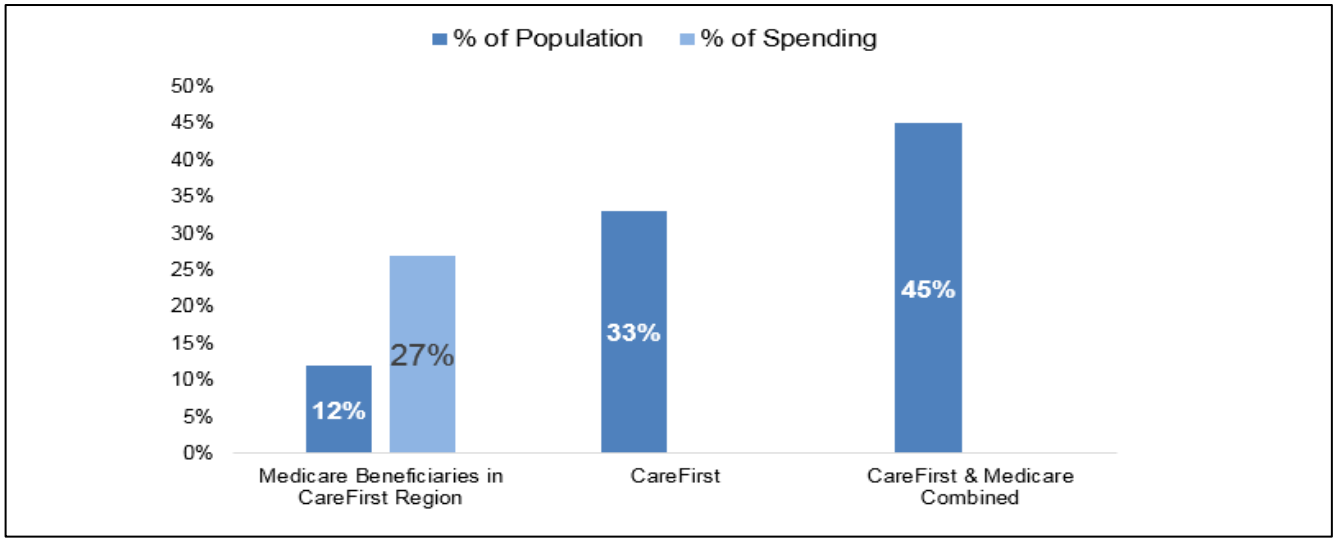
As is shown in **Figure 2** below, the CareFirst service region is generally representative of the nation as a whole in the proportion of the population that is over age 65 and Medicare eligible. There are an estimated 1.1 million Medicare eligible beneficiaries in the region accounting for approximately 12 percent of the total population. They account for approximately 32 percent of all health care spending in the region.

**Part IV, Figure 2: Percent Of Population Covered By Medicare, 2015**[2]




When looking at the combined picture of CareFirst and Medicare FFS enrollment and healthcare spending in the region, one can clearly see their large footprint in **Figure 3** below.

**Part IV, Figure 3: Percent Of Medicare Population And Spending, 2015**[3]

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[2] *Data include aged and/or disabled individuals enrolled in Medicare Part A and/or B through Original Medicare or Medicare Advantage*

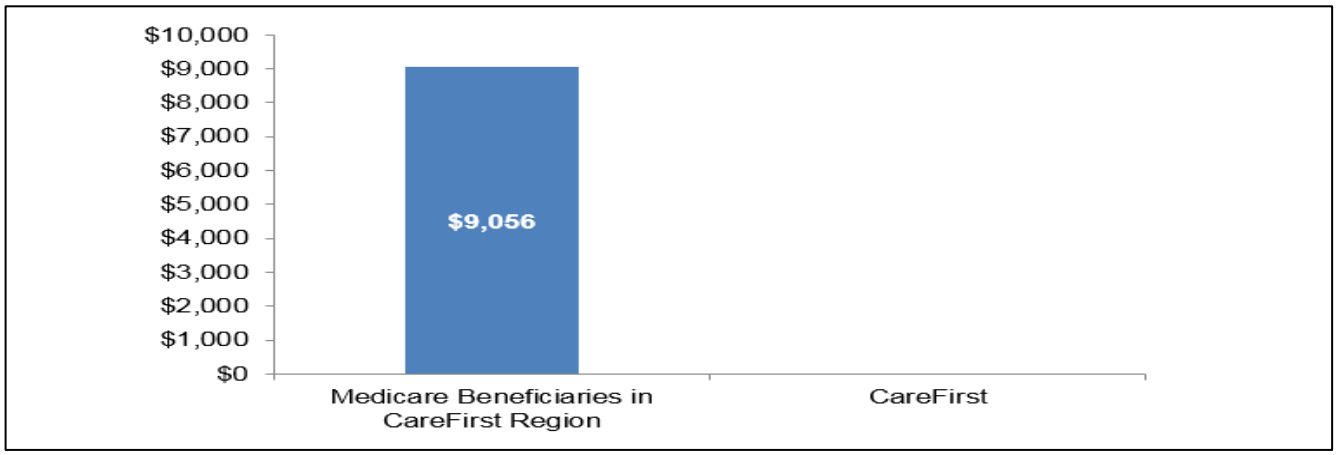
*Source: Kaiser Family Foundation State Health Facts. http://www.kff.org/state-category/medicare/*

[3] *Medicare beneficiaries include managed care and FFS beneficiaries; CareFirst total population, excluding Members outside of CareFirst Service Area.*

*Sources: Kaiser Family Foundation State Health Facts: http://www.kff.org/state-category/medicare; CMS. Health Expenditures by State of Residence; CareFirst Strategic Marketing*

**Figure 4** shows that total spending per Medicare beneficiary is three to four times greater than that of the level of spending on the under age 65 population that makes up the vast majority of all CareFirst Members.

**Part IV, Figure 4: CareFirst Members' Per Capita Costs**[4]

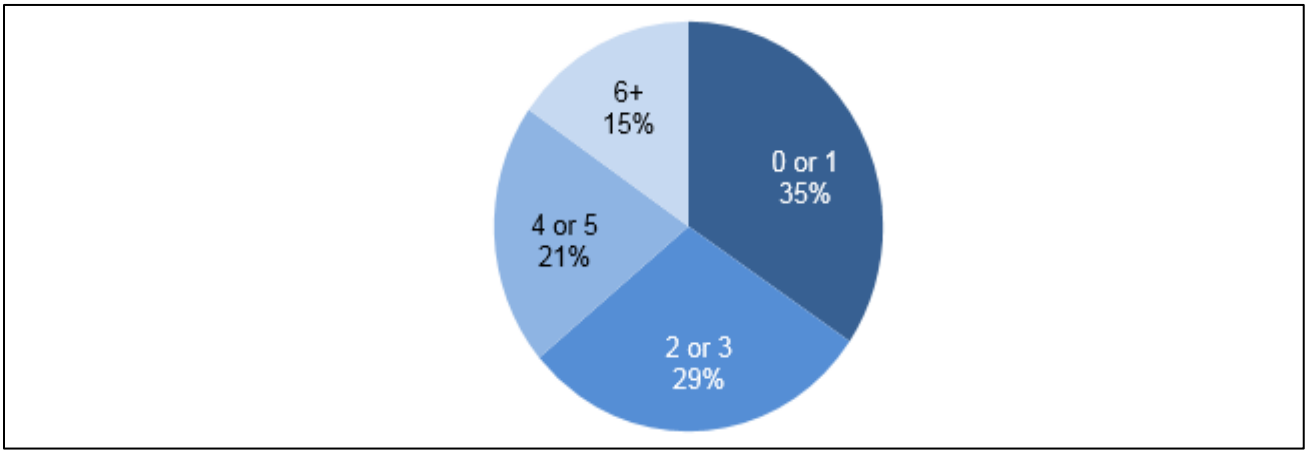



Significantly, the portion of Medicare beneficiaries in the CareFirst service region that are covered by Parts A and B is greater than the national average as is shown in **Figure 5**.

This population receives virtually no care coordination and is particularly vulnerable to breakdowns that lead to hospital admissions, readmissions, and greater use of hospital ERs.

This is highly significant because the prevalence of chronic disease among Medicare FFS beneficiaries is extensive as shown in **Figure 5** below.

**Part IV, Figure 5: Percent Of Medicare Fee-For-Service (FFS) Beneficiaries With Multiple Chronic Conditions, 2015 (Number Of Chronic Conditions Per Medicare Beneficiary)**[5]




[4] *Sources: CMS. Medicare Geographic Variation Public Use File. State/County Table. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html; CareFirst Healthcare Analytics.*

[5] *Source: Centers for Medicaid and Medicare Services (CMS). Medicare Chronic Conditions Dashboard, 2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/chronic-conditions-state/cc_state_dashboard.html.*

The presence of chronic conditions has a substantial bearing on the costs of care for the Medicare population nationwide, but the CareFirst service region shows particularly poor results in the level of hospital admissions and readmissions as is shown in **Figure 6** below.

**Part IV, Figure 6: CareFirst Service Region: Medicare Fee-For Service (FFS) Beneficiaries Admission/Readmission Rates Versus U.S.**[6]

| 2015 | Inpatient Costs Per Capita* | Admissions Per 1,000 | 30 day Hospital Readmission Rate |
|---|---|---|---|
| National Average | $3,152 | 270 | 17.9% |
| US Maximum | $4,544 | 316 | 21.4% |
| US Minimum | $2,321 | 162 | 12.7% |
| **MARYLAND** | **$3,487*** | **273** | **18.7%** |
| *Maryland Rank* | *50th* | *28th* | *42nd* |
| **DC** | **$4,544** | **316** | **21.4%** |
| *DC Rank* | *51st* | *51st* | *51st* |
| **VIRGINIA** | **$2,730** | **253** | **17.7%** |
| *Virginia Rank* | *16th* | *22nd* | *29th* |

* *Inpatient and Outpatient costs per capita in Maryland were adjusted down by 6.07 percent to adjust for indirect and direct medical education costs and down by 6.82 percent to adjust for uncompensated care costs. Without this adjustment, Maryland cost figures were overstated.*

As indicated earlier, the region has had the highest hospital admission and readmission rates in the country. This presents a major opportunity to improve. With this improvement could come enhanced quality of care – as measured by a reduction in the cycle of readmission. Lower overall use of hospital-based care can only occur through better coordination of care for the multi-chronic Member in the community and home. PCPs are in the best position to oversee and direct this care. These were core tenets of the Common Model Pilot.

There is no more dramatic way to illustrate the impact of chronic disease on health care spending for the Traditional Medicare population than to examine the percent of all costs that are accounted for by the five Illness Bands used in the PCMH/TCCCI Programs. This is shown in **Figure 7**.

[6] *Sources: CMS. Medicare Geographic Variation Public Use File. State/County Table. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html; CareFirst Healthcare Analytics.*

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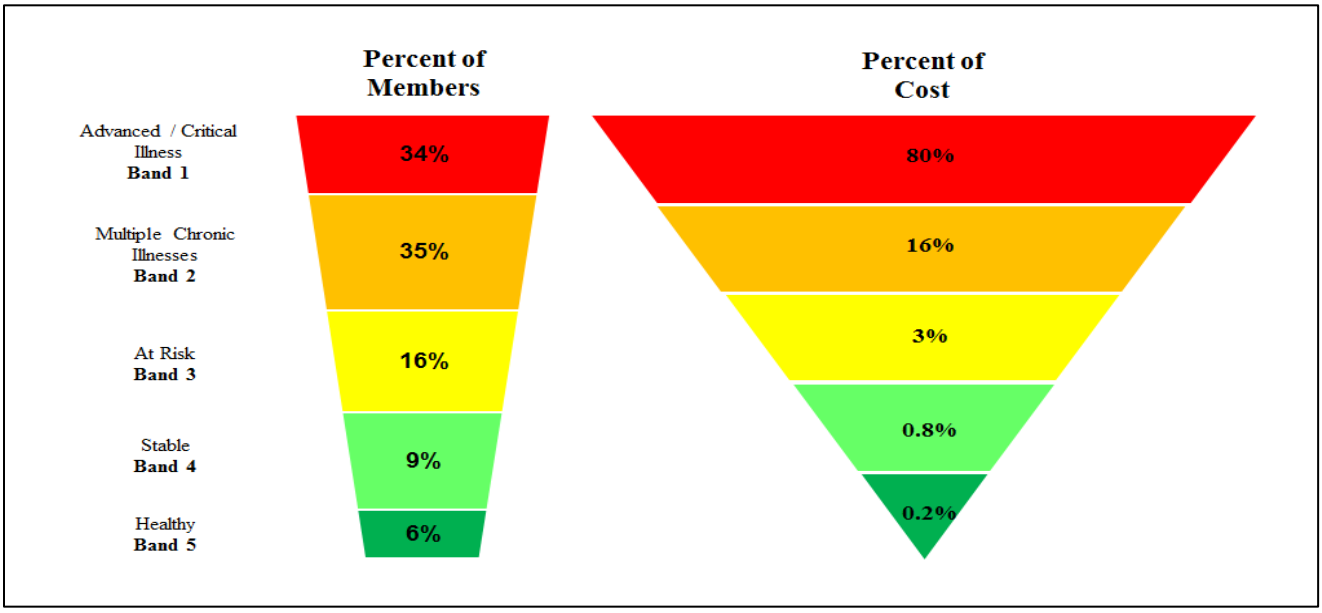
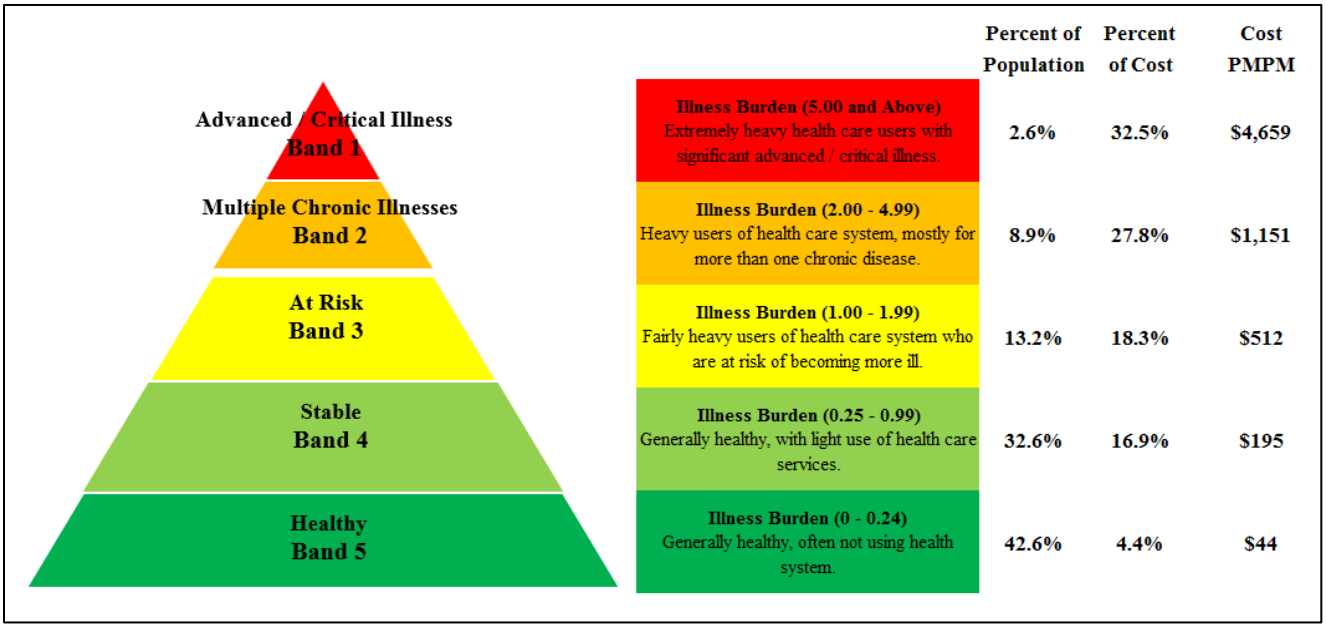
**Part IV, Figure 7: Medicare Fee-For-Service (FFS) Illness Burden Pyramid, 2015**[7]




This concentration of cost near the top of the Illness Burden Pyramid contrasts sharply with the pattern in the under age 65 population which, while also very concentrated in the top two bands, is nowhere near as dramatic as is shown in **Figure 8** below.

**Part IV, Figure 8: CareFirst Illness Burden Pyramid, 2016**[8]



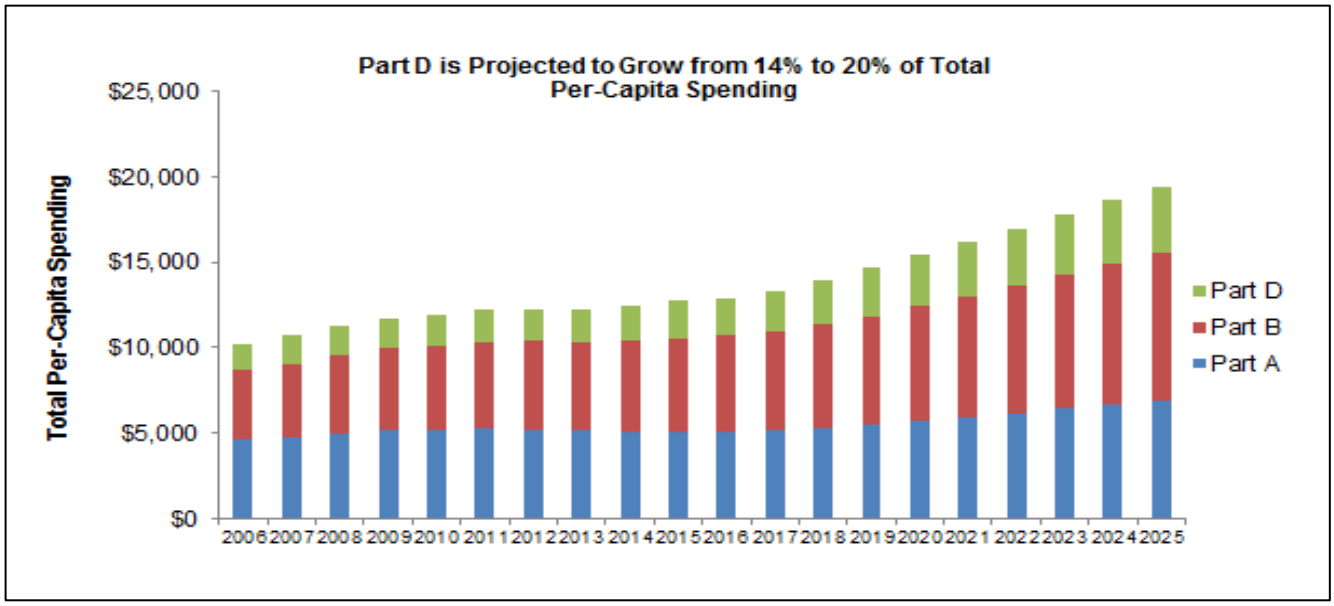

| | Percent of Population | Percent of Cost | Cost PMPM |
|---|---|---|---|
| **Illness Burden (5.00 and Above)** Extremely heavy health care users with significant advanced / critical illness. | 2.6% | 32.5% | $4,659 |
| **Illness Burden (2.00 - 4.99)** Heavy users of health care system, mostly for more than one chronic disease. | 8.9% | 27.8% | $1,151 |
| **Illness Burden (1.00 - 1.99)** Fairly heavy users of health care system who are at risk of becoming more ill. | 13.2% | 18.3% | $512 |
| **Illness Burden (0.25 - 0.99)** Generally healthy, with light use of health care services. | 32.6% | 16.9% | $195 |
| **Illness Burden (0 - 0.24)** Generally healthy, often not using health system. | 42.6% | 4.4% | $44 |

[7] *Source: HealthCare Analytics - incurred in 2016 and paid thru April 2017 – CareFirst Book of Business Medicare Primary Members.*

[8] *Source: HealthCare Analytics - incurred in 2015 and paid thru March 2016 – CareFirst Book of Business, excluding Medicare Primary and Catastrophic members*

Prescription medications are the primary means of treating beneficiaries with multiple chronic conditions. Yet, despite the fact that nearly 70 percent of Medicare beneficiaries have two or more chronic conditions, recent Medicare data suggests only about 11 percent of Part D enrollees have participated in any medication therapy management programs. This is likely because physicians and hospitals lack real-time data on a beneficiary's medication use, have little time to invest in adherence interventions, and have little financial incentive to allocate time or resources to improving medication use. This occurs as Part D drug costs continue to become a greater portion of overall spending for Medicare beneficiaries. This is shown in **Figure 9**.

**Part IV, Figure 9: Medicare Fee-For-Service (FFS) Per-Capita Spending 2006-2024[9]**



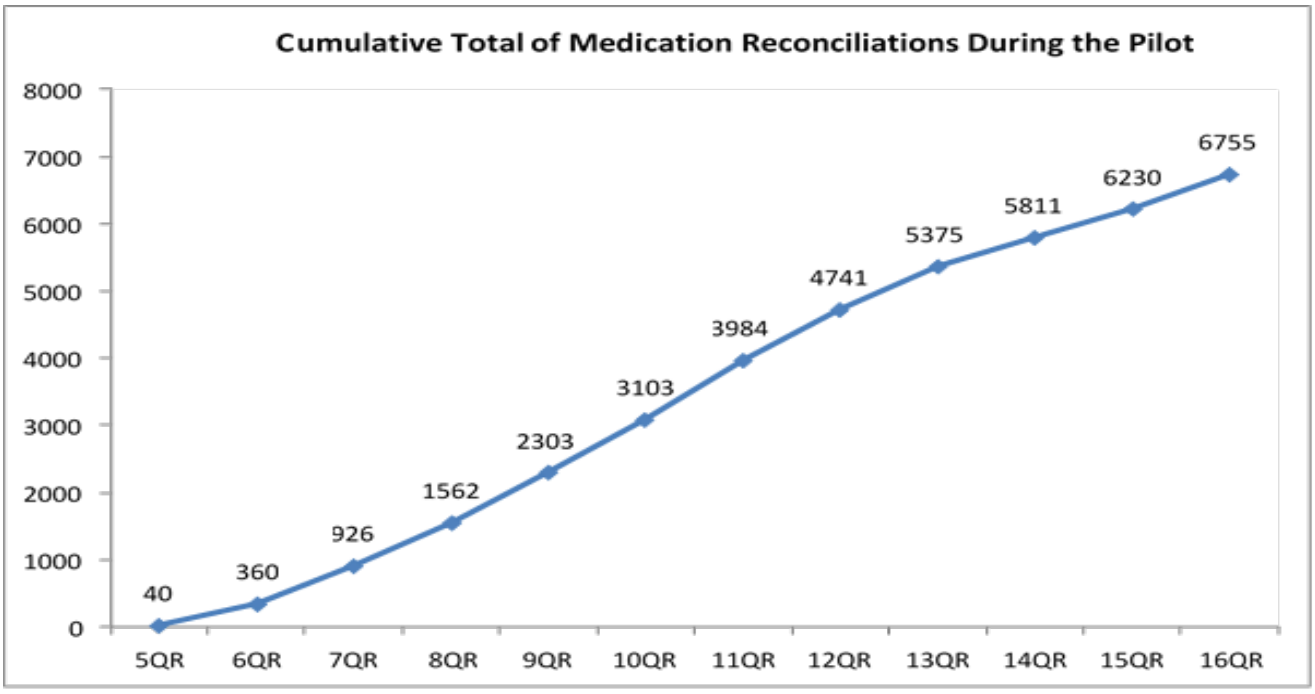

Pharmacy costs are a large percentage of all medical costs in the average Panel. Beneficiaries with multiple chronic conditions or acute illnesses are often on 10 prescriptions or more. Under the TCCI RxP Program, a pharmacist conducts medication reviews for beneficiaries at high risk for drug interactions or adverse events, and works directly with all of the beneficiary's prescribers to resolve or prevent drug-related problems. Similarly, a pharmacist works directly with beneficiaries who have chronic conditions or drug regimens that predict a risk of nonadherence, gaps in care, or other drug-related problems. Both Comprehensive Medication Review ("CMR") and MTM were provided to individuals who are likely to benefit, regardless of the pharmacy where they fill their prescriptions.

In the Common Model Pilot, Part D data was not available in a timely manner. Therefore, Care Coordinators conducted medication reconciliations for every beneficiary in a Care Plan by painstakingly reconstructing and documenting all medications each beneficiary was on. The medication information was derived from beneficiary interviews (based on medication lists or information developed after the beneficiary brings in pill bottles for review), provider records from all specialists involved in the beneficiary's care, as well as information from the Member Health Record, if available. Over the course of the Pilot, CareFirst performed thousands of medication reconciliations, as shown on the next page in **Figure 10**.

Through this, PCPs had improved visibility into all the medications beneficiaries were taking – from narcotics to over-the-counter medications. This led to dosage corrections and other changes in the prescriptions of beneficiaries as well as to more informed clinical decisions.

[9] *Source: 2016 Medicare Trustees Report*

**Part IV, Figure 10: Total Medication Reconciliation For Medicare Beneficiaries Under The Common Model Pilot**




## The Core Idea: The Common Model Would Strengthen Behavioral Change Toward Triple Aim

Given the facts above, there is a compelling opportunity to bring Traditional Medicare FFS beneficiaries into the PCMH/TCCI Programs in an attempt to achieve better quality and cost outcomes.

To start, it is useful to recognize that the average PCP in active practice in adult medicine has on average 250 Medicare beneficiaries in their practice. This means that the average Panel has between 2,500 and 3,000 total such beneficiaries for whom they provide care. Of these, over 85 percent are enrolled in the Traditional Medicare Program. Indeed, the Traditional Medicare FFS population that was attributed to the 14 Panels selected for the Common Model Pilot exhibited.

CareFirst's hypothesis was from the start, that if Medicare FFS beneficiaries were supported in the same manner as CareFirst Members in the PCMH Program – through care plans and the array of TCCI Programs – under the guidance of PCPs who are experienced with Care Plans and incented in the same manner as for CareFirst Members, that there would be a noticeable improvement in the quality of their care and a lessening of breakdowns resulting in high cost hospital-based services.

From a Panel's point of view, the development of a common model for Medicare FFS beneficiaries and CareFirst Members would enable them to modify and adopt consistent processes for both populations in order to focus more fully on the beneficiaries and Members who need them the most – regardless of which of the two payers was involved. And, they could make more informed decisions regarding the "buying" and "arranging" of specialty services for these two populations with far more purchasing power and complete information.

The power that comes from combining the two Programs through the Common Model is illustrated in **Figure 11** on the next page. The average Panel in the PCMH Program with about 3,000 CareFirst Members had a target budget of approximately $12 million in **2013 (Performance Year #3)** for its CareFirst Members. This target represented the sum of the "Credits" in its Patient Care Account ("PCA").

The inclusion of Medicare FFS beneficiaries added about $40 million more in Medicare "Credits" to the Panel's PCA for 3,000 Medicare FFS beneficiaries in the example below. This brought the Panel's overall target budget to over $50 million per year.

Given this size, even a modest savings against these target amounts could produce substantial OIAs. As shown in **Figure 11,** a six percent savings on Medicare and an eight percent savings on CareFirst Members would significantly reward PCPs in Medical Care Panels that lowered costs through improvement in cost and quality results.

**Part IV, Figure 11: Combined Medicare And CareFirst Patient Care Account (PCA) For Typical Panel[10]**

| | Medicare | CareFirst Commercial | Total |
|---|---|---|---|
| Beneficiaries/Members | 3,000 | 3,000 | 6,000 |
| Global Budget Target | $40M | $12M | $52M |
| Potential Savings (%/$) | 6% / $2.00M | 8% / $1.00M | $3.00M |
| OIA ($) | $0.5M* | $0.4M | $0.9M |

The potentially large OIAs had a profound impact on encouraging participating Panels to change their practice patterns and approach to Care Coordination as well as their workflows and referral patterns in pursuit of a higher reward for achieving better results. It also spurred Panels to more fully use the Program capabilities of TCCI to increase support to both populations within the same framework of rules – leading to efficiency as well as enhanced effectiveness then producing improved care outcomes and costs results.

The resulting impacts were felt well beyond the Panel itself and manifested themselves in lower admissions, readmissions, ER use, better medical outcomes, and more carefully decided referrals to more cost-effective specialists.

## The Goals Of The Common Medicare Fee-For-Service (FFS) And CareFirst Model

At the outset of the Common Model, CareFirst and CMS agreed on two goals for the Pilot and documented these goals in a written plan:

> **The first goal** was to control the rising total cost of care for Medicare beneficiaries and CareFirst Members attributed to Panels in the Pilot, principally by reducing hospital utilization. Specifically, the goals were to achieve a 7.5 percent reduction in hospital admissions over the period (from 2012 baseline levels) and slow the rise in PMPM total beneficiary costs to produce a rate of increase at least one percent lower than the State of Maryland's 3.5 percent per capita target for Part A spending, under the State's All-Payer Hospital Model, for total care costs in Parts A & B combined (including the cost of care coordination activities).
>
> **The second goal** was to improve the quality of care delivered to the beneficiary population as measured by a set of industry-standard "consensus" measures agreed to by CMS that CareFirst and other programs use in commercial adult populations.

In addition to these two goals, CareFirst set out with CMS to test whether:

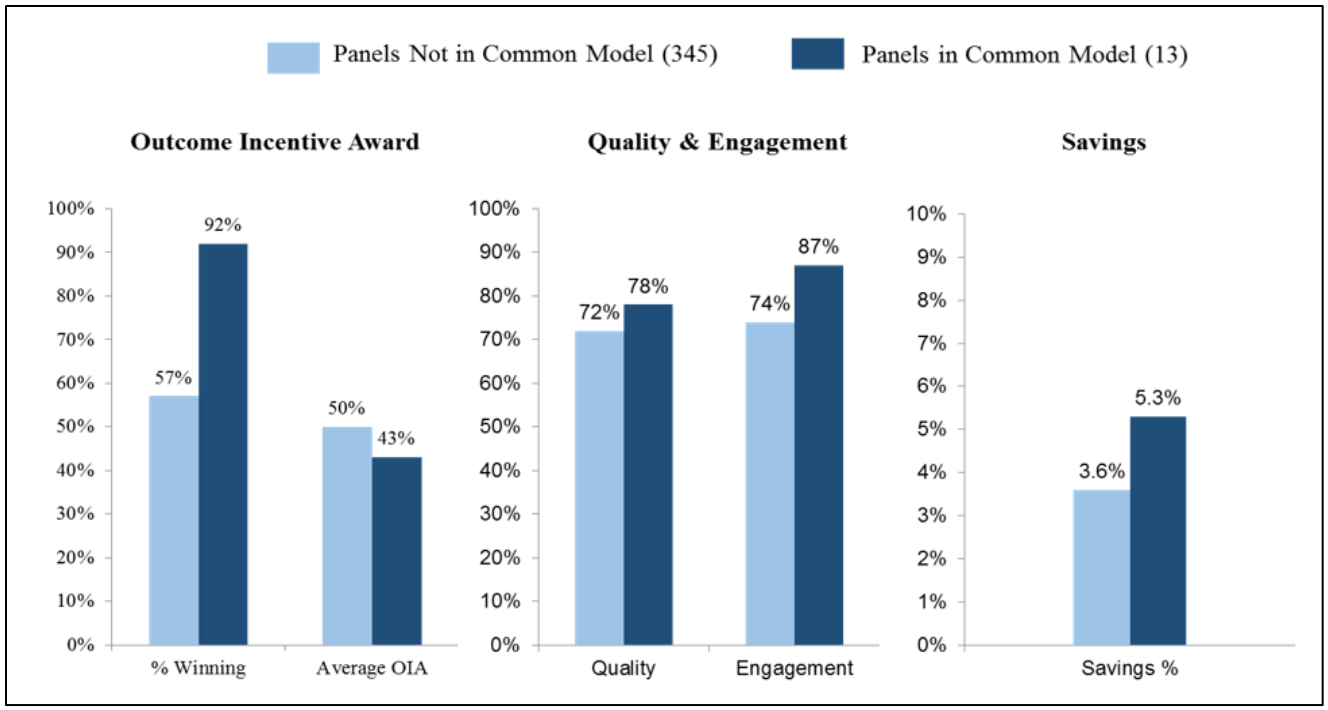
- A common set of rules, incentives, and infrastructure supports for the region's largest public and private payers would increase engagement among PCPs and accelerate and deepen behavioral change toward value-based care;
- A common care coordination infrastructure to support high-risk and high-cost beneficiaries would result in effective/deeper adoption and substantial declines in hospital-based services; and
- Sharing Medicare claims and enrollment data on a beneficiary specific basis could be implemented for care coordination and population health management purposes.

Taken together, these goals were intended to achieve the aims at the heart of CMS' interest: achieving better health, better health care, and lower costs. The results are shown in **Figures 12** through **17**.

[10] *Medicare OIA payouts to Panel winners have been restricted due to CMMI Grant OIA fund limitations.*

As shown in **Figures 12**, Panels in the Pilot became far more engaged in the Program and achieved far better outcomes in all aspects of the PCMH/TCCI, than other Panels that were only in the commercial Program.

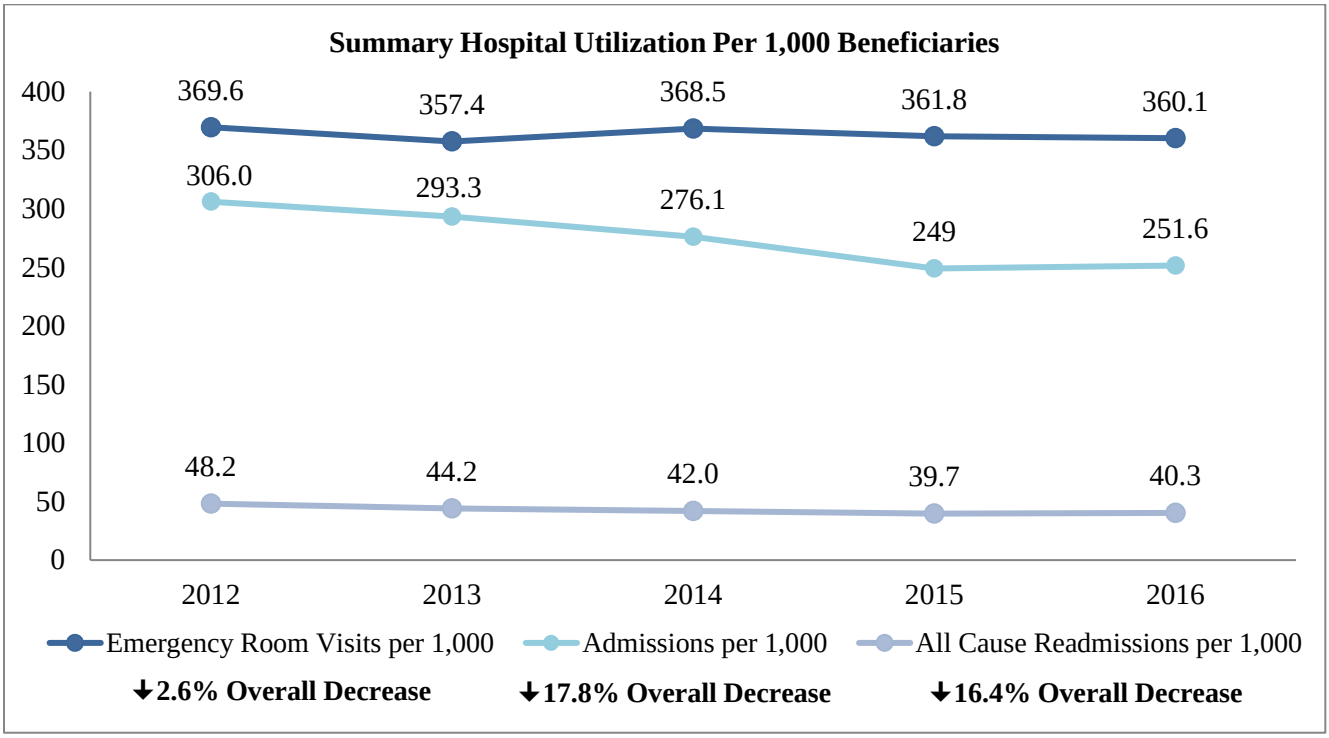
**Part IV, Figure 12: Panels Operating Under A Common Model Perform Better On Cost And Quality In 2016**




Under the Common Model Pilot, Panels placed greater focus on their referral patterns to specialists and identified areas of opportunity to shift beneficiaries to more cost-efficient specialists. All 14 Panels created a list of preferred high-value specialists and began to direct referrals to those specialists. Panels incorporated these specialist lists into their daily operations by uploading their lists into their Electronic Health Record and/or distributing paper forms to other PCPs and office staff. By empowering PCPs with new cost referral data, the 14 Panels provided beneficiaries with a wide array of choice, while sustaining a high percentage (86.6 percent) of referrals to high-value specialists.

This level of engagement and focus led to very encouraging results. As shown in **Figures 13** utilization metrics showed promising signs of trending in the desired direction. The number of hospital admissions and readmissions per 1,000 beneficiaries, which had continuously increased prior to the launch of the Award, saw a steady decline. ER visits saw an overall decrease and global medical cost remained flat from 2012 to 2016.

**Part IV, Figure 13: Common Model Hospital Utilization Per 1,000 Beneficiaries[11]**




The Common Model enabled a nearly complete uniformity in the way care for Medicare beneficiaries and CareFirst Members was coordinated through common, shared use of the PCMH/TCCI framework, data and incentives. This is outlined in the description below which describes how each PCMH and TCCI Design and Program Element was intended to work for Medicare FFS beneficiaries as part of the integrated Common Model.

## Integrating Medicare Fee-For-Service (FFS) Into The PCMH And TCCI Programs: Common Rules And Incentives Under The Innovation Award

### Data Comes First

The first step in the implementation of the Common Model was the monthly receipt by CareFirst of data on Medicare FFS beneficiaries from CMS. This process was developed jointly by CMS and CareFirst and was placed in routine operation in July 2013. Medicare data was loaded into the CareFirst Business Intelligence (CBI) environment and data warehouse, which supports all aspects of the PCMH and TCCI Programs. This process continued through CareFirst's temporary funding of the Common Model.

For the Panels that were selected to participate in the Pilot commencing on July 1, 2013, CMS provided complete and detailed enrollment and Part A and B claims data on each Medicare FFS beneficiary attributed to a PCP in one of the selected pilot Panels.

The data supplied by CMS included basic demographic information on each beneficiary as well as each beneficiary's detailed medical claims history going back to calendar year 2010 (Part A and B claims). Unfortunately, Part D drug data was not readily available on a real-time basis (it was 18 months out of date). This required that current drug data be obtained as part

[11] *Healthcare Analytics data through June 2017*

of a Care Plan for those selected beneficiaries whose care was to be coordinated. With the exception of the old or missing drug data, all information on Medicare beneficiaries and CareFirst Members was essentially the same and was derived from the same sources: 834 enrollment forms and 835 remittance forms.

Once Medicare data was obtained and held in the secure CareFirst data warehouse, all features of the iCentric System were enabled for Medicare FFS beneficiaries in the same manner as for CareFirst Members. This included the monthly generation of SearchLight Reports that showed emerging Panel experience for Medicare beneficiaries in the same way as for CareFirst Members (each is shown separately, but with the same views, drill downs and online features). This created a parallel, side-by-side set of views: One for Medicare beneficiaries and one for CareFirst Members. The only exception was the lack of current drug data on Medicare FFS beneficiaries which CareFirst overcame through alternative means.

In essence, other than the fact that there were two different payers involved, the entire infrastructure and data supports to Panels were the same - enabling Panels who have learned to use the Elements of the TCCI Program for CareFirst Members - to apply these Elements to Medicare beneficiaries in the same manner.

**Claims for Medicare FFS Beneficiaries Continue Through the Usual Intermediary Tracks**

It should be noted that primary care and other providers serving Medicare FFS beneficiaries continued to submit claims for their services to Medicare's administrative contractors in the standard way. These claims were processed and paid according to standard Medicare rules. This processing and payment by Medicare produced the data provided to CareFirst by CMS. Medicare fee payments to providers (Medicare Allowed Amounts) were posted to PCAs of participating Panels before application of any beneficiary cost sharing and became "Debits" in the PCAs of Participating Panels in exactly the same way as are Debits for CareFirst Members (as CareFirst Allowed Amounts).

With this said, it was possible to summarize how each of the 10 Design Elements of the PCMH Program were handled for Medicare FFS beneficiaries in the participating Innovation Award Panels.

**Treatment of Participation Fee**

There was no Participation Fee paid to PCPs for Medicare FFS beneficiaries in the Common Model Pilot as there is for CareFirst Members. For CareFirst Members, the Participation Fee is paid as a fee schedule increase. Under the Innovation Award, all Medicare FFS payments were paid by Medicare and, since a Participation Fee is not included in Medicare coverage, the elimination of the Participation Fee was required.

**No Risk to PCPs and Panels**

There was no risk taken by PCPs or Panels in the Common Model. The model extended the incentive-only feature of the CareFirst PCMH/TCCI Programs to the Panels participating in the Innovation Award for Medicare FFS beneficiaries.

**Design Element #1: Medical Care Panels**

Panels participating in the Common Model Pilot were already established with operating experience in the CareFirst PCMH/TCCI Programs. No changes in Panel composition or changes in the Program rules governing these Panels was needed to enable the integration of the Medicare FFS beneficiaries who were attributed to these participating Panels. Thus, **Design Element #1,** as described in **Part III,** continued to apply.

The only additional requirement placed on the participating Panels was that they voluntarily sign an addendum to their provider contract with CareFirst to apply all rules and features of the PCMH/TCCI Programs to their Medicare FFS beneficiaries and to cooperate with the Common Model Pilot Program and its evaluation/oversight.

**Design Element #2: Member Attribution**

The attribution of Medicare FFS beneficiaries to PCPs within the Panels selected for the Common Model Pilot was performed by CareFirst using CMS data in the same manner as attribution is performed by CareFirst for its Members as outlined in **Part III**, **Design Element #2**. Throughout the Award (2012-2015) and in the bridge period, this was performed by CareFirst on

the same cycle and with the same frequency as occurs for CareFirst Members. CareFirst used the monthly data files it received from CMS to perform the attribution process for Medicare FFS beneficiaries.

**Design Element #3: Calculation of Illness Burden Scores**

CareFirst calculated Illness Burden Scores for Medicare FFS beneficiaries in the Pilot in the same manner and on the same monthly cycle as for CareFirst Members as is described in **Part III**, **Design Element #3**. The results of these calculations were shown in SearchLight views in a manner that mirrors the views provided for CareFirst Members.

**Design Element #4: Establishing Global Targeted Care Costs for Each Participating Panel and Debiting Care Costs against these Targets**

CareFirst established a Base Year Global Target Care Cost for each Medicare FFS beneficiary in a manner consistent with that for CareFirst Commercial Members as described in **Part III**, **Design Element #4**. However, instead of the 2010 base year generally used for CareFirst Members, CareFirst used 2012 as the base year for Medicare FFS beneficiaries. This base year included all claims information supplied by CMS for each attributed Medicare FFS beneficiary. The Global Target Care Cost per beneficiary was updated with incremental new CMS data for periods beyond the Base Year in the same manner as for CareFirst Members.

To do so, CareFirst incorporated Illness Burden Scores in the Base Year for Medicare FFS beneficiaries and then reflected changes in these scores on a monthly basis in the same manner it does for CareFirst Members, including a final year end adjustment after three months run out of Medicare A and B claims experience following the Performance Year.

CareFirst applied a trend factor to the Illness Burden adjusted Base Year costs of Medicare FFS beneficiaries derived from a modified regional trend for Medicare Part A and B per capita expenditures. This is parallel to the Overall Medical Trend ("OMT") used to project the Illness Burden adjusted Base Year costs for CareFirst Members into each Performance Year. The Medicare OMT used for the 14 Panels was 2.5 percent in each year 2013-2016.

The first performance period for Medicare FFS beneficiaries was July 1, 2013 to December 31, 2013. This short period reflected the mid-year start of Award supported operations. The full calendar year 2014 was used to measure performance of the participating Panels in Grant Year #2 – which was Performance Year #4 for CareFirst. A separate settlement for each of these periods was made after allowing three months of claims run out (as explained below).

CareFirst established and maintained a common PCA for each participating Panel that reflects Medicare "Credits" and "Debits" for each Panel's Medicare FFS beneficiaries in the same manner as it does for each Panel's CareFirst Members. The PCA will separately show Medicare and CareFirst Debits and Credits for each participating Panel as well as show the sum of all Credits and Debits for the two payers combined.

All Debits for Medicare in the PCA of each Panel included the Care Coordination fees for TCCI services such as HBS, CMR and EMP services just as is done for CareFirst Members.

The same Individual Stop Loss ("ISL") protection (at $85,000 per Member/beneficiary per year) was used for Medicare and CareFirst Members with the same Panel participation in the costs above this level (20 percent) debited to the PCA.

**Design Element #5: Deciding and Making Referrals**

CareFirst integrated and included data in SearchLight Reports on Medicare payments to specialists used by participating Panels in the same manner it does for specialists used by these Panels for CareFirst Members. Referrals for both populations are often to the same specialists. Hence, the additional Medicare A and B data augmented the profile of the specialists used by the participating Panels and is made available to PCPs in deciding on referrals for both CareFirst Members and Medicare FFS beneficiaries.

In effect, the additional Medicare claims data was used to provide a more complete view of the cost patterns of the specialists that care for each participating Panel's Members.

**Design Element #6: Enhanced Focus on the Chronic Member Through Care Plans**

The development and maintenance of Care Plans for Medicare FFS beneficiaries were carried out in the same manner as for CareFirst Members – as described in **Part III, Design Element #6**. Documentation of Care Plans in the iCentric System for Medicare FFS beneficiaries was performed in accordance with the same Standard Operating Procedures contained in **Appendix C** to these Guidelines.

This was accomplished through the hiring of additional LCCs (supported by the Innovation Award) who are dedicated solely to Medicare beneficiaries in the participating Panels. These dedicated LCCs reported in the same manner to RCDs as their commercial counterparts and were subject to the same Care Plan quality review processes and standards. In total, over 40 LCCs were assigned to the fourteen Medicare participating Panels for the purpose of Care Coordination for Medicare FFS beneficiaries.

The selection of Medicare FFS beneficiary candidates for Care Plans was carried out in the same manner as for CareFirst Members. Generally, the same selection criteria were used. However, disproportionately more Care Plan Eligible Medicare FFS beneficiaries were targeted for Care Plans reflecting the far more extensive presence of chronic disease in the Medicare FFS population.

PCPs in participating Panels received the same $200 and $100 Care Plan Development and Maintenance fees for Medicare FFS beneficiaries as paid for CareFirst Members in Care Plans. These fees were paid directly to the PCPs from CareFirst using Innovation Award funds and were not be billed to Medicare. The same monthly charge for LCC support for active Care Plans ($380/month in 2015) was debited to the PCA of participating Panels for CareFirst Members and Medicare FFS beneficiaries as are the fees for other TCCI services such as HBS, CMR and EMP Services.

**Design Element #7: Maintenance of Online Member Health Record**

As with all CareFirst Members, CareFirst maintained an up to date Member Health Record for every Medicare FFS beneficiary in the same manner and to the same extent as for CareFirst Members. This record was composed of the same components as for CareFirst Members as presented in **Part III, Design Element #7**. The record could be accessed through iCentric in the same way as it is for CareFirst Members.

**Design Element #8: Measuring Quality – The Essential Ingredient**

All of the quality measures and the process by which these measures were determined was the same for Medicare FFS beneficiaries as for CareFirst Members, and were periodically updated to reflect the evolution of industry standards. This includes the calculation of Degree of Engagement in accordance with the Standard Operating Procedures that guide how Engagement is measured for CareFirst Members. All other quality measures were aligned to the measures CMS currently uses for its Medicare Shared Savings Program. The weightings with regard to the various categories of quality measures also were the same for Medicare FFS beneficiaries and for CareFirst Members as is the 100-point scale on which quality is measured. There was no departure from the methodology described in **Part III, Design Element #8** as further developed in **Appendix C**.

**Design Element #9: Reward for Strong Performance**

Within six months after the end of each Performance Year, CareFirst accumulated all Debits for services provided to CareFirst Members and Medicare FFS beneficiaries in each of the participating Panels during the Performance Year starting with 2013. As noted earlier, a short period (July 1, 2013 through December 31, 2013) was used for Medicare FFS beneficiaries due to the start of the Pilot on July 1, 2013. A full Performance Year was used in 2014 and 2015 for Medicare beneficiaries in parallel with CareFirst Members. Because federal grant funding of the Pilot ended on 12/31/15, no OIAs were paid to Panels for savings achieved in 2016.

In all respects, the methodology that was used to calculate an OIA is the same as presented in **Part III, Design Element #9**. This included the use of the same matrices for the determination of the intersection between the quality score of the Panel and the degree of savings the Panel achieved.

Any participating Panel that was entitled to a Medicare OIA based on its Medicare performance was paid this award in a lump sum during quarter three of the year following the performance year. This lump sum was calculated by multiplying the percentage OIA that is due the Panel times the Medicare allowed amounts for PCP services rendered to Medicare FFS beneficiaries in the Performance Year. For Virtual Medical Panels, this lump sum payment was divided up and paid to the constituent practices in the Panel based on each practice's portion of all primary care service claims that were generated by the Panel in the Performance Year.

## Conclusion

While the Common Model pilot was in operation for just over three years, meaningful behavior change occurred among PCPs, toward value-based care and improved cost and quality outcomes. These changes were more pronounced in the Common Model Panels than in the rest of the PCMH Program where CareFirst is the only payer. The Pilot's conclusions are consistent with the theory behind the Award and demonstrate the potential power of the Common Model in bringing about practice reform on a larger scale.

Final results show marked evidence that the Common Model caused improved quality in beneficiary care, a decline in costly hospital utilization, and an overall cost-savings to the Medicare Program. Results included the following:

- Overall Part A & B costs (PBPM) remained flat from 2012-2016 even after the costs of care coordination are included;
- Sharp reductions in beneficiary use of hospital-based services occurred;
- The Quality Score of PCPs consistently improved throughout the three-year period, even as quality standards became more rigorous;
- Beneficiaries served by care plans were highly satisfied with their care and health outcomes, growing more satisfied as the model progressed; and
- Virtually all providers involved expressed a strong desire to continue the model.

Over the course of the Award, the total Medicare Part A & B savings generated by the Common Model was substantial. CMS received over $90,000,000 in total savings when the actual results were compared to projected (trended) targets from the 2012 base-year. Savings equated to total savings of 5.3 percent from target levels. This far exceeded the estimate CareFirst made at the beginning of the Award.

In addition to the quantitative success described in this Part of the Guidelines, the participating practices began to reform the way they practiced by changing when and to whom they referred patients for specialty care, how they assessed patient need for care coordination, how they used data and what data they sought as well as how they made themselves more accessible to patients in greatest need. They also worked ever more effectively with the nursing and ancillary provider support they received in activating and maintaining care plans for their most vulnerable patients. These changes were deepening and accelerating as the Award ended.

# Part V: Benefit Design: Blue Rewards And Incentive-Based Designs - Higher Value Through Member Behavioral Change

# Preface

**UPDATE PENDING**

## HealthyBlue Design Elements And Rationale

**UPDATE PENDING**

## Incentives For How A Member Accesses Healthcare

**UPDATE PENDING**

## Incentives For What A Member Can Do

**UPDATE PENDING**

## Incentives For Efficient Communication Between Member And Plan

**UPDATE PENDING**

## Incentives For Member Compliance With Care Coordination Efforts

**UPDATE PENDING**

## Incentives For Staying Well Or Improving Health

**UPDATE PENDING**

## Incentives For Selecting High Performing Panels

**UPDATE PENDING**

CareFirst
Family of health care plans

# VOLUME II

## THE TOTAL CARE AND COST IMPROVEMENT PROGRAM ARRAY(TCCI)

## (Part VI)



Q4 2017

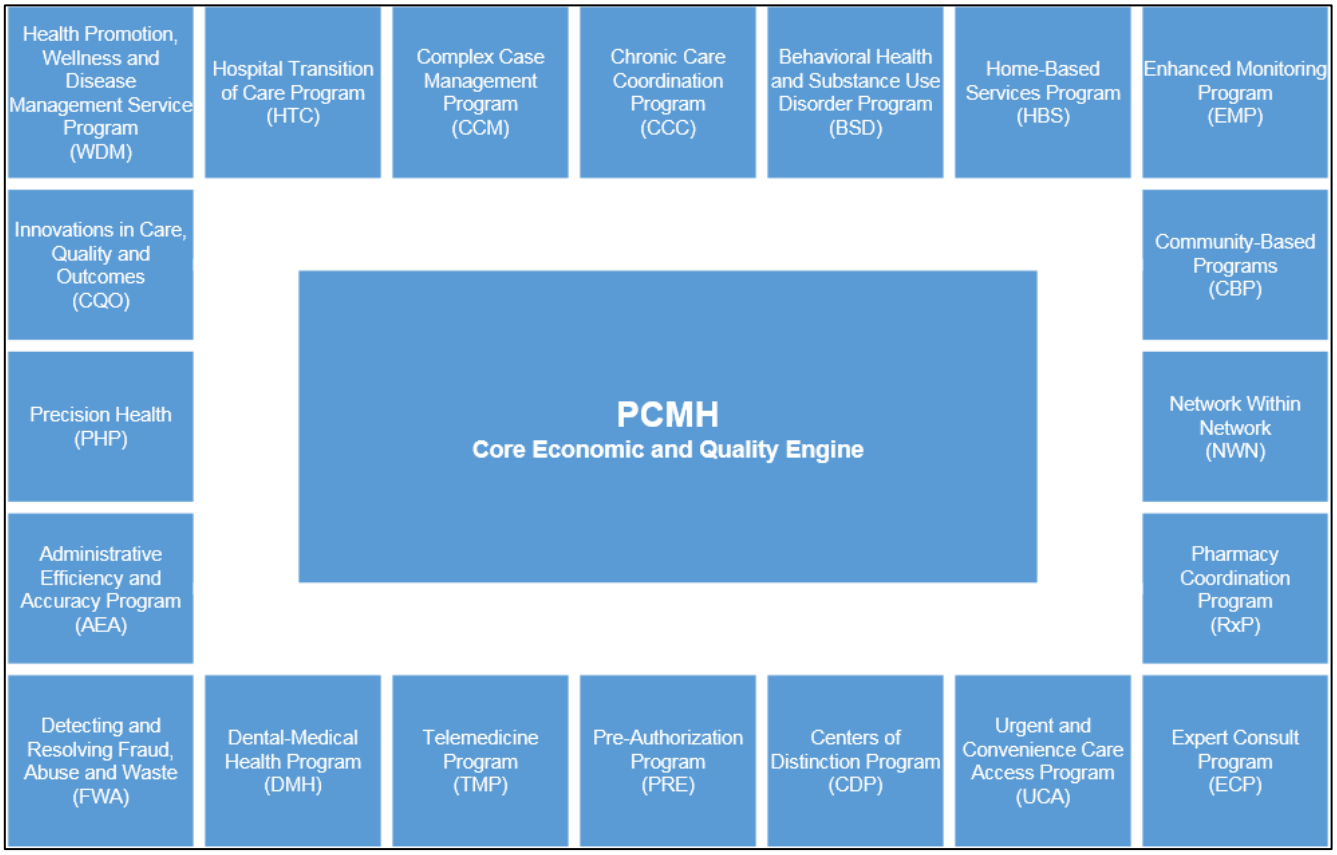
# Part VI: TCCI: Twenty Supporting Programs

## Preface

As first noted early in these Program Guidelines, the Total Care and Cost Improvement Program Array ("TCCI") is intended to wrap around, enable and support the core Patient-Centered Medical Home ("PCMH") model. They provide needed capabilities that are often called upon in helping Members achieve the highest level of recovery and stabilization possible. They are also critical to helping Panels achieve their goals of improving quality and restraining the rise in health care spending.

**Figure 1** below presents all 20 Programs of TCCI.

**Part VI, Figure 1: TCCI Program Array**



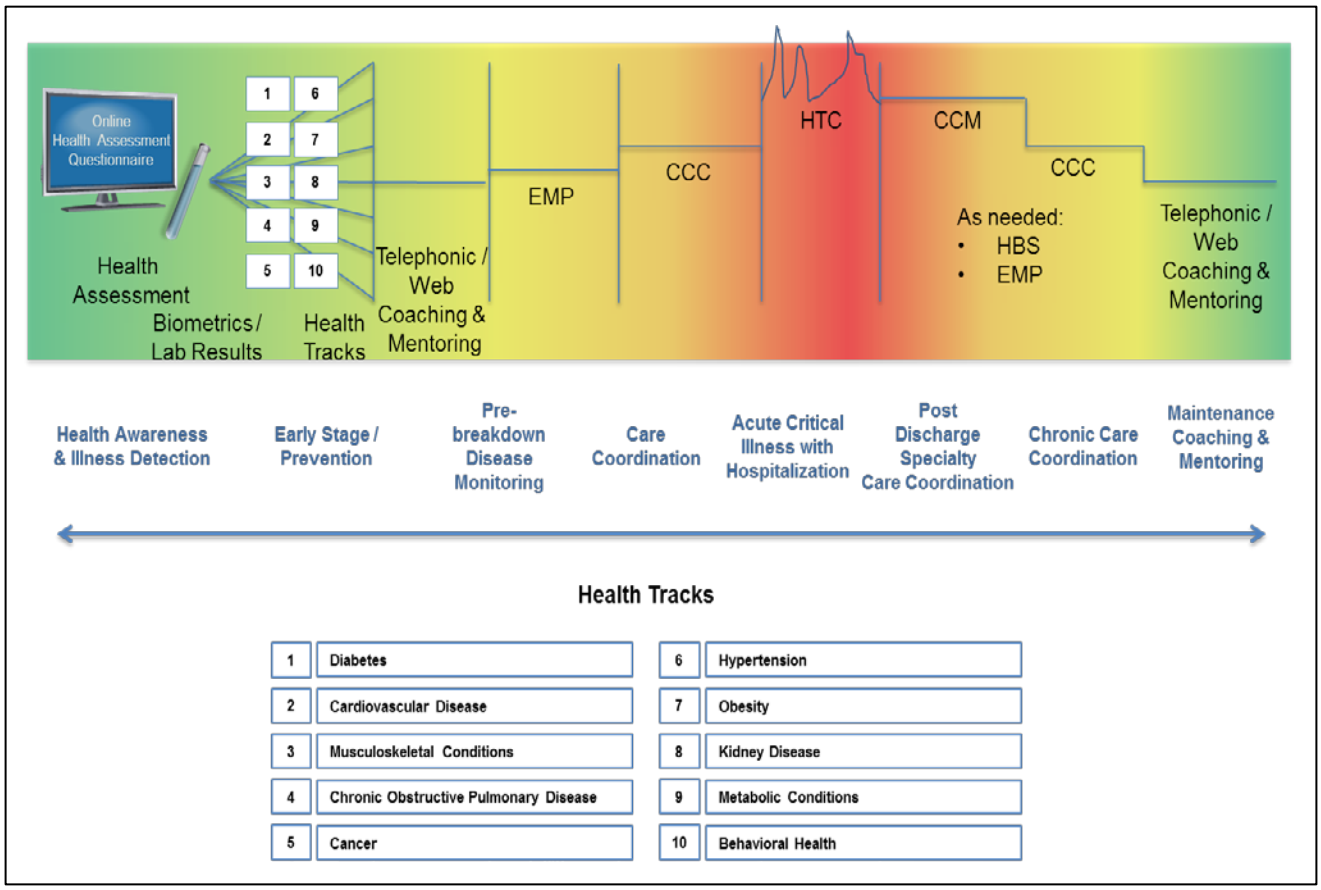

Some TCCI Programs – such as the HTC Program – serve CareFirst Members whether or not they are in the PCMH Program. For example, the Hospital Transition of Care Program ("HTC") monitors hospitalizations of CareFirst Members throughout the country. Yet, HTC is integrally connected to the PCMH Program as described more fully below.

TCCI Programs are intended to bring needed capabilities to bear at the right time, at the right level for the Member, through the right provider in the right setting. An example of this is the Chronic Care Coordination ("CCC") Program through which Care Plans are developed and maintained for Members in the PCMH Program with multiple chronic conditions that create instability and have an Illness Burden Score of at least six times greater than average. A Member in such a plan may receive services such as Home-Based Services Program ("HBS"), Enhanced Monitoring Program ("EMP") and any TCCI Program as part of their Care Plan.

The TCCI Continuum shown in **Figure 2** on the following page captures this idea. The TCCI Continuum starts with a Health Assessment and detection of early health risks (for which telephonic and online coaching/information is available). A life style and behavioral coach - for those at risk for one of 10 chronic disease or disease clusters - is available while Disease Management is available for those with active disease in one of these 10 clusters. Other more intense Care Coordination Programs (CCC and Complex Case Management Program ("CCM") are available, when these are needed, for the sickest Members.

Other Programs– like Urgent Care Access – are arranged as a backup to aid Members and Panels in seeking less costly alternatives to hospital Emergency Room ("ER") services. Community-Based Programs are intended to provide specific courses of treatment and therapy for certain diseases and conditions as part of a coordinated course of action set forth in a Care Plan. A wide range of such Community-Based Programs is available.

**Part VI, Figure 2: TCCI Continuum: Wellness Through Acute Illness And Recovery**



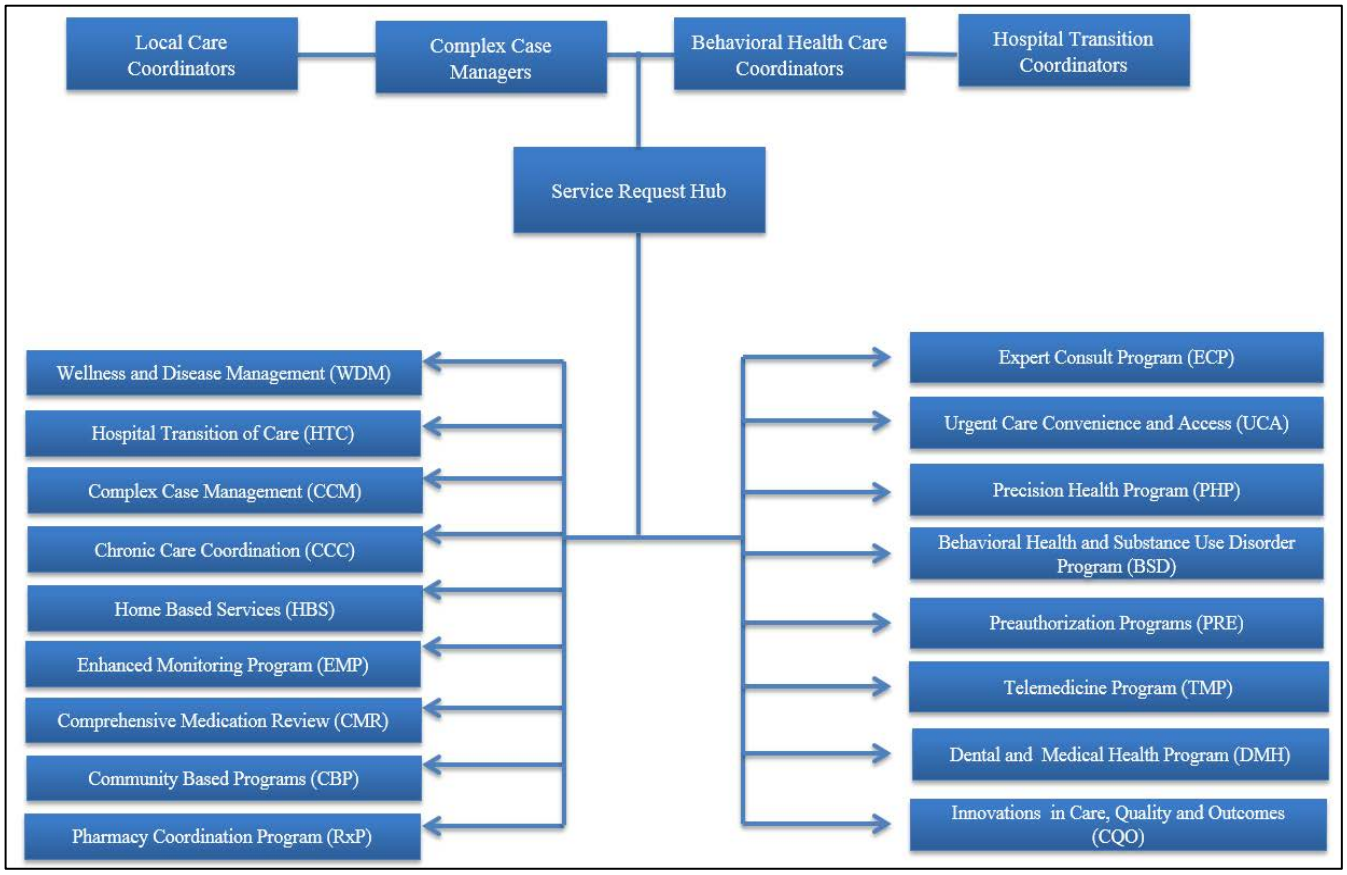

Members who need particular supports or services, under the direction of the Primary Care Provider ("PCP") and in coordination with appropriate specialists are placed in Care Plans as part of the CCC or CCM Programs. Then, any TCCI Program or combination of Programs can be brought to bear within the context of the Care Plan as appropriate and needed by the Member.

## Service Request Hub – The Gateway To TCCI Programs

To facilitate the introduction and coordination of TCCI Programs, CareFirst operates a Service Request Hub as part of the iCentric System. The Service Request Hub is the essential means by which Local Care Coordinators ("LCCs") and CCMs connect Members to the specific TCCI Programs and services they need. An LCC or CCM need only make an online referral to the Service Request Hub to assure a needed TCCI Program is brought to bear for the Member they are caring for. The Service Request Hub takes it from there – assuring that the right connection is made to the requested Program and confirming that the service request for the Program sought has actually been arranged and delivered as intended.

This is shown in **Figure 3** below.

**Part VI, Figure 3: Depiction Of Service Request Hub**



## Cost Share Waiver For Members In Care Plans And Certain TCCI Programs

CareFirst takes the point of view that improvement in quality is essential to long term cost savings and this goal can be greatly aided when there is coordination of services – across provider type, setting and time – for Members at high risk or with multiple chronic conditions. Further, quality outcomes can best be improved by the attentive guidance of a motivated PCP who is rewarded for differentially attending to these Members with the aid of a specific Care Coordinator dedicated to the Member.

The vehicle for all Care Coordination efforts in the TCCI Program Array is the Care Plan. There are three TCCI Programs that employ Care Plans: CCC, CCM and Behavioral Health and Substance Use Disorder Program (BSD).

Essential to Care Coordination and case management is the Member's consent to the creation, maintenance and faithful adherence to a Care Plan. The duration of a Member's Care Plan averages two to four months for CCM, six to nine months for CCC, and four to six months for BSD.

During this time, it is crucial that Members frequently communicate with their Care Coordinator and follow the steps and actions agreed to in their Care Plan. Examples of these tasks could include taking medications as prescribed, following a recommended diet, attending appointments with specialists as ordered, exercising as directed, meeting milestones in physical therapy, or any number of other things ordered by their physician.

In the early years of the PCMH/TCCI Programs, CareFirst observed that cost-sharing (i.e., copays, coinsurance and deductibles) was a barrier for Members managing chronic and acute conditions. The burden of cost-sharing thwarted use of the very services Members in Care Plans needed most and hindered the efforts of the Program. Thus, in 2015, CareFirst began to waive certain cost-sharing responsibility for Members in active Care Plans (the "Cost Share Waiver" or "CSW").

Generally, Member cost-sharing for services rendered outside of a hospital setting is waived while cost-sharing for services rendered in a hospital or for drugs is not waived. The central idea is to remove a key barrier to compliance while the Member is home and increase the Member's changes to stabilize or manage chronic illnesses or recover from an acute phase of illness.

**Figure 4** below shows the categories of services covered under the Cost Share Waiver:

**Part VI, Figure 4: Categories Of Services Covered Under The Cost Share Waiver**

| Cost Share for Certain Services | Compliant Member in Active Care Plan[1] |
|---|---|
| Durable Medical Equipment | Waived |
| In-Network Professional Services in Office Setting | Waived |
| Laboratory (Not in a Hospital) | Waived |
| Physical Therapy (Not in a Hospital) | Waived |
| Radiology (Not in a Hospital) | Waived |
| Drugs in the Medical Benefit | Not Waived |
| Drugs in the Pharmacy Benefit | Not Waived |
| Inpatient Hospital Facility Costs | Not Waived |
| Outpatient Hospital Facility Costs | Not Waived |
| Professional Services in Hospital Setting | Not Waived |

CareFirst also offers the following TCCI Programs without cost-sharing responsibility for all Members referred by a Care Coordinator:

- Chronic Care Coordination Program;
- Complex Case Management Program;
- Behavioral Health and Substance Abuse;

[1] *Cost-Sharing rules vary for Members with a Health Savings Account (HSA).*

- Pharmacy Coordination Program;
- Enhanced Monitoring Program;
- Expert Consult Program;
- Home-Based Services Program;
- Home Hospice/Palliative Care Program; and
- Wellness and Disease Management Program.

Once a Member successfully attains their Care Plan goals and the Care Plan is closed, cost-sharing in the form of copays, deductibles and coinsurance apply. Members who do not engage with their Care Coordinator in a meaningful way or fail to comply with the action steps required to reach their Care Plan goals lose the benefit of the Cost Share Waiver.

## Dedicated Customer Service Support For The TCCI Program Array

Before, during and after a Member consents to engage in a TCCI Program, it is critical that the Member and those in their Team understand how Care Coordination activities are covered under the Member's benefits.

To assure that all involved parties – and the Member most importantly - understand what and how Care Coordination services are covered, dedicated customer service support is arranged so that the Member receives a prompt and accurate explanation of their benefits whenever a TCCI Program is involved.

To enable this, each Strategic Business Unit ("SBU") at CareFirst maintains a team of Customer Service Representatives ("CSRs") specifically dedicated to answering all Member questions relating to the coverage of all TCCI Programs. These dedicated CSR Teams support proper benefit administration for Members who are participating in or being evaluated for participation in one or more of the TCCI Programs. Benefit questions may come directly from Members or from LCCs, Case Managers, Behavioral Health Care Coordinators (collectively referred to in this section as "Care Coordinators") and other TCCI Partners (i.e., Enhanced Monitoring Staff, Disease Management Coaches etc.).

**Activation Calls**

Activation of a TCCI Program – especially a Program with a Care Plan – is accompanied by a check of the Member's current medical and pharmacy benefits. A three-way conference call that includes the Member, Care Coordinator and a dedicated CSR is always the starting point for Care Plan activities. A specific CSR is always assigned to each Care Plan Member and the CSR is always "there" for the Member.

Once this initial "activation call" is completed, the call-routing system will direct any future inquiry to the dedicated CSR for resolution.

The activation call process is as follows:

- Care Coordinators dial the toll-free number provided.
- The caller is prompted to enter the Member's ID number, date of birth and zip code (or last name of the policyholder).
- The Member's eligibility is confirmed, the correct SBU is determined, and the Member is routed directly to the appropriate team of dedicated CSRs.
- A CSR receives the call and discusses with the Care Coordinator initial information related to the Member's Care Plan and other TCCI Programs which the Member may be referred.
- The Member is then connected to the call by the Care Coordinator and the CSR and LCC engage the Member, with full reference to the iCentric Member Health and Service Request Records.

**Maintenance Calls to the Member's Designated CSR**

When benefit questions arise after a Member's activation in a Care Plan, calls are routed to the same CSR that addressed benefit coverage at the outset. This assures that the CSR is familiar with the Member's Care Plan and better informed of the Member's circumstances. This CSR becomes the Member's "Designated CSR" and all calls to CareFirst regarding the Member are routed to this Designated CSR. If the Designated CSR is not available, the dedicated team of CSRs who support the TCCI Program Array will serve as back up.

To access the Member's Designated CSR, Care Coordinators dial a toll-free number and enter in the three data elements listed above that are necessary to identify the Member. Once the Member is engaged in a Care Plan, the Care Coordinator is directed to that particular Member's Designated CSR for any subsequent questions. If the Designated CSR is available, a call back can be arranged or, if necessary, another CSR can serve as back up. Calls directly from Members who are active or were recently active in a TCCI Program Care Plan are directed the same way.

**Care Coordination Card**

Member engagement and understanding of the Care Plan process is critical to the success of the TCCI Program Array. To facilitate this engagement and understanding, CareFirst provides every Member in a Care Plan with a Care Coordination Card. This card specifies the TCCI Programs in which the Member participates and lists contact information for key Members of the Care Coordination Team such as the Member's Care Coordinator and Designated CSR.

Hence, the Care Coordination Card is an informational card given to Members who, along with their PCP and Care Coordinator, consent to participate in one or more of TCCI's Care Plan Programs (i.e., CCM, CCC, and BSD). Once a Member's Care Plan is activated and an Activation Call has been completed, a Care Coordination Card and welcome letter are emailed to the Member immediately. To follow-up, a physical welcome letter and card are also mailed to the Member's home within three to five business days. The card is valid for the duration of the Member's Care Plan.

The welcome letter that accompanies the card encourages the Member to engage with their Care Coordinator and explains Care Plan compliance requirements. An image of the card is shown in **Figure 5** below.

**Part VI, Figure 5: Care Coordination Card**


The messaging on the Care Coordination Card alerts providers that a Member is eligible for the Cost Share Waiver and prompts providers to log on to the CareFirst provider Portal to check the Member's eligibility for a CSW to accurately determine the Member's out-of-pocket expense owed at the time of an office visit and to avoid erroneous charges. The Care Coordination Card is not an insurance card, but is meant to be provided to the physician's office in conjunction with the Member's CareFirst ID card to verify eligibility and benefits.

**Maintaining the Cost Share Waiver Benefit**

As already noted, for the duration of their Care Plan, CareFirst will waive a Member's cost-sharing - deductible, copay, and coinsurance – for many professional services, such as doctor's visits on the condition that the Member actively cooperates and complies with the actions and steps called for in the Care Plan and makes progress toward more stable health.

A Member must be actively engaged with their Care Plan to receive CSW benefits, by complying with three ongoing steps:

- Telephonic or in-person discussion with their Care Coordinator weekly to discuss progress;
- Completion of the tasks that the Member, their PCP and Care Coordinator have agreed are necessary as documented to stabilize the Member and improve their health; and
- Active and cooperative progress toward a desired "State-of-Being" and Care Plan "graduation" date.

Failure to meet these requirements will result in the closing of the Member's Care Plan and the Member will no longer have access to CSW benefits or the Care Coordination services a Care Plan brings. Hence:

- The Member's Care Coordinator will no longer support the Member in making progress toward their health goals;
- The Member will no longer have access to other supportive TCCI Programs which require participation in a Care Plan; and
- CareFirst will no longer waive cost-sharing on professional services and the Member will be responsible for paying their deductible, copays and coinsurance for all covered services.

See **Appendix E** for a full description of the care planning process and standards and processes that underlie it.

## Closing A Care Plan For Various Reasons

### Closing a Care Plan at Graduation

Members in Care Plans are guided by their PCP and Care Coordinator toward an intended or targeted "State-of-Being" which is stabilization of the Member's health and a sufficient ability on the part of the Member to self-manage their chronic conditions. Arrival at this "State-of-Being" triggers graduation from a Care Plan. Graduation from a Care Plan is a mutual decision made by the Member's treating PCP, Care Coordinator and the Member.

When Members are ready to graduate from their Care Plan Program, their Care Coordinator changes the status of their Care Plan within iCentric to "Closed" with a closure reason of "Graduation – Goals Met". The Member's consent to this action is documented in their Care Plan. This action triggers mailing of a Graduation Letter to the Member thanking them for their participation and reminding them of their need to stay vigilant regarding their health care needs and the maintenance of their achieved targeted "State-of-Being". The letter also explains the value of their CSW benefits and that CareFirst will no longer waive Member cost-sharing.

### Closing a Care Plan for Non-Compliance

#### *30-Day Warning Letter*

While in a Care Plan, a Member that fails to fully engage with their Care Coordinator is deemed non-compliant. If this occurs, the Care Coordinator initiates a process for closing the Care Plan due to non-compliance. Before doing so, Care Coordinators make multiple calls and attempts to re-engage the Member in their Care Plan resulting in a higher frequency of contact to obtain their willingness to complete the steps outlined in the Care Plan.

If this does not occur, the Care Coordinator issues a warning message to the Member advising them of their non-compliant status as is necessary in the CSW benefit. The letter notifies the Member that unless the Member re-engages with their Care Coordinator and makes progress on their Care Plan goals within the next 30 days, the Member's Care Plan will be closed and the CSW benefit will end. The warning letter is accompanied by a personal email from the Member's Care Coordinator. During the 30-day notice period, the Care Coordinator attempts to re-engage the Member in their Care Plan and Members are urged to contact their Care Coordinator to discuss a path to become compliant and remain in the Program.

#### *Termination Letter*

If, after 30 days, the Member has not re-engaged with their Care Coordinator, the Care Coordinator will recommend to the Member's PCP that the Care Plan be closed. If the PCP agrees with the recommendation, a final notice of Care Plan closure and termination is mailed to the Member from CareFirst. The termination letter explains that the Member's Care Plan has been closed due to failure to comply with the actions called for in the Care Plan and the Member's CSW benefit is immediately revoked. Enclosed with each termination letter is a description of the Member's appeal rights should the Member choose to appeal the revocation.

### Members Participating in Two or More TCCI Programs

Since Members may participate in more than one TCCI Program at the same time, a responsible lead Care Coordinator is assigned – either a CCM or LCC. Under the direction of the lead Care Coordinator, both Care Coordinators are expected to discuss the Member's progress weekly and work together to keep the Member engaged and successful in both Care Plans.

Care Plan benefits remain active and the CSW benefit continues to apply if the Member is engaged and compliant in both of their Care Plan Programs. The decision to deem a Member non-compliant or recommend termination of a Care Plan is made at the discretion of the responsible lead Care Coordinator after discussion with the other Care Coordinator for the Program in which the Member is also involved. Only the Member's PCP may decide to close one or both Care Plans.

## Finding And Focusing On Those Most In Need – Fulfilling Population Health Through TCCI Programs

CareFirst uses a population health approach to identify Members for each TCCI Program. As noted throughout the Guidelines, within any sizable population of people there is a small percentage who account for the majority of medical spending. The challenge is to identify those who would most benefit from programs such as those offered within the TCCI Program Array. No one illness measure or score captures the entire picture for an individual Member or for a cohort of Members. Therefore, CareFirst uses multiple measures to capture various health factors or statuses to determine which Members to focus on for greater support, Care Coordination or specialized programs.

Typically, a three-pronged process is used to target the Members most in need:

- a flag or indication from data mining;
- a clinical review and recommendation from a nurse; and
- a review/initiation by the Member's PCP.

Members flagged for greater attention are tracked in the iCentric System with their status regarding Care Coordination activity shown in Searchlight and displayed in the Account HealthCheck section of the Account Searchlight Report. CareFirst classifies the level of Care Coordination activity into four categories:

- "**Reviewed**" – The Member has been evaluated for a TCCI Program;
- "**Approached**" – Direct outreach to a Member is made by a Care Coordinator or TCCI Partner;
- "**Engaged**" – The Member consents to participate in the TCCI Program and receives services; and
- "**Completed**" – The Member no longer receives services provided under the TCCI Program.

### Core Target Population and Other Index Scores Provide Help in Focusing on Those in Greatest Need

Each month CareFirst identifies Members who are deemed most likely in need of Care Coordination based on their illnesses, conditions and diagnoses. This is explained fully in **Appendix E**. It is from the Core Target Population that the vast majority of Members who enter TCCI Programs are selected. The Core Target Population is comprised of between 45,000-50,000 CareFirst Members in any given month who have been identified through specific criteria that are characterized as having high costs, high hospital utilization, and health instability. These costly, unstable Members are the top priority to assess for Care Coordination needs. There are five routes to being identified as a Core Target Member:

1. Members flagged by Hospital Transition Coordinators as "High Cost" and/or High LACE Scores
2. Members with known high-readmission rates
3. Members with over $5,000 in medical expenses per month for six months
4. Members with Illness Burden Score ("IBS") of 10-24.99
5. Members with high risk indicators of progressive disease or instability in the last 12 months. These indicators include Overall Per Member Per Month ("PMPM") cost, Hospital Use, Multiple Comorbidities, Specialty Rx PMPM cost, Advanced Chronic Kidney Disease (CKD), and a Drug Volatility Score (DVS) of at least eight (on a scale of 1-10).

These Members typically experience far higher than average unplanned hospital events related to chronic conditions, multiple gaps in care, repeat admissions and ER visits or are taking a large number of prescription medications. An intense focus on these sensitive Member populations is a vital component in a Panel's approach toward finding and attending to the needs of high risk/high cost Members' outcomes.

### Index Scores

In addition to the Core Target, there are 10 Index Scores that are applied to all Members where and when appropriate are applied to all Members, on a monthly basis. All scores are displayed in the Member Health Record as they become available or are updated. This provides each Panel with a clear view of the Members within its own population who are in need of increased attention and possible care coordination activities. The 10 Index Scores are explained on the following pages.

**Description of Index Scores**

**Illness Burden Score (IBS) -** The IBS is calculated for each Member every month based on the Member's unique claims history, using trailing 12 months of claims experience. This score is based on the Diagnostic Cost Grouper (DxCG) classification model which has been researched and refined over 20 years. The DxCG model relies on diagnosis and demographic information to assess the level of illness of a Member. ICD-9-CM diagnostic codes in claims are grouped into Condition Categories that have a hierarchy and a numerical weight for relative importance. DxCG groupings are based on diagnosis codes, not procedure codes.

Thus, these groupings describe morbidity or illness level, not treatment or cost patterns. This has the benefit of limiting the potential impact of provider 'up' coding or 'under' coding of claims since the DxCG groupings are not affected by the type or intensity of health care services delivered. An added benefit is that the groupings are less sensitive to variations in local practice styles or health delivery system configuration.

Since neither utilization of service nor the unit costs of services affect this score, the score becomes a more "pure" indicator of a Member's clinical complexity and health status. The IBS demonstrates the relative recent illness level of the Member that is a useful factor in determining which Members are most likely to have high future needs or costs. The IBS is normalized for the CareFirst population to an average of 1.0. The Illness Burden Pyramid stratifies Members, based on their normalized IBS, into five bands to focus PCPs' attention on which Members may be most clinically appropriate for PCMH Care Plans and other TCCI Programs.

**LACE Index Score ("LACE") -** A LACE Index Score is determined for all hospital inpatients by the Hospital Transition Coordinator (HTC) responsible for the hospital into which a Member has been admitted. This index is calculated from four metrics, which include length of stay ("L"), acuity (planned/unplanned) of admission ("A"), the Charlson Co-morbidity Index ("C") and the number of emergency visits ("E") in the six months prior to admission. It is used to estimate the likelihood of inpatient readmission or death within 30 days, with higher scores being highly correlated with readmission events. Lace Scores are calculated at the time of discharge from the hospital, while an ACE Index Score is calculated on admission (since length of stay is unknown at that time). Higher values for either index indicate the need for more intensive post-hospitalization Care Coordination and prioritize the Member for TCCI interventions.

**Charlson Comorbidity Index Score ("CCI") -** The CCI is calculated on weights assigned to over 20 conditions, including both common chronic conditions and advanced illness, and is based on likely clinical risk. Examples include moderate to severe liver, renal, heart and pulmonary disease as well as Acquired Immunodeficiency Disease ("AIDS"), leukemia, lymphoma and diabetes. Higher scores indicate more serious conditions and/or greater number of conditions. The CCI serves as an independent measure of clinical complexity as well as an essential element in the LACE and ACE indices.

**Consumer Health Inventory Score ("CHI") -** The CHI is a structured health assessment that measures and tracks changes in mental well-being and physical functioning for individuals aged 14 years and older. For Members under age 14, the CHI-C is the corresponding scoring tool. Behavioral and Substance Abuse Case Managers administer the CHI/CHI-C at the time of Case Management Program enrollment, then periodically throughout participation in the Program, and finally at Program graduation to assess Member progress and Program outcomes.

**Patient Health Questionnaire Score ("PHQ-2") -** PHQ-2 is a brief depression screening tool administered by all Care Coordinators to Members with chronic illnesses, serious and acute catastrophic illnesses and/or Behavioral Health issues. A positive score indicates the need for further evaluation using more detailed survey instruments and/or prompt evaluation and intervention by Behavioral Health specialists.

**Framingham Heart Disease Score ("FHD") -** The FHD score is a gender-specific analysis of information supplied as part of a self-reported health assessment (supplemented with biometric data when available), which is used to estimate the 10-year cardiovascular risk of an individual. It predicts not only heart-related events, but also vascular risk such as stroke and peripheral artery disease. The score is useful in identifying Members who would benefit from using medication to prevent or delay cardiovascular disease and for referral to specific TCCI Programs.

**Well-Being Score ("WBS") -** WBS is provided to all Members who complete a Health Assessment as part of an individualized report that identifies specific health risks. The Well-Being Score, developed by Sharecare and Gallup, includes

five elements of well-being, each scored on a 0 to 10-point scale. The report provides data to the Member about their health and well-being for each of the five elements as follows:

1. Purpose (having motivation to achieve goals);
2. Social (having supportive relationships);
3. Financial (managing economic life and financial security);
4. Community (living in a safe, positive environment); and
5. Physical (having good health and energy for daily activities).

For each of these topics, the Member is informed of any identified risks for the development of a preventable chronic condition. The Well-Being Score is correlated with future health care costs, utilization of hospital services and worker productivity measures.

**Drug Volatility Score ("DVS") -** DVS is calculated monthly for every Member with CareFirst pharmacy benefits. The DVS model provides a way to stratify Members into different levels of potential instability, due to the drug(s) they are on. These are manifested by adverse or unpleasant physical symptoms, or mental/behavioral symptoms including confusion, depression or psychosis. These symptoms may lead to serious consequences as well as non-adherence. The DVS ranges from 0 to 10, with higher scores associated with higher risk of instability or breakdown. The DVS allows the pharmacist and PCP to prioritize efforts, focusing on those Members who appear to require intervention on a timelier basis because of their potential to rapidly decompensate into a lesser state of health. These Members are far more likely to break down and be admitted/readmitted or use ER services frequently. The DVS score is derived from prescription drug claims data and Member demographic information.

**Pharmacy Risk Groups ("PRG") -** PRG uses a Member's pharmacy claims and demographics to assess future health risk. PRG is measured using Optum's proprietary drug hierarchy, with an assigned Drug Class Code, that is further categorized into one of over 100 initial pharmacy risk groups. The PRG is refined using Member age and various combinations of initial PRGs, which are weighted and summed to develop a single risk score that reflects both clinical risk and likelihood of exceeding a cost threshold. The PRG Score is used to assess a Member's pharmacy "load" or use of drugs that when taken in combination indicate the level of risk a Member may have.

**Metabolic Index Score ("MIS") -** MIS indicates the risk of future medical breakdowns and poor health, based on both certain lab results and available key biometric parameters. The MIS encompasses five categories of a Member's health:

- Cardiac Health
- Glucose Metabolism
- Kidney Health
- Liver Health
- A Biometric Factor (derived from Body Mass Index and blood pressure) when available

The score incorporates an age adjustment factor. As a predictor of potential future disease, its primary use is to identify Members for targeted coaching programs or specific TCCI Programs, such as the Chronic Kidney Disease Program.

**Selection and Engagement of Members by Clinical Professionals**

With all this said, it is nevertheless, the judgement of clinicians that is vital to selecting the most appropriate Members for TCCI Programs. In a very real sense, flagging Members through Indices or through the Core Target is only the first level of review in discerning which Members will benefit from participating in one or more TCCI Programs. Each Member identified is reviewed by the Member's PCP.

Those Members on the Core Target List must be assessed and accounted for by their PCPs since they constitute the "bull's eye" for Care Coordination and for one or more focused TCCI Programs.

Typically, Members enter a TCCI Program in one of six ways:

1. Hospital Transition of Care Program (HTC);
2. Complex Case Management Program (CCM);
3. Chronic Care Coordination Program (CCC);
4. Behavioral Health and Substance Use Disorder Program (BSD);
5. Wellness and Disease Management Program (WDM); or
6. Automatic Data-Triggered Referrals.

**In Sum**

It is obviously the case that not all Members generate scores in all categories each month, so the scores that are available are used when they become available. Since so much disease is chronic in nature, those Members with multiple chronic conditions and those who are experiencing breakdowns or exacerbations of chronic disease are also those who most often evoke high scores, which naturally draws attention to them.

It is when there is a confluence of high scores on multiple indices that attention peaks. This is at the heart of what it means to be focused on "Population Health". There is much to be gained by seeing patterns of disease progression in an individual or in a whole population. This concept is best applied at a Panel level where motivated, attentive and engaged PCPs search through their population of attributed Members with the help of LCCs and Practice Consultants to find and focus on those Members who need them the most and for whom a TCCI Program may be just what is needed.

**Figure 6** below defines the four reporting categories for each TCCI Program.

**Part VI, Figure 6: Methods/Rules For Reporting Status In Each TCCI Program**

| Program | Reviewed | Approached | Engaged | Completed |
|---|---|---|---|---|
| **HTC Program** | An HTC nurse reviews admissions to acute care hospitals to determine whether the nature of the Member's illness/ condition is likely to require post discharge services. Each admission is categorized:<br>• Category 1 indicates the Member will likely need post-discharge services.<br>• Category 2 indicates that post-discharge services are not required. | An HTC nurse approaches Category 1 Members and their family to ask questions and make a more refined judgment as to whether the Member could benefit from post-discharge Care Coordination. | An HTC nurse refers the Member to another TCCI Program based on an active discussion with the Member and family and makes a referral to this Program with the Member's consent. | The Member has completed the HTC Program when:<br>• The Member has an accepted referral to the CCM Program;<br>• The Member has an accepted referral to the CCC Program;<br>• The Member has an accepted referral to the BSD Program; or<br>• An HTC nurse confirms that the referral to one of these Programs has been completed and the receiving Program has accepted the Member. |

**Part VI, Figure 6: Methods/Rules For Reporting Status In Each TCCI Program (continued)**

| Program | Reviewed | Approached | Engaged | Completed |
|---|---|---|---|---|
| **CCM Program** | CCM receives referrals primarily from the HTC and CCC Programs or from data-triggered flags. Once a referral is received:<br>• A nurse triages the Member based on their diagnosis and assigns the Member to a specialty CCM; and<br>• A CCM assesses the information provided in the referral, consults with the Member's physician and reviews the information in the MHR. | The CCM calls the Member to:<br>• Conduct a more in-depth assessment;<br>• Describe the CCM Program to the Member; and<br>• Obtain consent to be placed in a CCM Care Plan.<br>A Member is still considered "Approached" if they are unable to be reached or declines to participate. | Following the Member's consent to participate in the CCM Program, a CCM works closely with the Member, their family and other clinicians in developing and carrying out the Member's Care Plan.<br>The Member remains "Engaged" as long as they are in an active CCM Care Plan. | The Member has completed the CCM Program when:<br>• The Member successfully meets the Care Plan goals;<br>• The Member has an accepted referral to the CCC Program;<br>• The Member voluntarily or involuntarily terminates from the Program; or<br>• The Member is no longer covered by CareFirst. |
| **CCC Program** | In the CCC, a Member is "reviewed" through the following approaches:<br>• The LCC assesses Members who are flagged on Top 50 Lists, Index Scores or Core Target list.<br>• The LCC accepts the referral of a Member from the HTC or CCM Programs; or<br>• A PCP directly identifies a Care Plan candidate. | The LCC and PCP work to schedule an appointment with the Member in order to:<br>• Conduct a more in-depth assessment;<br>• Describe the CCC Program to the Member; and<br>• Obtain written consent to be placed in a CCC Care Plan.<br>A Member is still considered "Approached" if they are unable to be reached or declines to participate. | Following the Member's consent to participate in the CCC Program, the LCC works closely with the Member and their PCP in developing and carrying out the Care Plan.<br>The Member remains "Engaged" as long as they are in an active CCC Care Plan. | The Member has completed the CCC Program when:<br>• The Member successfully meets the Care Plan goals;<br>• The Member has an accepted referral to the CCM Program;<br>• The Member voluntarily or involuntarily terminates from the Program; or<br>• The Member is no longer covered by CareFirst. |

**Part VI, Figure 6: Methods/Rules For Reporting Status In Each TCCI Program (continued)**

| Program | Reviewed | Approached | Engaged | Completed |
|---|---|---|---|---|
| **BSD Program** | A referral for the Behavioral Health and Substance Use Disorder Program (BSD) is accepted from BHTCs, LCCs or CCMs.<br><br>Behavioral Health Care Coordinator (BHCC) reviews the behavioral and medical history of all Members referred to determine if the Member is appropriate for the Program. | The Member, if appropriate, is called by a BHCC, who:<br><br>• Conducts a more in-depth assessment;<br><br>• Describes the BSD Program to the Member; and<br><br>• Obtains consent to be placed in a BSD Care Plan.<br><br>A Member is still considered "approached" if they are unable to be reached or declines to participate. | Following the Member's consent to participate in the BSD Program, the BHCC works closely with the Member, their family and other clinicians in carrying out the Care Plan.<br><br>The Member remains "Engaged" as long as they are in an active BSD Care Plan | The Member has completed the BSD Program when:<br><br>• The Member successfully meets the Care Plan goals;<br><br>• The Member voluntarily or involuntarily terminates from the Program; or<br><br>• The Member is no longer covered by CareFirst. |
| **WDM Program** | After receiving data from the Member's Health Assessment, Biometric Screening or available claims data, CareFirst assigns the Member to one of three At Risk categories and identifies any Health Condition Track(s).<br><br>Every Member CareFirst assigned in a "High Risk" or "Full Expression" category is contacted to gain consent to participate in coaching services.<br><br>A Member may also be reviewed if the WDM Program accepts the referral of a Member from CCC or CCM Programs. | The Member, if "High Risk" or at "Full Expression", is called by an Engagement Specialist, who attempts to:<br><br>• Introduce and describe the WDM Program to the Member; and<br><br>• Obtain consent to participate in coaching sessions.<br><br>A Member is still considered "Approached" if they are unable to be reached or declines to participate. | The Member is considered "Engaged" when the Member has consented and has at least one successful contact within the last 12 months from the end of the reporting period. | The Member has completed Lifestyle or Disease Management Coaching when:<br><br>• The Member graduates from the Program;<br><br>• The Member has a confirmed referral into the CCM or CCC Programs;<br><br>• The Member voluntarily or involuntarily terminates from the Program; or<br><br>• The Member is no longer covered by CareFirst. |

**Part VI, Figure 6: Methods/Rules For Reporting Status In Each TCCI Program (continued)**

| Program | Reviewed | Approached | Engaged | Completed |
|---|---|---|---|---|
| **HBS Program** | A CCM/LCC along with the Member's physician review the Member's case to determine if the Member is an appropriate candidate for the Home-Based Services Program (HBS)<br><br>If the Member is an appropriate candidate, a referral is sent to a preferred home health agency in the region where the Member lives. | A selected home health agency contacts the Member to:<br><br>• Obtain consent in order to receive Home-Based Services, and<br><br>• Schedule a visit to complete a home care assessment.<br><br>A Member is still considered "Approached" if they are unable to be reached or declines to participate. | Following the Member's consent to a HBS Plan, a Member is "Engaged" as long as they remain in compliance with the HBS Plan. | The Member has completed the HBS Program when:<br><br>• The Member successfully meets the HBS plan goals;<br><br>• The Member voluntary or involuntary terminates from the Program; or<br><br>• The Member is no longer covered by CareFirst. |
| **EMP Program** | A CCM/LCC along with the Member's physician review the Member's case to determine whether enhanced Home-Based monitoring is needed.<br><br>If the Member is an appropriate candidate, a referral is sent to the EMP Program. | The Member is contacted by a CCM/LLC who:<br><br>• Describes the EMP Program to the Member; and<br><br>• Obtains consent to be placed in the EMP Program<br><br>A Member is still considered "Approached" if they are unable to be reached or declines to participate. | Following the Member's consent to enhanced monitoring services, a monitoring device is delivered and activated at the Member's home.<br><br>The Member remains "Engaged" as long as they remain in compliance with the enhanced monitoring plan. | The Member has completed the EMP Program when:<br><br>• The Member reaches a sufficiently improved state of stability;<br><br>• The Member voluntary or involuntary terminates from the Program; or<br><br>• The Member is no longer covered by CareFirst. |

**Part VI, Figure 6: Methods/Rules For Reporting Status In Each TCCI Program (continued)**

| Program | Reviewed | Approached | Engaged | Completed |
|---|---|---|---|---|
| **RxP Program (CMR Element #5)** | A CCM/LCC reviews the Member's health record to determine whether the Member could benefit from a Comprehensive Medication Review ("CMR") by a pharmacist.<br><br>If appropriate, a referral is sent to the CMR Program. | N/A | A CMR Program pharmacist contacts one or more parties (the Member or prescribing physicians) involved in the CMR to complete the review and make recommendations. | The Member has completed the CMR Program when:<br><br>• Recommendations have been made to prescribers, and<br><br>• The Member is notified of their recommendations. |
| **ECP Program** | A CCM/LCC and Medical Director review the Member's case, along with the Member's PCP.<br><br>If the Member would benefit from an expert consultation on a complex medical situation, a referral is sent to the ECP Program. | The Member is contacted by the CCM/LLC who introduces and describes the ECP Program and prepares the Member for contact by ECP Program partner, Best Doctors. | Best Doctors contacts the Member and the Member's treating physicians to seek their assessment of the Member's medical situation. | The Member has completed the ECP Program when:<br><br>• Best Doctors provides an Expert Consult Report to both the Member and their treating physicians. |

**Reporting on TCCI Program Array**

In the TCCI reporting sections of the HealthCheck Report, the volumes of Members in each TCCI Program during a performance year in each status category is displayed on a Year-to-Date basis. Taken as a whole across all TCCI Programs, this affords a complete picture of how many Members are – or have been – in a TCCI Program out of a Panel's total population of attributed Members, or who have been reviewed and approached for these Programs. This gives an overview of the degree to which TCCI Programs are being used to coordinate the care of a Panel's attributed membership.

## Summary And Overview Of The TCCI Program Array

Once an assessment of a Member's need is established that indicates the Member could benefit from Care Coordination through one or more TCCI Programs, a request is made by an LCC, CCM or BHCC through the Service Request Hub. This triggers entry into one or more of 20 different Programs that comprise the larger TCCI Program so that needed capabilities and services can be brought to bear in meeting Member needs. Each TCCI Program is briefly summarized below:

1. **Health Promotion, Wellness and Disease Management Services Program ("WDM")** consists of Lifestyle and Disease Management coaching by licensed professional coaches who are expert in motivating people toward healthier lifestyles and reducing risk if they are headed towards or already have certain common chronic diseases. Also, included in this program is a Health Assessment – with and without biometric screening - that reveals one's overall health and wellbeing as well as the changes in this over time – not only for each individual, but for an employer group as a whole. A broad array of supporting programs on fitness, smoking cessation and other health promotion activities is available as is a rich online set of resources and information to Members that support their wellness and Disease Management efforts.

2. **Hospital Transition of Care Program ("HTC")** monitors admissions of CareFirst Members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC Program assesses Member need upon admission and during a hospital stay with a focus on post discharge needs. It begins the Care Plan process for Members who will be placed in the CCM or CCC Program. The HTC process also categorizes Members based on the level of their severity of need and the nature of their illness or condition so that they can be placed in the best possible "track" for follow-up Care Coordination services and flags cases that will likely result in high cost to ensure they receive the attention they need.

3. **Complex Case Management Program ("CCM")** offers Care Plans for Members with advanced or critical illnesses. These Members are typically being cared for by specialists. CareFirst Specialty Case Managers provide Care Coordination services in concert with the various specialists involved. Case management services most often follow a hospitalization. The HTC is typically the entry point for Members into Case Management prior to discharge. All Specialty Case Managers are registered nurses with substantial experience in their respective specialties.

4. **Chronic Care Coordination Program ("CCC")** offers Care Plans to targeted Members that are developed under the direction of the PCP. This Program provides coordination of care for Members with multiple chronic illnesses. While Care Plans often result from a case management episode, they can also result from a review of the trailing 12 months of healthcare use by an attributed Member who is identified as likely to benefit from a Care Plan. Care Coordination for these Members is carried out through the LCC, a registered nurse who is assigned to each provider/practice within a Panel. The LCC assists the PCP in coordinating all Elements of the Member's healthcare and ensures all action steps in the plan are followed up and carried out.

5. **Behavioral Health and Substance Use Disorder Program ("BSD")** includes a range of services that deal with the Behavioral Health needs of Members (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program Category are substance abuse services as well as psycho-social services.

6. **Home-Based Services Program ("HBS")** serves Members in CCM or CCC who often need considerable support at home, sometimes on a prolonged basis. These services can include home health aide, psycho-social services and other Behavioral Health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following an assessment of the home situation by a registered nurse Home Care Coordinator (HCC) and become part of the overall plan of care maintained by the LCC or Case Manager responsible for the Member. HBS are often critical to avoiding the cycle of breakdown (admission, readmission) that commonly occurs with Members who have multiple chronic diseases. Only Members specifically referred to the Home-Based Care Coordination Program through the CCM and CCC Programs are eligible for full assessment and integrated Home-Based Services pursuant to a Care Plan. A preferred list of home care agencies is used in the provision of services within the HBS Program.

7. **Enhanced Monitoring Program ("EMP")** focuses on those Members at high risk for disease progression to more advanced or serious illness. The EMP uses prescription drug and other data to identify Members that have patterns

of illness that suggest incipient high risk for progression or have chronic conditions already that need active monitoring to ensure Member stability. EMP services are provided at home or in the work setting using mobile and digital capabilities that send a stream of data to a central monitoring station staffed by specially qualified nurses. The EMP Program issues alerts to PCPs as necessary.

8. **Community-Based Programs ("CBP")** is a compendium of local Programs that have been reviewed and selected in advance by CareFirst to be made available to Members with identified needs that could benefit from such Programs. These selected programs are created in collaboration with specifically contracted Providers on an ongoing basis and typically reflect improvements in organization of care within existing benefits that are linked to other TCCI Programs to enable Care Coordination and reporting. Examples include, but are not limited to, programs to better manage diabetes and congestive heart failure, as well as improved processes for supporting Members in need of skilled nursing facility care or palliative care/hospice care.

9. **Network Within Network Program ("NWN")** is a program that refers Members to preferred, high-value providers in a variety of specialties. While many insurers have embraced the "narrow network" strategy, the NWN Program was created in lieu of narrow networks, which often restrict Members' choice. The NWN Program seeks to direct Members under the direction of their PCPs to a subset of preselected ancillary and speciality providers who are particularly effective without locking in either the Member or the PCP to a compulsory choice of these providers.

10. **Pharmacy Coordination Program ("RxP")** is a program available for Members with pharmacy benefits as part of their coverage plan. This includes management of retail and wholesale pharmacy benefits, including formulary management as well as specialty pharmacy benefits for certain disease states (such as hepatitis C, rheumatoid arthritis, and multiple sclerosis) that require high-cost pharmaceuticals that must be administered according to rigorous treatment plans. The RxP program consists of five key elements including obtaining the best possible ingredient cost pricing for generic and brand drugs, optimum formulary design and administration, specialty pharmacy preauthorization and case management, analysis of drug therapy problems and identification of Members taking drugs for Behavioral Health purposes.

11. **Expert Consult Program ("ECP")** allows network physicians or CareFirst to seek an outside expert opinion from leading, recognized medical experts when this is needed for highly complex cases. Through this Program, CareFirst has access to the top physicians in the nation in every specialty and sub-specialty category, organized by disease state. Cases referred to this program from CCM and CCC after CareFirst Medical Director review are complex, expensive and have the characteristic that diagnosis and treatment have not been complete, accurate or effective up to the point of referral. Recommendations are made in each case by the expert reviewers that are almost always followed by treating providers resulting in lower overall cost due to fewer Member breakdowns or inappropriate treatments.

12. **Urgent and Convenience Care Access Program ("UCA")** offers organized back up for PCPs to support Members with urgent care needs that might otherwise go to a hospital based Emergency Department ("ED") or outpatient facility. Generally, the costs are one-third of what they would otherwise have been had these services been provided in a hospital ER.

13. **Centers of Distinction Program ("CDP")** is a TCCI Program focused on highly specialized, high cost categories of hospital care. Hospitals that demonstrate expertise in delivering quality specialty care in these high volume/impact specialty areas are designated by the Blue Cross Blue Shield Association as Blue Distinction Centers ("BDCs").

14. **Preauthorization Program ("PRE")** provides a review of certain proposed services to Members that are usually infrequent but that are high cost and where evidence of medical need must be established before approval for payment is given. Examples include high cost specialty drugs and certain durable medical equipment and medical procedures such as transplants.

15. **Telemedicine Program ("TMP")** offers the integration of voice, data and image to create a "Video Visit" to a provider for a Member. Through "Video Visit", the Program also enables a specialty consult for a Member or PCP in certain cases where this is more responsive than an in-person visit. TMP also applies in cases where an off-hours visit to a Member's PCP is not readily available.

16. **Dental-Medical Health Program ("DMH")** recognizes dental care is an important part of overall health. This Program is designed to enable and encourage appropriate dental care as determined by the Member's treating dentist and to integrate the Member's dental health into their overall health profile.

17. **Detecting and Resolving Fraud, Waste and Abuse ("FWA")** is a TCCI Program that detects – based on claim patterns – areas of abuse or outright fraudulent billing. There is an underlying heavy reliance on data mining and analytics to identify these patterns, which is derived from the same data warehouse that is used for SearchLight Reporting. This data warehouse is extremely comprehensive including all claims for all services ever rendered by any provider to any Member over a multi-year period. Once fraud or abuse is shown, this Program initiates recoupment yielding an 8:1 savings for every dollar spent.

18. **Administrative Efficiency and Accuracy Program ("AEA")** is a TCCI Program that provides both the means and incentives to providers to maintain accurate and timely information for credentialing and payment purposes as well as for inclusion in the CareFirst provider directory.

19. **Precision Health Program ("PHP")** is a TCCI Program that connects Members to treatment and prevention that takes into account the individual genetic variability in each person. This Program allows providers to predict more accurately which treatment and prevention strategies for a particular disease will work for a specific Member. Some elements of this Program require preauthorization.

20. **Healthworx: Innovations in Care Quality and Outcomes Program ("HWX")** is a TCCI Program aimed at developing strategic partnerships with emerging healthcare companies that have products and/or services that can improve the health and well-being of CareFirst Member while reducing the total cost of care but that are not yet in widespread use.

**Continuous Tracking of TCCI Programs**

All Programs used in support of a specific Member are tracked and shown in the PCMH and Account SearchLight Reports. Included in this tracking is a pre- and post-view of the Member's claims experience in order to assess the degree to which the Program(s) are working to improve care to the Member and reduce breakdowns that may involve expensive hospital based services.

It should be noted that Care Coordination fees and the costs of TCCI Programs are charged to each Panel's Patient Care Account ("PCA"). Typically, the reduction in care costs resulting from these Programs far outweighs any Debits, which average two to three percent of allowed care costs. See **Appendix N** for a more complete understanding of how TCCI fees are included as Debits in the PCAs of Panels.

In the pages that follow in this **Part VI**, each of the 20 TCCI Programs is more fully described and relevant data applicable is presented.

# DETAILED PROGRAM DESCRIPTIONS

# OF

# TCCI PROGRAM ARRAY

## Program #1: Health Promotion, Wellness and Disease Management Services Program ("WDM")

### Preface

The burden imposed by chronic disease on society is driven by a relatively small set of medical conditions and risk factors, each of which often can be preventable. The 15 most costly chronic conditions shown in **Figure 7** below[2] account for more than 80 percent of the total cost of all chronic illnesses:

**Part VI, Figure 7: Top 15 Costly Chronic Conditions**

| | | | | |
|---|---|---|---|---|
| **Diabetes** | **Chronic Obstructive Pulmonary Disease (COPD)** | **Asthma** | **Arthritis** | **Hypertension** |
| **Obesity** | **Coronary Artery Disease (CAD)** | **Cancer** | **Back Pain** | **Chronic Kidney Disease** |
| **Dyslipidemia** | **Heart Failure** | **Sinusitis** | **Allergies** | **Depression** |

Unhealthy lifestyle behaviors – such as a lack of exercise, poor nutrition and smoking – lead to most of the consequences and costs linked to chronic diseases and conditions.[3] Chronic conditions often occur in combination with one another after developing over an extended period. They create a cause and effect pattern that systematically undermines health, while contributing to the high cost of health care through demand for prescription drugs, ER visits, and hospital stays.

CareFirst's analysis of over multiple decades of Member claims data shows that there are often predictive signs of chronic conditions that occur early in life - well before full manifestation is obvious. CareFirst's analysis further shows such individuals incur significantly more cost once they reach the full manifestation of one or more chronic conditions.

Research shows that without a change in behavior, a significant percentage of patients in the initial stages of chronic disease will proceed toward full manifestation in the future. For example, the Centers for Disease Control and Prevention (CDC) indicate that people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing Type 2 diabetes by as much as 58 percent.[4]

The TCCI Program Array, in general, focuses the most resources on the Core Target population (approximately the top two to three percent of sickest Members), who use a high degree of resources and account for nearly 40 percent of total healthcare spending. The WDM Program is designed to help Members stay well and to slow the rate of disease progression in those that are headed – or already have – one or more chronic conditions.

**Overview of the CareFirst Wellness and Disease Management Program**

To further the TCCI Program's goals, the Wellness and Disease Management (WDM) Program has two main objectives.

**First**, the WDM Program seeks to actively engage all Members - particularly the majority of Members who are healthy - through easily accessible, consumer-focused modalities to encourage healthy lifestyles as an ongoing matter.

**Second**, to better identify those Members who have incipient conditions that will destabilize their health down the road and, therefore, set up likely costly breakdowns in the future. This enables interventions before breakdown.

The WDM Program focuses on data from multiple sources, including comprehensive health assessments, biometric screenings, claims and informational resources readily available online to stratify Members based on their current level of health needs and target the most appropriate services to them.

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[2] *The New Discipline of Workplace Wellness, Enhancing Corporate Performance by Tackling Chronic Disease; World Economic Forum, 2010.*

[3] *Centers for Disease Control and Prevention: Chronic Disease Prevention and Health Promotion 2016. https://www.cdc.gov/chronicdisease/overview/*

[4] *Centers for Disease Control and Prevention Diabetes At A Glance 2016. www. cdc.gov/chronic disease/resources/publications/aag/diabetes/htm*

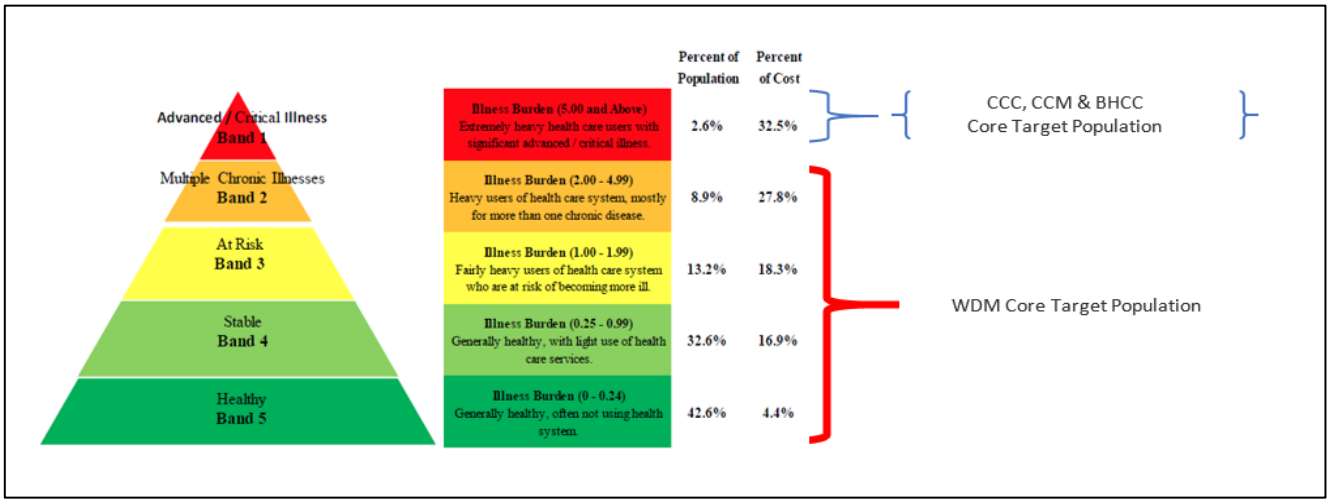
**Figure 8** compares the PMPM cost of someone in the initial stages of disease versus someone who has the full expression of disease. The increased costs are generated as the patient begins to require an increased level of clinical intervention to prevent critical breakdowns or to deal with other manifestations of their condition(s).

**Part VI, Figure 8: Cost Of Selected Conditions**

| HEALTH CONDITION | Average Condition Cost Per Member | | Average Total Cost Per Member | |
|---|---|---|---|---|
| | Initial Year Cost | 3-Year Cumulative Cost | Initial Year Cost | 3-Year Cumulative Cost |
| Overweight and Obesity | $2,489 | $8,322 | $4,623 | $21,636 |
| Cardiovascular Disease | $5,518 | $10,341 | $8,881 | $22,567 |
| COPD | $2,580 | $7,991 | $6,988 | $26,772 |
| Diabetes | $823 | $4,273 | $2,212 | $14,572 |
| Hypertension | $1,034 | $1,943 | $2,759 | $10,396 |
| Cancers | $17,401 | $27,636 | $22,280 | $42,886 |
| Renal Function Failure | $10,709 | $82,779 | $22,028 | $127,679 |
| Osteoarthritis | $3,970 | $11,656 | $6,339 | $25,461 |
| Depression | $1,413 | $3,659 | $2,864 | $10,749 |

The WDM Program offers three ways to reach and serve Members wherever they are in the Illness Burden Pyramid shown below:

**Part VI, Figure 9: Targeted And Personalized Services To Members Across The Risk Stratification Continuum**




- ***Self-Directed Care***: Most Members are healthy and in Bands 4 and 5 (75 percent of Members). The WDM Program focuses on providing these Members access to an engagement platform that is available through any computer, tablet or smartphone and that connects to wearable devices and smart clothing in order to facilitate and foster Member engagement in their health in the way that best suits their individualized needs. Fully engaged Members tend to be proactive about improving their health.

- ***Coach-Directed Care:*** A smaller number (20 percent) of Members are in Bands 2 and 3 and have begun to display signs of the development of a chronic disease or already have a disease and are not effectively managing it. The WDM Program offers these Members wellness and disease management coaches to provide one-on-one support and targeted interventions to help manage their condition and direct them toward improved health.

- ***Clinical Intervention Through the TCCI Program***: The smallest percentage of all Members are in upper Band 2 and are already unstable or experiencing a breakdown in their health. These few Members need more targeted, clinical interventions – often as part of a TCCI Care Plan, with coordinated clinical program support.

All data and interactions in the WDM Program are arranged through iCentric, CareFirst's proprietary technology platform. iCentric serves as the hub for population management and referrals in concert with the WDM engagement platform that provides all the tools for Members to engage in and improve their health.

**Getting Started - Annual Health Assessments - RealAge - Biometric Data - Baseline**

The WDM Program emphasizes personalized feedback and insights predicated on initial and ongoing assessments, for all Members age 18 and older. This promotes Member awareness of their health status and helps find the best path for their engagement in health promotion.

Individual awareness of health status and risks is one of the strongest factors affecting the likelihood of behavioral and lifestyle change. Studies show that those who complete a health assessment are more likely to improve their overall health status. A 2009 study from the American College of Occupational and Environmental Medicine showed that over a three-year period, those who completed a health assessment improved their overall health status[5] and experienced a decrease in high-risk health factors as well as an increase in favorable factors. In fact, those who completed more than one assessment over the three-year period showed an even greater degree of favorable change.

CareFirst uses the RealAge™ (RealAge) health assessment and biometric screening survey to promote individual awareness and measurement of a Member's health. The RealAge test is a clinically validated health risk assessment that is delivered online and provides personalized results to inform Members of their physiological age – a measure of how well their bodies are functioning relative to their actual calendar age.

The test was developed using 640 studies on independent predictors of mortality, and examines up to 125 impactors related to an individual's overall health, including purpose, social, financial, community and physical factors. The test's questions cover a wide-spectrum of the degrees of wellness, ranging from how often people eat fish versus red meat too often, exercise and what their sleep habits are. It also seeks information on asthma, smoking, aspirin use, cancer history, parental longevity, and conditions such as high blood pressure and diabetes. The RealAge test is available on the web (desktop and mobile) and native mobile applications for iOS and Android.

Professionally-collected biometric screenings, which include basic measurements such as weight, Body Mass Index (BMI), cholesterol, blood pressure, nicotine, and blood glucose levels, are also critical to the assessment process. Depending on the measure, the accuracy level of self-reported data can be as low as 50 to 65 percent. Without an accurate starting point, tracking is less effective, and the Member does not engage in the behavior change needed to improve their health as often or persistently.

Biometric screenings may be conducted at the employer worksite, a convenience care site or through a visit to the Member's Primary Care Provider (PCP). Generally, the participation rate is higher if worksite screening is made available.

To ensure that a Member's RealAge paints an accurate picture of their health and well-being, the WDM Program dynamically updates a Member's RealAge assessment by integrating biometric screening data, eligibility data, medical claims, pharmacy claims, self-reported and monitored activity, and lab values throughout the year. Instead of a once a year event, RealAge can be updated via mobile phone or other device, keeping Members engaged through a personalized experience and involved in their health outcomes. At the same time, the WDM Program sends RealAge data to each Member's PCP to foster timely and appropriate intervention. All data is stored in the MHR in iCentric.

***Risk Stratification – A Key to Finding Members at Different Levels of Health Status***

In conjunction with the RealAge assessment and biometric screenings, the WDM Program stratifies Members based on their claims record that indicates their Illness Burden Score ("IBS"). This helps deliver individualized information to the Members

[5] *Pai,C.W.; Hagen, S.E.; Bender, J.; Shoemaker, D.; Edington, D.W. Effect of Health Risk Appraisal Frequency on Change in Health Status. Journal of Occupational and Environmental Medicine 51(4):429-434, April, 2009.*

most in need of support to avoid future breakdowns. It also helps determine which of the three modes of WDM Program intervention – Self, Coach or Clinically Directed – is best for the Member. Presenting Members with a picture of their health does not prevent Members from developing one of the 15 costliest health conditions but can inhibit onset due to greater attention by the Member to their health status.

In order to make an initial determination of which Program intervention mode is best suited to a Member, the WDM Program assigns each Member to one of the three categories below:

**Part VI, Figure 10: Risk Stratification Of CareFirst Members**

| |
|---|
| **1. Low-Risk** – These Members are generally healthy and exhibit a low-risk for developing a preventable chronic condition. They have an Illness Burden Scores (IBS) equal to 0.99 or below (75 percent of population)<br>. |
| **2. High-Risk** – These Members have a high-risk for developing a preventable disease related to one or more of the lifestyle habits, but do not yet have the disease or condition. For high-risk Members, early identification of their health track is important to proactively address any underlying risk factors and behaviors and slow or stop progression toward disease.<br>• Obesity • Metabolic Cluster • Kidney Disease<br>• COPD • Diabetes • Mental Health Cluster<br>• Hypertension • Preventable Cancers • Cardiovascular Disease<br>• Musculoskeletal Cluster • • |
| **3. Full Expression --** These Members already have the full expression of one or more of the following chronic conditions:<br>• Asthma • Diabetes • Atrial Fibrillation<br>• COPD • Coronary Artery Disease • Osteoarthritis<br>• Heart Failure • Chronic Low Back Pain • Fibromyalgia<br>• Irritable Bowel Syndrome |

Clinical instability is one of the key differentiators that influences which of the various interventions are selected for Members. Members who may be at Low or High-Risk for a chronic condition but are maintaining their health or managing their behavior need different resources and services than Members who are Low or High-Risk and tending towards instability or have the Full Expression of a condition and are unstable.

A Member who is at risk for developing a chronic condition will be considered High Risk if they are tending towards instability and have one or more of the following factors:

- Obesity
- Current tobacco usage
- IBS of 1.0 or higher

A Member who has the Full Expression of a condition will be considered tending towards instability if the Member also has one or more of the following factors (not an inclusive list):

- IBS $\geq$ 4
- Has patterns of disease progression
- Presents multiple risk factors and/or is unstable or prone to break down and whose condition is expected to worsen
- Has serious emerging conditions or diagnosis that may have recently or suddenly appeared and are not yet reflected in their IBS but, without intervention, are likely to experience breakdown and incur high levels of medical cost

Once the WDM Program has stratified each Member as Low Risk, High Risk or Full Expression, it makes the most appropriate and cost-effective method of intervention available to each Member.

**Self-Directed Care**

Members categorized as Stable or Low-Risk are typically looking for convenient access to services, tools, and information they need, whether through a mobile application, online trackers, or by participating in onsite workplace wellness services. Alternatively, Members who are High-Risk or have the Full Expression of a condition but are, nevertheless, stable - such as a diabetic Member who is managing their diabetes - benefit from easy access to information, feedback and digital services tailored to their condition in order to maintain their health.

The WDM platform is accessible from any computer, tablet or smartphone but mobile application is the most readily used by Members.

After Members complete their registration process (including consent) and identify their preferred method of contact (telephonic, email, text, or in-app), they are able to download the mobile application and access their health status and related information 24 hours a day. Consent for electronic communication – as required by law – is a necessary pre-condition.

The information collected about a Member's RealAge, combined with clinical information from claims and lab data, enables the WDM engagement platform to create a personalized profile for each CareFirst Member. This profile is constantly updated, based on self-reported data (such as interactions with online programs and content, synced wearable devices, answers from quizzes and search criteria) and professionally collected data (captured from biometric health screenings, claims) in order to provide each Member with the most up-to-date and clinically appropriate resources applicable to their health status and/or issues.

Hence, once Members are logged into the WDM engagement platform, they will see content and programs specific to their needs. For a stable diabetic this can range from messaging focused on nutrition advice and recipes to prompt to test, record and upload their glucose as part of their ongoing management. A Member who is obese and looking for weight management help can be presented content about various diets to connect to a fitness tracker. These personalized tools and resources are further outlined in **Figure 11.**

**Part VI, Figure 11: WDM Tools And Resources Available To All Members**

| Health Consultations | Health Guides and Articles |
|---|---|
| **Interactive quizzes on over 50 major medical** | Daily, weekly and/or monthly trackers in key areas – |
| **Health challenges to focus on specific behaviors** | Healthy recipes |
| **Links to organizations supporting healthy** | Interactive and HIPPA compliant messaging |
| **Identifying possible causes behind symptoms** | Tips and guides for preparing for a provider |
| **Guidance for managing a condition or symptom** | |

In effect, the Member is connected to a world of resources and information that is available online in a manner tailored to their needs and that allows continuous refinement, tracking and assessment as they progress (or not) toward improving or maintaining their health.

Additionally, the updated contact information and communications preferences that Members completed during registration allows CareFirst to send targeted communications via the engagement platform for various behavior change messaging. For example: Members who have not had a preventive screening could receive an email or in-app message, Members receiving costly specialty infusion treatments in a hospital setting could receive a text message about alternative options, or Members could be pushed information about the location of the nearest convenience care center after they search "ear infection" on the platform to avoid costly Emergency Room visits.

Members can also take advantage of the various wellness programs to directly address their individual health conditions, including a Tobacco Cessation Program, a Weight Management Program, and a Diabetic Education Program.
Incentives (further described below) can be incorporated into the Members' medical benefit plan or an employer's wellness program to encourage Members to take charge of and maintain their health and engage in the various available resources and TCCI Programs. Through the mobile application, Members can be prompted with personalized messages and alerts to remind them to complete the necessary steps to earn their incentives and better engage in improving their health.

In this manner, the WDM Program provides all Members with numerous resources through multiple channels that can be used at their discretion to help them gain a better understanding of their health and improve their lifestyle.

**Coach-Directed Care**

For Members tending towards instability, the WDM Program provides lifestyle management and disease management coaches.

- **Lifestyle Management Coaching** is targeted to Members who are High-Risk and tending towards instability, but have not yet experienced the full onset of chronic disease. This coaching seeks to improve Members' risk by addressing unhealthy behaviors that can lead to serious illness through the management of underlying behavioral factors associated with the condition.

  Lifestyle management coaching is conducted by trained behavioral health coaches who work with the Member to make incremental lifestyle modifications to reduce the chance of developing preventable disease. Lifestyle management coaches have - at a minimum - an undergraduate degree in a health-related field and, on average, two to five years coaching experience. Many of these coaches hold licenses and certifications, including Certified Health Education Specialist and Registered Dietician.

- **Disease Management Coaching** is targeted for Members who already have the Full Expression of one or more chronic conditions and are tending towards instability, and focuses on the clinical management of these disease condition(s). The coaching is conducted by specially trained and licensed registered nurses. The coach works with the Members to mitigate the progression of the disease and lessen the impact of their condition(s) on their quality of life. The Program emphasizes monitoring and adherence to recommended treatment plans as well as self-care strategies.

  Disease management coaches are registered nurses with a bachelor's degree in nursing preferred, three to five years of related experience in a clinical health care setting and appropriate licensure and certification depending upon position (respiratory therapist, etc.). The credentialing process, which recurs every two years, includes primary source verification of licenses and/or registrations, national practitioner database querying, and a peer-review process.

The goal of Lifestyle and Disease Management Coaching is to engage Members in activities and programs designed to slow or stop the deterioration of their health. Through coaching, Members are encouraged to take charge of their health and are encouraged/educated in avoiding related potential problems as well as preventing an exacerbation - or worsening - of their current health condition(s).

Coaches outreach to Members within fourteen days of receiving information from the WDM Program to ensure that coaching can begin quickly to avoid their further health deterioration and put them on the right path for improving their health. Outreach is performed using multiple modalities, but phone-based outreach is a priority for unstable Members.

For the convenience of Members, all telephonic coaching is offered Monday through Friday 8:30 a.m. to 8:30 p.m. EST and Saturday 8:30 a.m. to 5:30 p.m. EST. The coach makes five attempts within the first two-week period via phone and secure messaging, and one attempt via mail to initially engage a Member. A "no call list" is maintained for Members who have refused all WDM services and/or other CareFirst TCCI Programs. This refusal remains in effect for the individual Member unless revoked by the Member from the mobile phone platform used by the Program.

If a Member is identified for both Lifestyle and Disease Management Coaching, the Disease Management Coach is trained to provide both categories of service to the Member to avoid confusion that might arise from multiple points of outreach. If a Member is already engaged with a LCC as part of an active Care Plan or a Complex Case Manager as part of a CCM plan, the coach will not outreach to the Member unless requested by the LCC.

A one-on-one model is used for all coaching. This connects each Member with a primary coach for the duration that fits the Member's need. Experience has shown that this primary coach model fosters a trusting and collaborative relationship between coach and Member and accelerates behavior change. Coach assignment takes into consideration a combination of Member health needs, goals, preferences and availability. While most Members communicate exclusively with their primary coach, the model accommodates referrals to engage additional experts when appropriate.

Once the Member has consented, the assigned coach evaluates the Member's health/conditions, reviews the individual's readiness to change the behaviors that are causing risk, and develops/adjusts the individual's plan. The coach and Member collaboratively establish goals that are aligned to targeted health behaviors, supported by action steps.

Coaching is based on initial high intensity contact frequency that allows the coach to build rapport, assess specific needs and collaboratively set goals with the Member. To ensure continuous Program engagement, coaching includes frequent touch points allowing the Member to choose the modality that most appeals to them. This allows interaction over the channel that is most conducive to the Member's lifestyle and lends itself to sustained engagement.

**Special/Focused Programs**

Coaches can refer Members directly to the focused/specialized Programs listed below via the Service Request Hub. A Member may continue to participate in WDM coaching while participating in these Programs, thereby allowing coordinated supports for a Member to address their individual health needs and avoid future breakdowns. The three specialized programs available are:

- **Diabetes Management Program –** This program is available to newly diagnosed Members with diabetes who require extensive education regarding their care or Members whose diabetes is unmanaged, as evidenced, by recent HbA1c results >8; and

- **Tobacco Cessation Program –** This program is available to Members who have a positive indicator of current tobacco use; and

- **Healthier Weight Program –** This program is available to Members who have a BMI $\geq$ 30 .

For each directed support, the Member may decide, at any time, what they want their contact cadence to be. This allows coaching to be adjusted accordingly. During the first two months of the Program, coaches and Members interact more frequently, with an average of at least one contact every two weeks. As the Member begins to work on goals and demonstrate progress through action step completion and make other measurable health improvements, contact frequency decreases. Members then transition from the intensive intervention phase to a moderate intervention phase (with an average of at least one contact every four to six weeks). Coaches continue to reinforce positive developing behaviors and correlate changes to positive health outcomes.

Every three months, the WDM Coach reassesses the Member's progress and collaborates with the Member to determine the most appropriate interaction schedule for the upcoming three-month period. Depending on the Member's confidence and health needs, the Member and coach decide together if the Member will continue with the Program at the same or modified outreach cadence, or transition to a personalized digital-only, more self-directed experience.

The WDM Coach documents the Member's progression by logging and teaching the Member to log key health metrics, goals and progress measures as well as lifestyle behavior changes. This data is transmitted daily to the iCentric-based MHR of the Member from the mobile phone platform used by the Program.

***Tobacco Cessation Program***

Once a Member either self-refers or is identified to participate in tobacco cessation and the Member has chosen to participate in coaching a WDM Coach specialized in tobacco cessation is assigned to outreach to the Member within three business days of receipt of the service request to obtain consent, discuss their goals and set up a follow-up session, which may be a phone call or messaging protocol with a coach.

Participants are assigned a single coach for the duration of their relationship with the Program. This enables the coach and the Member to build the trust that often provides additional insight into triggers or obstacles that can potentially lead to relapse. The coaching protocol is built around five coaching sessions scheduled at strategic intervals within the quit process, with a high frequency contact cadence to concentrate interactions around the quit date and common relapse points; active coaching program participation is typically 60 days.

Alternatively, a face-to-face Tobacco Cessation Program is available for Members who are referred by a LCC. This is initiated

through the Service Request Hub in iCentric and uses **CVS Minute Clinic** as the delivery vehicle for in person coaching/support.

Finally, a digital, self-directed option is available in addition to expert coaching support. The Member has access to multiple online tools to assist with their cessation needs such as:

- Online access to social community of others who are participating in the Program (peer-to-peer interaction);
- Taking the daily pledge to "join the chain" of quitters by pledging daily not to smoke;
- Quit tips texts and personalized emails at the Members request; and
- Step-by-step workbook.

***Healthier Weight Program***

More than two-thirds of the adults in the United States are overweight or obese. This alarming trend also carries an increased possibility of obesity-related health issues including high blood pressure, Type 2 diabetes, heart disease, and stroke.[6] This Program is a highly personalized Program for long-term weight loss developed in part by Johns Hopkins Medicine, one of the world's leaders in weight management research. The Healthier Weight Program helps people reach a healthier weight through gradual lifestyle changes that become lifelong habits.

For Members with a BMI of 30 or greater, personalized weight loss coaching is provided by weight loss coaches who are certified in adult weight management and have experience working on behavior change with individuals or groups. The one-on-one coaching model builds effective personal relationships through frequent communication both by phone and digital interaction.

Coaches encourage Members to have ongoing communication with their doctor. A shareable physician report makes it easy for Members to discuss plans and progress with their doctors. Members can receive two years of one-on-one coaching consisting of weight-loss guidance and ongoing maintenance support.

The Program's primary goal is to achieve a clinically meaningful reduction in weight of five to 10 percent from baseline at seven months and maintenance of this weight loss at 24 months. Individual participants are encouraged to lose as much weight as they can, provided they lose at a safe rate (an average of one to two pounds per week) and do not reduce below a BMI of 21 kg/m2 (normal weight).

Members participate in weight loss coaching sessions once per week for the first 12 weeks, then once per month for the rest of the program year. A second optional year is offered to members to help focus on sustaining weight loss long-term. Coaching sessions often transition to every six to eight weeks during year 2. Members review an online learning focus each week to help master proven skills and strategies for success related to eating, activity, and other habits. Their progress is tracked using online/mobile trackers for weight, activity, and food. Other online resources help keep them on track such as the anonymous online Member community, articles, recipes, and flexible meal plans.

***Diabetes Management Program***

According to the American Diabetes Association, more than 30 million (9.4 percent) of Americans have diabetes, with nearly 1.5 million Americans diagnosed with diabetes every year.[7] Strikingly, 24 percent of those with diabetes are undiagnosed.[8] In the CareFirst population, 200,000 Members have diabetes with as many as 50,000 additional Members undiagnosed. If trends persist, by the year 2050, one in three Americans will suffer from diabetes.[9]

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[6] *"Understanding the American Obesity Epidemic," http://www.heart.org/HEARTORG/HealthyLiving/WeightManagement/Obesity/Understanding-the-American- Obesity-Epidemic_UCM_461650_Article.jsp#.V9hJG_5TFaQ, accessed September 13, 2016.*

[7] *"Statistics About Diabetes." American Diabetes Association, 12 Dec 2016. http://www.diabetes.org/diabetes-basics/statistics/?loc=db-slabnav*

[8] *"Statistics About Diabetes." American Diabetes Association, 12 Dec 2016. http://www.diabetes.org/diabetes-basics/statistics/?loc=db-slabnav*

[9] *John Anderson et al. "How Proven Primary Prevention Can Stop Diabetes." Clinical Diabetes 2012 April, no. 2, 76, 76.*

The Diabetes Management Program is a specialized, intensive intervention, that delivers Diabetes Management Program directly to the Member in a virtual setting over three to six months. Members are paired with a highly qualified Certified Diabetic Educator (CDE) who remains dedicated to the Member throughout the Program and teaches them how to manage and control their disease with an emphasis on medication adherence, nutrition, and exercise. Coaching is reinforced through the offering of a diabetes self-management mobile application that provides blood sugar tracking capabilities and is provided during the intervention as well as for six months following graduation.

The service is intended for Members whose diabetes is uncontrolled or who are newly diagnosed. While referred Members are best identified by the clinical judgment of their doctor, typically, members entering the Program will either be those with an A1c of 8 or higher (uncontrolled) or someone who was recently diagnosed with diabetes. This population ranges from those at an early state of the disease to those who have a more complicated stage of the disease and may be in care coordination.

**Clinical Interventions Through More Advanced TCCI Programs**

Between five and 10 percent of Members have at least one complex illness that may require a more intensive clinical intervention. WDM Coaches are trained and knowledgeable about the TCCI Program Array and may recommend Members tending towards instability for one or more TCCI Programs.

A WDM Coach makes a referral to these more advanced TCCI Programs through the Service Request Hub. Generally, a Member must exhibit one or more instability factors that are shown in **Figure 12** for a Coach to refer them to a TCCI Program**.**

**Part VI, Figure 12: Member Conditions That Must Be Present For A WDM Coach To Recommend A Member To Engage In The TCCI Program Array**

| Instability Based on Medical Status | Instability Based on Medications or Behavioral Health Status | Instability Based on High-Risk Encounters or Conditions |
|---|---|---|
| Multiple co-morbid conditions and complex cases for conditions not covered through WDM Program | Medication non-adherence (may include non-adherence due to financial constraints) | Multiple hospitalizations or ER visits in the last three to six months |
| Multiple PCP/specialist visits (more than one visit per month) | Polypharmacy (eight or more prescribed medications) with evidence that the Member does not adhere to or understand medication regimen (excludes: vitamins, over-the-counter) | High-risk pregnancy |
| Deteriorating physiologic indicators such as BMI, HTN, or Hemoglobin a1C | Deteriorating behavioral health status | Request for private duty nursing services or hospice services request |
| Previously managed by PCMH with deterioration or instability | Members with known diagnosed psychiatric conditions such as bi-polar, schizophrenia, paranoia, depression, anti-social disorder, personality disorders, etc. | Multiple urgent care visits for chronic condition management |
| Cancer diagnosis and Member is currently receiving treatment | | |
| New diagnosis of a chronic condition within the last three months with little understanding of their disease and/or is non-compliant with self-care management (diet, exercise, medication, interventions, preventive screenings, etc.) | | |

Upon the Member's consent to be referred into one or more of the recommended TCCI Program(s), the WDM Coach confirms the Member's contact information and their preferred method of contact and notes this in the referral to the Service Request Hub.

Once these referrals are received in the Service Request Hub they are directed to the Intake, Assessment and Appointment Team (IAA) within the Hub. The IAA is comprised of registered nurses and licensed behavioral health and substance abuse specialists who review the Member Health Record, evaluate the Member's coverage plan and appropriateness for the requested TCCI Program, and, if approved, submit the referral to the appropriate TCCI provider partner. For Members attributed to a PCMH PCP, the IAA also notifies and consults the LCC assigned to the PCPs during the approval process to obtain any necessary advice or orders or requirements from the Member's PCP.

Once the IAA Team approves the recommendation of the WDM Coach and refers the Member to the requested TCCI Program, the Coach is notified of the results and communicates this to the Member. The WDM Coach then determines whether a Member is best suited for remaining in WDM coaching while in a TCCI Program. For Members transitioned into the CCC, CCM or BSD Programs, the Member's LCC, CCM or BHCC will assume responsibility for coordinating the Member's care once a confirmed hand off has occurred. At this point, the WDM Coach will cease providing WDM coaching.

If the IAA Team believes that another TCCI Program would benefit the member, the WDM Coach will be notified through the Service Request Hub. The WDM Coach who made the specific referral to a TCCI Program is responsible for monitoring the Member's progress even if the referral was never activated due to non-acceptance. This continual monitoring better enables the Member to move through the continuum of available services in multiple modalities to maintain and improve their health.

**Workplace Wellness Services**

As part of the WDM Program, CareFirst provides additional workplace wellness services as may be requested by the employer account. These are generally discussed as part of the strategy for addressing the health of the employer account population. It is important to note that some employers want to provide wellness services to their entire population of employees regardless of the health insurance carrier involved due to the strong correlation between productivity and overall health and well-being.

This enables the employer to provide services to those employees who waive health coverage, have coverage through another carrier, or are not eligible for health coverage due to their status under the employer's policy. CareFirst can provide workplace wellness services to both our Members and non-CareFirst Members in an integrated and seamless fashion.

A number of factors increase the odds of developing a successful workplace wellness program. These are:

- ***Plan -*** A successful program starts with a commitment from company leaders, and its continued success depends on ongoing support at all levels of the organization. Leaders at companies with successful programs establish a healthy work environment by integrating health into the organization's overall vision and purpose.

- ***Engage -*** A wellness program must be developed with employees. Boosting engagement in wellness can only be achieved when workers own the program, understand how they and the company benefit, and are given a meaningful voice in its ongoing operation.

- ***Access -*** Wellness program efforts should be based on the unique needs of the population and align with the company's culture.

- ***Measure -*** A healthy company culture is built intentionally. It is about creating a way of life in the workplace that integrates a well-being model into every aspect of business with consistent evaluation of outcomes and communication about program progress.

The WDM Program offers consultative services to employer groups to help develop their specific programs to maximize these factors, employee engagement, and wellness program success. The Program also provides the following supplemental workplace wellness programs and services that can be purchased separately by an employer:

- Additional biometric screening categories;
- On-site inoculation services;
- Targeted wellness educational sessions which can be provided on site or via webinar;
- On-site professional services such as personal training, dietician, and therapeutic massage;
- Professional fitness class instruction;
- Support and tracking for workplace wellness contests and Program activities; and

- Customized incentive tracking.

***Blue Rewards Financial Incentives for Fully Insured Members***

Financial incentives can effectively encourage Members to take an active role in their own health. Through Blue Rewards - the CareFirst Health and Wellness Incentive Program - Members can earn a reward for completing specific activities that increase the likelihood of success in their wellness efforts.

Further, the use of Member incentives is essential to raising wellness program participation levels in a meaningful way. Independent studies show that participation can regularly reach 80 to 90 percent of Members in an employer group when the right incentives are introduced.[10]

Launched in 2015, the Blue Rewards Program is available as an integral part of fully insured products and available to all self-insured groups at no additional cost of administration. Members are financially rewarded when they complete activities that align with future health improvement.

The current fully insured program (through the 2018 calendar year) encompasses the steps outlined in **Figure 13** which Members and their spouse/domestic partner must complete to earn their incentive. In the group market, where outcomes-based incentives are permitted, there is also an additional reward for meeting or making progress on certain health factors (BMI, blood glucose, blood pressure, smoking status and flu vaccination status).

**Part VI, Figure 13: Steps To Earn Rewards**

| Incentive Steps | Underlying Principles Behind Each Step |
|---|---|
| Select/visit a PCMH PCP | Encourages Members to access care in the most efficient manner and form a relationship with their doctor. |
| Complete a health assessment and participate in a biometric screening | Increases Members' awareness of and involvement in managing their own health. Also provides data to identify/stratify Members for engagement in Programs. |
| Consent to receive wellness emails | Enables cost- and time-efficient access to plan and benefit materials. |

By choosing a PCP who participates in our PCMH Program, Members have the benefit of being cared for by a PCP who is incented to achieve quality outcomes. Also, Member completion of an annual health assessment provides critical insights we use to identify, attract, and engage them in the appropriate coaching or clinical TCCI Programs.

***Self-Funded Financial Incentive Program Design***

Although the Blue Rewards Program is core to all CareFirst fully insured medical products, there are differences between the self-funded and fully insured programs.

Today, most large employers who offer health benefits also offer some form of wellness program.[11] To maximize Member participation, as well as satisfy the unique needs of self-funded accounts, CareFirst's incentive platform can accommodate a myriad of incentive configurations.

[10] *Chapman, Larry S. MPH; Whitehead D'Ann PsyD; Connors, Megan C. The Changing role of Incentives in Health Promotion and Wellness. The Art of Health Promotion.23(1): 1-11. 2008. Taitel, Michael S. PhD; Haufle, Vincent MPH; Heck, Debi MA; Loeppke, Ronald MD, MPH; Fetterolf, Donald MD, MPH. Incentives and Other Factors*

[11] *The Henry J. Kaiser Family Foundation: Workplace Wellness Program Characteristics and Requirements, May 19, 2016. http://www.kff.org/private-insurance/issue-brief/workplace-wellness-programs-characteristics-and-requirements/*

The WDM platform addresses lifestyle behaviors or core competencies that contribute to overall physical health and well-being, regardless of condition status. These behaviors include things like stress, activity, sleep, relationships, weight, blood pressure, glucose, cholesterol, tobacco use, alcohol use, diet and fitness. The platform can also track and integrate data from verified sources, such as biometric screenings, fitness device integration, prevention activities, and more.

**Self-Insured Employee-Based Programs – Care First Dedicated WDM Team**

CareFirst's dedicated WDM CareFirst Account Team makes recommendations for employers that want to strengthen their current incentive program or create one from start to finish.

The following Program considerations help lead to long term success:

- **An incentive program should evolve over time as an employer's culture of wellness develops and goals become more ambitious.** In the first year or two, an employer is advised to primarily reward activities based on participation. Participation-based rewards help get employees comfortable and trusting of the process. Once a credible number of employees participate—generally 50 percent of the eligible population[12] —sufficient data is available to determine account-specific priorities. A financial incentive program can then be tailored to focus more on outcomes-based rewards (like achieving a BMI below 30), or connecting Members with clinically appropriate Care Coordination Programs to achieve desired outcomes. It is important to consider how the program will evolve over time, so communications and reward strategies can anticipate and effectively reinforce program objectives.

- **The incentive program activities should be a mixture of activities that create Member awareness of their health status and offer them personalized opportunities to address their individual needs.** The financial incentive program may offer a variety of activities that fall in both categories to meet employer groups' needs. As individual Members within an account have different health goals and motivators, offering a mixture of the two activities helps maximize engagement. By giving the Members freedom to choose, they feel in control and the incentive program enables the adoption of new habits and long-term behavior change.

- **The incentive program should provide Members with points-based activities.** Points-based incentive solutions tend to perform better than other types of reward programs. Utilizing points is a form of branded "currency" that can be used in a variety of ways, appealing to the interests of many different types of Members – increasing program "stickiness" and participation rates.[13] Points-based incentive programs offer the flexibility to adapt quickly to changing company needs, program objectives, and audiences. Points allow the employer to determine the value of certain activities – which may vary for different populations - and are readily understood by Members ("I select a PCP and get 100 points to earn $10"). Lastly, the accumulation and issuance of points creates usable, measurable data that offers insight about participants' relationships with the incentive program.

- **The incentive program should include activities within each engagement category.** It is important to understand the various stages of engagement which are core to a successful financial incentive program that keeps Members involved over time. Each category listed below represents the engagement cycle within the incentive program. Providing activities within each category helps guide Members through their health journey and their various unique motivators.

  Long-term engagement activities are broken down into five main categories: activation, one-time, recurring, Care Coordination, and account-specific (as shown in **Figure 14**). Each category includes different activities that can be incented.

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[12] *Levin-Scherz, J., & Nyce, S. (2017, April 13). Health outcomes: Employers should re-evaluate their wellness and incentive programs. Retrieved August 15, 2017, from https://www.willistowerswatson.com/en/insights/2017/04/health-outcomes-employers-should-re-evaluate-their-wellness-and-incentive-programs*

[13] *Points Incentive Programs: Sticking with what works. (2017). Retrieved August 15, 2017, from https://qualityincentivecompany.com/qic-at-a-glance/recognition-incentive-resources/articles-white-papers/points-programs/*

**Part VI, Figure 14: Engagement Activities Categories**

| Engagement Categories | Description | Activities |
|---|---|---|
| Activation | Once the Member completes the activation step, they gain access to the engagement platform. | • Register<br>• Download the mobile app<br>• Provide consents |
| One-time activities | One-time activities are presented to Members at the top of their engagement platform homepage and provide the necessary data to personalize their experience. | • Health assessment<br>• Biometrics<br>• Select PCMH PCP<br>• Preventive screening |
| Recurring activities | Within this section, Members are offered the ability to track health-related activities on a daily or weekly basis. Recurring activities keep Members engaged over a longer period and require more interaction. | • Tracking<br>  ○ Activity<br>  ○ Diet<br>  ○ Sleep<br>  ○ Stress<br>• Health challenges<br>• Educational webinars<br>• Onsite events<br>• Daily personalized content and insights |
| Care Coordination Activities | These activities are only offered to Members when they meet certain clinical criteria. Although this category may be the most important to achieve long-term behavior change, not all Members of an account will qualify. | • Activation, engagement, compliance with TCCI Programs<br>• Coaching (telephonic, digital) |
| Account-Specific Activities | Represent factors that connect back to employer groups' unique corporate culture. | Activities that align with the corporate culture:<br>• Use of on-site clinic<br>• Safety compliance |

- **The incentive program should include incentive types that are desirable to Members while meeting the financial goals of the employer.** Based on the organization's preference, employers can determine which incentive type will be made available for their Members when redeeming their earned points: a medical expense debit card, deductible reduction, health plan premium contribution, gift cards, or non-cash rewards such as additional vacation days or company-wide recognition.

The dedicated WDM CareFirst Account Team continues to work with the employer to evaluate and refine the financial incentive program to ensure it meets their needs and accomplishes the guidelines above. Incented activities are critically reviewed to confirm they are providing value, while also creating opportunities to increase Members' involvement in their health. Consumer research data helps understand and project the level of interest and engagement among Members in the group. Third party reports and research are used to understand market trends and best practices for incentives and engagement.

An essential component of the WDM Program is continuous feedback that enables employers to better understand their employees' health status and needs.

***Member Reporting***

All Members who participate in the health assessment process can access their personalized information and reporting through a CareFirst designated portal or their mobile device. This includes the Member's overall assessment and screening results, personalized RealAge score, risk factors, available programs, resources, tools, and strategies for improvement to initiate a well-being plan.

The Member portal is designed to include all Member-level information such as program enrollment, assessment, and screening completion; enrollment in self-management tools; and establishment of a plan and the tracking of activity and progress related to the plan, including activity related to coaching programs.

***Reporting for Providers***

Within iCentric, year-over-year historical data is kept within the Member Health Record so the Member's PCP and treating providers have access to all assessment data, claims, and TCCI Program activity and results, including WDM coaching. The Member Health Record also has a section dedicated to wellness and disease management. Data from the health assessment process and claims are automatically loaded into iCentric. Key data from the health assessment and all subsequent lifestyle management or disease management activity is stored in the Member Health Record along with daily updates from WDM coaching programs including Member outreach, interaction and engagement, clinical notes, and outcomes.

iCentric's complete view into each Member's personalized health history allows treating providers, particularly PCPs, to track in real time each Member's current and progressing health status that allows them to provide timely and appropriate services to the Member.

***Employer Reporting***

Large group risk and self-insured employers who participate in the WDM Program are provided with WDM data through CareFirst's SearchLight® reporting package. Information about the WDM Program is provided in the following areas:

- Overall wellness Program participation including demographic breakdowns for Members aggregate participating (and not participating) in the health assessment and biometric screening;
- Member costs and IBS for those participating (and not participating) in the health assessment and biometric screening;
- The overall RealAge distribution for the group comparing results year over year;
- The number of Members identified as either full expression, high-risk and low-risk, total PMPM, and average IBS of those in each of the health conditions for full expression identified above. This information is also compared against the PMPM cost for those more fully advanced in the condition track, showing the potential exposure without intervention; and
- The total number of Members identified as either full expression or high-risk who have been reviewed, approached, engaged, or completed coaching and those achieving improved outcomes. The reporting also highlights the number of Members that have refused coaching services.

CareFirst also makes available certain standard and ad-hoc employer reports as needed to supplement the SearchLight reporting package.

**WDM Program Costs and Financing**

The WDM Program is integral to the overall CareFirst PCMH and TCCI approach, and is the "gateway" to greater health for many. WDM Program costs are included in the administrative fees CareFirst charges self-insured groups and there are no separate, itemized administrative costs are charged to an employer group for the WDM Program.

However, direct services related to the WDM coaching or other TCCI Program care of the Member such as biometric screenings, flu shots, lifestyle or disease management coaching services, and other services are processed as a claim and

attributed to the Member receiving the service. To encourage maximum engagement and participation, these claims have a no Member cost share (copay) under the CareFirst Model Benefit Design unless required by federal law regarding the administration of certain high deductible health plans. The advantage of this approach is obvious: Claim charges are limited to only those Members who use the services – not to the entire employee group.

Supplemental workplace wellness or services may be purchased at an employer's discretion and are charged separately as an administrative fee based on a schedule of fees for the services selected.

The overall cost of the WDM Program depends on the degree to which an account uses elements of the Program, but is generally less than one percent of overall health care premiums or premium equivalent, including the cost for annual biometric and/or health screening with a PCP. Actual return on these dollars is calculated in terms of reduced claims costs, utilization, and absenteeism along with higher productivity.

While the amount of return varies by account and by participation level, studies show that every dollar spent on these types of services will generally yield two percent or more in savings in return.[14] As noted earlier, even a small change in a Member's RealAge score can make a difference. The elimination of only a few hospital admissions or ER visits per year can easily create a positive return on investment for an account.

Traditional wellness and disease management programs bill employers whether Members participate or not. CareFirst only bills for those Members who actually use WDM services directly as shown in medical claims. We have found that this is a more cost-effective way to finance a Wellness and Disease Management Program.

**Conclusion**

CareFirst's WDM Program plays an important role in enhancing the health awareness and status of Members – using technology including smartphones and wearable devices to engage and capture Member-specific data to better identify and help coordinate their care. The focus is on preventing or limiting the progression of disease for the vast majority of Members who do not require intensive clinical coordination through other Elements of the TCCI Program Array.

[14] *Naydeck, Pearson, Ozminkowski, Day & Goetzel. The Impact of the Highmark Employee Wellness Programs on 4-Year HealthCare Costs. Journal of Occupational and Environmental Meicine. 2008.*

## Program #2: Hospital Transition Of Care Program (HTC)

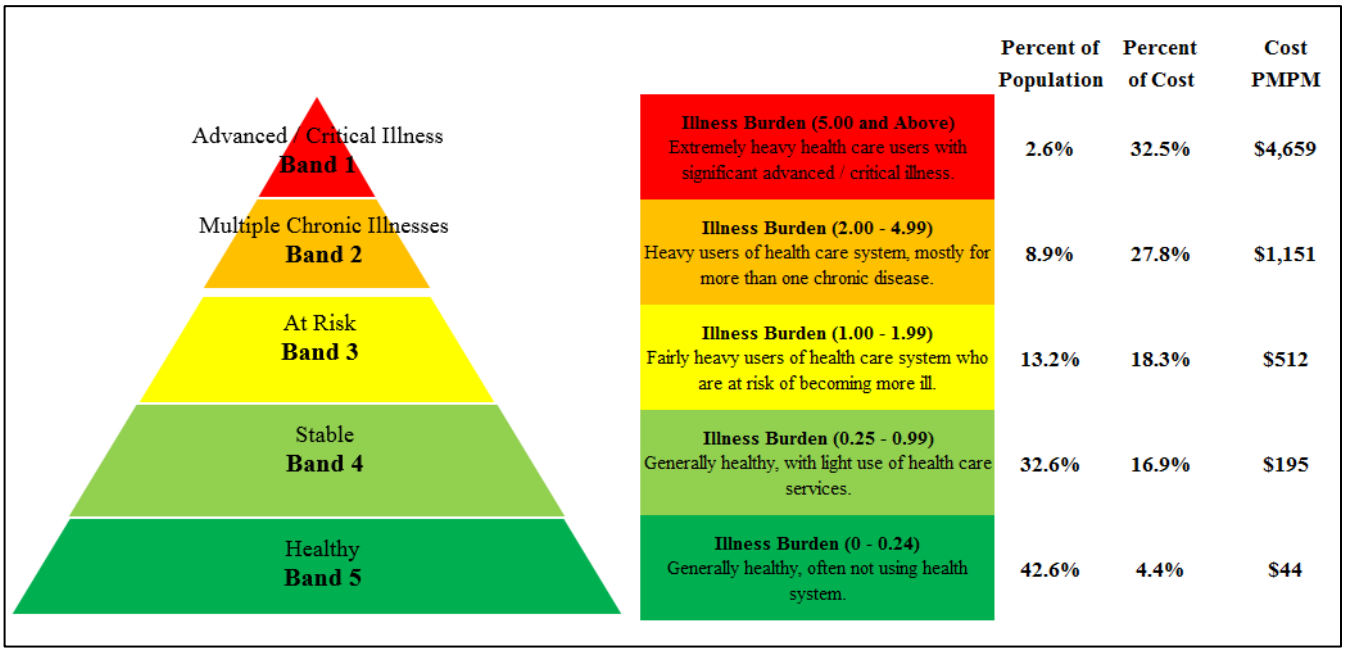
Of all the transitions of care that occur, the most significant is from hospital to home or to another setting. A Member left to navigate this transition alone – particularly one with multiple ongoing chronic conditions - has a higher likelihood of readmission in the 30-day period following discharge. This risk often remains elevated for a considerable period of time – up to 90 days or more.

As pointed out in **Part I**, CareFirst operates in a region with among the highest admission and re-admission rates in the country. This is shown more specifically in **Figure 15** below.

**Part VI, Figure 15: Inpatient Admission And Readmission Rates**[15]

| AVERAGE | Inpatient Admissions per 1,000 | | | | 30 day Hospital Readmission Rate | | |
|---|---|---|---|---|---|---|---|
| | 2012 | 2013 | 2015 | 2015 Rank | 2012 | 2013 | 2013 Rank |
| US Average | 295 | 283 | 74 | N/A | 18.6% | 18.1% | N/A |
| Maryland | 309 | 295 | 99 | 38th | 20.6% | 19.7% | 49th |
| DC | 358 | 344 | 160 | 51st | 24.1% | 22.6% | 51st |

**Part VI, Figure 16: CareFirst Illness Burden Pyramid, 2016**




In total, CareFirst's membership produces about 7,500 admissions per month or approximately 90,000 per year. This is down markedly from 2012 levels when CareFirst Members were admitted to a hospital over 130,000 times on a comparable membership base. Each admission is a signal event since nothing so predicts the likelihood of future health care expenditures as a hospital admission. Indeed, an admission is followed by a readmission within 30 days in approximately 12 percent of cases. This readmission rate rises to 27 percent within 90 days of admission.

[15] *Source: CMS State/County Table All Beneficiaries Data, December 2014*

The average admission costs $19,445 for hospital billed services. Hence, the avoidance of 30,000 admissions in a year produced $583,350,000 in avoided costs before considering the affects for Maryland's All-Payer hospital Waiver, which counteracts virtually all of these savings. Lower rates of admission are continuing into 2016. CareFirst overall membership has remained steady over the last five years, so, this drop in admissions has largely been responsible for moderate trends in recent years in overall per capita spending.

The key goal of the HTC Program is to quickly assess each admission as it occurs and decide which ones will likely need follow-up attention post discharge to best assure recovery to the extent possible with an eye toward avoiding the breakdowns that lead to readmissions and further complications.

This capability is critical to Medical Care Panels because most admissions and their aftermath occur out of sight of PCPs and without their knowledge or awareness. Yet, so many consequences flow from these admissions for the Members involved as well as for the Panels who inherit all the costs ("Debits") for the care involved.

To provide this much-needed support capability, CareFirst employs approximately 70 HTC registered nurses, all of whom have extensive experience in working in a hospital setting on Care Coordination and discharge planning. These HTC nurses monitor all hospital admissions every day throughout the CareFirst service region and more broadly, throughout the United States. Under cooperative arrangements with regional hospitals, the majority of the nurses are physically stationed in the hospitals that account for 75 percent of all CareFirst regional admissions. Other HTC nurses remotely monitor daily admissions in smaller hospitals and in hospitals around the country.

For out of area admissions that constitute approximately 20 percent of all admissions, CareFirst is notified by a call from the admissions staff of the admitting hospital. This typically occurs within the first 24 hours following admission. Information on the admission is gathered telephonically and is then loaded into the iCentric System by the CareFirst representative who took the call. Full time, dedicated representatives are assigned to this function.

Once an admission notification occurs, the responsible HTC nurse reviews the case to determine whether the nature of the illness/condition of the Member is likely to require post discharge services. This results in the assignment of one of two designations in the iCentric System:

> **Category 1 Admission.** If the Member is likely to need post discharge services, they are designated as a Category 1 admission. Members in this category have acute or critical illness or the acute manifestation of one or more chronic illnesses.
>
> **Category 2 Admission.** If the Member is not likely to need follow-up care post discharge, they are designated a Category 2 admission. Members in this category are likely to quickly recover. Examples include childbirth and routine surgeries in otherwise generally healthy people.

These designations are entered into the iCentric System and made part of each Member's Health Record by the HTC nurse. Roughly 60 percent of all admissions fall into Category 1, and this percentage appears to be rising. All subsequent claim information on each admission is entered into the Member Health Record as are any HTC notes.

For those in Category 1, a further, more refined categorization is made by the HTC nurse after gaining a better understanding of the Member's condition(s) and illness(s). This more refined judgment is based on direct interaction by the HTC nurse with the treating providers in the hospital, the Member and family as well as a review of the clinical records available on the Member during their hospital stay. These further categorizations are as follows:

> **Level 1A: Advanced Illness/Palliative –** End stage disease, end of life care, end stage organ failure, palliative care and/or hospice care. This distinction may apply to any terminal condition or illness such as metastatic cancer (even if newly diagnosed), as well as advanced COPD and CHF (NYHA Stage 4). End Stage Renal Disease and Transplants are excluded since they are covered in 1G and 1H below.
>
> **Level 1B: Catastrophic Events** – Sudden catastrophic event or diagnosis causing critical illness but with an expected return to baseline or stability (MVA, trauma, stroke, non-metastatic cancer diagnosis).

**Level 1C: Multi-morbid Chronic Conditions** – An acute episode within the context of ongoing chronic illness usually with comorbidities present. High risk for impending re-hospitalization or multiple ER visits with continuing chronic conditions expected to present elevated risk for hospital based services into the foreseeable future.

**Level 1D: NICU Babies** – Premature babies, feeders and growers, and babies with complications requiring NICU stays with a high likelihood of follow on care needed.

**Level 1E: Special Needs Pediatrics** – Children with complex medical or congenital conditions requiring hospitalization and high likelihood of extended post discharge services needed.

**Level 1F: Complex Infectious/Immunological Conditions ("Specialty Pharmacy")** – Members with admissions for MS, Rheumatoid Arthritis, HIV/AIDS, Hepatitis C, Growth Hormone Deficiency, RSV, Fertility, Hemophilia and Inflammatory Bowel Disease; such as Crohn's and Ulcerative Colitis.

**Level 1G: Transplant** – Members admitted for organ transplant or complications post organ transplant excluding kidney since they are covered in 1H below.

**Level 1H: Chronic Kidney Disease and End Stage Renal** – A Member with Chronic Kidney Disease Stage 3 or greater or receiving kidney dialysis or kidney transplant services.

**Level 1I: Other –** This is a catch all category for Members who do not fall in one of the categories above or may be in more than one category.

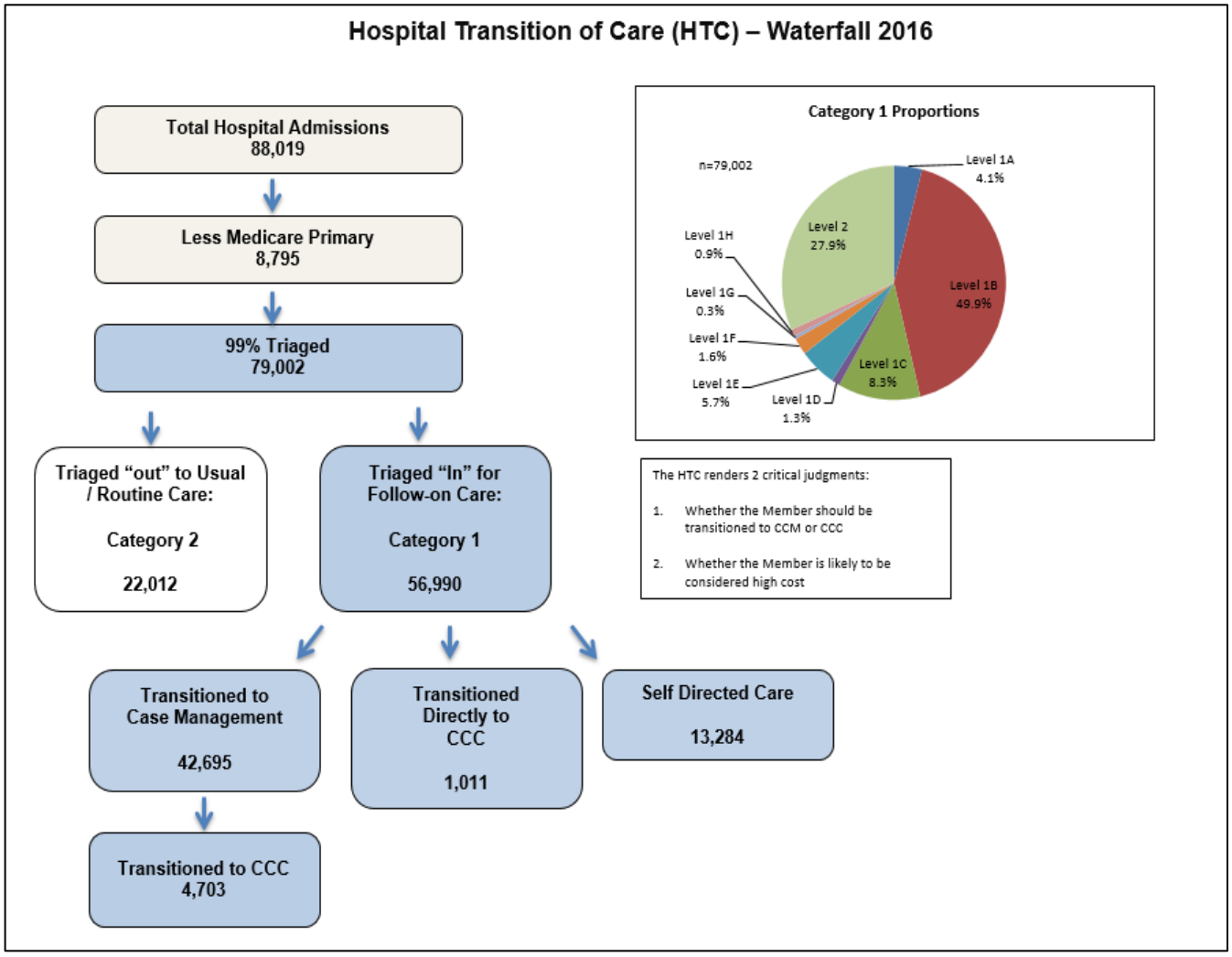
For each Category 1 admission, two additional critical judgments are made by the HTC nurse. The first of these is whether the Member is likely – given their condition(s) and illness(s) – to be considered a "high cost" Member. This applies to Members whose costs could exceed various thresholds starting at $25,000 in annual costs. These cases are flagged so that they can be given a heightened level of attention and so that they can be tracked in the SearchLight Reporting process (See **Part VII**). These cases either are – or are likely to become – cases that are subject to the Individual Stop Loss protection given Panels in the PCMH Program.

The second judgment is whether the Member should be placed in either a CCM or CCC Care Plan or whether sufficient provision for their post discharge needs can be met by alternative means, including family support and self-directed care.

All admissions involving a behavioral health or substance abuse condition or diagnosis are reviewed by CareFirst's strategic partner, Magellan. This is described in the BSD Program which is TCCI **Program #5**.

**Figure 17** on the next page shows the flow of Members through the HTC process into the two major categories and then on to CCM, CCC Care Plans or self-directed care.

**Part VI, Figure 17: "Waterfall" Of Cases Hospital Transition Care (HTC), 2016** [16]




To support the critical judgments made in the HTC process, HTC nurses complete a LACE Index Score on every Category 1 admission for which they are responsible in order to understand the potential risk of breakdown and Member re-admission.

The LACE Index was developed through independent research (in Canada)[17] to help quantify the risk of unplanned re-admissions or early death after discharge from a hospital to the home or community and is useful in determining post discharge support needs for Members at highest risk of poor outcomes and instability following hospital-based care.

The LACE Index incorporates a number of values associated with acute length of stay ("L"), acuity on admission ("A"), Charlson co-morbidity ("C") and the number of emergency visits ("E") in the six months prior to admission to determine the risk of re-admission to acute care. Scores range from 0 to 19. Scores greater than 10 predict a higher risk for readmission to acute care. Accordingly, these cases are prioritized by HTC nurses as most in need of coordinated post discharge services and are the cases most likely to be referred to the CCM and CCC Programs.

[16] *Source: CareFirst Data & Informatics. January-December 2016 with claims paid through April 2017*

[17] *To predict early death or unplanned readmission after discharge from hospital to the community, Carl van Walraven, et al., Canadian Medical Association Journal, April 6, 2010 p. 551-557.*

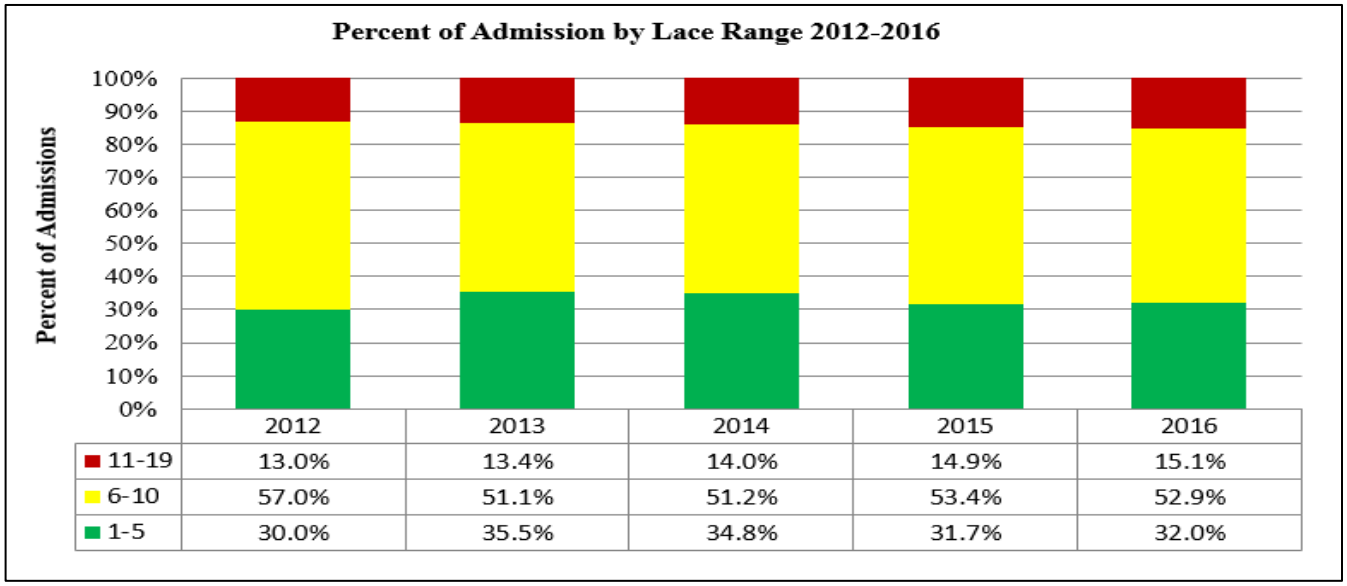
The general reliability of the LACE Index in predicting future readmission likelihood can be seen in actual CareFirst experience over the past three years.

The figures below show different views of Members readmitted**,** one is based on the LACE Score; the other is based on Category 1 and 2 compared to the general CareFirst population.

**Figure 18A** below shows the percent of admissions by LACE range for all CareFirst Members and shows 2012, 2013, 2014, 2015 and 2016 results. As noted, the percentage of admissions in the highest LACE range has increased slightly over the past five years.

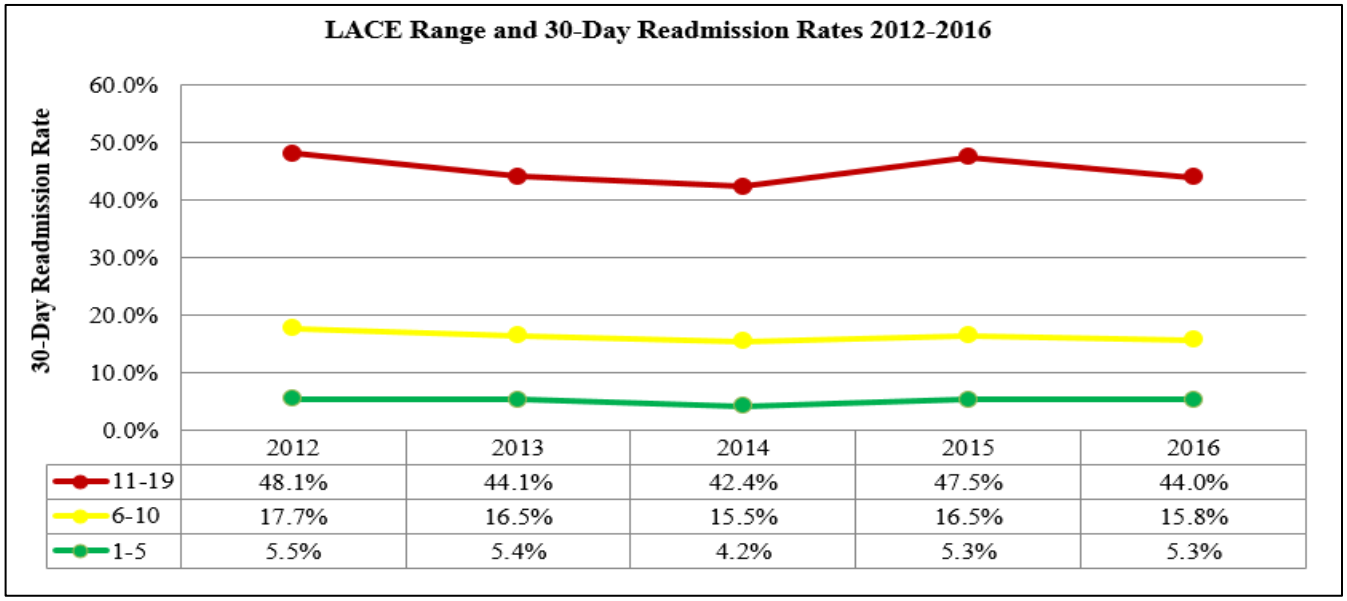
**Figure 18B** below shows the 30-day readmission rates by LACE range and demonstrates readmissions for Members with high Lace Scores (11-19) are nine times that of Members in the lowest LACE range.

**Part VI, Figure 18A: LACE Scores And Readmissions 2012-2016**




| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| 11-19 | 13.0% | 13.4% | 14.0% | 14.9% | 15.1% |
| 6-10 | 57.0% | 51.1% | 51.2% | 53.4% | 52.9% |
| 1-5 | 30.0% | 35.5% | 34.8% | 31.7% | 32.0% |

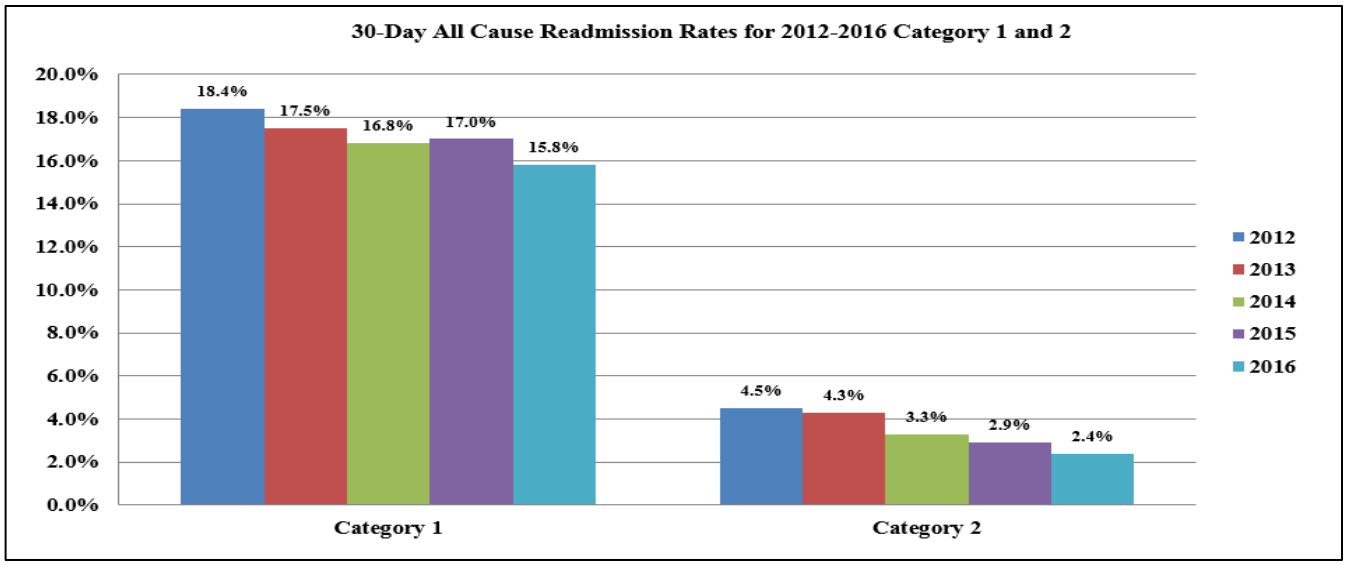
**Part VI, Figure 18B: LACE Range And 30-Day Readmission Rates 2012-2016**




| | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| 11-19 | 48.1% | 44.1% | 42.4% | 47.5% | 44.0% |
| 6-10 | 17.7% | 16.5% | 15.5% | 16.5% | 15.8% |
| 1-5 | 5.5% | 5.4% | 4.2% | 5.3% | 5.3% |

**Figure 19** below shows the 30- and 90-day readmission rates for 2012, 2013, 2014, 2015 and 2016 for Category 1 and 2 Members. The stark difference in the rate between Category 1 and Category 2 readmissions - that is concealed in the average – is revealed in this Figure. The readmission rate among Category 1 admissions is five times that of Category 2 admissions.

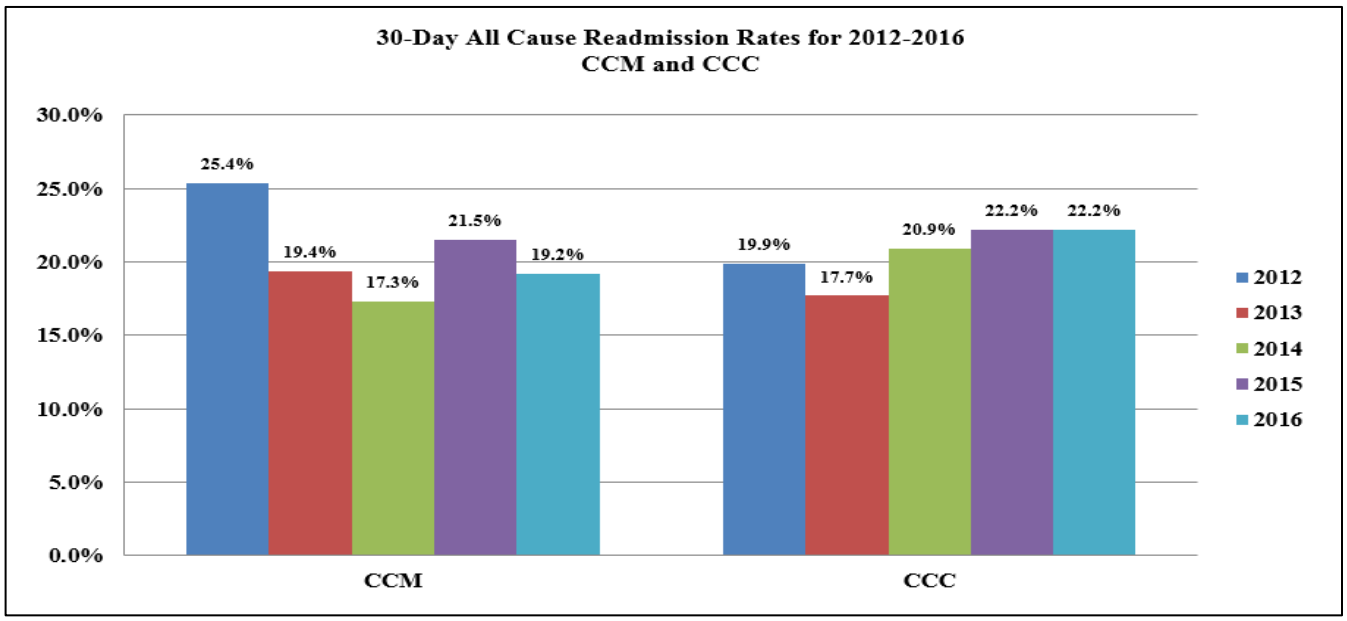
**Part VI, Figure 19: 30-Day All Cause Readmission Rates, 2012-2016**




Based on actual experience in 2016, 60 percent of admissions were triaged into Category 1 for post discharge follow-up. Approximately 80 percent of these Category 1 admissions go into CCM for an average duration of three to four months. Approximately 15 percent go into CCC for durations of six to nine months or longer. The balance is discharged to home under alternate arrangements when there is a credible basis to believe that the supports Members receive from family and others are adequate to meet their needs. **Figure 20** below shows the readmission rates for CCM and CCC.

Members which have both decreased, despite the fact that these Programs focus effort on managing the most complex, vulnerable Members.

**Part VI, Figure 20: Readmission Rates For Subcategories Of Category 1 Admissions**



As soon as an HTC nurse believes that a Member will need either CCM or CCC, the nurse enters the beginning description of the circumstances of the case in the Care Plan template in the iCentric System. If the HTC nurse has a Member for whom a referral is suitable, the nurse will alert the CCM or LCC prior to the Member's discharge.

Depending on the Member's needs, the HTC nurse then sends the case online, via iCentric, to a CCM or LCC who confirms receipt of the case. This includes an initial assessment of the needs of the Member following discharge. No transition of the case can be made without a confirmed affirmation from the receiving CCM or LCC that they have accepted lead responsibility for the case. This is shown and tracked in the iCentric System.

From here, a more complete Care Plan is developed in concert with and under the direction of the lead specialist involved in the case of CCM or of the PCP in the case of the CCC Program.

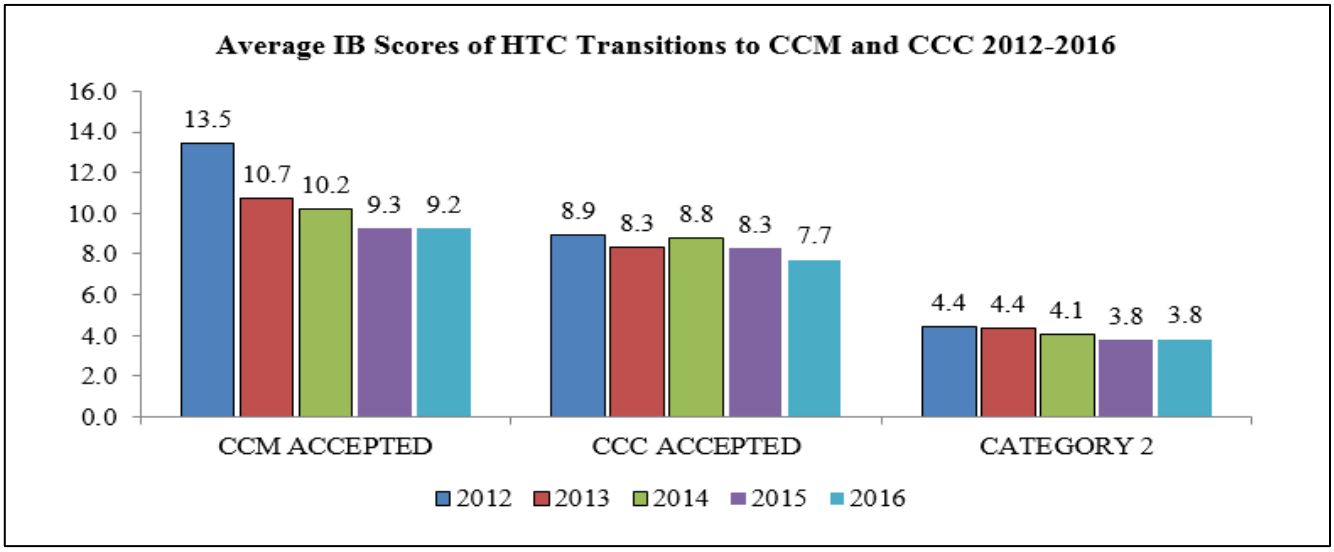
The iCentric System is kept up to date by the responsible CCM or LCC. As the CCM or LCC documents the emerging progress (or lack thereof) of the Member relative to the goals in the Care Plan, the iCentric-based Care Plan is immediately viewable by all treating providers at any time to assure timely and up to date understanding on the part of all involved.

In addition, SearchLight Reporting shows all cases flowing through the HTC process and on to other TCCI Programs. This tracking of Members is shown in various views through the SearchLight Report that is updated monthly.

So begins – for these Members – a continuous, longitudinal record of their illnesses and conditions as well as their treatment and progress. This is kept indefinitely in the iCentric System and is available online 24/7.

It is noteworthy that Members chosen for CCM or CCC have higher Illness Burden Scores – as might be expected – than those Members who were not selected for these Programs and are in self-directed care at home. This reinforces the value of the contemporaneous, personalized review and case selections made by the HTC nurses. The differences in the Illness Burden Scores of Members selected for CCM, CCC versus Category 2 admissions (which are not sent to CCMs or CCCs) is shown in **Figure 21** below.

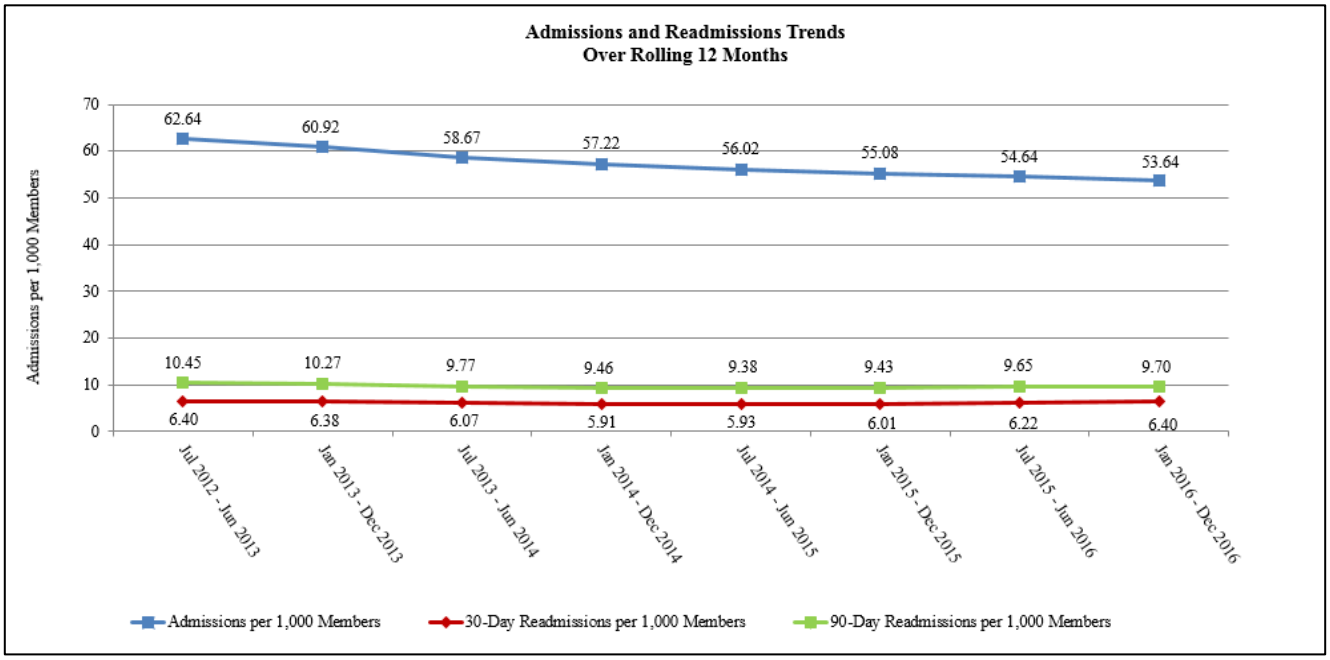
**Part VI, Figure 21: Differences In Illness Burden Scores Of Members In Category 1 And 2**




**Noteworthy Changes in Hospital Admission Trends**

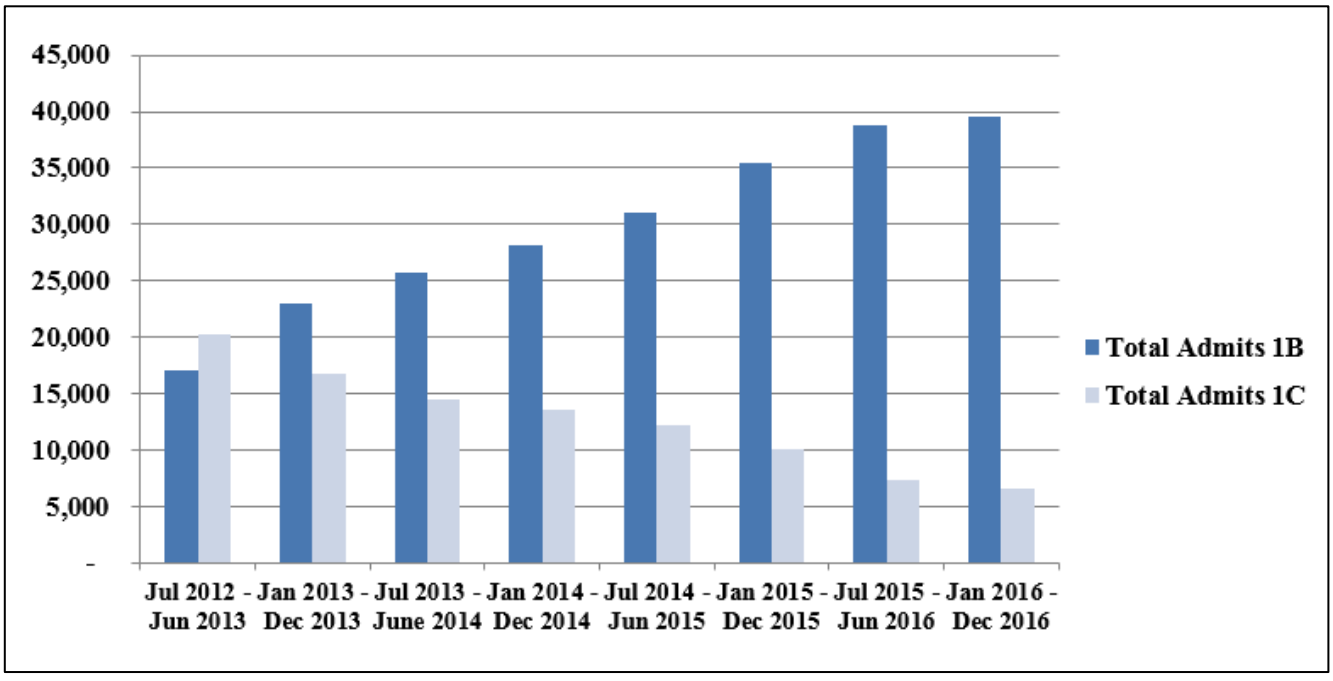
As noted earlier, since the Program's inception, there have been significant decreases in hospital admissions as shown in **Figure 22** on the next page. While admissions have shown a significant decrease, readmissions have remained relatively flat in the last several years due to the increased complexity of Members admitted. During the same period of time, the overall CareFirst membership has decreased by approximately 3.5 percent but included the addition of the more acutely ill Affordable Care Act membership in the Consumer Direct products. We believe a flat readmission rate on a sicker cohort of admitted Members is indicative of the effects of increased Member stabilization through the CCM and CCC Programs.

**Part VI, Figure 22: Admissions And Readmissions Trends**



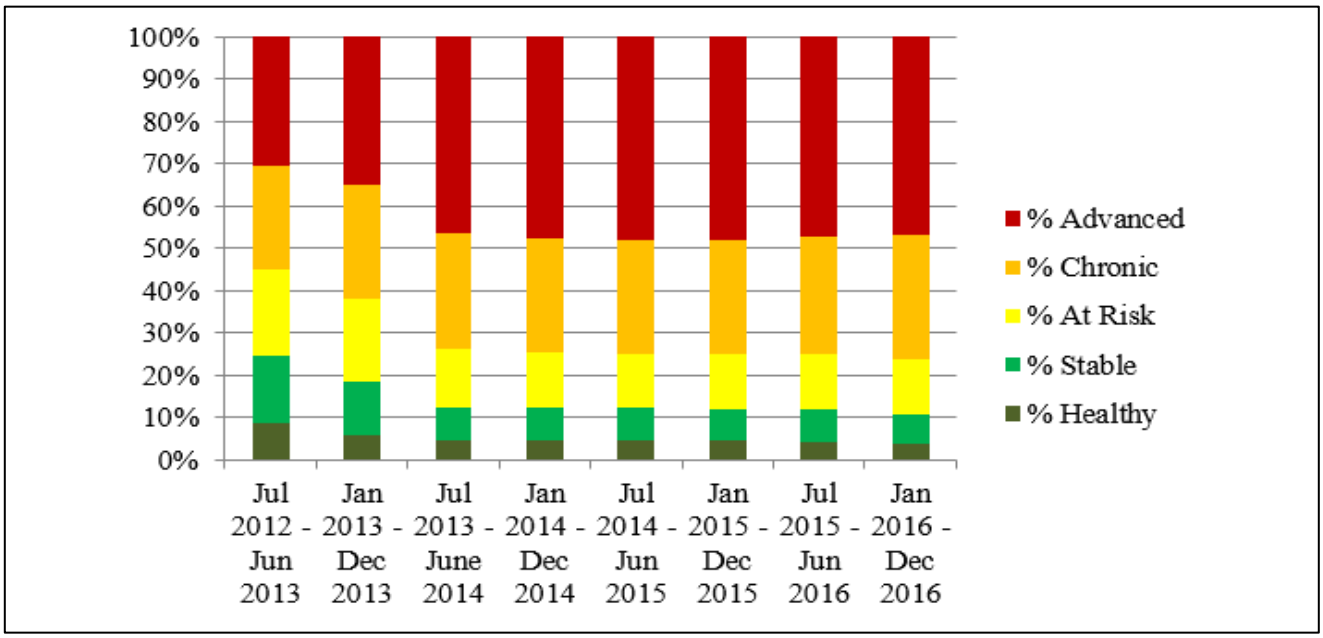

The decrease in admission rate has been accompanied by a significant rise in the acuity of the admissions that have occurred with a corresponding increase in the number of Members categorized as 1B (Catastrophic). **Figure 23** below shows the increase in Level 1B categorization representing the increased severity of hospitalized Members. During the periods below, the criteria used by the HTC nurses has remained constant. Hence, the rise in 1B admissions clearly demonstrates rising acuity/complexity.

**Part VI, Figure 23: Changes In Triage Levels 1B And 1C**

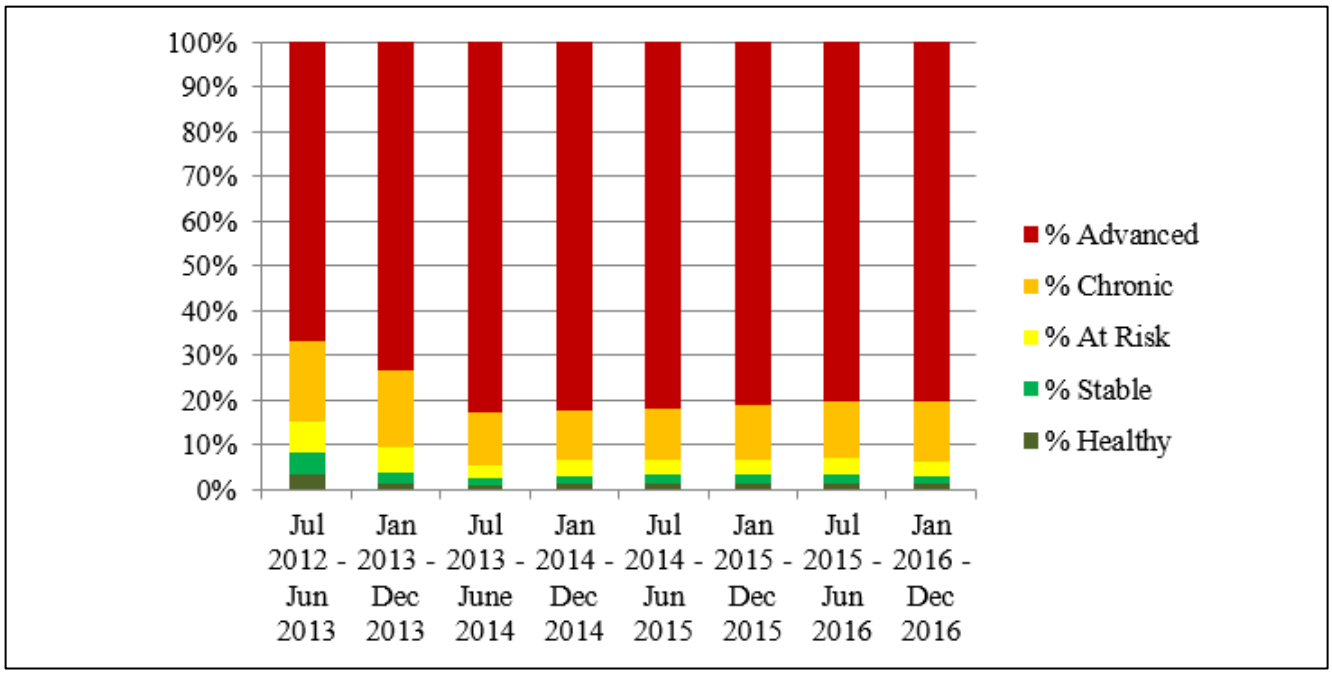


And, as shown in **Figure 24** below, depicting Illness Burden Scores, over 70 percent of admissions come from Members in Bands 1 and 2 compared to approximately 50 percent in early 2012. In addition, **Figure 25** demonstrates the increasing proportion of Members readmitted to the hospital from Illness Bands I and II. This underscores the increasing complexity, acuity and instability of Members who are being admitted to the hospital.

**Part VI, Figure 24: Proportion Of Admissions By Illness Band**




**Part VI, Figure 25: Proportion Of 30-Day All Cause Readmission Rates By Illness Band**



**Enhanced Coordination Between HTC and Hospitalists**

Members routinely present to hospital EDs and undergo extensive evaluation, which often includes numerous laboratory tests and imaging procedures. Some are admitted to the hospital and during the course of the hospital stay, hospitalist physicians (hospitalists), who are usually general internists, provide direct care in collaboration with one or more specialists. Referrals to specific specialists are generally determined by clinical urgency and specialist availability. Discharge plans for follow up care are generally arranged with the referral specialists who have provided inpatient care.

This entire process typically occurs without the awareness of or discussion with the Member's PCP, who knows the Member the best. PCPs do not make hospital rounds, nor communicate in any way with Hospitalists during the hospital stay to discuss ongoing hospital care, specialist referrals or post-acute follow up plans. This process results in increased fragmentation of care, unnecessary duplication of imaging and testing by physicians unfamiliar with the Member and the incurring of potentially avoidable expense.

Approximately 43 percent of all CareFirst Member admissions are unplanned and come in through the ED. This equates to nearly 43,000 unplanned admissions per year.

To mitigate the fragmentation of care associated with these admissions and to assure better communication with and guidance from a PCMH Member's PCP. CareFirst began in 2015 to enter into amended hospital contracts with certain network hospitals to provide improved communication and Care Coordination between HTCs, Hospitalists and PCPs.

This amended relationship requires the HTC, upon learning of an emergency-related admission of a CareFirst Member to:

- Directly call or personally meet with the hospitalist responsible for the Member.
- Discuss with the hospitalist the salient issues, concerns and Member needs in the case after reviewing information in the Member's MHR and the information surrounding the emergency admission.
- Provide the direct contact information of the Member's PCMH PCP.
- Alert the LCC assigned to the PCP that the Member has been or is about to be admitted.

The hospitalist then promptly seeks to contact the Member's PCMH PCP so that the circumstances of the Member's situation can be discussed and a course of action determined under the guidance of the PCP. This includes a discussion of which specialists are to be involved in the Member's care post discharge as well as during the Member's hospital stay.

The goal of this enhanced communication is to better assure that the care received by the Member post their unplanned emergency is as planned and coordinated as possible and is carried out by specialists with whom the PCP has an established relationship.

After direct verbal contact has been made between the PCP and hospitalist, the LCC documents the course of action agreed upon in the MHR and notifies the HTC. Together, the LCC and HTC implement the agreed upon plan. The HTC will monitor the Member through the rest of their hospital stay. Any coordination with CCM or with the LCC assigned to the Member's PCP is handled as part of the HTCs usual role.

The hospitalist also follows the case through discharge and works directly with the HTC, CCM and LCC as well as with the hospital discharge planning staff to assure that care is being coordinated as agreed to with the PCP. This includes additional follow up phone-based communication with the PCP as necessary throughout the Member's hospital stay.

If, at any time in attempting to carry out this enhanced communication and Care Coordination protocol, the hospitalist is unable to reach the Member's PCP after three attempts, the hospitalist will inform the HTC who will work with the LCC involved to overcome whatever has caused PCP unresponsiveness.

This process is intended to be fluid and rapid with a maximum emphasis on verbal communication. Electronic forms of communication between hospitalist and PCP are not intended to be the principal means of communication but are used to follow up, confirm or clarify aspects of the discussion between the parties and to share the underlying information that is the basis for Care Coordination decision making.

In due course, CareFirst will introduce video capabilities into this dialogue so that PCP, hospitalist, HTC and LCC can all simultaneously hear, see and consider the facts and circumstances of the Member. This is intended, where appropriate, to include the Member directly or their family/significant other.

**Conclusion**

In sum, the HTC Program provides a critically important way of quickly focusing on the sickest, most unstable Members who are hospitalized and transitioning them into the right subsequent TCCI Program that is best suited to minimize breakdowns and complications that become so costly over time. This is done with the knowledge and concurrence of the Member's PCP, where possible.

## Program #3: Complex Case Management Program (CCM)

By far, the single greatest source of cases that flow into the CCM Program come from HTC referrals – accounting for over 90 percent of all CCM cases. This crucial referral judgment, brought to bear by the HTC while the Member is still hospitalized, becomes a "hot" lead or hand off to CCM. The HTC's rapid triage and identification of vulnerable Members in need of post discharge Care Coordination enables CCMs to engage Members before they are discharged from the acute care setting. The Members who make up this flow are typically those at the top of the Illness Burden Pyramid (Band 1 and upper Band 2) whose care is being directed by one or more specialists or super specialists. This target population also includes those Members headed toward palliative care.

While the PCP of the Member is informed of the admission and any post discharge CCM services, CCMs usually work directly with specialists – at least in the period following discharge from the hospital.

Thus, the CCM Program cares for Members and their families during the most acute phase of their illness and recovery. CCM is designed to help Members with advanced or critical illness or complex and catastrophic conditions that have the highest medical spend. CCM focuses on Members with Illness Burden Scores of 10 or greater.

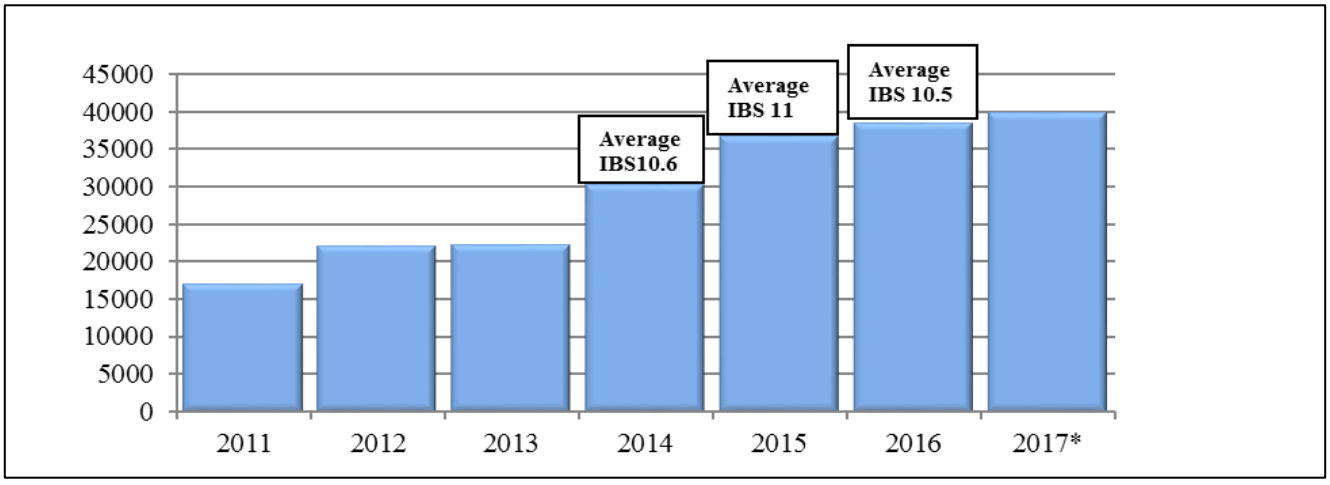
These Members are at risk for readmission, complications and breakdown in the home. The Members in the CCM Program require intense Care Coordination and frequent nursing contact. While less than three percent of all CareFirst Members fall into the Advanced/Critical Illness Band category, these Members account for a third of the total health care costs paid for by CareFirst. Members in the Advanced/Critical Illness Band are over three times as likely as Members in the Multiple Chronic Illness Band to be readmitted within 30 days, and approximately five to six times more likely to be readmitted within 30 days as Members in the At Risk or Stable Illness Bands.

CCM services are available for all CareFirst Members and are not dependent on a Member being in the PCMH Program. The Program serves Members wherever they live – including outside of the CareFirst service region.

The CCM Program provides ongoing assessment and evaluation of the Member's progress toward their specific goals. The Member and CCM are in contact at least weekly to determine progress relative to Care Plan goals and to assess barriers to these goals. In addition to contact with the Member on a weekly basis, the CCM also collaborates with PCPs, specialists, family members and interdisciplinary team members involved in their care as well as with any TCCI Program partners serving the Member. The CCM coordinates authorization of high cost services or complicated treatment regimens needed and maximizes the Member's benefit coverage by charting the most cost-effective path.

The CareFirst Complex Case Management Program was created in 2011 and quickly became a core TCCI Program. The CCM Program has grown every year since inception. The volume of cases managed rose steadily from 2011 to 2016 as noted below in **Figure 26.** In 2016, CCM managed over 38,500 Members and is expected to reach over 40,000 Members in 2017. The average Illness Burden Score for Members in CCM in 2016 was 10.5 (10 times sicker than the average Member).

**Part VI, Figure 26: 2011–2017 Complex Case Management Program (CCM) Cases Managed**



Complex Case Managers use the entire range of TCCI Programs in developing and carrying out Care Plans to assist the Member and their families. Given the clinical complexity of the Members coordinated by the CCM Program and the skills required to assist the Member in a comprehensive fashion, the Program is staffed by specialized nurse case managers who have had considerable clinical experience in the specialty area needed by the Member. To this end, CareFirst maintains over 80 full-time registered nurses who serve as Complex Case Managers. Each Complex Case Manager handles an active caseload of 40 Members in their specialty area and coordinates the care of these Members for an average of two to three months' post discharge.

The specialty categories around which the CCM work force is organized are as follows:

- Adult Oncology
- Pediatric Oncology
- Complex Medical
- Trauma/Rehabilitation
- Skilled Nursing Facility Care
- Specialized Needs/Complex Pediatrics
- High Risk Obstetrics
- Hospice/Palliative/End of Life Care

All nurses in the CCM Program have a minimum of five years of clinical experience in their specialty area(s) in a hospital or physician practice. Case Manager certification is attained prior to hire by most nurses.

**Figure 27** below summarizes the qualifications by specialty area that is required for the nurses serving in the CCM Program:

**Part VI, Figure 27: Qualifications By Specialty Area Required For Nurses In The Complex Case Management Program (CCM)**

| Case Management Specialty | Qualifications (in addition to multiple levels/years of experience in each discipline) |
|---|---|
| Special Needs/High Risk Pediatrics | Certified Pediatric Nurse, Certified Neonatal Nurse, or Certified in Developmental Disabilities |
| Pediatric Oncology | Certified Pediatric Oncology Nurse, Certified Hospice/Palliative Nurse with concentration in Pediatrics, or Certified Pediatric Nurse |
| Adult Oncology | Certified Oncology Nurse, Certified Hospice/Palliative Care Nurse, or Certified Clinical Transplant Coordinator |
| High Risk Pregnancy | Certified Maternal Health Nurse or Certified Childbirth Educator/Nurse |
| Complex Medical Illnesses: Neurology, Cardiology, Pulmonology, Immunology, Gastroenterology, Endocrinology | Certified in Medical/Surgical Nursing or one of the specialty disciplines such as Neurology or Cardiology, Certified Case Manager, or Certified Geriatric Nurse |
| Palliative Care/Hospice | Certified Oncology Nurse, Certified Hospice/Palliative Care Nurse |
| Trauma/Rehabilitation | Certified Rehabilitation Nurse, Certified Orthopedic Nurse, Certified Neurology Nurse |

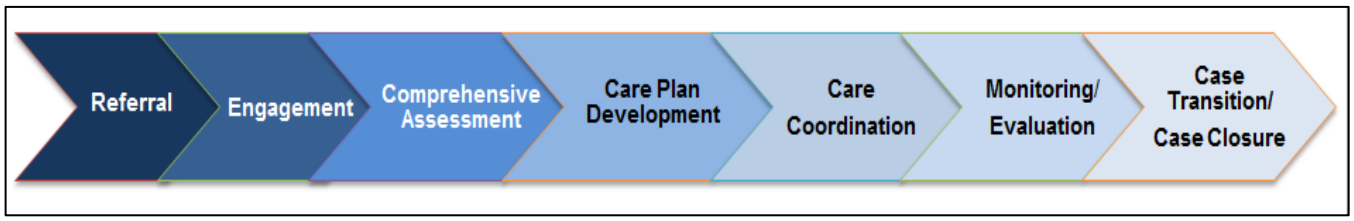
For each such Member, a designated, responsible CCM nurse is assigned. The approximate breakdown of these cases – into the categories shown above – is presented in **Figure 28** on the next page.

**Part VI, Figure 28: 2016 Breakdown Of Member Conditions/Illness In The Complex Case Management Program (CCM)**

| Program | Percent |
|---|---|
| Complex Medical | 30 |
| Adult Oncology | 20 |
| Rehabilitation/Skilled Nursing Facility (SNF) | 15 |
| Trauma/Injury | 15 |
| Hospice/Palliative/End of Life Care Adult and Pediatrics | 7 |
| High Risk Obstetrics | 6 |
| Special Needs/Complex Pediatrics | 6 |
| Pediatric Oncology | 1 |

The CCM Program adheres to the Case Management Society of America's (CMSA) guidelines for case management. "Case Management is a collaborative process of assessment, planning, facilitation, Care Coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes." The Complex Case Management continuum is shown in **Figure 29** below.

**Part VI, Figure 29: Complex Case Management Program (CCM) Continuum**




The CCM Program is Member-centric, holistic in nature and promotes the management of cases with evidence-based care. This continuum of care is provided across all health care settings-inpatient, alternative levels, rehabilitation, hospice, home health, ambulatory, and outpatient services. Quality audits are conducted on each Complex Case Manager monthly to insure the highest standards of CCM practice.

The CCM process begins the same day the referral is received. The Complex Case Manager reaches out to the Member and/or Member's family and the specialist. This early connection allows the Complex Case Manager to be actively involved in the discharge planning process and ensures smooth transitions of care. Complex Case Managers also engage with the PCP and other clinical disciplines such as hospital discharge planners. All Care Plan components are documented and maintained online in the iCentric System.

For each case, the CCM establishes a written Care Plan in the iCentric template that is composed of a number of parts including a narrative summarizing the Member's circumstances, actionable goals and progress and encounter notes that track progress toward these goals. The foundation of every CCM Care Plan is a comprehensive assessment. The focus of the assessment is to identify the main complex or catastrophic conditions requiring intervention and action. The Complex Case Manager identifies short and long-term needs, as well as barriers to compliance, and is responsible for coordination of care with the Member's treatment team. Assessment and reassessment of the Member's needs occurs on an ongoing basis and addresses the Member's medical conditions, Behavioral Health status, including cognitive functioning, any psychosocial issues, cultural and linguistic needs, caregiver resources, health benefits, and available health care benefits.

Every CCM Care Plan has prioritized goals. The CCM establishes a timeline and tasks for each goal reflecting the resources to be utilized to achieve the goals, and contain a schedule for follow up. If barriers to meeting goals are identified, a specific Plan to address each of these barriers is developed. A self-management plan is developed and communicated with every Member in Complex Case Management. All elements of each Plan are documented in the Care Plan component of the Member Health Record maintained online in the iCentric System.

The CCM works closely with the Member, their family and other supporting persons as well as the specialists involved in carrying out the Care Plan. This is done telephonically. The lead specialist guides and approves the Care Plan that the CCM nurse documents and carries out.

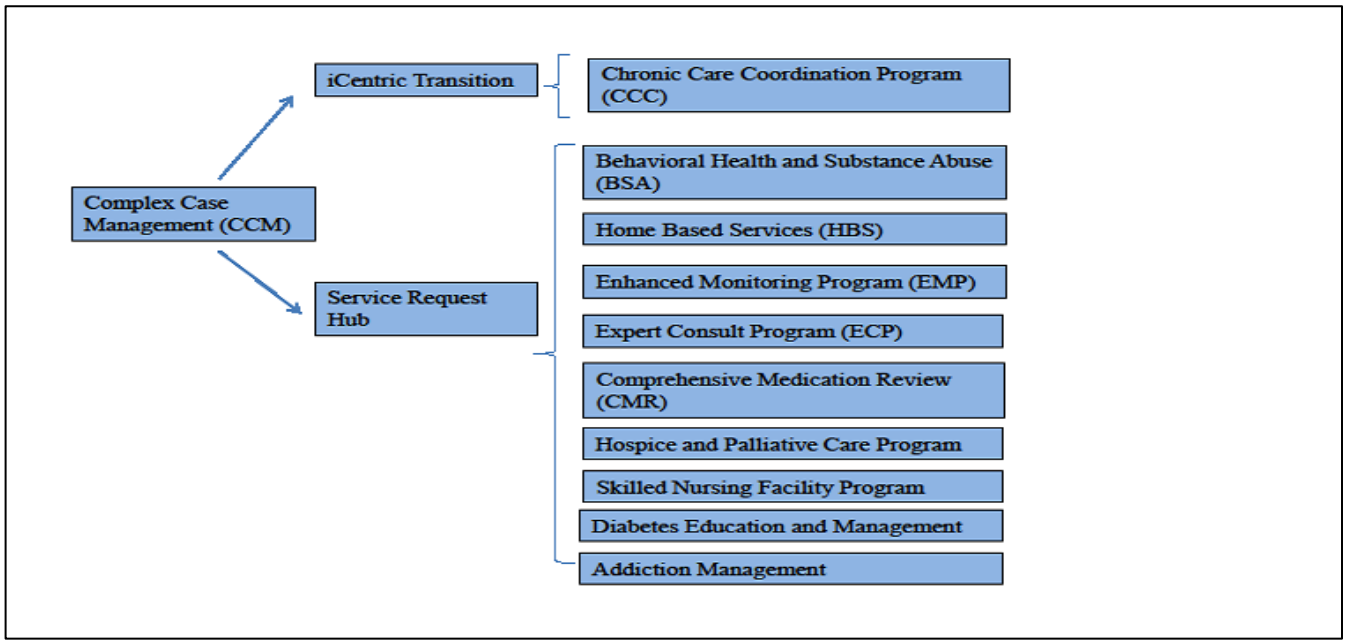
When a Member becomes engaged in a Care Plan, the Member and their CCM discuss and outline a targeted "State-of-Being" that, when reached, constitutes completion of the Member's Care Plan and enables graduation from the Care Plan. Graduation occurs when the Member is stabilized and can better self-manage their condition. At graduation, Members are surveyed regarding satisfaction with their individual CCM and the overall CCM Program. In 2016, over 2,400 CCM Member Satisfaction Surveys were completed with an overall CCM satisfaction rate of 92.9 percent. Member Satisfaction with CCM services continues to improve year after year and many Members go beyond the survey questions to write detailed notes about the impact of CCM services on their lives. With Member permission, a number of Member testimonials have been captured as a way of demonstrating the benefit of the CCM Program to Members.

If a Member in the CCM Program progresses to the point where a transition to Chronic Care Coordination is appropriate, the CCM nurse transitions the case to the LCC who is supporting the PCP of the Member. The CCM and the LCC engage the PCP early on in the Care Plan process, enabling a smooth transition once the Member's acute condition stabilizes. As with transitions from HTC to CCM, the transitions from CCM to CCC must be confirmed in the iCentric System and a formal change in lead responsibility must be established before the transition is complete. Approximately 15 percent of all CCM cases transition to the CCC Program. The balance of CCM Members continue their recovery through self-directed care in accordance with their physician's instructions.

The CCM nurse may make a referral through the iCentric Service Request Hub to arrange for TCCI Programs to be brought to bear. Should these other Programs be arranged, they are made part of the larger Care Plan of the Member – in effect, "nesting" these additional services into the larger Plan. All are documented and updated in the iCentric System. The CCM who referred the case remains the lead who is responsible to oversee all Program components, ensuring continuity of care.

TCCI Programs that the CCM can refer to are listed in **Figure 30** below. The transition from CCM to HTC does not happen often (about 600-700 per year). Usually the CCM transitions back to HTC if the Member will be hospitalized for a considerable period of time.

**Part VI, Figure 30: Complex Case Management Program (CCM) Referrals To TCCI Programs**




The CCM Program optimizes value for Members and employers by identifying appropriate providers and facilities across the continuum of health care services for the very ill Member identified for CCM-thus insuring that resources are timely, cost effective and efficient and services are provided in accordance with the Member's Benefit Plan. Since implementation in 2011,

the CCM Program has repeatedly demonstrated substantial improvements in Medical PMPM costs, ER visits per 1,000 and Readmissions per 1,000. For Members continuously enrolled in CCM, the decreases are striking across all categories, as noted in the Percent Change column in **Figure 31** below.

**Part VI, Figure 31: For Members With 12 Months Pre- And 12 Months Post-Complex Case Management Program (CCM) Activation**

| | | Medical PMPM | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | Members in CCM | 12 months prior CCM Engagement | 1 month after CCM Engagement | 2 months after CCM Engagement | 3 months after CCM Engagement | 6 months after CCM Engagement | 9 months after CCM Engagement | 12 months after CCM Engagement | % Change from pre to 12 Months Post |
| 2012 | 6,182 | $4,659.76 | $7,785.79 | $6,464.33 | $5,826.69 | $4,878.33 | $4,210.82 | $3,811.68 | -18.2% |
| 2013 | 10,136 | $3,830.15 | $5,426.14 | $4,879.04 | $4,422.54 | $3,656.97 | $3,183.70 | $2,915.81 | -23.9% |
| 2014 | 11,149 | $3,795.02 | $4,804.67 | $4,225.06 | $3,890.66 | $3,207.09 | $2,807.53 | $2,594.36 | -31.6% |
| 2015 | 5,113 | $3,771.92 | $4,714.02 | $4,245.74 | $3,938.25 | $3,401.02 | $2,989.90 | $2,740.47 | -27.3% |
| **Total** | **32,580** | **3,966.4** | **5,549.45** | **4,856.7** | **$4,430.96** | **$3,694.60** | **$3,219.45** | **$2,948.28** | **-25.7%** |
| | | ER Visits per 1,000 | | | | | | | |
| Year | Members in CCM | 12 months prior CCM Engagement | 1 month after CCM Engagement | 2 months after CCM Engagement | 3 months after CCM Engagement | 6 months after CCM Engagement | 9 months after CCM Engagement | 12 months after CCM Engagement | % Change from pre to 12 Months Post |
| 2012 | 6,182 | 829.2 | 914.3 | 832.7 | 787.4 | 748.6 | 719.9 | 694.9 | -16.2% |
| 2013 | 10,136 | 782.0 | 885.6 | 802.7 | 749.4 | 678.2 | 647.6 | 621.1 | -20.6% |
| 2014 | 11,149 | 792.4 | 997.8 | 848.1 | 789.7 | 709.3 | 675.3 | 651.0 | -17.8% |
| 2015 | 5,113 | 792.9 | 854.3 | 825.0 | 774.5 | 708.4 | 653.2 | 631.5 | -20.4% |
| **Total** | **32,580** | **796.2** | **924.5** | **827.4** | **774.3** | **706.9** | **671.7** | **647.0** | **-18.7%** |
| | | Admits per 1,000 | | | | | | | |
| Year | Members in CCM | 12 months prior CCM Engagement | 1 month after CCM Engagement | 2 months after CCM Engagement | 3 months after CCM Engagement | 6 months after CCM Engagement | 9 months after CCM Engagement | 12 months after CCM Engagement | % Change from pre to 12 Months Post |
| 2012 | 6,182 | 1,196.4 | 1,382.1 | 1,196.7 | 1,083.1 | 1,003.9 | 870.7 | 778.1 | -35.0% |
| 2013 | 10,136 | 1,194.6 | 1,037.1 | 886.1 | 801.9 | 710.7 | 615.2 | 557.1 | -53.4% |
| 2014 | 11,149 | 1,162.6 | 849.2 | 712.0 | 665.5 | 575.8 | 504.6 | 467.9 | -59.8% |
| 2015 | 5,113 | 1,167.0 | 835.5 | 717.0 | 668.9 | 603.2 | 522.3 | 485.8 | -58.4% |
| **Total** | **32,580** | **1,179.7** | **1,006.6** | **858.9** | **787.7** | **703.3** | **611.3** | **557.3** | **-52.8%** |
| | | Readmits per 1,000 | | | | | | | |
| Year | Members in CCM | 12 months prior CCM Engagement | 1 month after CCM Engagement | 2 months after CCM Engagement | 3 months after CCM Engagement | 6 months after CCM Engagement | 9 months after CCM Engagement | 12 months after CCM Engagement | % Change from pre to 12 Months Post |
| 2012 | 6,182 | 249.1 | 656.1 | 507.6 | 427.0 | 316.7 | 257.1 | 223.1 | -10.5% |
| 2013 | 10,136 | 152.6 | 609.7 | 427.4 | 341.0 | 245.1 | 197.8 | 171.6 | 12.4% |
| 2014 | 11,149 | 125.5 | 569.4 | 397.7 | 322.5 | 219.6 | 170.3 | 149.3 | 18.9% |
| 2015 | 5,113 | 134.8 | 577.4 | 397.8 | 320.0 | 244.9 | 191.4 | 166.0 | 23.2% |
| **Total** | **32,580** | **158.8** | **599.6** | **427.8** | **347.7** | **249.9** | **198.6** | **172.8** | **8.8%** |

The CCMs seek to help manage plan benefits, close gaps in care and manage available resources. If a service requires plan authorization, the CCM will coordinate with the treating provider to ensure all authorization requirements are met. The CCM will follow the authorization in iCentric to ensure approved services are rendered as documented in the CCM Care Plan.

In order to remain in the Care Plan and continue to receive Care Plan related benefits - including a Cost Share Waiver - the Member must be meaningfully engaged with the CCM, and follow the actions and steps called for in the Care Plan. Specifically, to remain compliant in a Care Plan a Member must:

1. Engage with the CCM at least once each week for the duration of the Care Plan, as measured by the CCM's documentation of the frequency of successful contacts with the Member in iCentric;

2. Complete the activities outlined in the Care Plan, to assist in stabilizing the Member in order to avoid unnecessary hospitalizations or ER use; and
3. Make progress toward the Care Plan's envisioned State-of-Being for the Member.

When a Member is not adhering to the above requirements the Member is deemed non-compliant and given 30 days to re-engage with the CCM and make progress toward Care Plan goals. If the Member has not appropriately re-engaged after 30 days of non-compliance, the CCM will recommend that the Care Plan be terminated by the treating physician as explained more fully earlier in this **Part VI**.

**Conclusion**

In each Program year since inception, the CCM Program has reduced overall medical costs for critically ill Members by reducing readmissions and ER visits. The 2016 Average Illness Burden Score for Members in CCM has steadily risen. In addition to reducing the cost of care, the CCM Program strives to improve the Member's quality of life and empower the Member in decision making about their health. This robust and comprehensive approach, where the CCM is the central in the recovery of the Member during an acute event, facilitates positive and significant results for the Member in the present and has far reaching effects on their future.

## Program #4: Chronic Care Coordination Program (CCC)

Care Coordination for Members with multiple chronic diseases is a central goal of the PCMH Program and the TCCI Program Array. Without it, little can be done to reduce expensive hospitalizations and the costs associated with the repeated complications and breakdowns that characterize this small portion of the population.

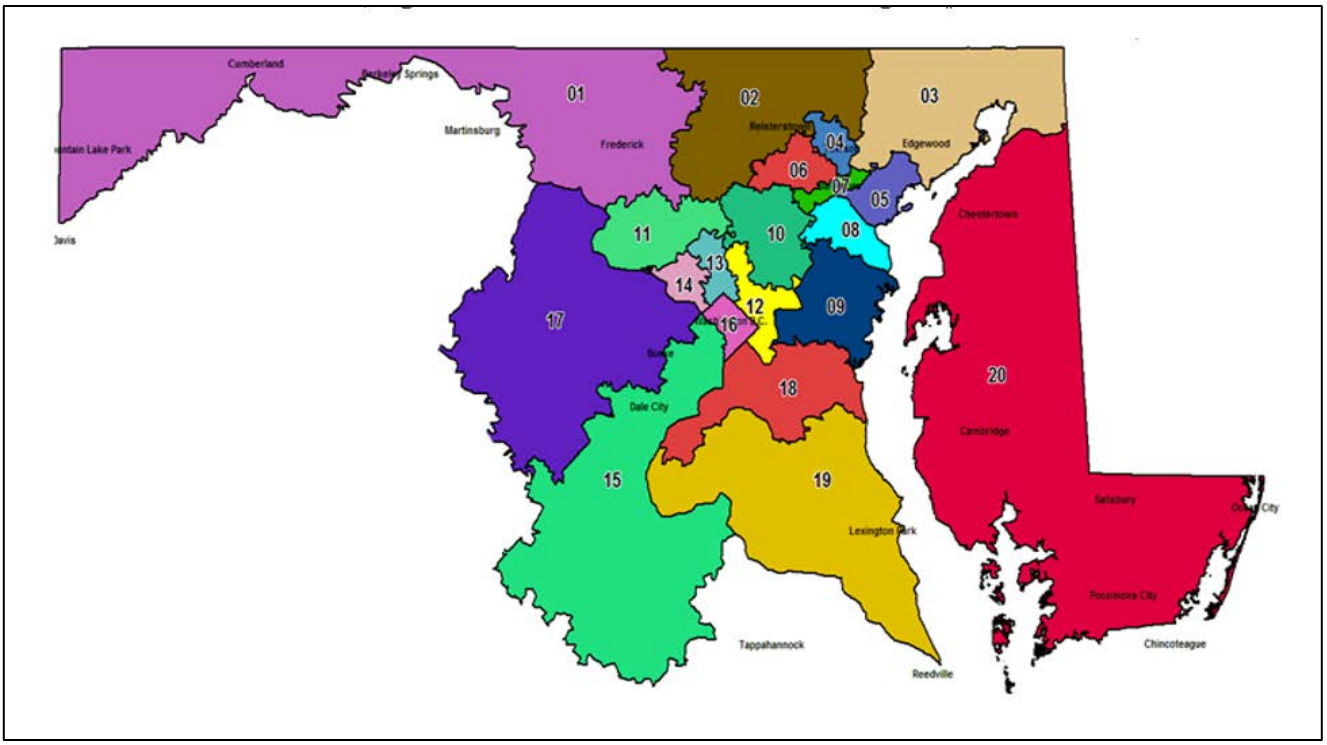
The CCC Program is carried out by a field force of over 250 registered nurses, all of whom have had prior clinical and working experience in various aspects of Care Coordination. This workforce of LCCs is organized by sub-region within the CareFirst service area which is divided into 20 sub-regions that represent approximately co-equal portions of the population within the overall region and, yet, recognize the differences that exist among rural, suburban and urban communities and cultures within each of these communities.

In effect, these sub-regions recognize the essential micro local nature of primary care and most other health care services. LCC nurses are assigned to a particular sub-region and to a particular practice within a Panel in the sub-region. All of these nurses live within the sub-region to which they are assigned and have considerable knowledge of the local physician community before they begin their duties in the PCMH/TCCI Programs.

It should be noted that a separate team of National Care Coordinators ("NCCs") is available for Members who live outside these twenty regions. NCCs develop and maintain Care Plans for out of area Members telephonically. These Care Plans are subject to the same standards and review processes as LCC developed plans and are documented in the same way in the iCentric System as well as reported in various views of Panel data provided in SearchLight Reports. A full dataset is kept on Members not attributed to a PCMH PCP inside the CareFirst service area.

**Figure 32** below shows the sub-regions within the overall CareFirst service area:

**Part VI, Figure 32: CareFirst PCMH/TCCI Sub-Regions**




A registered nurse, who is an employee of CareFirst, is in charge of each sub-region and is responsible to oversee all CCC activities within his/her sub-region. These nurses are called Regional Care Directors ("RCDs"). They direct all Care Coordination activities and the implementation of the TCCI Program Array within their sub-region.

Each of the over 400 Medical Panels within the PCMH Program is located within one or more of these sub-regions based on the location of the practices that make up each Panel. So, each RCD has a discrete number of Panels for which he/she is responsible. Their goal is to help the Panels succeed in earning an OIA by coordinating the care of Members with multiple chronic diseases most in need of Care Coordination.

LCCs work intensively with the PCPs to whom they are assigned. In so doing, they essentially become an integral part of the practice. It is expected that each LCC will build a trusted and active relationship with the practice(s) to whom they are assigned and that they will have frequent, regular contact and engagement with the practice. So, while the LCC is not physically embedded in the practice, the LCC is expected to be well known to it and operate as an integral part of the practice.

Most LCCs are employed by Sharecare, a strategic partner of CareFirst. Sharecare is a specialty Wellness, Disease Management and Care Coordination company with a large established presence in the CareFirst region. All Sharecare LCCs work under the direction of the various RCDs. The methods by which this workforce is recruited, trained, overseen and monitored are extensively documented in **Appendix E** as are their qualifications and performance standards, including the quality of the Care Plans they develop and maintain.

The level of illness of Members in Care Plans is over five times that of the general population as shown in **Figure 33** below. The level of illness in the selection of CCC cases is also shown in **Figure 33**.

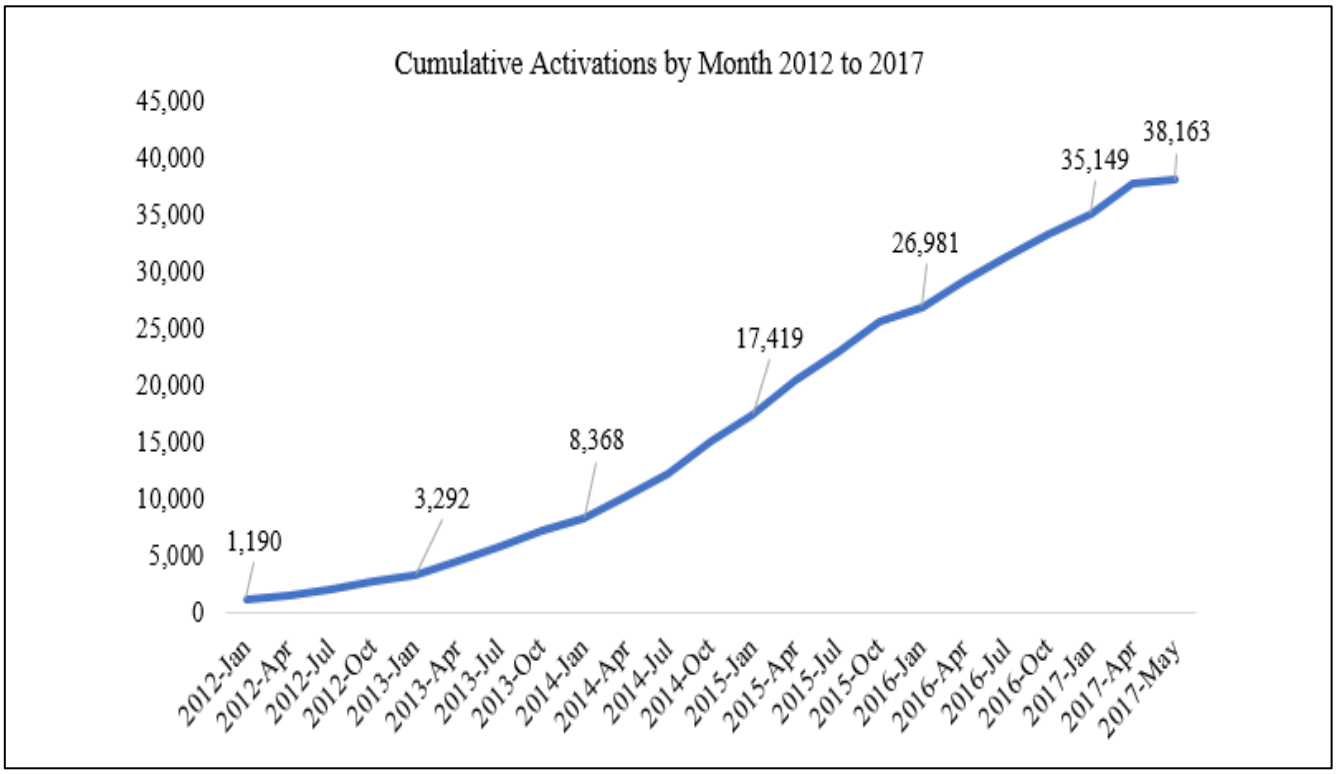
**Part VI, Figure 33: Illness Level Of Members In Chronic Care Plans As Of October 1, 2013 And December 1, 2016**

| Rgn # | Region Name | Average IBS | | | |
|---|---|---|---|---|---|
| | | 10/1/13 | 12/1/2014 | 12/1/2015 | 12/1/2016 |
| 1 | Western Maryland | 4.15 | 5.89 | 6.52 | 7.49 |
| 2 | North Central Maryland | 4.77 | 5.4 | 6.37 | 7.21 |
| 3 | North Eastern Maryland | 2.81 | 6.21 | 6.16 | 8.73 |
| 4 | Towson and I-83 Corridor | 3.81 | 5.61 | 5.72 | 7.11 |
| 5 | North East Baltimore Metro | 4.17 | 5.71 | 6.4 | 7.09 |
| 6 | North West Baltimore Metro | 3.67 | 6.48 | 5.92 | 6.99 |
| 7 | South West Baltimore Metro and City | 4.36 | 6.44 | 6.76 | 8.10 |
| 8 | North Anne Arundel | 3.11 | 5.71 | 6.92 | 6.84 |
| 9 | Annapolis and South Anne Arundel | 3.68 | 4.89 | 6.64 | 9.56 |
| 10 | Howard and Northern Prince George's County | 4.05 | 5.33 | 7.12 | 8.43 |
| 11 | Northern Montgomery County | 3.14 | 4.08 | 6.26 | 8.52 |
| 12 | College Park, Greenbelt, and Hyattsville | 4.58 | 5.39 | 5.94 | 8.34 |
| 13 | Silver Spring and Wheaton | 3.65 | 5.31 | 7.03 | 6.66 |
| 14 | Rockville and Potomac | 2.98 | 4.22 | 5.14 | 6.46 |
| 15 | Arlington, Alexandria, and Annandale | 4.44 | 5.93 | 6.04 | 7.55 |
| 16 | District of Columbia | 2.24 | 5.77 | 7.45 | 9.51 |
| 17 | McLean, Sterling, and Leesburg | 3.3 | 5.42 | 6.54 | 7.52 |
| 18 | Southern Prince George's County | 4.64 | 5.42 | 7.32 | 6.99 |
| 19 | Southern Maryland | 4.01 | 4.57 | 5.87 | 8.32 |
| 20 | Eastern Shore | 4.07 | 5.35 | 6.77 | 8.18 |
| | **Overall Average** | **3.75** | **5.51** | **6.44** | **7.78** |

One of the essential duties of an LCC is to work with the practice to which they are assigned to identify the best candidates for Care Plans from among the practice's population of Members. This is done in a number of ways as outlined earlier in this

**Part VI** using the scores and indices described. And, as noted earlier, many CCC Plans come from HTC or CCM transitions. The growth of Care Plan volume is depicted in **Figure 34** below.

**Part VI, Figure 34: Chronic Care Plan Volume By Month Since 2012**




The cumulative volume of Care Plans has steadily increased over time. The identification of the Core Target Population spurred substantial growth in volume as well as in Member morbidity. Using Members identified as in the Core Target Population, LCCs, in concert with PCP judgment, make final selections of Members for a CCC Plan. As presented in **Figure 35** on the next page, the Members in the Core Target Population most often exhibit the characteristics listed.

**Part VI, Figure 35: Member Selection Criteria For Chronic Care Coordination Program (CCC)**

**MEMBER SELECTION RATING CRITERIA**

**Member is clinically unstable demonstrated by many factors, including, but not limited to:**

- Multiple hospitalizations or ER visits in the last three to six months.
- An Illness Burden Score (IBS) of 6.0 or greater.
- Multiple PCP/specialist visits (more than one visit per month).
- Multiple urgent care visits for chronic condition management (example: COPD or asthma exacerbation).
- Medication non-adherence (may include non-adherence due to financial constraints).
- Deteriorating physiologic indicators.
- Deteriorating Behavioral Health status.
- Other indicators of instability identified by the PCP

**In addition to clinical instability, the Member needs to meet four or more of the below criteria:**

- Three or more abnormal clinical indicators (elevated hemodynamic measurements, elevated tests or diagnostics, etc., such as BMI >50, uncontrolled HTN, Hemoglobin A1C >9. These indicators must demonstrate instability (trending towards poorer values).
- Two or more specialists involved in care (excludes: dentists, optometrists, gynecologists unless the Member has significant clinical conditions in these specialties).
- Eight or more prescribed medications – Polypharmacy with evidence that the Member does not adhere to or understand medication regimen (excludes: vitamins, over-the-counter).
- Two or more barriers to care (financial, psychosocial, cultural, language, access, etc.).
- LACE score (within the last 60 days) of 10-19.
- Pharmacy Burden Score (PBS) of five or more.
- Charlson Comorbidity Index Score (CCI) of three or more.
- Member has little understanding of their disease and/or is non-complaint with self-care management (diet, exercise, medication, interventions, preventive screenings, etc.).
- Little evidence of social support system.
- Members with known diagnosed psychiatric conditions such as bi-polar disorder, schizophrenia, paranoia, depression, anti-social disorder, personality disorders, etc.
- Need for home-based interventions (home O2, assistive devices, PICC lines, G-tube, etc.)
- Vision or hearing impairments that impede the ability to execute self-care measures.
- New diagnosis of a chronic condition within the last three months.

The Members who are identified on the Core Target list constitute the "bull's eye" for Care Coordination by LCCs in concert with the judgment of PCPs to whom they are assigned. All identified Core Target Members must be assessed for their need for a Care Plan.

It is critical once a Care Plan is developed and maintained by the LCC in the Care Plan Template in the iCentric System, that frequent and responsive communication with the Member in the Care Plan occurs. The goal is to prevent breakdowns leading to admission, re-admission and ER visits and to help the Member achieve the highest possible level of independent functioning they are capable of on a sustained basis.

Over the next several years, the Member population in Care Plans is projected to increase substantially. When this point is reached – together with 40,000 CCM Care Plans – a substantial change in the patterns and use of hospital-based services is expected throughout the CareFirst region for CareFirst Members. Evidence of this is already occurring with a 20 percent decline in the rate admission of CareFirst Members in the 2011 to 2016 period – with no corresponding decline in enrollment which has remained essentially flat.

All Care Plans require the consent of the individual Member involved. The best party to seek this consent is the Member's PCP with the support of an experienced LCC. Consent is obtained in over 85 percent of the cases in which it is sought. The process of obtaining consent is the first step in engaging the Member in his/her own Care Plan and in obtaining the best possible results.

Members in CCC Care Plans are surveyed quarterly through an independent survey process to ascertain whether they perceive they are benefiting from the Care Plan process and whether they have an effective, engaged relationship with the PCP and LCC. Scores on these surveys are consistently high averaging 4.4 to 4.5 on a 5-point scale.

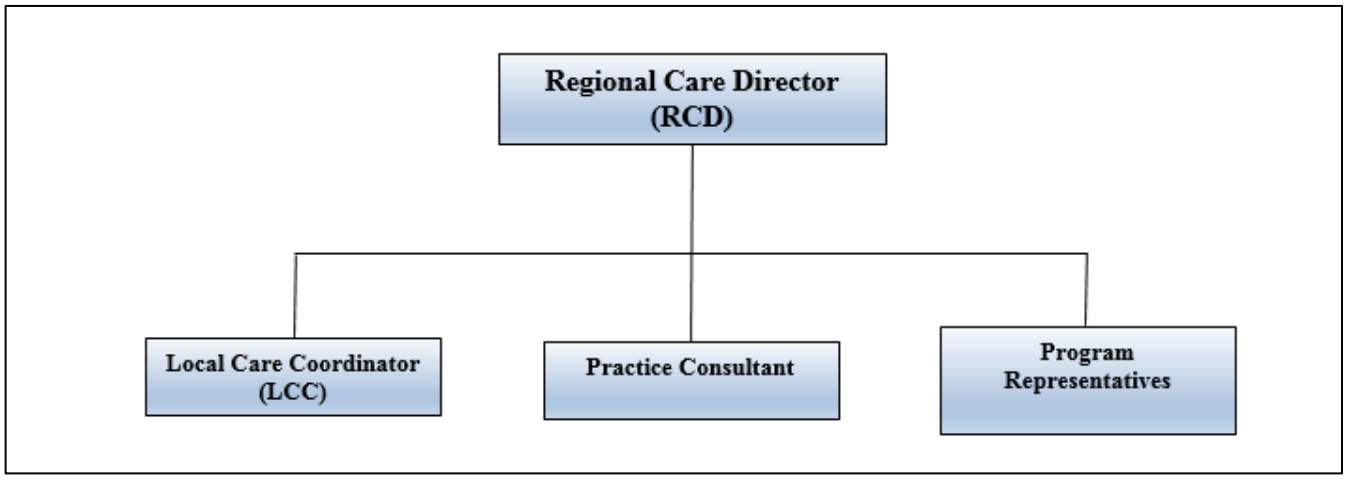
It is important to note that each sub-region operates as an integrated team in seeking to develop Care Plans for targeted Members and generally help Panels in the sub-region win an OIA.

The LCC is joined by a Practice Consultant who is assigned to the same sub-region on a full-time basis and who becomes fully familiar with the patterns of the practices and Panels in the sub-region. The Practice Consultant's job is to continually analyze the data in the SearchLight Reports for the Panels in the sub-region, consult with the PCPs who make up these Panels and convene Panel meetings to discuss emerging trends. The Practice Consultants report to the Vice President, PCMH Practice Consulting.

Another key Member of the regional team is the Program Representative who meets with PCPs in the practices and Panels in the sub-region to which they are assigned to assure a smooth, knowledgeable and efficient administrative functioning of the Program. This administrative support facilitates attention to the substance of the work to be done and minimizes the level of dysfunction that arises with improperly understood or used administrative features of the Program. The Program Representatives report to the Manager of PCMH Provider Relations.

The RCD is the leader of this team in the sub-region.

**Part VI, Figure 36: Team Structure At Sub-Regional Level**




Finally, it is essential to note that the LCC – like the CCM – has at their disposal, all Programs of the TCCI Program Array that can be incorporated to any degree necessary in Care Plans or offered individually to Members not in Care Plans if these Programs would assist in recovery or stabilization of the Member. These TCCI Programs are a simple, online service request away – easily made through the Service Request Hub in the iCentric System.

This means that a whole array of TCCI Programs, from BSD to CMR, HBS, ECP and EMP, can be brought to bear in the treatment and Care Coordination of a Member in a Care Plan.

Only LCCs and CCMs have the role-based authority to order these additional services for Members in Care Plans. The integration of these additional services in the context of a Plan that can be put together under the direction of the Member's PCP is fundamental the PCMH Program and TCCI Program Array designs.

## Program #5: Behavioral Health And Substance Use Disorder Program (BSD)

### Preface

One in four Americans experiences a behavioral health illness or substance use disorder each year. The majority of these individuals also have a comorbid physical health condition. Typically, medical expenses for Members with behavioral health conditions are twice as high as those in the general population and these conditions account for 10 percent of total hospital admissions. Total health costs for behavioral health are likely understated because these problems often go undetected as well as untreated due to several factors including: lack of access to primary care and behavioral health professionals, lack of proper diagnosis, and concern with the stigma associated with behavioral health diagnoses leading to gaps in care or under-treatment.

These factors exact a substantial toll on patients, their families, employers, and communities, as well as the PCPs who are tasked with coordinating care for patients with these significant and complex needs – challenges that increase when they occur along with chronic disease such as diabetes, asthma, and heart disease. Behavioral health problems such as depression, anxiety, and substance use often exacerbate an underlying medical condition in a negative cycle of reduced health and deeper despair. As many as a third of Members who develop chronic diseases such as diabetes, heart disease, and chronic pulmonary diseases also suffer from depression. Behavioral health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other.

At a time when demand is growing for behavioral health and addiction services, PCPs working with PCMH LCCs constitute the first line of defense in the health care system where the patient is often confronted with a system of support that is fragmented, confusing, and difficult to access.

Through the Behavioral Health and Substance Use Disorder Program (BSD), CareFirst seeks to help Members access licensed behavioral health providers, in an effort to assist them in obtaining appropriate care for these conditions. For those Members with alcohol and/or drug addiction, CareFirst partners with select addiction recovery centers to provide Intensive Outpatient Programs ("IOP") and continued follow-up care thereafter.

The BSD Program is closely integrated with the TCCI Program Array and the PCMH Program. The integration of medical care with behavioral health and addiction services is a central objective of the PCMH and TCCI Program array. This is accomplished through the BSD Program. The BSD Program and Pharmacy Coordination Program also work together to provide a comprehensive approach to address the opioid crisis in the CareFirst region. The Program provides a coherent framework to:

- Identify Members with behavioral health and substance use conditions who may need help;
- Coordinate a comprehensive range of services these Members need;
- Make available a reliable flow of information to help PCPs integrate and manage the Member's medical, behavioral health, and substance use care more effectively; and
- Direct Members with substance use disorder to preferred addiction recovery centers for IOP services and long-term follow-up care.

The sections that follow describe the nature and extent of the BSD services available to Members who may need them.

**The Challenges in Behavioral Health Care**

Identifying Members with behavioral health conditions is often difficult. There are numerous ways in which behavioral health conditions may manifest themselves, resulting in conditions going misdiagnosed or untreated. In some cases, behavioral health disorders such as major depression, bipolar disorder, psychosis, and schizophrenia present in a typical fashion with challenges revolving primarily around treatment to mitigate symptoms and prevent progression. However, at other times, diagnosis is difficult, and these conditions can be hidden.

Not infrequently, Members can present suddenly with no previous history. Sometimes, symptoms appear as another condition entirely. For example, schizophrenia commonly presents in populations 19 to 26 years of age with no previous history of behavioral health disorders. Bipolar disorder and other mood disorders can masquerade as depression with no obvious signs of euphoria or mania.

The range of treatment options for behavioral health disorders is expanding and can be difficult for patients, their PCPs, and families to understand and access. New pharmacotherapy options can help patients, but also may be misused. Best practices for the use of new modalities such as Trans-Cranial Magnetic Stimulation ("TMS") and computerized Cognitive Behavioral Therapy ("CBT") are continually changing, making it difficult to stay abreast of the evolving body of best practice.

In addition, fragmented and/or limited provider networks may create a barrier to achieving needed behavioral health care services for Members. Of all the specialties, psychiatrists and other behavioral health professionals are the least likely to join a health insurance network. A study conducted by JAMA Psychiatry found that 55 percent of psychiatrists accepted private insurance compared with 89 percent for other doctors.[18] The failure to accept insurance coverage and participate in payor networks has posed challenges for Members trying to select and access behavioral health providers.

Since the demand for behavioral health services is likely to continue to outstrip capacity, improving care integration to better manage patient care and arrange needed services becomes imperative. If access is not managed properly, the care of patients with concurrent physical and behavioral health disorders is costly, fragmented, and ineffective.

Screening for mental illness and connecting Members to the treatment they need is an important part of primary care, but this taxes the PCP's time, resources, and capabilities. Further, care coordination for Members with persistent and serious psychiatric conditions or long-standing substance use problems goes well beyond the capabilities of the typical PCP.

Making matters more challenging, behavioral health emergencies can be unpredictable and dangerous. Frequent users of ER services also present with symptoms of behavioral health disorders and substance use. Members with behavioral health conditions often need on-call access to specialized care, on a 24/7 basis.

The challenges described above cause behavioral health disorders to have a profound social and economic impact on the community. Behavioral health conditions are often serious enough to cause limitations in daily living, ability to maintain employment, and participate in social activities. Employers are particularly harmed, for example, when behavioral health conditions hinder worker productivity and increase absenteeism. Of all conditions driving overall health care costs (defined as work related productivity loss together with medical and pharmacy costs) depression is ranked number one. Similarly, behavioral disorders account for 50 percent of all disability days. All of these factors drive increased cost of care – often with poor outcomes.

It follows, therefore, that a proactive program dealing with these challenges for those with behavioral health and substance use needs/conditions is vital. Helping Members manage and treat their conditions is heavily dependent on a proactive program which integrates needed medical and behavioral health services into a coherent plan over an extended time period. These resources are critical to improving overall health outcomes and reducing the costs associated with breakdowns. This is the purpose of the BSD Program.

[18] *Pear, Robert. "Fewer Psychiatrists Seen Taking Health Insurance." New York Times December 11, 2013.*

## CareFirst Population Characteristics

An analysis of CareFirst membership data reveals that over 260,000 Members received treatment for a behavioral health diagnosis in 2016 as shown in **Figure 37** below. Identification of these Members was determined by analysis of Members with claims for depression and major depressive disorders, anxiety, neuroses, substance use disorder, bi-polar disorders, psychoses, personality disorders, obsessive compulsive disorder, autism, schizophrenia, or eating disorders.

While these Members make up nearly 10 percent of the general CareFirst population, they have almost three times the admission rate of the general population. Moreover, the readmission rate among Members with behavioral health conditions is almost twice the rate of CareFirst's overall book of business. As with national data, the annual PMPM cost of a Member with a behavioral health condition is almost twice as high as the general CareFirst population.

**Part VI, Figure 37: CareFirst Members With Behavioral Health And Substance Use Disorder (BSD) Diagnoses, 2016[19]**

| CareFirst Members Overall | | | | | | |
|---|---|---|---|---|---|---|
| Illness Band | Members | | Avg IB Score | Debits PMPM | Admits Per 1,000 | 30-Day Readmits |
| | # | % | # | $ | # | % |
| Advanced/Critical Illness | 65,189 | 2.6% | 11.51 | $4,659 | 868 | 13.0% |
| Multiple Chronic Illnesses | 219,808 | 8.9% | 2.94 | $1,151 | 194 | 1.0% |
| At Risk | 325,929 | 13.2% | 1.43 | $512 | 59 | 0.1% |
| Stable | 805,065 | 32.6% | 0.55 | $195 | 6 | 0.0% |
| Healthy | 1,052,586 | 42.6% | 0.10 | $44 | 1 | 0.0% |
| **Total** | **2,468,577** | **100.0%** | **1.00** | **$392** | **52** | **14.2%** |
| **Members with a Behavioral Health Diagnosis** | | | | | | |
| Illness Band | Members | | Avg IB Score | Debits PMPM | Admits Per 1,000 | 30-Day Readmits |
| | # | % | # | $ | # | % |
| Advanced/Critical Illness | 14,516 | 5.5% | 11.66 | $4,569 | 1,246 | 34.4% |
| Multiple Chronic Illnesses | 46,456 | 17.5% | 2.98 | $1,243 | 244 | 17.2% |
| At Risk | 60,666 | 22.9% | 1.44 | $592 | 79 | 22.6% |
| Stable | 119,248 | 44.9% | 0.58 | $250 | 12 | 18.7% |
| Healthy | 24,471 | 9.2% | 0.18 | $126 | 4 | 8.6% |
| **Total** | **265,358** | **100.0%** | **1.77** | **$718** | **134** | **26.7%** |
| **Type of Diagnosis** | | | | | | |
| BSA Episodes | Members | | Avg IB Score | Debits PMPM | Admits Per 1,000 | 30-Day Readmits |
| | # | % | # | $ | # | % |
| Depression | 107,496 | 40.5% | 1.99 | $143 | 94 | 16.1% |
| Anxiety Disorder | 86,300 | 32.5% | 1.69 | $76 | 71 | 14.9% |
| Neuroses | 66,019 | 24.9% | 1.27 | $73 | 43 | 12.7% |
| Substance Abuse | 17,953 | 6.8% | 3.35 | $588 | 235 | 24.4% |
| Bipolar Disorder | 17,049 | 6.4% | 2.60 | $324 | 159 | 21.2% |
| Antisocial Personality Disorder | 5,016 | 1.9% | 1.36 | $240 | 81 | 14.0% |
| Psychoses | 4,636 | 1.7% | 3.18 | $111 | 175 | 18.0% |
| Obsessive Compulsive Neurosis | 3,941 | 1.5% | 1.44 | $120 | 59 | 15.9% |
| Autism | 3,224 | 1.2% | 1.22 | $322 | 43 | 10.8% |
| Schizophrenia | 1,831 | 0.7% | 3.55 | $569 | 387 | 19.9% |
| Eating Disorders | 1,134 | 0.4% | 2.92 | $884 | 129 | 15.1% |
| **Total Distinct Members*** | **265,358** | | **1.77** | **$718** | **134** | **26.7%** |

[19] *Members can have more than one BSD Diagnosis.*

**Identifying Members in Need**

Behavioral Health and Substance Use Disorder conditions manifest in the CareFirst membership across a wide spectrum of presenting diagnoses. The continuum ranges from common conditions such as generalized anxiety disorder to a core subgroup of those with Serious and Persistent Mental Illness ("SPMI"). Similarly, the needs of Members range from urgent to routine and require skilled review to determine the appropriate level of care required. Thus, an essential element of the BSD Program is the identification and assessment of Members who have unmet behavioral health and substance use needs, especially those who, were it not for the BSD Program, would be most likely to be admitted, readmitted, use ER services, and suffer complications.

There are 10 sources from which Members are identified for engagement in the BSD Program:

1. CareFirst LCCs/CCMs for Members who are identified on the Medical Core Target List and/or following an admission.

2. PCPs to whom Members are attributed.

3. Members on the Behavioral Health and Substance Use Core Target List (described below).

4. Members flagged by a Behavioral Hospital Transition Coordinator ("BHTCs") who are admitted to a hospital for a behavioral health and/or addiction service.

5. Members flagged by a Medical Hospital Transition Coordinator ("MHTCs") who are admitted with behavioral health or substance use needs upon admission.

6. Professional behavioral health specialists (psychiatrists, therapists, and other behavioral health providers).

7. Addiction clinics where Members present for intensive outpatient treatment.

8. Confidential Member self-referrals via web or phone.

9. Pre-service review of selected outpatient services including Applied Behavior Analysis ("ABA"), Transcranial Magnetic Stimulation ("TMS"), Electroconvulsive Therapy ("ECT"), and Complex Psychological Testing.

10. Members identified for non-adherence with specific behavioral health medications.

**The Behavioral Health Core Target Population**

The single most important way to identify Members who are most likely in need of Behavioral Health and Substance Use Disorder Care Coordination is through the Behavioral Health and Substance Use Disorder Core Target List ("BSD Core Target"). This list is identified by CareFirst through both medical and behavioral health claims data to which criteria are applied. The following are examples of criteria that aid in identifying Members who are candidates for the BSD Program because they are likely on the BSD Core Target List:

- 25 inpatient days or three or more admissions in a rolling 12-month period
- Members with substance use disorder related admissions associated with serious mental health issues
- Pregnant women who have abused substances
- Children, age 12 and under, with any behavioral health and/or substance use disorder hospitalization
- Chronic medical condition with depression, anxiety, or substance use disorder
- Behavioral health polypharmacy or use of medications used for treatment resistant conditions
- Cluster of behavioral health conditions
- Repeat alcohol /drug testing in the ER over a six-month period
- Autism and an ER visit or hospitalization
- Members with at least two ER visits with behavioral health diagnosis

**Assessing Members and Directing Them to Appropriate Care**

For each Member attributed to a PCMH PCP, who has been identified in the BSD Core Target Population, a clinical review is conducted by the LCC and PCP to assess the Member's level of instability on a monthly basis. An Assessment Outcome (AO) is determined for each Member, which indicates whether the Member needs behavioral health services and/or other services in the TCCI Program Array. If the assessment indicates that the Member needs behavioral health services, the LCC directs the Member, through the Service Request Hub, to the Behavioral Health Care Coordinator ("BHCC") embedded in the same region. The LCC and PCP work to schedule a time for the Member to visit the PCP's office to meet with the BHCC who will initiate a Care Plan and coordinate the Member's specific behavioral health needs and to seek the Member's consent to participate in the Program.

For Members in the BSD Core Target Population who are not attributed to a PCMH PCP, a clinical review is conducted by a centralized team of licensed BSD clinicians who are part of the BSD Assessment Team in CareFirst's Intake, Assessment, and Appointment ("IAA") Unit. The BSD Assessment Team reviews the Member Health Record and reaches out to the Member telephonically to engage them in the BSD Program. Where appropriate, the IAA Team works with the Member's non-PCMH PCP to engage the Member.

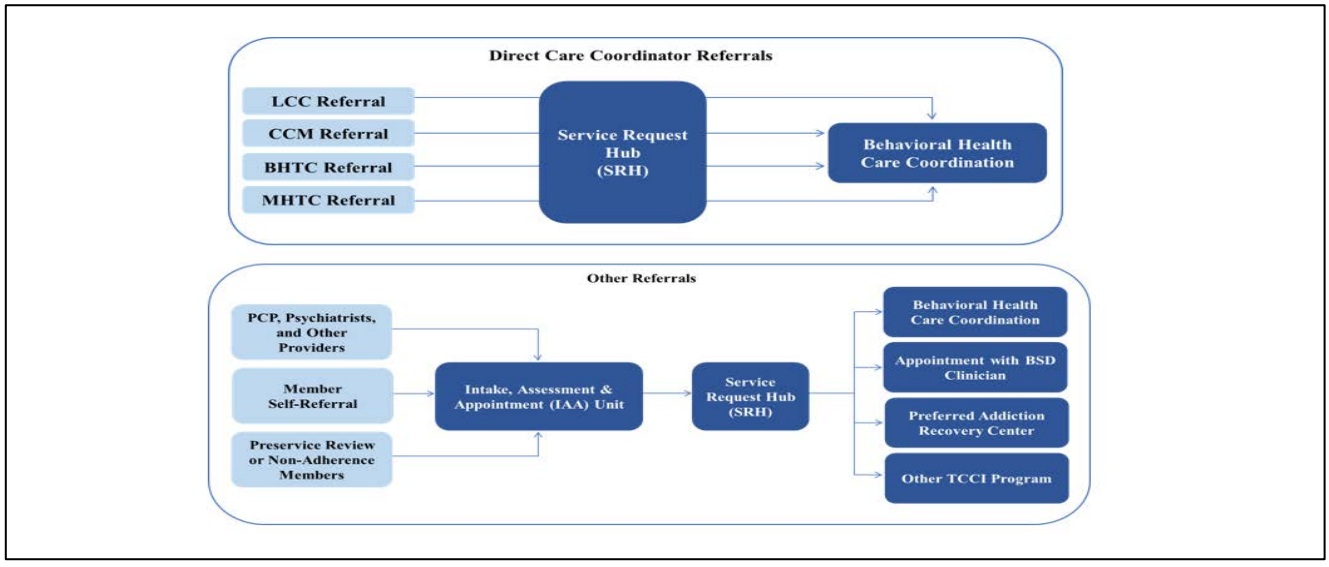
All TCCI Care Coordinators (LCCs, MHTCs, BHTCs and BHCCs) may refer Members not on the BSD Core Target List who have had a recent behavioral health admission or who reveal behavioral health needs as a result of a clinical review in a medical Care Plan. Care Coordinators refer Members via the Service Request Hub to the appropriate setting and provider best positioned to coordinate the Member's behavioral health care needs.

Referrals into the BSD Program may also come from community BSD clinicians, addiction clinics, Wellness and Disease Management Coaches, and from Members themselves. In these cases, the BSD Assessment Team, gathers information from the referring source and the Member's claim history in the Member Health Record to evaluate potential behavioral health needs. If the Member's case is appropriate for a Care Plan, the BSD Assessment Team will send a service request to the BHCC who is assigned to either the Member's PCP (for attributed Members) or to the region in which the Member lives (for unattributed Members).

Even if the BSD Assessment Team determines a Member is not appropriate for a BSD Care Plan, the Member may be connected to a CareFirst Appointment Advocate in the IAA Unit who will assist the Member in obtaining an appointment with an appropriate BSD clinician for future assessment and care.

**Figure 38** below illustrates the process flow for Members who are referred to the BSD Program.

**Part VI, Figure 38: Behavioral Health And Substance Use Disorder Program (BSD) Member Assessment And Referral**



**Behavioral Health Care Coordination**

BHCCs are licensed, masters-prepared, behavioral health professionals with a minimum of two years of experience in behavioral health care. They are overseen by a fully dedicated BSD Medical Director (a board-certified psychiatrist). These professionals are skilled in motivational interviewing techniques focused on behavioral change. This skill is particularly valuable in coordinating care for Members with comorbid medical and behavioral conditions. There are at least two BHCCs for every one of the 20 sub-regions within the CareFirst service area - and more than two, where needed. LCCs form mature, trusted relationships with their BHCC counterparts.

As noted, each BSD Care Plan begins with an assessment. The assessment covers, as appropriate, the Member's behavioral and medical history, clinical circumstances, support system, medications and substance use history, self-management skills, provider status, lethality issues, urgency status, readiness to change and motivations, stressors, cultural issues, and other relevant factors.

In making an assessment, BHCCs exercise clinical judgement and, once a Member consents to participating in the BSD Program, have the authority to:

- Develop the BSD components of a Care Plan and document these;
- Activate BSD Care Plans for Members;
- Terminate a Care Plan when the Member is non-compliant;
- Outreach to a Member when they show signs of breakdown after Care Plan completion; and
- Reactivate a Care Plan if clinically appropriate.

The first goal of every BSD Care Plan is to assure that the Member is connected to a behavioral health clinician in the community/region where they live who can assess the Member and provide ongoing clinical treatment. If the Member is not already being treated by such a clinician, the BHCC submits a request to the IAA Unit via the Service Request Hub triggering an Appointment Advocate in the IAA Unit to link the Member to a local provider and/or facility that offers the type of behavioral health care needed by the Member. Though the Member will receive behavioral health care directly from these community facilities and providers, coordination of care between the LCC, PCP, and BHCC will continue throughout the BSD Care Plan duration.

Throughout the course of the Care Plan, the BHCC works with the Member toward clinical stabilization and supports the Member as they progress toward stabilization. Once the Member has demonstrated successful and sustained stability with independent self-management, the Member is ready for graduation from the Care Plan.

To assess whether the Member attains stability during the Care Plan, a periodic assessment is used to track the Member's progress and risk for breakdown over time. This assessment measures changes in mental well-being and physical function. The BHCC administers this assessment at the time of consent and every 60 days throughout participation in the program, as well as at graduation from a Care Plan and periodically thereafter.

More specifically, this assessment measures behavioral health through a series of questions, and responses that are scored, taking into account the Member's gender and age. This is designed to cover the following domains: resiliency, pain interference, thought disorder, social activity, sleep, work-school participation, alcohol use, tobacco use and non-prescribed drug use.

After Care Plan graduation, the BSD Program closely monitors Member admissions and ER visits for a full 12 months thereafter. The same BHCC who managed the Member's Care Plan outreaches to the Member three and six months after graduation, when an adverse event occurs or when there is evidence of a breakdown, in order to conduct a new assessment and determine if the Member has regressed toward instability.

**Cost Share Waiver**

The duration of a Member's behavioral health Care Plan averages four to six months. During this time, it is crucial that Members frequently communicate with their BHCC and follow the steps and actions agreed to in their Care Plan. The Cost Share Waiver ("CSW") is designed to incent Members to stay connected to their Care Coordinator in all Care Plan Programs and to remove the barrier of cost sharing directly related to treatment which keeps the Member from accessing appropriate

levels of care. The CSW waives certain cost-sharing responsibility for Members in active Care Plans that allows them to receive the services within the Care Plan without cost as an impediment. Generally, Member cost-sharing for services rendered outside of a hospital setting is waived while cost-sharing for services rendered in a hospital or for drugs is not waived. The central purpose is to remove cost as a barrier to compliance while the Member is home and to increase the Member's chances to stabilize and recover from an acute phase of illness.

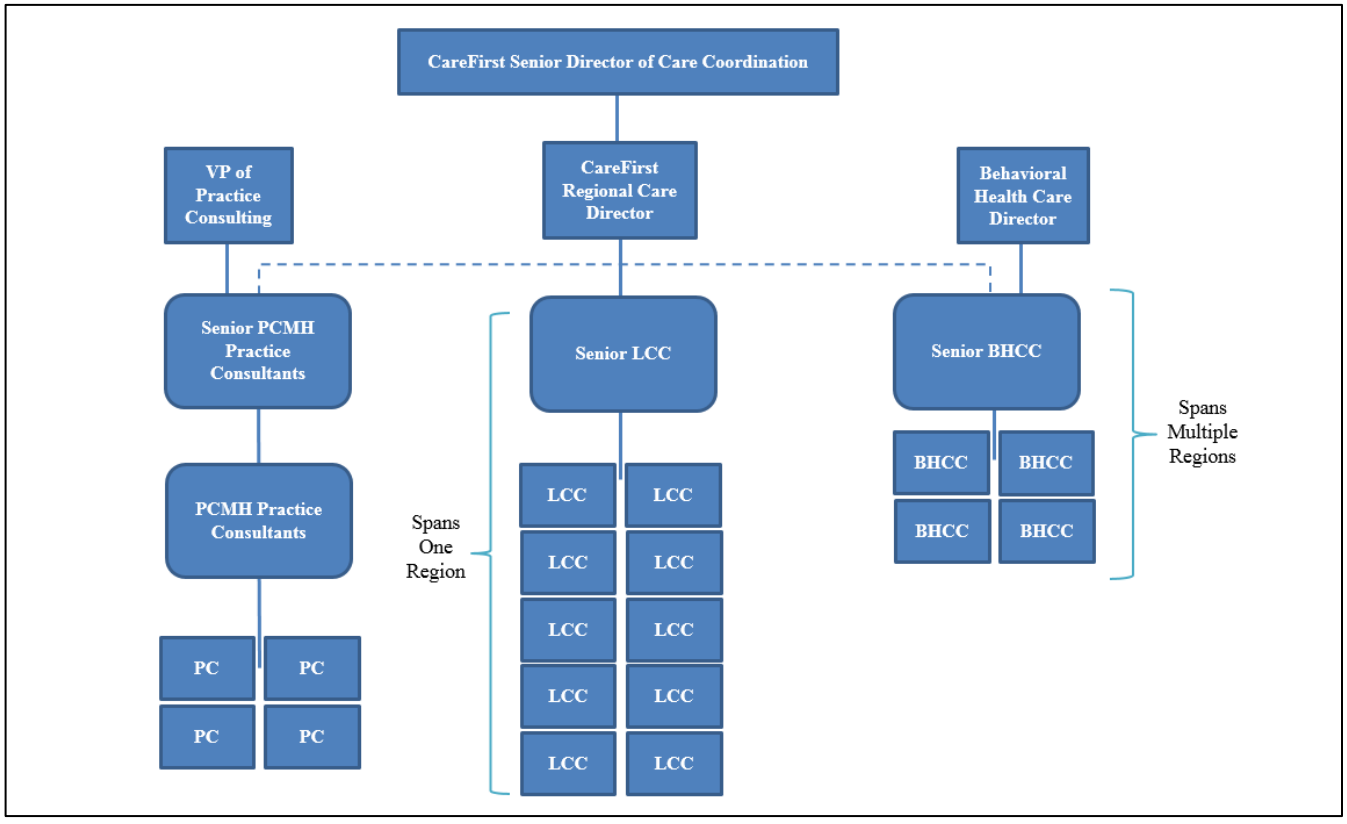
**Organizational Structure and Coordination**

CareFirst Regional Care Directors ("RCDs"), Behavioral Health Clinical Director ("BHCD") and Senior Behavioral Health Care Coordinators ("Senior BHCCs") work closely to carry out BSD Care Coordination. The RCD in each PCMH region is the authority for the overall clinical management of care coordination activities in their region for both medical and behavioral health services. The Behavioral Health Clinical Director (BHCD) provides clinical expertise in behavioral health to Senior BHCCs and reviews the substantive quality of BSD Care Plans. The BHCD, LCCs, and Senior BHCCs interview all candidates for BHCC positions and make recommendations to the RCD on each candidate prior to hiring.

The role of the Senior BHCC is to provide ongoing mentoring and support to each BHCC assigned to them. Senior BHCCs fully discuss with each BHCC, any aspect of their performance that relates to the goals for which they are responsible and keep the RCDs fully informed of the progress or lack thereof for each BHCC. Because of their additional duties, Senior BHCCs maintain reduced caseloads of between 15 to 25 Care Plans per Senior BHCC. This parallels the structure used for LCCs. All other BHCCs maintain a caseload of between 45 and 50 Members at any one time.

**Figure 39** below displays the organizational structure for BSD Care Coordination in a PCMH region. This structure is applied to all 21 PCMH Regions. It demonstrates how the organizational structure of each PCMH region supports the integration of medical, behavioral health, and addiction services.

**Figure 39: Behavioral Health And Substance Use Disorder Program (BSD) Care Coordination Organizational Structure**



As noted earlier, the co-existence of medical and behavioral health conditions creates the fundamental necessity for strong coordination and expertise in both areas of care. Hence, LCCs and BHCCs, and their Senior counterparts, are required to work closely together to achieve integrated Care Plans under the direction of the RCD in each CareFirst region. To further reinforce this close coordination, BHCCs and LCCs participate in daily team meetings together and take part in PCMH Panel meetings in their region. BHCCs attend PCMH and TCCI forums, and educational meetings with their medical counterparts and maintain constant communication with these in the regional teams.

**BHCC Training**

The training program for BHCCs has three major goals:

1. To assure that BHCCs are knowledgeable about the infrastructure, processes, and goals of the PCMH Program and TCCI Program Array so that they can effectively work with providers and Members, as well as other interested parties within the context and goals of these Programs.

2. To assure that BHCCs can effectively identify appropriate Members for BSD Care Plans.

3. To assure that BHCCs can develop and write clear, concise, and actionable Care Plans for Members who consent to them, and coordinate care for their Members with the goal of improving their health outcomes and reducing breakdowns resulting in hospitalization or emergency department visits.

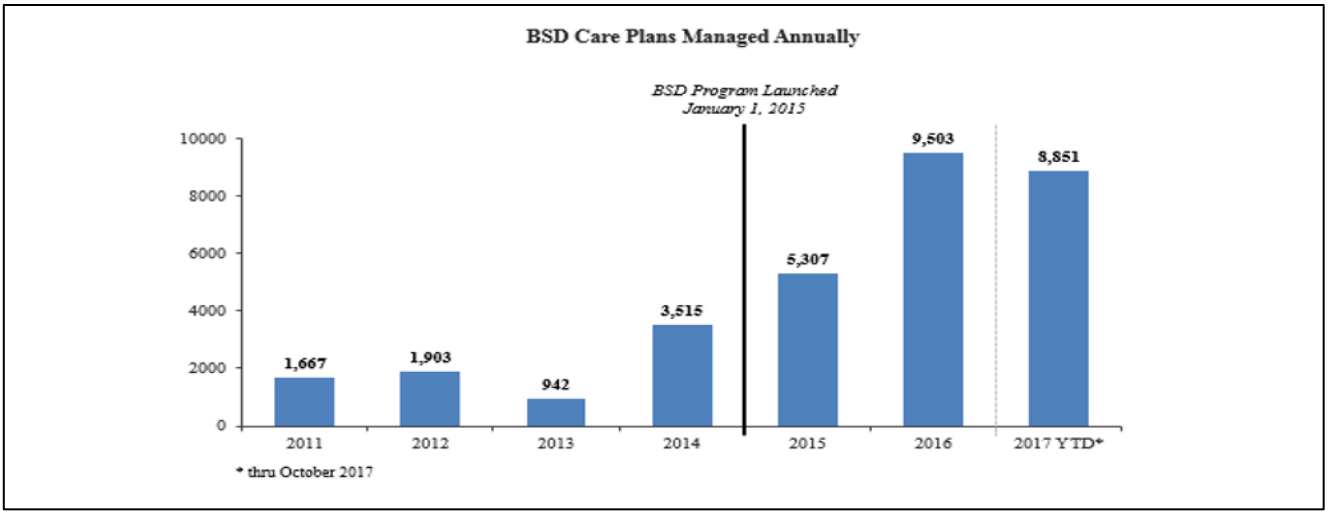
New BHCCs attend the CareFirst PCMH/TCCI Orientation and Training Program with their LCC counterparts. BHCCs also receive refresher training at least twice a year on the updates to the PCMH/TCCI Programs. BHCCs receive targeted training on how to effectively approach and engage a Member in the BSD Program. In this targeted training, BHCCs are taught how to explain the BSD Program to Members and the benefits of Care Coordination with the collaborative support of a LCC. They are also trained in the financial benefits of the CareFirst Cost Share Waiver ("CSW") which applies to Members in BHCC Care Plans.

Likewise, LCCs receive behavioral health training to effectively identify and work with CareFirst Members who have behavioral health and substance use disorders.

**BSD Referrals are Growing**

The BSD Program has had significant impact in care management since its inception in 2015. Over the two-year period, approximately15,000 CareFirst Members have benefited from a BSD Care Plan. As shown in **Figure 40** on the next page, the number of Members reached has dramatically increased, especially in the last two years with the advent of the BSD Program.

**Part VI, Figure 40: Behavioral Health And Substance Use Disorder Program (BSD) Care Plans 2011-2016, 2017 YTD**




When Members are referred for BSD Care Coordination, they are contacted by a BHCC within two business days for non-urgent referrals and within one business day for urgent referrals. Members experiencing an emergency or who are in crisis have access to a 24/7 crisis line. The initial contact with the Member includes an assessment of needs which guides the course of the Care Plan.

After the initial assessment and establishment of a BSD Care Plan, the Member is typically contacted no less frequently than weekly by phone for the duration of the Care Plan. A typical BSD Care Plan lasts between four and six months. Each contact with the Member is between 30 and 60 minutes in duration. The frequency and length of contact are adjusted depending on individual Member progress and needs with more severe circumstances requiring more time.

With the Member's consent, BHCCs collaborate with the family, treating providers, and community supports to develop a Care Plan that focuses on recovery and stabilization. A central focus is placed on assisting the Member in navigating the behavioral health delivery system and connecting the Member to the services and providers they need.

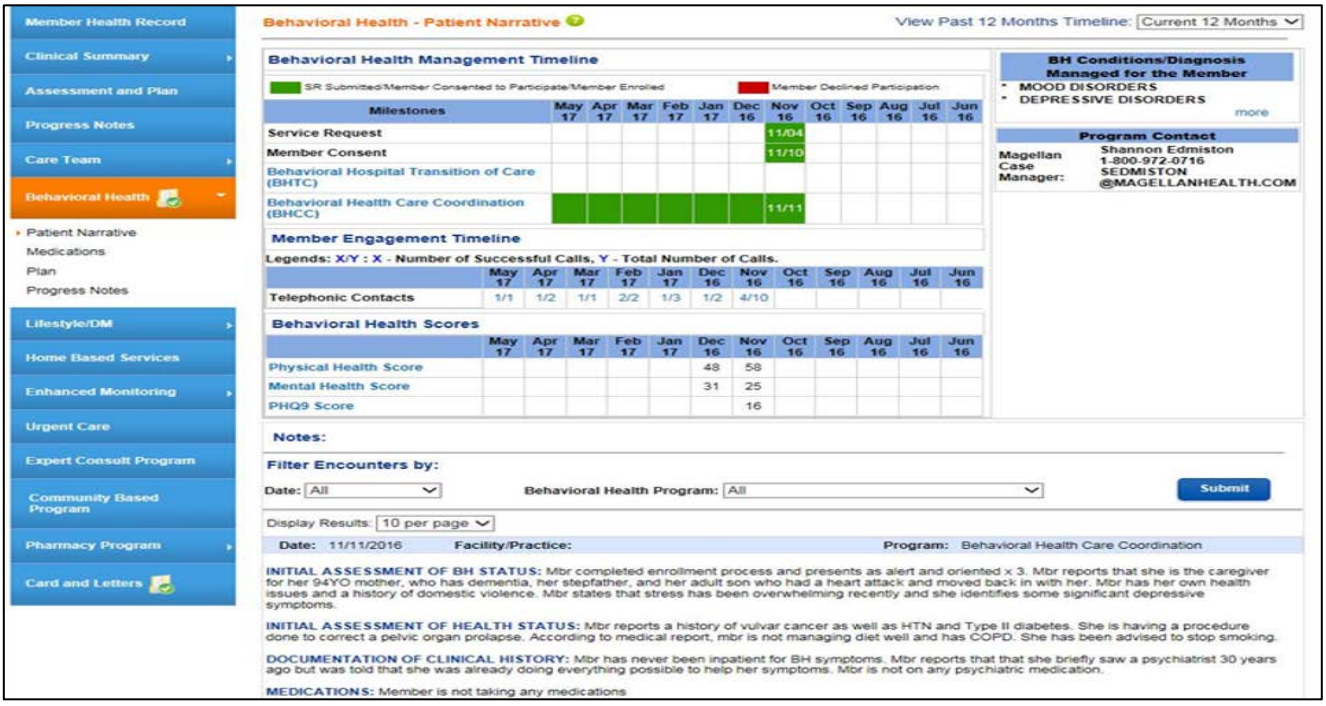
The BHCC assesses gaps in care, links the Member to appropriate services, facilitates referrals, provides assistance with arranging appointments, follows up to verify that appointments are kept, and helps to ensure that prescriptions are filled and taken as directed. The BHCC also checks with the Member to make sure that they receive the necessary instruction on their condition and that they understand these instructions.

For Members who have medical co-morbidities, such as diabetes, heart failure, chronic obstructive pulmonary diseases, to mention a few of the more common ones, attention is especially focused on developing the Member's ability to self-manage their medical conditions. To assure this, the BHCC routinely maintains contact with the LCC to assess Member progress and need.

**Clinical Content of BSD Care Plans is Maintained on an Up-to-Date Basis**

Findings, observations, and judgments are documented immediately after completion of a Member contact and are updated daily in iCentric for entry into the Member's Member Health Record (MHR) as depicted in **Figure 41** on the following page.

**Part VI, Figure 41: iCentric Behavioral Health Screen**




Clinical notes and information recorded by the BHCC are presented in four subsections: Patient narrative, medications, assessment and plan, and progress notes. When a Member becomes engaged in a Care Plan, the Member and their BHCC discuss and outline an envisioned target "State-of-Being" that, when reached, constitutes completion of the Member's Care Plan and enables graduation from the Care Plan. Graduation occurs when goals toward the target "State-of-Being" are attained and the Member is stabilized, engaged with the appropriate providers, has community and/or family support, is less at risk for breakdown and can better self-manage their condition due to having an adequate understanding of how to remain stable.

During the implementation of a BSD Care Plan, BHCCs document all sessions with Members in progress notes using the same format used by all CareFirst Care Coordinators. These notes are organized in three sections: Situation, Intervention, and Plan ("SIP"). By following this structure, each BHCC consistently documents their progress with the Member and plans for the next session in each weekly encounter. These notes are integrated with medical notes in the MHR.

To be compliant and achieve healthier outcomes, the Member must be meaningfully engaged with the BHCC, follow the actions and steps called for in the Care Plan and make progress toward the target "State-of-Being" for Care Plan graduation. Specifically, the goal of the BHCC is to assure that the Member remains compliant by:

1. Completing the activities outlined in the Care Plan, as evidenced by making and keeping provider appointments and taking medications as prescribed.

2. Meaningfully engaging in discussion with the BHCC at least once per week about their progress (or lack thereof) or more frequently as called for in the Care Plan. This is measured by the BHCCs documentation of the frequency of successful contacts with the Member as shown in iCentric and reflected in daily encounter notes. If the Member fails to meet this expectation, they will receive a warning letter, at which point the BHCC will initiate a 30-day process to re-engage the Member, as described below.

3. Participating in all relevant health inventories and questionnaires to track progress toward Care Plan graduation.

When a Member is not adhering to the requirements of their Care Plan, the Member is deemed non-compliant and given 30-days to re-engage with the BHCC and make progress toward Care Plan goals. If the Member has not appropriately re-engaged after 30-days of non-compliance, the BHCC will recommend to the BHCD that the Care Plan be closed prior to termination

for non-compliance. Reasons to close a behavioral health Care Plan other than non-compliance occur if the Member notifies the BHCC of a desire to discontinue the Program or the Member is no longer covered under a CareFirst health plan.

**Behavioral Health Care Plan Quality Reviews**

The quality of all BSD Care Plans is evaluated following procedures that closely align with medical Care Plan reviews.

The purpose of the Care Plan review process is to assure that Care Plans and the Care Coordination that flows from them are maintained at a high-quality level so as to promote consistency in Care Plan standards across the various PCMH/TCCI Care Coordination Programs. Care Plans are scored for appropriateness, documentation completeness, clarity, actionability, and quality through a peer review process in an exact parallel to medical Care Plans, as outlined in Appendix E of these Guidelines.

To accomplish this, the following steps are taken:

- The Senior BHCCs meet weekly and randomly select newly developed Care Plans that represent each BHCC.
- The Care Plans are reviewed by the Senior BHCCs as a team, on a blinded basis.
- The review team collectively determines a score. Each component is either met or not met (meaning that the BHCC receives all or none of the points associated with the standard in question).
- The BHCC is required to maintain an average score of 35/45 points in Care Plan quality and Care Coordination quality to successfully pass the review process.
- For each Care Plan review, a Senior BHCC gives feedback and coaches the BHCC. If needed, the BHCC revises the Care Plan; after which the Senior BHCC reviews and offers feedback. For those BHCCs unable to maintain an average score of 35 points, corrective action will be taken by the BHCD.

Scores for each BHCC and the overall Program are determined and reported every week.

**Member Satisfaction Survey**

The BSD Member Satisfaction Survey is intended to gauge the degree to which the Member is aware of, engaged in and receiving benefit from the BSD Program. This process is essentially identical to the process conducted for Members in medical Care Plans. An independent third-party research firm conducts a quarterly telephonic survey of each Member in an active BSD Care Plan. The BHCC is responsible for obtaining the preferred telephone number for all Members and transferring this information to the vendor through iCentric. The BHCC is also responsible for encouraging each Member to participate in the survey to ensure a high participation rate. The BHCC is held accountable for the survey completion rate of each Member assigned to them. The goal is a $90^{+}$ percent participation rate.

Members rate their satisfaction in relation to the following five statements:

1. You understand your Behavioral Health Care Coordination plan, including the actions you are supposed to take.
2. Your Behavioral Health Care Coordinator talks to you often enough to understand and meet your needs.
3. Your Behavioral Health Care Coordinator is helpful in coordinating and arranging the care you need.
4. The information and assistance you receive is helpful to you in understanding your condition and improving your health.
5. Finally, overall, your health is improved and better managed as a result of your Behavioral Health Care Coordination plan.

After each statement, the interviewer asks the Member, "Do you:"

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

The Member may also volunteer that he or she does not know the answer to a statement and the interviewer will record this response. After the Member rates his or her degree of agreement with each of the above statements, he or she is asked one open-ended question:

6. What suggestions or comments do you have that could improve your Behavioral Health Care Coordination experience?

Each of the first five questions is scored on a scale of 1 to 5, with a score of 1 for a response of "Strongly Disagree" and a score of 5 for "Strongly Agree." Results are analyzed on a quarterly basis and used to evaluate BHCC effectiveness in gaining Member engagement and to drive improvements to the Program.

**Obtaining Approval (Preauthorization) for Behavioral Health Care Admission to a Hospital or Residential Program**

Behavioral health admission preauthorization is carried out in a manner exactly consistent with medical admissions. Both seek, prior to or upon the admission of a Member to an inpatient setting (in the case of an emergency admission), to identify and assess the needs of the Member, the suitability of the hospital or residential facility in meeting these needs and to identify the subsequent services the Member will require after discharge, including participation in a BSD Care Plan, if appropriate.

As a general rule, any admission to a hospital or a residential treatment center is an indicator of a serious behavioral health or substance use disorder event. To more effectively assess and engage Members who are experiencing these health issues, BHTCs are located onsite at nearly 20 hospitals that represent 60 percent of the in-area BSD admissions. This enables BHTCs to meet face-to-face with the Member to assess and focus on post-discharge needs. The work of the BHTC mirrors what MHTCs do for medical admissions. The BHTCs coordinate closely with local BHCCs to assist in making connections to psychiatrists, therapists, and other professionals as well as locating community resources.

A substantial majority (approximately 80 percent) of Members admitted to inpatient care for a behavioral health or substance use disorder, are admitted on an emergency basis through the ER. These admissions are automatically authorized. However, locating an open psychiatric bed that matches the unique needs of a Member on an emergency basis can be challenging for those on the front line treating the Member. Members may need care in specialized units (i.e., eating disorders, post-traumatic stress syndrome, child and adolescent psychiatry, or specialized abuse units).

Hence, the BSD Program provides consultation and assistance through the BSD Medical Director to help meet this challenge. The BHTCs stay closely connected to the BSD's Medical Director and notifies him/her if they believe a Member's case warrants closer assessment. The IAA team often assists in locating a facility that has an open bed appropriate to the Member's need.

Within one business day of being notified of an admission, the BHTC connects with the Member, assesses the Member's condition and begins to develop a post-discharge plan in close coordination with the Member's treating providers. The BHTC remains engaged throughout the Member's inpatient stay to assure the Member's post-discharge needs will be met and works with BHCCs to arrange post-discharge services. BHTCs also build relationships with hospital staff, who help the BHTC stay informed of the Member's progress and discharge date, once determined. Additionally, the BHTC seeks to obtain a timely post-discharge appointment for the Member to an appropriate community-based provider(s). Appointment Advocates in the IAA Unit help with obtaining this and other appointments as needed.

The BHTCs follow the 10 steps for every hospital admission at the facility they service. They:

1. Meet with clinical hospital staff to determine which Members are appropriate for meeting with the appropriate BHCC.

2. Meet one-on-one with the Member in the hospital to establish a relationship and assess the Member's need for a BSD Care Plan following discharge. This includes discussing the benefits of being in such a plan, obtaining consent to participate in a Care Plan, and obtaining a psychosocial history to set initial goals for the Care Plan.

3. Develop a comprehensive discharge plan that begins in cooperation with hospital discharge staff.

4. Work with the hospitalized Member to ensure post-discharge appointments are set up and that the Member is prepared for and understands post-discharge care.

5. Call the Member within 48 hours of discharge to assess the status of the Member and ensure that all components of the discharge plan are understood and that barriers to adherence with the Care Plan are resolved.

6. Contact the IAA Unit if assistance in obtaining a follow-up appointment post discharge with an appropriate provider is needed.

7. Verify that the initial post-discharge appointment has been kept and remain in close contact with the Member to ensure they continue to move forward toward their Care Plan goals.

8. Assure measurement of progress by conducting an ongoing assessment following the Member's transition from the hospital to the community to confirm all care is having the intended impacts if the Member is not in a Care Plan.

9. Refer Members to the CCC Program for co-morbid conditions as appropriate and/or connect the Member to an Intensive Outpatient Program (IOP) or other programs as needed.

10. Follow up to assure that any and all referrals are picked up by the referred program or provider and that the Member is actually receiving needed care.

***Obtaining Approval (Preauthorization) for Care***

A subset of behavioral health and substance use conditions have been chosen for focused clinical review on a pre-service basis. For these services, clinical review is carried out by clinical staff with specialized knowledge, using industry established medical policies and criteria.

The reason that these subsets of services are reviewed and preauthorized is that they often entail one or more of the following characteristics: Safety or abuse concerns, highly variable treatment, excessive cost, and/or high complexity.

Services requiring preauthorization include the following inpatient services:

1. Residential Treatment, Psychiatric Adult
2. Residential Treatment, Psychiatric Child and Adolescent
3. Residential Treatment, Eating Disorders
4. Residential Treatment, Substance Use Disorders, Detoxification
5. Residential Treatment, Substance Use Disorders, Rehabilitation, Adults and Geriatric
6. Residential Treatment, Substance Use Disorders
7. Residential Treatment, Child and Adolescent

Outpatient services requiring preauthorization:

1. Electroconvulsive Therapy ("ECT")
2. Repetitive Transcranial Magnetic Stimulation ("rTMS")
3. Complex Psychological Testing
4. Applied Behavioral Analysis, ("ABA")

Members whose admissions are preauthorized are assessed by BHTCs who provide consultation and assistance to referring providers as to where to find the appropriate services that best match the unique BSD needs of the Member. And, as already explained above, BHTCs assist in coordinating post-discharge services and support for the Member in concert with the

involved BHCCs. No preauthorization for any service is needed if a Care Plan does not involve a hospital admission or the outpatient services listed above.

**Out-of-Network Care**

If out-of-network services are needed, a recommendation is submitted by the BSD Medical Director for approval. These cases are reviewed and approved on a case-by-case basis.

**Behavioral Health Provider Network**

Undergirding the BSD Program is a contracted network of professional and facility providers that is available for all Members in need of behavioral health care. This network includes psychiatrists, psychologists, clinical social workers, acute care hospitals with behavioral health capabilities, and specialty behavioral health facilities, such as residential treatment centers, and addiction facilities. The network complies with all credentialing standards as recognized by the National Committee of Quality Assurance ("NCQA").

CareFirst has also developed a Network in a Network ("NiN") of select providers who have agreed to give priority access to CareFirst Members. These practices work closely with CareFirst and the BHCCs to help members access timely care. **Figure 42** shows the number of practitioners by licensure in the CareFirst behavioral health network and the subset of NiN providers committed to providing priority appointments.

**Figure 42: Behavioral Health Practitioners In The CareFirst Network As Of December 2017**

| Behavioral Health Specialty | Number of Network Providers | NiN |
|---|---|---|
| **Licensed Professional Counselor** | 2,057 | 260 |
| **Psychiatric Social Worker** | 2,994 | 316 |
| **Psychologist** | 1,353 | 71 |
| **Psychiatrist** | 1,075 | 90 |
| **Psychiatric Nurse Practitioner/Nurse** | 240 | 34 |
| **TOTAL PRACTITIONERS** | **7,719** | **771** |

CareFirst also supports telehealth psychiatric appointments within these networks. This delivery method has proven particularly beneficial for those Members who live in remote areas. In addition, telehealth appointments are becoming an important component in response to increased demand for psychiatric services. Increasing numbers of network behavioral health providers offer online services.

**Enhancing Member Access to Behavioral Health and Substance Use Disorder Services**

As noted throughout, there are often challenges that Members face in accessing services or in even learning what services to access. The IAA Unit has two components that support the BSD Program: The Intake and Assessment Team and the Appointment Advocacy Team that assist Members in navigating the complex Behavioral Health and Substance Use Disorder landscape.

The goal of the IAA Unit is to assure that Members are connected to the Program or clinical service that is appropriate to their needs. Once a needed service is identified, it is arranged and tracked through the CareFirst Service Request Hub. Requests are received from multiple sources, vetted, directed to the services and Programs that best meet the Member's needs, and tracked to assure that Members receive the care intended.

The Intake and Assessment Team includes specially trained BHCCs who assess Members with behavioral health needs that come from all sources including self-referrals. Staff of the Intake and Assessment Unit use their training and professional judgment to direct Members to appropriate clinical services and/or TCCI Program, as appropriate. The Intake staff handles all incoming calls from Members while the Assessment staff reviews referrals to determine appropriate next steps. Since these functions often overlap, the Intake and Assessment staff are cross-trained and are able to perform both of these functions.

If an appointment with a community-based clinician is needed, the Appointment Advocacy Team serves as a scheduling service, assuring Members obtain access to appropriate behavioral health clinicians. Selecting and accessing behavioral health providers can be frustrating since getting an appointment is often difficult. This is, in part, due to the array of different types of providers and the number of provider specialties in behavioral health. The complexities of provider types – ranging from social workers to counselors to psychologists to psychiatrists – combined with the challenges associated with closed practices and out-of-network providers make the appointment process challenging.

Appointment Advocates are degreed professionals with backgrounds in behavioral health care who are very familiar with the behavioral health providers in the CareFirst region. As an ongoing matter, the Appointment Advocacy Team continually updates the list of network providers who are available for appointments by specialty. Appointment Advocates also connect out-of-area Members with behavioral health professionals nationwide.

For Members requiring outpatient addiction services, Appointment Advocates help the Member make an initial appointment at one of the recovery centers that participate in the CareFirst Addiction Program.

Appointment Advocates are also available to LCCs and BHCCs seeking BSD appointments for Members in Care Plans. In addition, PCPs, behavioral health providers, and hospital discharge planners responsible for ambulatory follow-up care post hospitalization, have access to Appointment Advocates for their CareFirst patients.

Follow-up calls are made to Members and providers by Appointment Advocates to ensure that appointments have been kept and that the care Members are receiving is serving their needs, as well as to gain insight into Member experience. The Appointment Advocacy Team reschedules or actively seeks other providers if the services by a particular provider to whom the Member has been directed are not adequate. The Member is surveyed for satisfaction with the services received during the appointment. Member satisfaction is reported quarterly.

The Appointment Advocacy Team assisted Members with over 6,000 calls in 2016. This is expected to increase considerably in 2018.

**Substance Use Disorder Program**

Collectively, drug overdose and alcohol abuse lead to nearly 140,000 deaths per year.**Error! Bookmark not defined.** Addiction in general, and opioid addiction in particular, is a growing problem in the United States, with staggering numbers of people caught up in an epidemic-sized, societal problem. There are enough prescriptions written for opioids to give every adult American their own bottle. The CDC reports nearly 70 opioid prescriptions per 100 persons across the US.[20] The growth in these prescriptions has led to tens of millions of Americans using prescription medications non-medically every year. As a result, approximately 90 Americans die every day from an opioid overdose.**Error! Bookmark not defined.**

The opioid epidemic took many decades to develop and was driven by various factors including:

- heavy marketing of prescription opioids by pharmaceutical companies;
- the effort to standardize and improve pain treatment; and
- overprescribing by doctors

The role of pharmacy manufacturers in contributing to, or even creating, this epidemic is undeniable. Taking OxyContin, a blockbuster opiate developed in the mid-90s, as a case study, it is apparent that manufacturers marketing these drugs as cure-all pain relievers with little to no side effects or addictive qualities contributed to the epidemic. Within its first five years of launch, Oxycontin was grossing over a billion dollars in revenue even though it is a chemical cousin of heroin and twice as powerful as morphine.**Error! Bookmark not defined.**

[20] *Annual Surveillance Report of Drug-Related Risks and Outcomes, Center for Disease Control, United States, 2017,* https://www.cdc.gov/drugoverdose/pdf/pubs/ 2017-cdc-drug-surveillance-report.pdf.

Pharmaceutical manufacturers knowingly blurred the lines between clinical effectiveness and maximizing utilization to grow revenues. In a ten-year timeframe, the manufacturers allocated nearly $900 million to lobbying and political contributions – eight times what was spent by the gun lobby[21]. These lobbying efforts on behalf of the manufacturers have added to their overall influence, making it more difficult to create a balanced, safe approach to drug education and use.

Perhaps even more troubling is that the numbers only relay a part of the story. For example, many Members with substance use disorders are taking medications without a prescription, paying cash to obtain medications. These Members often fly under the radar because they cannot be tracked in any claim or health plan payment system. Therefore, the actual effect of alcohol and drug addiction is likely understated in the available data for health plans.

In response to the rising need for addiction treatment, CareFirst created the Substance Use Disorder Program as part of the TCCI Program Array. The core tenet of this Program is the recognition that addiction is a chronic disease of the brain and that there are treatment centers in the CareFirst service region that accept this as the foundation of treatment and successfully work with Members who are referred for treatment.

The goals of the Substance Use Disorder Program are to:

1) Provide Members with necessary treatments to deliver the best outcomes for their individual clinical circumstances.

2) Provide access to cost-effective addiction treatment programs that offer the most up-to-date clinically appropriate standards.

3) Educate Members, PCPs, and all stakeholders as to the causes, identification and treatments of addiction.

4) Connect Members to appropriate care in a community setting outside of a hospital or residential setting to enhance sustainable outcomes and lower costs.

**Social and Economic Impact of Addiction**

Data collected by the National Center for Health Statistics at the Centers for Disease Control and the Department of Health and Human Services find that eight to ten percent of people in the United States, ages 12 years or older, are addicted to alcohol, or other drugs; both legally or illegally obtained.[22] Substance use disorders cost the US an estimated $700 billion annually in health care costs, increased crime, and lost productivity.[23] Alcohol use disorder is associated with having a statistically higher chance of having an accident, engaging in violent or criminal acts, or committing suicide.[24] According to the National Highway Traffic and Safety Administration, alcohol-impaired vehicle crashes alone cost the nation $44 billion annually, and claim approximately 10,000 lives every year.[25]

Opioids, in particular, are connected to criminal activities, among both users and prescribers.**Error! Bookmark not defined.** Additionally, opioid users, especially those administering drugs intravenously, have a high incidence of viruses and bacterial infections.**Error! Bookmark not defined.** In 2012, the average hospital stay for an opioid user cost approximately $28,000. This figure jumps to roughly $107,000 if the patient has

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[21] *Keefe, P. R. (2017, October 30). The Family That Built an Empire of Pain. The New Yorker. Retrieved from https://www.newyorker.com/magazine/2017/10/30/the family-that-built-an-empire-of-pain?mbid=nl_Weekly%20102417%20Magazine&CNDID=18246040&spMailingID=12210756&spUserID=MjI2MjM0MTY0N zkxS0&spJobID=1262123261&spReportId=MTI2MjEyMzI2MQS2*

[22] *SAMHSA, Center for Behavioral Health Statistics and Quality, National survey on Drug Use and Health, 2013*

[23] *National Drug Threat Assessment, Washington DC Department of Justice, National Drug Intelligence Center 2011*

[24] *American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC. https://doi.org/10.1176/appi.books.9780890425596.dsm16*

[25] *National Highway Traffic Safety Administration. (2016). Retrieved from* https://www.nhtsa.gov/risky-driving/drunk-driving

an infection.[26] Total inpatient charges for opioid abuse increased more than fourfold between 2002 and 2012, to nearly $15 billion, of which $700 million went to paying for hospitalizations related to opioid-associated infections.**Error! Bookmark not defined.**

In October 2016, the CDC published a report showing that substance users have $15,500 in excess costs per year over non-users. While the economic burden of this epidemic is staggering, the impact on mortality is even more pronounced. In Maryland, 86 percent of all intoxication deaths in 2015 were opioid-related. An estimated 44,000 people die each year from drug overdoses related to heroin, cocaine, benzodiazepines, and prescribed opiates. The risk of early death from trauma, suicide or infectious disease is also markedly higher among those who are addicted.

In March 2017, Maryland Governor Larry Hogan declared a state of emergency due to the opioid-addiction crisis and committed an additional $50 million over the next five years to provide additional resources for enforcement, prevention, and treatment services. Bringing further attention to the opioid epidemic, on March 29, 2017, President Trump declared the opioid crisis a "national emergency".

Unfortunately, it is estimated that 90 percent of people with addiction who are in need of treatment services do not receive them, according to surveys conducted by the Substance Abuse and Mental Health Services Administration.[27] Because patients are often not diagnosed or not willing to admit their addictions, statistics for this population are inadequate.

The lack of care stems from the continuation of past approaches to treatment in which addiction behaviors have been treated primarily as personal failures or crimes, and not as a disease. Even today, patients must overcome the stigma of failure and shame in recognizing they need help. Nationally, there are gaps in access due to lack of insurance that does not cover needed treatments, or the presence of high deductibles that require large out of pocket payments before coverage begins. Also, despite the proliferation of opioid use and addiction in the United States, there are too few high-performing treatment centers to accommodate all patients in need.

**Biological and Social Influences on Addiction**

Addiction is a chronic disease. As with other chronic diseases, periods of exacerbation and remission are expected. While there is no complete cure, there is treatment. Those affected may be reluctant to admit they need treatment and there are challenges in adhering to treatment. For those addicted, their susceptibility varies as with any chronic disease.

Exposure to substances is not always indicative of addiction. In fact, only a modest fraction of those exposed to potentially addictive drugs and alcohol become addicted. For those who do become addicted, the risk factors include: family history, exposure to drug and alcohol use early in life, poor social supports, or permissive attitudes toward drug use or alcohol consumption.

The interaction between certain genetic, social, and environmental factors play a significant role in the development of a substance use disorder. For some types of substance use disorder, the genetic component can have a substantial impact. For example, among parents with alcohol use disorder, there is a three- to four-fold increase in risk that their children will develop the disorder, even if the children are adopted and raised in a different environment.**Error! Bookmark not defined.**

**Children and Adolescents**

Maternal substance use is linked to a host of complications and birth defects. For example, maternal opioid use has been linked to Neonatal Abstinence Syndrome ("NAS"), neural tube defects, gastroschisis, and congenital heart defects. Newborns with NAS exhibit withdrawal symptoms such as irritability, seizures, vomiting, diarrhea, fevers, and poor feeding behavior. These complications result in longer, costlier hospital stays. In 2012, the average length of a hospital stay for a newborn with NAS was 23 days and the average hospital charge was $93,400, resulting in a total cost to the healthcare system of $1.5 billion.[28]

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[26] *Ronan, M. V., & Herzig, S. J. (2016). Hospitalizations Related To Opioid Abuse/Dependence And Associated Serious Infections Increased Sharply, 2002-12. Health Affairs, 35(5), 832-837. doi:doi: 10.1377/hlthaff.2015.1424*

[27] *American Addiction Centers (2014) Retrieved from americanaddictioncenters.org/rehab-guide/success-rates-and-statistics*

[28] *Barfield, W. (2016). The problem of neonatal abstinence syndrome. Retrieved from: https://www.cdc.gov/cdcgrandrounds/pdf/archives/2016/august2016.pdf*

According to the CDC, between 2008 and 2012, approximately one-fourth of privately insured and over one-third of Medicaid-enrolled women of reproductive age filled a prescription for an opioid each year.[29] There is a clear relationship between increased use of prescription opioids and increases in the incidence rates of newborns with NAS. In 2000, only 2,920 newborns were born with NAS; in 2012 this number increased to 21,732 – a 644 percentage increase.**Error! Bookmark not defined.** This equates to one infant born with NAS every 25 minutes.**Error! Bookmark not defined.** One may surmise that these figures and their associated costs are likely even higher in 2017, given that the rate of opioid use has skyrocketed.

Adolescents are a special risk group because the adolescent brain is not fully developed. This is particularly true with regard to the areas of the brain in the prefrontal cortex that control executive functioning. These areas are involved in decision making and control of impulsivity; and do not fully mature until age 25. It is also thought that the brain is more "plastic" during this period with greater vulnerability to maladaptive effects on the brain's reward centers.[30]

**The Stages of Addiction [31]**

There are several stages to addiction that a person passes through that are well documented and form the basis of understanding upon which treatment is based. These are described briefly below.

**Stage 1:** Upon taking an addictive drug or consuming alcohol, dopamine is released and the brain's receptors register it as a reward. With continued use, the brain's dopamine cells start firing in anticipation of receiving the drug or alcohol. The brain learns to associate reward with the environmental stimuli at the time.

This means all the factors surrounding drug or alcohol use (who you were with, where you were, etc.) can trigger strong desires resulting in relapse or binges. This conditioning becomes so ingrained that even in a person with years of successful recovery, cues can immediately arise to trigger drug or alcohol-seeking behavior.

**Stage 2:** As drug or alcohol use continues, the brain adapts by resetting its reward system, dulling the ability of the person to experience pleasure from the drug or from the other things in life that used to motivate them, such as relationships and activities. In fact, chronic drug and alcohol use causes changes in brain circuitry that set in motion an overactive "anti-reward" system which leaves the addict unable to cope with stress and prompting negative feelings when a drug or alcohol is withdrawn.

Eventually, the person no longer uses a drug or alcohol to get high but to simply stave off cravings and the pain of withdrawal. This sets up a vicious cycle: the more the drug is used, the worse the cravings and withdrawal become, which pushes the person to even greater dependency.

**Stage 3:** As the addiction progresses, the person becomes more and more obsessed with their drug or alcohol even though they may be desperate to stop. At this point, addiction not only affects reward circuits, it interferes with signaling in the parts of the brain involved in executive functions such as self-regulation, decision-making, and the ability to monitor error. Without these to rely upon, the desire to stop often becomes no match for the desire to use.

**CareFirst Population Characteristics**

Although addiction is recognized as a national crisis, it is largely unidentified in reporting due to stigma, lack of standards, and a deficiency of knowledge in the medical community. Psychiatrists and therapists do not typically collect data or report on results of patients they treat for addiction, nor are they required to do so. Many Members seek help outside of insurance to avoid notice and/or the scrutiny of employers, family and friends. Other Members are unwilling or unable to recognize their addiction and do not seek help.

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[29] *Ailes, E. C., Dawson, A. L., Lind, J. N., Gilboa, S. M., Frey, M. T., Roussard, C. S., & Honein, M. A. (2015). Opioid Prescription Claims Among Women of Reproductive Age — United States, 2008–2012. Morbidity and Mortality Weekly Report, 64(02), 37-41. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6402a1.htm.*

[30] *Castellanos Ryan, N, Rubia K, Conrod PI. Response inhibition and reward response bias mediate the predictive relationships between impulsivity and sensation seeking and common and unique variance in conduct disorder and substance misuse. Alcohol Clin Exp Res 2011; 35-140-55.*

[31] *Patterson, Kendall; www.elementsbehavioralhealth.com, A Look Inside the 3 Stages of Addiction, March 22, 2016*

In addition, privacy laws hinder care coordination between medical and addiction professionals even though addiction goes hand in hand with co-occurring medical issues. As a result, the true number of Members in need of addiction treatment remains hidden. One of the goals of the Substance Use Program is to enhance reporting and track outcomes to more accurately identify the issues and opportunities for improvement in treatment and follow on care.

Because of this hidden need, Member counts in the table below represent a remarkably low percentage of the overall CareFirst population. This is because current claims data does not accurately represent the volume of Members with addiction problems. In the U.S., only one in 10 people with addiction to alcohol and/or drugs receive treatment compared to 70 percent of people with hypertension or diabetes.[32]

**Part III, Figure 43: Summary Of Members With Addiction Episodes**

| Year | Members | Total Spend PMPM | Medical Spend PMPM | Rx Spend PMPM | Admits / 1,000 | ER / 1,000 | Average IB Score |
|---|---|---|---|---|---|---|---|
| 2014 | 20,452 | $1,491.13 | $1,322.67 | $289.19 | 440.7 | 852.2 | 3.13 |
| 2015 | 20,229 | $1,673.85 | $1,488.03 | $311.16 | 491.7 | 839.8 | 3.11 |
| 2016 | 20,672 | $1,684.47 | $1,493.66 | $326.44 | 515.1 | 797.0 | 3.30 |

In the comparative data shown, Members diagnosed with addiction are admitted to the hospital and visit the ER at a much greater rate than the general population. In addition, the addiction population costs approximately $1,000 more PMPM than the overall book of business.

**Part III, Figure 44: Summary Of Members In CareFirst Book Of Business 2014-2016**

| Year | Members | Total Spend PMPM | Medical Spend PMPM | Rx Spend PMPM | Admits / 1,000 | ER / 1,000 | Average IB Score |
|---|---|---|---|---|---|---|---|
| 2014 | 2,065,888 | $412.87 | $355.71 | $103.40 | 56.4 | 203.6 | 1.04 |
| 2015 | 2,077,107 | $437.48 | $371.57 | $117.99 | 54.9 | 200.0 | 1.04 |
| 2016 | 2,040,609 | $449.81 | $379.92 | $126.91 | 54.0 | 190.7 | 1.05 |

The most common episodes of addiction each year are due to alcohol while opioid addiction is the second most common. Almost 3,000 Members identified each year have episodes for multiples types of drug addiction.

**Part III, Figure 45: Summary Of Addiction Members By Episode Type 2014-2016**

| Year | Alcohol Only | Opioid Only | Other Drug Only | Combination of Alcohol, Opioid & Other Episodes |
|---|---|---|---|---|
| 2014 | 7,800 | 4,290 | 5,582 | **2,780** |
| 2015 | 8,186 | 4,252 | 4,715 | **3,076** |
| 2016 | 8,287 | 5,125 | 4,328 | **2,932** |

To provide more context for the CareFirst population, in 2016 approximately 204,000 CareFirst members received at least one opioid prescription. This represents approximately 17 percent of all CareFirst members with a CareFirst prescription benefit. To further put this into context, approximately 8.9 million days of opioid therapy were filled for CareFirst Members in 2016. In the same timeframe 17,953 CareFirst Members had a diagnosis for substance use disorder. Because these figures are based on insurance claims, they likely represent only a fraction of the total amount of opioid or other substance use.

[32] *Lloyd Sederer; http://www.usnews.com/opinion/blogs/policy-dose/2015/06/01/america-is-neglecting-its-addiction-problem; A Blind Eye for Addiction, June 1, 2015*

**Primary Care as a Source of Identification**

Since many patients with addiction have co-occurring medical and behavioral health disorders, PCMH PCPs, LCCs, CCMs, BHCCs, psychiatrists and other behavioral health providers as well as Members and their families are a key source of identification and referral for those addicted.

Because behavioral health issues exacerbate medical conditions if not identified and treated, communication between PCPs and behavioral health providers is critical to improve the outcomes of patients with addiction behaviors, especially with regard to related medical conditions such as AIDS, Hepatitis C, pneumonia, accidental injuries, cirrhosis of the liver, pancreatitis and systemic infections.

**Principles of Effective Treatment for Addiction**

Committing to treatment and maintaining sobriety is extremely difficult for those Members suffering from addiction. The goal of treatment is to help individuals to stop using, stay alcohol or drug free and lead a full, productive life. The following are well-established principles of effective treatment:

- Addiction is a complex but treatable chronic disease that affects brain function and behavior.
- No single treatment is right for everyone.
- People need to have quick access to treatment.
- Effective treatment addresses all the patient's needs, not just his or her drug use.
- Staying in treatment long enough is critical. (often a year)
- Medications are a critical part of treatment, especially when combined with behavioral therapies.
- Treatment plans must be reviewed often and modified to fit the patient's changing needs.
- Treatment should address other possible mental disorders.
- Medically assisted detoxification is only the first stage of treatment.
- Treatment doesn't need to be voluntary to be effective.
- Drug use during treatment must be monitored continuously.

**Types of Addiction Programs**

Treatment programs are typically organized into two categories: inpatient/residential treatment and outpatient treatment. A Member may go through multiple types of therapy. There is no standard order of treatment or strong evidence that suggests one treatment is superior to the other. In these programs, Cognitive Based Therapy ("CBT") and Medication Assisted Therapy ("MAT") may be used. These specific programs and related therapies are explained more fully below.

Inpatient/Residential treatment, typically lasts 28 days and removes the patient from the community and the triggers of their addiction. Members are not usually admitted unless there are indications of alcohol or drug use on admission. Licensed residential treatment facilities offer 24-hour structured and intensive care, including safe housing and medical attention. Residential treatment facilities may use a variety of therapeutic approaches typically focusing on detoxification as well as providing initial intensive counseling and preparation for treatment in a community-based setting.

Intensive Outpatient Programs (IOPs) are usually the next step in recovery treatment after completing a residential program. However, many patients begin treatment in an outpatient program because it is the most clinically appropriate treatment setting. Outpatient programs are also more cost effective.

IOPs provide treatment three to five days a week in group and individual counseling sessions. Instead of isolating the Member from the community and the triggers that cause relapse, the Member returns to the community each day while working with a counselor to overcome the temptations Members are actively experiencing. Treatment is highly individualized and great attention is placed on communication with the Member's Primary Care Physician.

IOP Treatment phases include:

1) An outpatient detoxification phase for those needing withdrawal management.

2) A rehabilitation phase which typically lasts eight weeks and includes individual and group sessions, using psychiatrists where needed.

3) A continuing care phase consisting of clinician-led group therapy sessions that may last a year or more. Family services and groups sessions are also typically offered.

Step-down outpatient therapy is commonly the next step in the recovery process after completing an IOP. Regular outpatient treatment continues one to two days per week for a year or more. To achieve treatment goals, long term engagement of usually a year or longer in outpatient sessions is critical. During this time, the brain heals, coping strategies are strengthened, and relationships are solidified in therapy groups.

**Cognitive Behavioral Therapy (CBT)**

Cognitive Behavioral Therapy (CBT) is useful in a number of ways in the treatment of addictions and relapse prevention. CBT is a goal-based psychological treatment designed to analyze and change how patients view challenging situations. Patients can be taught to make behavioral changes such as avoiding people, places, and things that trigger their desire for alcohol or drugs. People in early recovery are often also in need of skills training in assertive communication, stress management, and refusal skills.

Equally important is the need to recognize and address maladaptive cognitive patterns. This can take the form of identifying a faulty belief or expectation. For example: "I won't be able to stay sober", or "I'm a chronic relapser". Through CBT, patients are taught to challenge and correct these behaviors with positive thinking; "I've had trouble staying sober in the past, but I've been learning new skills." CBT also includes a number of exercises designed to improve the likelihood of sustained recovery. These tools include exercises listing the advantages and disadvantages of substance use, and exercises designed to identify relapse warning signs such as isolation and dishonesty.

**Medication Assisted Therapy (MAT)**

Medication Assisted Therapy (MAT) is particularly effective at preventing relapse while the brain is healing, helping to restore normal decision making. It is common for the healing process to take over a year with greater risk of relapse without medication therapy. MAT is individually tailored and has proven to significantly reduce the need for inpatient services.

MAT treatment and counseling have been shown to:

- Reduce relapse rate post treatment
- Improve patient survival
- Decrease illicit opiate use and other criminal activity
- Increase patients' ability to gain and maintain employment
- Improve birth outcomes among women who are using substances during their pregnancy

Despite this success, MAT is greatly underused. Reasons for the slow adoption include lack of training for physicians and a lack of understanding, even among health care professionals, of the biological basis of addiction in the community at large.

Despite strong programs and evidence-based therapies for addiction, relapse is very common. People may go in and out of programs multiple times in phases of stability and relapse. The National Institute on Drug Abuse ("NIDA") reports the relapse rate for drug addiction is 40 to 60 percent.[33] Approximately 90 percent of alcoholics will experience one or more relapses

[33] *McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA, 284(13), 1689-1695.*

during the four years after treatment, according to a publication from the National Institute on Alcohol Abuse and Alcoholism.[34]

Due to the high risk of relapse, those undergoing treatment are encouraged to stay in outpatient programs for up to one year or more. Therapy groups can cultivate peer pressure to stay clean. Strong relationships develop with therapy groups connecting both in and outside of therapy. Many times, someone who has relapsed can be reached through other Members of the group.

In an IOP or Outpatient Program, having a relapse is not viewed as a failure but an opportunity to identify the cause and establish a plan to manage the trigger.

One of the most effective ways to prevent a relapse is to establish new, healthy habits in the course of treatment. Recovery Centers have nutritionists on staff and counselors who focus on assisting those recovering with identifying emotions and stressors that cause relapse. Recommended lifestyle changes include the following:

- Changing diet
- Improving hygiene
- Starting an exercise program
- Paying more attention to mental health
- Managing stress
- Modifying sleep habits
- Spending more time around people who do not use drugs

**Collaboration with Selective Addiction Recovery Centers**

Against this background, CareFirst has partnered with high performing Addiction Recovery Centers and specialists throughout MD, DC, and Northern VA who are leaders in the provision of IOPs. These IOPs consist of individual evaluation, MAT therapy, and group therapy. Many people engaging in an IOP do not require residential treatment or are moving from residential treatment to a step-down program.

The Substance Use Disorder Program begins by actively managing and tracking the Member's progress on inpatient admission through an IOP and follow-up treatment. Documentation of progress is entered into the recovery center's EMR at 30, 90, 120, 180, 270 and 365 days after IOP treatment is completed. By staying in close touch, Members maintain engagement in their own outcomes and reduce relapse with greater likelihood for continued stability.

The goal is to keep a Member engaged when transitioning from IOP to less intensive outpatient treatment. The recovery center develops a Care Plan for the Member and carries it out during the 12-month outpatient period following the IOP treatment. Those with comorbid behavioral health or medical conditions may require a Care Plan set up by a BHCC or additional TCCI services that are coordinated by a LCC.

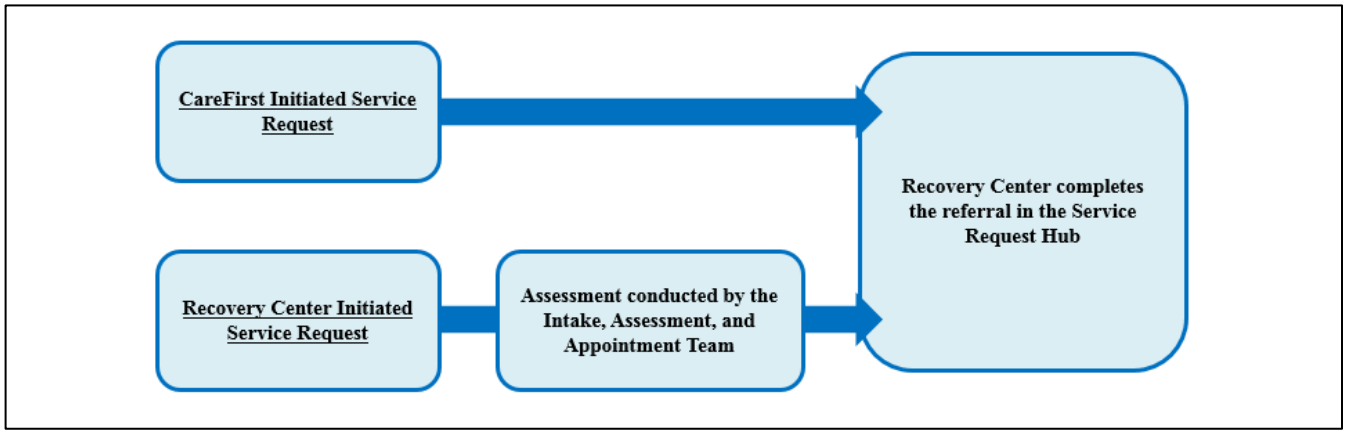
**Oversight and Process Flow for the Substance Use Disorder Program**

A CareFirst Member may be referred to one of the regional Addiction Recovery Centers in the CareFirst Substance Use Disorder Program through one or more of the following sources:

- CareFirst LCCs or BHCCs after a diagnosis is made by a PCP or specialist (attributed)
- CareFirst's IAA Team (unattributed)
- Direct referrals from a PCP or specialist (attributed and unattributed)
- Residential treatment centers (attributed and unattributed)
- Voluntary enrollment by Members (attributed and unattributed)

[34] *Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism, United States, (1989). Retrieved from https://pubs.niaaa.nih.gov/publications/aa06.htm*

**Part VI, Figure 46: Referral Sources**




A step by step process follows the referral as outlined below:

- The recovery center receives a service request through the Service Request Hub for any LCC or BHCC referrals. The recovery center enters a service request when the Member accesses the Recovery Center on their own. The service request is documented by the center's admissions staff with a notation in iCentric identifying the referral source, condition(s), and date of admission.

- Any recovery center initiated service request is routed through the Service Request Hub to the IAA for assessment. The IAA determines whether the recovery center's notation in iCentric provides justification for the Member to enter into a recovery center Care Plan.

- Once the service request is approved by the IAA, the recovery center conducts an initial evaluation appointment within one business day of admission. The assessment is conducted by the recovery center's licensed/certified staff. A care plan is then developed for the Member in the recovery center. The service request is activated within 24 hours on the date of admission.

- Member consent must be obtained and documented in iCentric by the recovery center. The Member's out-of-pocket costs under this benefit plan design are waived once the Member consents to treatment and is engaged in an IOP and during the subsequent 12 months in an Outpatient Program when the member remains in compliance.

- The recovery center enters progress notes no less frequently than monthly into their EMR system throughout the course of treatment. In addition, the recovery center feeds the EMR data to iCentric and works with the Member's LCC and PCP, as appropriate, in monitoring Member progress. This monitoring occurs on monthly intervals, except for the first review which occurs within 14 days of activation.

- The CareFirst Substance Use Disorder Oversight Team reviews all aspects of service on a monthly basis to ensure proper documentation, progression, and adherence to Program requirements.

- If a Member does not remain engaged, the recovery center will seek assistance, as appropriate, from therapy group Members, the LCC, PCP, BHCC, or the initial referral source to re-engage the Member.

- If a Member drops out of the program prior to completion, the recovery center contacts the PCP, LCC, or BHCC and makes every effort to re-engage the Member. If unable to re-engage the Member, the Member's treatment plan is canceled in iCentric with the appropriate cancellation reason and notice.

- Upon IOP completion, the Addiction Recovery Center motivates and encourages the Member to consistently attend outpatient sessions. The center continues to update Member progress for the 12 months post IOP graduation. At a minimum, the recovery center contacts the Member 30, 90, 120, 180, 270 and 365 days after IOP treatment and documents each Member outreach in their EMR system. Members are actively tracked by the Recovery Center for one year to maintain participation in outpatient therapy and assist if a relapse occurs. All data and notes are sent to CareFirst and entered into the iCentric System.

- The recovery center reaches out to the Member when ER visits, hospital admissions or other breakdowns have occurred. These events are identified when a Member does not attend two or more outpatient sessions. The recovery center then immediately tries to contact the Member for support. In addition, the CareFirst addiction oversight team works with recovery centers to reveal these occurrences in the claims data.

In the case of relapse, the Addiction Recovery Center will attempt to re-engage the Member at an appropriate level of treatment. Relapse treatment may be a referral to a residential treatment facility or re-entry into the IOP.

**Treatment Compliance**

As noted above, essential to the success of the Care Coordination is the Member's consent to the creation, maintenance, and faithful adherence to a Care Plan. The duration of a Member's Care Plan averages up to 12 months for Substance Use Disorder. During this time, it is crucial that Members frequently communicate with their BHCC or their Addiction Recovery Center and follow the steps and actions agreed to in their Care Plan. The CSW incents Members to remain engaged with their BHCC or their Addiction Recovery Center and removes the barrier of cost-sharing directly related to Substance Use Disorder treatment (e.g., IOP and OP treatment).

**Graduation from IOP and Follow on Care**

In order to graduate from the Program a Member must demonstrate continued engagement throughout the eight-weeks in IOP and remain in further treatment for one year (one to two sessions per week). The Member must demonstrate the capability to remain independently drug or alcohol free.

Follow on care, also known as after care, is of vital importance to Members with addictions. The longer someone with an addiction remains engaged in the program, the greater the likelihood of continued success in remaining drug or alcohol free. The relationships that develop in group oriented programs become part of the Members lifestyle and sustained focus on continued recovery.

Follow on care programs are focused on encouraging participants to seek reintroduction into treatment at the earliest sign of slippage or breakdown. Many addiction recovery centers hold programs on site to promote this message. After completing treatment in an outpatient setting, evening and weekend programs such as SMART (Self Help Addiction Recovery), Celebrate (Spiritual Recovery), Alcoholics Anonymous, Narcotics Anonymous, and IOP alumni meetings offer ongoing support and play a critical role after formal treatment has concluded.

**Recovery Center Standards**

Each partner in CareFirst's Substance Use Disorder Program maintains the following standards:

- Accreditation under one of the following: The Accreditation Commission for Health Care ("ACHC"), The Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Accreditation ("COA"), The Joint Commission ("TJC").

- Use of evidence-based treatments.

- Capability for ambulatory detoxification or close relationships with other providers in the network that provide this service.

- Capability for assessing/diagnosing co-occurring mental health disorders.
    - Medicating and treating in the center or
    - Referral relationships to other network providers with this capability
- Use of therapy groups led by licensed or certified staff.
- Clinical staff who meet regularly to discuss patient and treatment issues.
- Staff training that enables staff to remain current on developments in the field and reinforce best practices.
- Reporting of Member progress to referral sources and other treating providers including PCPs.
- Ability to allow CareFirst Addiction Oversight Specialists to view monthly progress of all Members in the Program.
- Discharge planning that includes transition/referral to a step-down level of treatment and other wrap around services.
- Follow-up care 30, 90, 120, 180, 270 and 365 days after IOP graduation to assess and measure Member progress.

**Partner Incentives for Continued Engagement**

To promote long-term Member Engagement and increased opportunity for success, CareFirst offers Outcome Incentive Awards to recovery center partners. The three elements upon which outcome incentives are based include:

1. Graduation rates for the IOP and post IOP after care programs for one year.
2. Rapidity and effectiveness of follow up with a Member when breakdowns, ER visits or inpatient admissions occur as measured by a reduction in inpatient admissions and ER visit rates.
3. The quality, consistency, and completeness of the notes for Members in treatment.

The first-year results of the Substance Use Program (2017) are the baseline in measuring for these three levels of performance. In the second year of the Program, all recovery centers become eligible for performance incentives. All results reported are subject to a CareFirst audit including notes and Member claims.

**Focus on Opioid Management and Control**

Recent estimates reveal that between eight and 12 percent of those prescribed opioids develop an addiction and four to six percent who misuse prescribed opioids transition to heroin.[35] Both the pharmacy preauthorization process and claims data provide timely and actionable information about the conditions, diagnoses and treatment of Members.

To provide a comprehensive strategy to prevent, identify and treat substance use disorders, CareFirst has taken a multifaceted approach by addressing unnecessary or excessive opioid prescription use and monitoring for potential fraud, waste, and abuse.

Each of these areas is described in further detail below.

- Formulary Management
- Drug Safety and Monitoring
- Legislative Action

[35] *National Institute on Drug Abuse (NIDA). (2017). Retrieved from: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis*

**Formulary Management**

The most common way those with substance use disorders access opioids is through legitimate prescriptions from a physician either prescribed directly for them, a friend, or family member. In an effort to decrease the number of unnecessary opioids in its service region, CareFirst implemented a two-part strategy beginning October 2017 that is based on CDC Guidelines for the Management of Chronic Pain. Certain conditions (e.g., cancer, palliative care) are exempt from these strategies. The two parts of the strategy are:

**Opioid Quantity Limits**: Prescription limits are based on morphine milligram equivalent ("MME"), which is a method to compare the strength of different opioid medications. This approach provides a standard way to help identify patients that may be at greater risk of abuse or overdose. New initial limits for obtaining opioids without prior-authorization ("PA") are 90 MME/day. Quantities higher than initial limits require PA and are limited to a maximum of 200 MME/day.

**Opioid Duration Limits**: Limiting immediate-release ("IR") opioids to seven-day supply for acute pain in situations where an opioid (immediate or extended-release) is absent in prescription claim history during the previous three months. Duration limits do not apply if the patient is being treated for cancer in the past year. Preauthorization is required for coverage of treatment beyond seven days.

CareFirst does not have any preauthorization requirements for the use of medications indicated for treatment of substance use disorders (e.g., methadone, buprenorphine). Additionally, CareFirst has removed all opioid medications from its maintenance drug list. This action helps reduce the availability of potentially unused opiates by eliminating prescription quantities greater than 30 days. This, combined with promotion of prescription "take back" programs and safe disposal methods, helps aid in decreasing the number of unnecessary opioids in the possession of CareFirst Members.

**Drug Safety and Monitoring**

Opioids and other controlled substances that are prone to abuse or misuse are monitored by the Comprehensive Medication Review ("CMR") Tier II Program. As mentioned in the pharmacy coordination section of these guidelines, the Program identifies Members in need of an intervention by looking for high use of controlled substance claims, multiple prescribers, multiple pharmacies, excessive use or high total claim cost. In a CMR, a pharmacist reviews flagged profiles and verifies the need for prescriber and/or Member intervention. This not only reduces the costs associated with prescription fraud, misuse, and abuse but also protects Members from overdose and other serious health consequences.

Claims data is analyzed to identify Members for:

- Total number of controlled substance claims
- Total number of controlled substance prescribers
- Whether prescriptions are filled at multiple pharmacies
- Excessive utilization
- Geographic distribution of prescribers and pharmacies
- Excessive claim cost

Pharmacy claims data is monitored to reduce utilization of controlled substances among targeted Members. Savings are evaluated based on a reduction of pharmacy costs and medical cost avoidance due to unnecessary physician visits, ER visits, and laboratory fees. In the first three quarters of 2017, 8,665 prescriber faxes were sent, targeting 2,835 Members whose profiles were flagged due to concerns with their controlled substance utilization. For 1Q-3Q 2017, the program yielded $2,330,916 in pharmacy savings and $16,016,240 in medical cost avoidance, totaling $18,347,156 in gross savings.

The following drug classes are targeted for CMR review:

- Narcotic/narcotic combination drugs
- Anti-anxiety and sedative/hypnotic agents
- Non-benzodiazepine sedatives/hypnotics
- Muscle relaxants
- CNS stimulants

Members are identified for opioid management through monitoring each Member's pharmacy claims data and revealing patterns based on that data. Claims are continuously reviewed for volume of opioid prescriptions and dosage, the number of doctors prescribing opioids to the Member, the number of pharmacies where prescriptions are filled, as well as the total cost of prescriptions and the geographic distribution of the Member's prescribers and pharmacies to determine suspicious behavior patterns.

Once a Member is identified through claims data, a pharmacist reviews all flagged Members and assesses them to determine if further action is needed. Members are sorted into three categories by the reviewing pharmacist: Suspicion of Abuse, Likely Abuse, and No Action Needed.

> **Suspicion of Abuse** – For Members with suspicious patterns, letters are sent to all treating prescribers notifying them of the Member's patterns. The letter also requests prescribers to respond and indicate whether they reviewed the Member's case and if any changes will be occurring to the current drug therapy.
>
> **Likely Abuse** – Members whose opioid patterns are more severe, suggesting fraud or abuse. Treating prescribers are contacted and given notice that the pattern identified is of concern. Each Member is also reviewed monthly by a clinical group composed of pharmacists and medical and behavioral health medical directors who examine the details of the patient's medical case and decide whether a referral should be made directly to an addiction recovery center or to the BHCC Assessment Team for further assessment.

**Prescriber Monitoring**

Outlier prescribers are identified by benchmarking them against others on several parameters. Claims data is used to identify outliers within prescribers of opioids, stimulants, and benzodiazepines. Prescribers are compared with others in the same geographic region who have the same listed specialty. Prescribers' pharmacy claims are scanned for prescribing patterns not in compliance with established guidelines, based on volume of prescriptions, the number of patients that pay cash for prescriptions and the proportion of noncontrolled substances to controlled substances within each prescriber's practice.

Once identified, CareFirst's Pharmacy and Medical Management teams work closely with behavioral health clinicians to make decisions about the most appropriate response. Generally, the initial steps involve provider education. Providers are sent pain medication treatment guidelines and given materials to recognize the signs of medication addiction, fraud, and diversion. Peer-to-peer telephonic consultations are also conducted by an independent pain management physician specialist.

Subsequent steps may include referral to CareFirst's Special Investigations Unit and termination of the provider from the network. It may also be necessary to involve local, state, and federal law enforcement in certain cases.

**Legislative Action**

The opioid crisis and the rise in overdose deaths both from prescription opioids, heroin, and nonprescription fentanyl have raised significant concern among legislators and regulators on the federal and state levels and on a bipartisan basis. Legislation has focused on increased funding for treatment, requiring insurers to cover certain pharmaceuticals and services, and increased access to naloxone or "Narcan".

Two significant actions have been taken recently at the Federal level to address the opioid crisis. First, the Comprehensive Addiction and Recovery Act ("CARA"). This was signed into law July 2016 and established funding to support a variety of measures such as expanding use of naloxone, expanding prescription drug monitoring programs and promoting evidence-based treatment. In December 2016, the 21st Century Cures Act was signed into law. This law provides funding for states to combat the opioid epidemic. In our service area, Maryland received approximately $10 million, Virginia received approximately $9.8 million, and DC received $2 million.

Many other laws have been passed at the state level over the past year. These primarily focus on increasing treatment for substance use disorders, increased access to naloxone, prescriber limits, and insurance mandates such as prohibiting preauthorization for medications used to treat substance use disorders.

## Program #6: Home-Based Services Program (HBS)

### Preface

Home care services are covered services in most CareFirst benefit plans. Prior to the HBS Program introduction, use of these services for Members with chronic care needs was often random and almost never coordinated. Often, home care services are used for recovery from acute conditions and, because of the degree of cost-sharing in the benefit plans, services are not used for the longer-term maintenance of Members with chronic diseases even though they are often urgently needed.

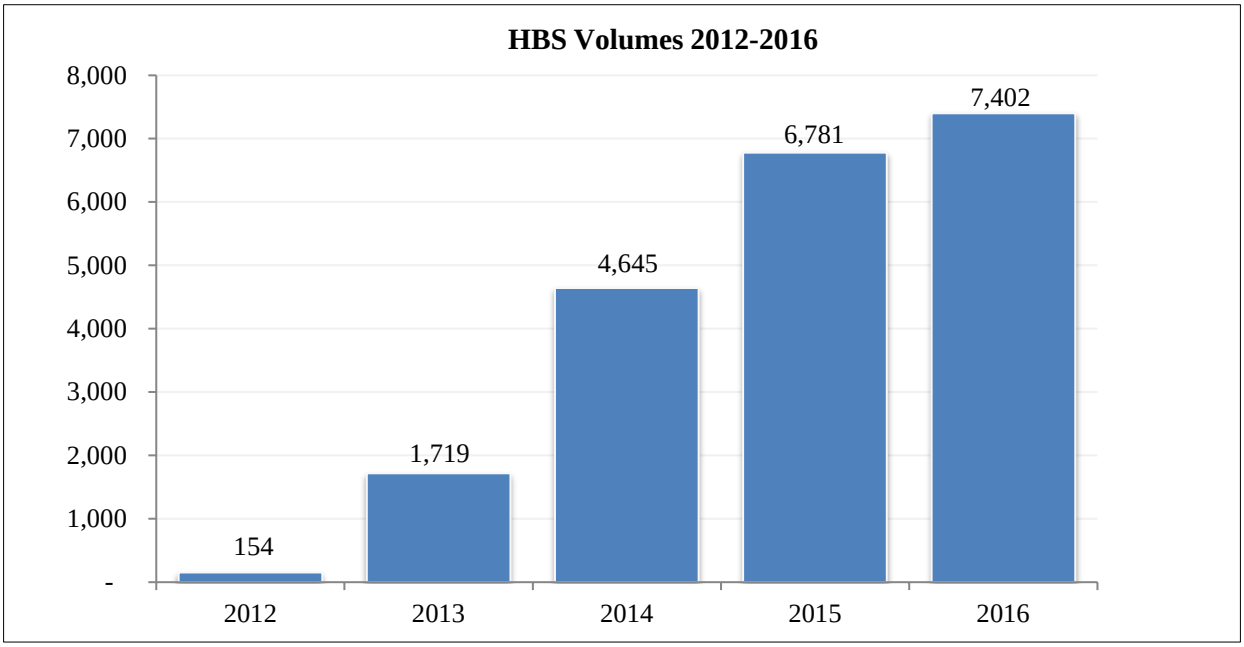
With the creation of the HBS Program, CareFirst has launched an enhanced, purposeful use of HBS for those Members in CCM or CCC Care Plans with the highest risk of hospital readmission or frequent ER visits. The HBS Program offers these Members support at home that is more extensive, more carefully directed and more targeted at longer term, complex cases. It also is more inclusive of a range of services including psycho-social and Behavioral Health services that are necessary to stabilize Members at home and to ensure their enhanced compliance with prescribed medications and other treatment protocols.

In 2016, CareFirst developed CCM or CCC plans for nearly 50,000 Members that have been carefully selected as having a high likelihood for breakdown if their care is not coordinated. The HBS Program drew from this population. Only Members who are in an active CCM or CCC Care Plans are eligible for an advanced HBS plan provided under the HBS Program. The number of HBS cases has grown steadily since Program inception as noted in **Figure 47** below.

As noted earlier, the Cost Share Waiver for Members placed in HBS pursuant to Care Plans is essential to encourage these Members to comply and cooperate with their treating providers and the terms of their Care Plans. This provides a special, elevated benefit to Members who meet criteria for the HBS Program and who remain engaged and compliant with their Care Plans.

Due to the focus on multi-chronic Members, Home-Based Services are often provided on a sustained basis over a considerable period of time – often many months – and are, therefore, not episodic in nature. Member consent is required in order for each HBS service to be rendered. A PCP or Specialist order is needed as well since the HBS will proceed under their guidance.

**Part VI, Figure 47: Home-Based Services Case Volumes Program To Date**



There are five specific, practical goals of the HBS Program:

- Reduce preventable re-admissions
- Reduce ED visits
- Reduce Member non-compliance/misunderstanding of prescriptions
- Reduce the cycle of breakdown, depression, confusion in the home
- Remove barriers to multiple services in the home by better assuring they are delivered in a coordinated way in the context of a holistic understanding of the Member's needs

**Guidelines for Selection of Members for Home-Based Services (HBS)**

The selection guidelines for Member referral to the HBS Program are intended to identify those Members who, were it not for the HBS Program, would likely be admitted, readmitted, or inclined to use ER/hospital inpatient services. The factors used to identify candidates for HBS from among those in active CCM or CCC Care Plans are as follows:

1. LACE Score >6
2. Hospital stay > 5 days
3. High Drug volatility score (8 to 10 on a 10-point scale)
4. More than three ER visits within the previous six months
5. Two unplanned admissions for the same condition within six months
6. Multiple providers involved in care and treatment simultaneously
7. Multiple chronic diseases
8. Poly-Pharmacy and history and Medication compliance issues
9. Psycho-Social Issues that threaten recovery or compliance with the Care Plan or medications

**Selected Home Care Agencies and Process for Referral to Them**

As the foundation for the HBS Program, CareFirst has identified and contracted with a select group of Home Health Agencies to carry out services in the HBS Program based on a systemic review of the capabilities of these agencies on such factors as geographic adequacy, quality and cost performance as well as managerial and technical sophistication. At least two agencies in each of the twenty PCMH regions have been identified.

The HBS Program begins with a referral from a CCM, LCC or BHCC who has already developed a Care Plan for an individual Member. The referral request is made through the CareFirst Service Request Hub in the iCentric System which then directs the request to the appropriate HBS agency covering the geographic area in which the Member lives.

HBS referrals are further based upon the urgency of care need. HBS Tier 1 cases include Members discharged from an inpatient, rehabilitation or skilled nursing facility, as well as Members with urgent medication or compliance issues. HBS Tier 2 cases focus on Member education regarding the condition or diagnosis of the Member and specific instruction as to how to better manage their conditions. Tier 2 cases may also include a pre-op visit or home assessment for Members in a care plan.

For Tier 1 cases, the HBS Program requires that a Home Care Coordinator ("HCC") from the referred to agency to conduct a comprehensive assessment of the Member and the situation in their home within 24 to 48 hours of referral. Based on this assessment, the HCC makes recommendations to the LCC or CCM who referred the case. All relevant facts and aspects of the comprehensive assessment are entered by the HCC into the HBS section of the Member Health Record of the Member in the iCentric System. For Tier 2 cases, the HCC must conduct a home visit within 72 hours of the referral or as scheduled according to need. For example, an HBS pre-op visit may be requested one week prior to surgery.

After discussion between the HCC and/or the referring CCM, LCC or BHCC, the HCC and referring source solidifies a HBS plan which must be approved by the Member's PCP or other treating provider (specialist). This plan is incorporated into the larger Care Plan that already exists for the Member and is documented in the HBS section of the Care Plan Template in the online iCentric Member Health Record. The LCC or CCM maintains oversight of the implementation of the Care Plan – including the HBS portion – and stays in close touch with the HCC responsible for the HBS portion of the plan.

**Components of Home-Based Services (HBS) Plan**

Each HBS plan developed by an HCC as a result of a request by an LCC or CCM must include and start with a comprehensive assessment which must cover the elements listed below:

**Environment and Psychosocial Assessment**

- Family/care giver support and education
- Advanced Directives
- Home Safety issues
- Functional Limitations and Nutrition

**Clinical Assessment**

- Vital signs
- Pain Assessment
- Risk Factors
- Behavioral Health Assessment
- Allergies
- Screenings and Immunizations

**Community/Resource Needs/Community-Based Services**

- Financial Situation
- Community Programs support Community-Based Services Programs
- Enhanced Monitoring
- Custodial needs
- Transportation

**Medications and Assessment**

- Complete review and reconciliation

**Services Needed**

- Equipment required
- Skilled services
    - Social work services
    - Home health aides
    - Behavioral Health

**Overall Situation Analysis**

- Conclusions and key observations
- Basis for recommended course of action for Member

Thus, the Comprehensive Home Assessment entails an analysis of the overall home situation and recommends a clear action plan that is documented in the iCentric Home-Based Service portion of the Care Plan template that is applicable to the Member.

**Process Guidelines**

- The Home-Based Services Member must be referred to the Home-Based Services Program by a CCM, LCC or BHCC.

- The referral must be sent to the selected agency in the region where the Member lives via a Service Request through the CareFirst iCentric System.

- The home health agency must acknowledge and accept or deny the Service Request within 24 hours from receipt of Service Request. If denied, specific justifiable reasons must be presented and documented in the iCentric System.

- The home health agency must contact the Member, schedule a visit and complete a comprehensive assessment within 48 hours from receipt of the referral for Tier 1 cases or within 72 hours for Tier 2 cases.

- The home health agency must document the Comprehensive Assessment in the iCentric HBS Template within 24 to 48 hours after completion of the assessment by entering their findings, observations and analysis into the iCentric Portal. All these sections listed must be completed. The HCC must document ongoing activities in the HBS Plan and/or the Encounter Notes section of the HBS portion of the iCentric System.

- Discussion must occur between the LCC/CCM/BHCC and HCC before the HBS plan is finalized and the agency must obtain approval from LCC/CCM/BHCC before proceeding with services pursuant to the Plan.

- The home health agency must communicate, at least once a week, with the referring CCM, LCC or BHCC and document all follow-up in iCentric.

- The home health agency must monitor and carry out services for the Member in accordance with the Home-Based Services plan.

Overall Member Satisfaction is measured by an independent survey arranged by CareFirst and overall Program satisfaction with the home health agency's services is measured by the CCM, LCC or BHCC that made the referral.

As each HBS plan proceeds for each Member, the goal is to reach the highest possible functioning level for the Member and to achieve a "graduation date" for the Member that when achieved, will free them from the need for continuing HBS to the maximum extent possible. Such a date must be agreed to by the referring LCC, CCM or BHCC who is responsible to obtain PCP or specialist consent.

## Program #7: Enhanced Monitoring Program (EMP)

### Preface

There are a substantial number of CareFirst Members whose chronic conditions warrant careful monitoring to avoid or minimize the ongoing threat of breakdown resulting in hospital re-admissions and repeated ER visits.

Advances in digital technology have made such monitoring in the home practical and effective. Monitoring involves daily information feedback from a Member in answer to questions posed via monitoring equipment (targeted to the Member's conditions and illnesses) as well as hard biometric readings that indicate whether a Member is heading to a trigger point (decompensating) by passing pre-set parameters for their condition.

There are a wide range of conditions and diagnoses that can be remotely monitored. They correlate closely to the WDM Condition Tracks in the TCCI Continuum and include:

- Heart Failure ("HF")
- Chronic Obstructive Pulmonary Disease ("COPD")
- Diabetes Mellitus ("DM")
- Hypertension ("HTN")
- Chronic Kidney Disease ("CKD")
- End Stage Renal Disease ("ESRD")

The EMP that is offered as an integral part of the broader TCCI Program is intended to bring this new technology and its related capabilities to bear for carefully identified Members for whom it might be best suited. This is done through a strategic partnership with an Enhanced Monitoring Partner specializing in remote monitoring services.

Remote monitoring of a Member's condition at home is carried out through the placement in the home – by the Enhanced Monitoring partner – of a device that sends digital signals to a central monitoring station staffed by a qualified, trained medical monitoring team that continually tracks the responses and signals from the Member during normal business hours for up to seven days per week. This is the health care equivalent of home security monitoring that has been available on a wide scale for many years.

Mobile devices extend this monitoring capability to the worksite or other locations of the Member if this is best.

Depending on the Member's status, pre-set parameters are established under the direction of the Member's PCP that are derived from nationally established evidence-based guidelines specific to the Member's condition. If these parameters are exceeded, contact is made with the Member by a registered nurse in the monitoring station to determine the Member's status and trigger appropriate follow-up action ranging from a simple discussion and advice to contact with the Member's PCP or even arranging for an urgent physician or clinic appointment.

The monitoring device placed in the Member's home can accept multiple biometric measurements from peripheral instruments including blood pressure, weight, blood sugar, and blood oxygen levels.

The device also collects answers to questions by the Member on a daily basis. These questions are offered on a yes/no basis with branching logic. For example, a Member would provide responses to questions about shortness of breath, their ability to move or whether they are taking their medications as directed.

Taken together, the combined information from Member responses and hard biometric readings provides a daily stream of data that reveals the Member's health status. This data reinforces proper behavior on the part of the Member that substantially increases compliance with treatment and medication protocols. Alert parameters are built into this streaming picture of a Member's status. For example, a Member with Heart Failure who experiences a two to three-pound weight gain in one day or a five-pound gain in seven days will trigger an appropriate intervention to prevent a break down.

**Primary Focus – HF, COPD, DM**

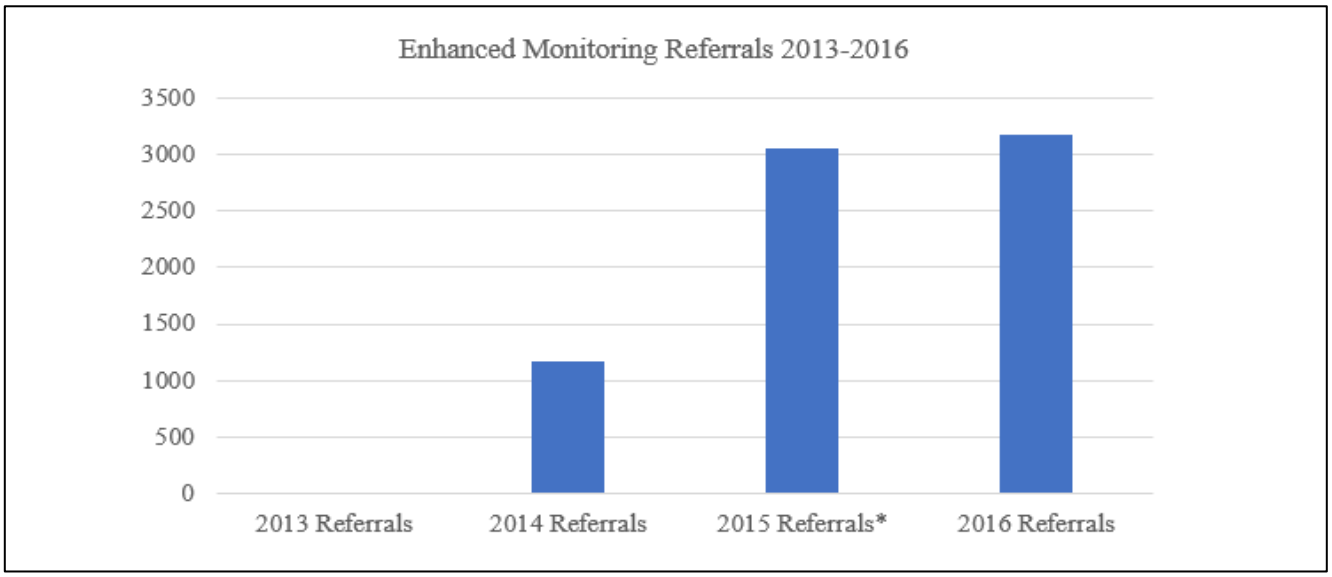
The focus of the EMP is on the most common and expensive chronic conditions: HF, COPD and DM.

These three conditions are among the most common in Members in Illness Band 2. The statistics relating to these three conditions are startling: While the overall rate of inpatient Member admissions among the general CareFirst population is just above 50 per 1,000 Members, the admission rates per 1,000 among Members with these three conditions are 345, 594, and 204 respectively. While the rate of readmission in the general Member population is approximately 10 to 15 percent, the rate among Members with these three conditions is as high as 20 to 25 percent (within 30 days of the first admission) with an average cost per readmission in excess of $11,500.

For each of these conditions, there are clear warning signs that signal trouble ahead for the Member, making them very suitable for enhanced monitoring. Further, all three conditions can be reasonably stabilized with appropriate, consistent behavior on the part of the Member.

Enhanced Monitoring volumes have increased since Program inception in 2013 as is shown in **Figure 48** below. In 2017, Enhanced Monitoring Program referrals are projected to reach well above 2016 levels.

**Part VI, Figure 48: Enhanced Monitoring Referrals 2013-2016**[36]




**Eligibility/Target Population**

In order to be eligible for EMP services, a Member must be in either an active CCC or CCM Care Plan and be referred for the service by the LCC or CCM responsible for the case. This is accomplished through an online request to the iCentric Service Request Hub causing the request to enter the work queue of Medtronic. Any such request must be approved by the Member's PCP or other treating provider before being sent to the Enhanced Monitoring partner.

Members who are not in a Care Plan, but who meet certain pre-established criteria, may be selected by an LCC, CCM or PCP for referral through the iCentric Service Request Hub. This is intended to reach a broader spectrum of Members who do not need a full Care Plan but whose conditions or illnesses could be more effectively managed through the EMP Program. All such freestanding requests would require the approval of the Member's PCP or treating specialist.

[36] **2015 Diabetes pilot data excluded*

**Initiation of Enhanced Monitoring Service**

Member Selection by an LCC or CCM is based on the Member's course/progression which must demonstrate clinical instability or threat of deterioration with increased likelihood of emergency care and/or hospitalization. Members who need assistance in adhering to a Care Plan or with self-management knowledge and skills are the core of the target population for EMP services.

Educational content regarding the use and benefits of the monitoring device as well as specific Disease Management material is conveyed to the Member by the LCC or CCM with reinforcement from the monitoring team. This focuses on Member understanding of discharge instructions, medication adherence issues, coordination of post-discharge services and the Member's ability to address red flags/warning signs.

**Service Requests**

All service requests for EMP are made using the Service Request Hub in iCentric. Each Service Request must indicate the specific condition or combination of conditions to be monitored and the number of days per week (Monday-Friday or seven days per week) monitoring is needed. The LCC or CCM making the request provides an estimate of how long the Member will need to be in the Program up to a maximum of 180 days.

In addition to the days per week of monitoring requested, the Member's language preference is also entered in the service request along with any other notes that may be relevant to the proper fulfillment of the service request. Any specific parameters (ranges for blood pressure, pulse oximetry, lung function, weight) that may be directed by the Member's PCP or treating provider must also be noted. Parameters can include "critical" values as well as "rate-of-change" values that when noted cause a notification to the Member's PCP. If parameters are not specified, default parameters are used based on evidence-based guidelines.

Members in a Care Plan are contacted in advance by the LCC or CCM to assure their consent, engagement and knowledge of the EMP services to be arranged on their behalf. This is noted in the Member's Care Plan and in the service request itself. The Member's demographic information and preferred contact information must be contained in the request.

Member consent and PCP orders will be obtained prior to the Service Request creation for non-Care Plan Members. Both the Member consent and PCP orders will be attached to the Service Request in iCentric, which will be subsequently sent to the Enhanced Monitoring partner to begin the Member outreach process.

The order entry into the Service Request Hub includes the following data:

- Program Type (Diagnoses)
- Requested peripherals
- Monitoring services five or seven days per week
- Special instructions (e.g., custom triggers and home glucometer brand in use)
- Language preference (Spanish/English)

When making a referral in the Service Request Hub, CCMs and LCCs pick from the following list of diagnoses which drive the Programming of the monitoring device and the peripherals that are shipped to the Member:

- Diabetes: Includes Glucose Cable
- CHF: Includes Blood Pressure Cuff, Scale, Pulse Oximeter
- COPD: Includes Pulse Oximeter
- HTN: Blood Pressure Cuff
- CKD: Includes Blood Pressure Cuff and/or Glucose Cable

Once the initial order is entered into the Service Request Hub, the iCentric System tracks and reports on key milestones during a Member's EMP participation. These milestones include:

- Date/Time Service Request Entered
- Date/Time Accepted by Medtronic

- Date the Member is Enrolled
- Date when Monitoring First Occurred
- Date when Monitoring Ended

If a Member refuses to comply with the EMP, the refusal is logged and automatically creates a scheduled action to the referring LCC or CCM for follow-up with the Member. For non-Care Plan Members, the PCP is contacted.

**Shipping of Monitoring Device and Peripherals**

Within one to two business days of the receipt of a referral through the Service Request Hub, the Member is contacted and receives a description of the services to be provided, confirmation of the shipping address and arrangements for shipping of the appropriate device and peripherals in accordance with shipping protocols and standards established and approved by the LCC or CCM. The nurses that do the monitoring have full 24/7 access to the Member's Care Plan through the iCentric System and to all information in the Member's Health Record in order to aid service fulfillment and ongoing monitoring activities.

Device shipping occurs within one to two business days following contact with the Member. If the Member cannot be reached, the shipping of the device will be delayed. Peripheral options for the device include:

- Blood pressure cuff
- Scale
- Pulse oximetry
- Cable for compatible glucometer

The device shipment contains step-by-step graphic installation instructions in English or Spanish with color coded input slots for each peripheral. If the Member needs installation assistance, step-by-step directions over the phone will be provided.

**Initial Device Activation**

Once the device is delivered, the Member is contacted by the monitoring team to identify and resolve any difficulties with set-up, identify family Members or others who can assist with set-up, if needed, and to explain the benefits and goals of the EMP and how the Member's health data will be communicated to his or her health care provider. This is referred to as the "Device Setup Call."

Within two business days following the device setup call, an Enhanced Monitoring Nurse will contact the Member to begin service. In the event the Member cannot be reached on the first attempt; the registered nurse will make multiple staggered attempts to contact the Member (by outbound telephone call) between the hours of 8:00 a.m. and 5:00 p.m. Central Time. If the Member cannot be reached after three attempts, the Enhanced Monitoring Nurse so notes in the iCentric System for follow-up by the referring LCC or CCM.

The Enhanced Monitoring Nurse promptly notes on a concurrent basis in the iCentric System, when the device has been activated and monitoring services have begun. In the event the device has not been activated by the Member within the 10 days following delivery, the Enhanced Monitoring Nurse enters a note in the iCentric System through the Service Request for follow up. With the approval of the Member, family Members or other caregivers can remain involved while the Member is participating in the Program including sharing their data and alerts.

Once the device is activated and data begins to be collected on a daily basis, telephonic outreach is matched to meet the gaps, needs and goals of each Member. Typically, there is a higher frequency of contact at the start of the Program as well as following any hospitalization driven by a higher frequency of alerts and gaps in understanding hospital discharge instructions. The increased frequency of outreach in the beginning of the Program (as well as matching the need of the Member to the outreach) is a key building block to Member Engagement and successful outcomes.

Outreach to the Member for an alert reason includes:

- Biometric values (e.g., blood pressure, weight, heart rate, oxygen level) outside of the parameters established at the outset of monitoring.
- Biometric values trending away from evidence-based recommended target values.

- Report of symptoms in response to the questions being asked appropriate to the Member's condition(s).
- System analytics noting symptom variances (when the patient's symptom score does not exceed their established threshold but has increased by more than X points in Y days).
- Adherence issues related to medication, dietary, and daily monitoring compliance.
- Report of a recent hospitalization or ER visit.

Outreach to the Member following a hospitalization, in addition to the outreach for alert reasons, is matched to the level of need required to gain understanding of common readmissions issues related to the following areas:

- Understanding of discharge instructions
- Symptoms and/or side effects to watch for
- Who and when to contact for changes in status or questions
- Appropriate follow up appointments
- Assessment of medication, equipment obtainability, compliance and proper usage
- Assessment of family and caregiver support

Based on the above, the level of the intensity of outreach is matched to the needs of each Member. For example, if the Member is showing signs of a potential exacerbation, their alert frequencies will increase, triggering an increase in outreach.

Likewise, if a hospitalization was the reason the Member was placed in the Program or a hospitalization occurred several weeks into the Program, the level of outreach will automatically escalate to meet the care needs of the Member and enhance their level of understanding.

As the Member's awareness and understanding of how behaviors affect their chronic condition increases, they are expected to become more active participants in managing their health, the frequency of alerts and outreach typically decreases. The Program is designed to deliver services to help Members reach their goals and assure understanding and compliance by intervening at the "teachable moment" thereby effectively engaging the Member and affecting change.

Enhanced Monitoring Nurses have a clearly defined process they use during the initial and subsequent calls with Members in the EMP. The clinical workflows for each call are created using evidence-based clinical guidelines for the specific conditions of the Member. In general, EMP follows the nationally-accepted Coleman, Naylor, and Care Transition models to prevent hospital readmissions, identify precipitating biometric triggers, and coordinate care more appropriately.

Enhanced Monitoring Nurses also assist in the coordination of care needs to help promote Member independence, wellness and safety in the home. This includes assisting the Member and his or her caregivers with Care Coordination between multiple physicians/facilities and obtaining support within the community, in collaboration with the LCC or CCM. All Member responses and biometric data are transmitted in real time to the monitoring center where a running record of the Member's progress is maintained that is accessible by the referring LCC or CCM on a 24x7 basis in iCentric.

After the initial start-up period described above, Members compliant with their daily question and answer sessions and no alerts in 30 days receive a courtesy call to check on general progress.

**Management of Alerts**

Depending on the specific issue and in accordance with CareFirst-approved operating protocols, an Enhanced Monitoring Nurse may take appropriate action, including conducting follow-up phone calls to the Member, notifying the treating physician and LCC or CCM and initiating emergency medical services in situations where a trigger or reason for concern occurs (for example, if the Member is reporting chest pain). All discussions and interventions are documented in the iCentric System. CareFirst approved protocols determine which circumstances dictate specific notification to the treating physician and LCC/ CCM.

Outreach for non-adherence alerts (for Members who are non-adherent in the daily use of their Device) consists of outbound telephone call(s) to:

- Provide education and counseling on the importance of daily health monitoring;
- Inquire about concerns that Members may have with regard to use of Devices; and

- Motivation coaching that garners the Member's support to avoid hospitalizations that may result from non-use of the monitoring device.

The monitoring team contacts any Member who has not taken biometric measurements or taken a survey in three consecutive days to determine if there is an equipment malfunction or some other reason for not complying. If there is a malfunction or defective equipment, the equipment is replaced and a notice is sent to the LCC or CCM. At any time, if the Member ceases participation in the Program, or is otherwise non-adherent a notice is sent to the LCC or CCM.

An alert can result in a health coaching or education session conducted by the Enhanced Monitoring Nurse according to evidence-based standards applicable to the Member's condition(s). When alerts occur that require the intervention of the Member's PCP or by the LCC or CCM, the Enhanced Monitoring Nurse promptly contacts the appropriate party in accordance with CareFirst operating protocols.

**Coordination with Existing Care Plan**

In every care plan case, the interactions between the Enhanced Monitoring Nurse and the Member are coordinated with the Member's existing Care Plan or Case Management Plan. This assures that communications with the Member (or his or her caregivers) regarding clinical guidelines or plans of care are made in the context of a full understanding of the Member's case. This entails close coordination between the Enhanced Monitoring Nurse and the Member's LCC or CCM who is responsible for the case.

**Management of Hospitalization and Hospital Discharge**

If a Member is hospitalized while participating in the EMP or begins the Program on discharge, Enhanced Monitoring Nurses use their access to CareFirst HTC, CCM or CCC Care Plan notes in the Member Health Record to better support the execution of discharge instructions to prevent readmission. This includes communication regarding disease process, decompensation warning signs, compliance barriers and reinforcement of medication adjustments, scheduling of follow up appointment(s), and assuring access to provider ordered follow-up care.

**Bilateral Data Access**

The Enhanced Monitoring team has full read/write access to each Member Health Record and Care Plan in CareFirst's iCentric System for those Members enrolled in the EMP. Conversely, LCCs and CCMs, as well as treating PCPs, have access to the monitoring data and notes collected. This is accomplished by clicking on the EMP tab in the iCentric Member Health Record. When viewing the EMP tab, iCentric users can see the following results:

- History of data collected from the device including days where session was not completed
- Weight graph and grid
- Blood pressure graph and grid
- Glucose graph and grid
- O2 saturation graph and grid
- Heart rate graph and grid
- Vital sign summary grid (includes weight, BP, HR, Glucose, Sp02 and EMP data on a single summary grid)
- Exception report available with one click in a PDF form
- Encounter notes recorded directly into iCentric

**Member Graduation from EMP**

The goal of appropriate, sustained Engagement on the part of the Member while in the EMP is to progress the Member to an improved state of independence where enhanced monitoring is no longer necessary. Parameters that indicate a Member's preparedness for graduation are agreed to on a case by case basis between the Enhanced Monitoring Nurse and the referring LCC or CCM. The overall guidelines for these parameters are set by the CareFirst Medical Director in concert with the Enhanced Monitoring medical team. Upon meeting requirements, Members are gradually transferred to less high touch options as their disease state and overall compliance improves.

An Enhanced Monitoring Nurse performs routine graduation checkpoint reviews to monitor the Member's progress towards self-management and graduation 30 days after Program initiation and every 30 days ongoing. These frequent check points allow all involved to work collaboratively to monitor progress towards "graduation" and self-management. At any time, the LCC, CCM or Enhanced Monitoring team can initiate subsequent reviews of the Member's progress toward graduation. The Graduation Checkpoint Pathway analyzes enhanced monitoring data, nursing intervention(s), Member action(s) and response to intervention(s) along with the graduation pathway driven assessments to gauge Member's readiness for self-management.

Evaluation for graduation includes the use of following criteria and tools:

- Enhanced Monitoring Member adherence (Reporting ≥90 percent in the previous 30-day period).
- Exception/Alert rate ≤10 percent in the previous 30-day period.
- No hospitalizations (non-elective) in the previous 60 days.
- Evidence that the Member has an understanding of their disease and monitoring process, knows the warning signs/triggers of exacerbation and when to report to physician.

Since Program inception over 76 percent of the Members referred have successfully graduated the Enhanced Monitoring Program. The LCC or CCM uses information gathered through the Graduation Checkpoint Pathway and in collaboration with the PCP to determine eligibility for graduation or need for continued monitoring. Graduation is at the discretion of the LCC or CCM in consultation with the Member's PCP. The graduation is entered in the Service Request Hub which immediately sends notice to the Enhanced Monitoring partner that services should cease.

**Termination of EMP Services**

Members may be terminated from Enhanced Monitoring Services by the referring LCC or CCM for failure to comply with the monitoring plan. Low adherence is defined as device usage less than 75 percent of the days the Member is enrolled in the EMP. A low adherence rate requires a review with the referring LCC or CCM to maintain EMP as a viable option.

In the event that the Member is no longer eligible for Covered Services, CareFirst notifies the Enhanced Monitoring team by way of a cancellation of the Member's iCentric service request. The Enhanced Monitoring partner then discontinues monthly billing for the Member until further notice by the Member's LCC or CCM. No reimbursement is made for a Member for which CareFirst provided notice that the Member is no longer active in the EMP.

## Program #8: Community-Based Program ("CBP")

### Preface

The Community-Based Program ("CBP) brings to bear on a number of pre-selected community-based medical services that are focused on different illnesses and conditions that require specialized capabilities. These Community-Based Programs are built on partnerships between CareFirst and key medical providers within the region that, in addition to their specialized capabilities, address various cultural, linguistic and ethnic diversities.

Members who are engaged in CBPs are more likely to follow up with their PCP and actively engage with treatment plans. When an LCC, CCM or BHCC identifies a Member who would benefit from such services, a Service Request is submitted via the Service Request Hub, connecting the Member to the target Program within their community. Additionally, by linking CBPs with other needed services such as HBS, Enhanced Monitoring, and CMR, Members can better achieve the highest level of recovery and stabilization possible.

The compendium of CBPs is growing and includes:

- Addiction Program
- Hospice and Palliative Services
- Skilled Nursing Facility (SNF) Care
- Chronic Kidney Disease
- Diabetes Management Program
- Pain Management
- Congestive Heart Failure
- Cardiac Rehabilitation
- Sleep Disorders

CBPs rely on one of the region's greatest strengths – an array of high quality, innovative medical programs developed by local providers that support Members where they live and work. These Programs are described in the pages that follow.

## Addiction Program

In response to the rising need for addiction treatment, CareFirst has created the Alcohol and Drug Addiction Community-Based Program. The core tenet of this Program is the recognition that addiction is a chronic disease of the brain and that there are recognized treatment centers of excellence in the CareFirst service region that accept this as the foundation of treatment and are able to successfully work with Members who are referred for treatment.

The goals of the Alcohol and Drug Addiction Community-Based Program are to:

5) Provide Members with necessary treatments to deliver the best outcomes for their individual clinical circumstances.

6) Provide access to cost effective addiction treatment programs that offer the most up-to-date clinically appropriate standards.

7) Educate Members, PCPs and all stakeholders as to the causes, identification and treatments of addiction.

8) Provide appropriate care in a community setting outside of a hospital or residential setting to enhance sustainable outcomes and lower costs.

**Social and Economic Impact of Addiction**

Data collected by the National Center for Health Statistics at the Centers for Disease Control and the Department of Health and Human Services find that eight to 10 percent of people in the United States 12 years or older are addicted to alcohol, or other drugs; both legally or illegally obtained.[37] This abuse costs the US an estimated $700 billion annually in health care costs, increased crime and lost productivity.[38] An estimated 44,000 people die each year from drug overdoses related to heroin, cocaine, benzodiazepines and prescribed opiates. The risk of early death from trauma, suicide or infectious disease is also markedly increased among those who are addicted.

Unfortunately, it is estimated that 90 percent of people with addiction who are in need of treatment services do not receive them, according to surveys conducted by the Substance Abuse and Mental Health Services Administration.[39] Because patients are often not diagnosed or not willing to admit their addictions, statistics for this population are inadequate.

The lack of care stems from the continuation of past approaches to treatment in which addiction behaviors have been treated primarily as personal failures, and not as a disease. Even today, patients must overcome the stigma of failure and shame in recognizing they need help. Nationally, there are gaps in access due to lack of insurance that does not cover needed treatments, or the presence of high deductibles that require large out of pocket payments before coverage begins. Also, despite the proliferation of opioid abuse and addiction in the United States, there are too few high-performing treatment centers to accommodate all patients in need.

**Biological and Social Influences on Addiction**

Addiction is a chronic disease. As with other chronic diseases, periods of exacerbation and remission are expected. While there is no complete cure, there is treatment. Those affected may be reluctant to admit they need treatment and there are challenges in adhering to treatment. For those addicted, their susceptibility varies as with any chronic disease. Genetic, social and environmental factors play a significant role. In fact, only a modest fraction of those exposed to potentially addictive drugs become addicted.

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[37] *SAMHSA, Center for Behavioral Health Statistics and Quality, National survey on Drug Use and Health, 2013*

[38] *National Drug Threat Assessment, Washington DC Department of Justice, National Drug Intelligence Center 2011*

[39] *American Addiction Centers, americanaddictioncenters.org/rehab-guide/success-rates-and-statistics, 2014*

For those who do become addicted, the risk factors include: family history, exposure to drug and alcohol use early in life, poor social supports, or permissive attitudes toward drug taking or alcohol consumption.

**Adolescents**

Adolescents are a special risk group. The adolescent brain is not fully developed. This is particularly true with regard to the areas of the brain in the prefrontal cortex which controls executive functioning. These areas are involved in decision making and control of impulsivity; and are not fully mature until age 25. It is also thought that the brain is more "plastic" during this period and more vulnerable to maladaptive effects on the brain's reward centers.[40]

**The Stages of Addiction [41]**

There are several stages to addiction that a person passes through that are well documented and form the basis of understanding upon which treatment is based. These are described briefly below.

**Stage 1:** Upon taking an addictive drug or consuming alcohol, dopamine is released and the brain's receptors register it as a reward. With continued use, the brain's dopamine cells start firing in anticipation of receiving the drug or alcohol. The brain learns to associate reward with the environmental stimuli at the time.

This means all the factors surrounding drug or alcohol use (who you were with, where you were, etc.) can trigger strong desires resulting in relapse or binges. This conditioning becomes so ingrained that even in a person with years of successful recovery, cues can immediately arise to trigger drug or alcohol-seeking behavior.

**Stage 2:** As drug or alcohol use continues, the brain adapts by resetting its reward system, dulling the ability of the person to experience pleasure from the drug or from the other things in life that used to motivate them, such as relationships and activities. In fact, chronic drug and alcohol use causes changes in brain circuitry that set in motion an overactive "anti-reward" system which leaves the addict unable to cope with stress and prompting negative feelings when a drug or alcohol is withdrawn.

Eventually, the person no longer uses a drug or alcohol to get high but to simply stave off cravings and the pain of withdrawal. This sets up a vicious cycle: the more the drug is used, the worse the cravings and withdrawal become, which pushes the person to even greater dependency.

**Stage 3:** As the addiction progresses, the person becomes more and more obsessed with their drug or alcohol even though they may be desperate to stop. At this point, addiction not only affects reward circuits, it interferes with signaling in the parts of the brain involved in executive functions such as self-regulation, decision-making and the ability to monitor error. Without these to rely upon, the desire to stop often becomes no match for the desire to use.

**CareFirst Population Characteristics**

Although addiction is recognized as a national epidemic, it is largely unidentified in reporting due to stigma, lack of standards and a deficiency of knowledge in the medical community. Psychiatrists and therapists do not typically collect data or report on results of patients they treat for addiction, nor are they required to do so. Many Members seek help outside of insurance to avoid notice and/or the scrutiny of employers, family and friends. Other Members are unwilling or unable to recognize their addiction and do not seek help.

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[40] *Castellanos Ryan, N, Rubia K, Conrod PI. Response inhibition and reward response bias mediate the predictive relationships between impulsivity and sensation seeking and common and unique variance in conduct disorder and substance misuse. Alcohol Clin Exp Res 2011; 35-140-55.*

*Nees F, Tzschoppe J. Patrick CI, et al. Determinants of early alcohol use in healthy adolescents; the differential contribution of neuroimaging and psychological factors. Neuropsychopharmacology 2012; 37-986-95.*

*Quinn PD, Harden KP. Differential changes in impulsivity and sensation seeking and the escalation of substance use from adolescence to early adulthood. DevPsychopathol 2013; 25-223-39.*

[41] *Patterson, Kendall; www.elementsbehavioralhealth.com, A Look Inside the 3 Stages of Addiction, March 22, 2016*

In addition, privacy laws hinder care coordination between medical and addiction professionals even though addiction goes hand in hand with co-occurring medical issues. As a result, the true number of Members in need of addiction treatment remains hidden. One of the goals of the Addiction Community-Based Program is to enhance reporting and track outcomes to more accurately identify the issues and opportunities for improvement in treatment and follow on care.

Because of this hidden need, the member counts in the episode table below represent a remarkably low percentage of the overall CareFirst population. Simply put, current claims data does not accurately represent the volume of Members with addictive problems. In the U.S., only one in 10 people with addiction to alcohol and/or drugs are diagnosed and receive treatment compared to 70 percent of people with hypertension or diabetes who receive treatment.[42]

**Part VI, Figure 49: Summary Of Members With Addiction Episodes**

| Year | Unique Members | Medical Member Months | Total Spend | Total Spend PMPM | Medical Spend PMPM | Rx Spend PMPM | Admits / 1,000 | ER / 1,000 | Average IB Score |
|---|---|---|---|---|---|---|---|---|---|
| 2014 | 20,452 | 221,366 | $330,084,732 | $1,491.13 | $1,322.67 | $289.19 | 440.7 | 852.2 | 3.13 |
| 2015 | 20,229 | 219,093 | $336,729,108 | $1,673.85 | $1,488.03 | $311.16 | 491.7 | 839.8 | 3.11 |
| 2016 | 20,672 | 225,916 | $380,548,224 | $1,684.47 | $1,493.66 | $326.44 | 515.1 | 797 | 3.30 |

In the comparative data shown, Members diagnosed with addiction are admitted to the hospital and visit the ER at a much greater rate than the general population. In addition, the addiction population costs approximately $1,000 more PMPM than the overall book of business.

**Part VI, Figure 50: Summary Of Members In CareFirst Book Of Business**

| Year | Unique Members | Medical Member Months | Total Spend | Total Spend PMPM | Medical Spend PMPM | Rx Spend PMPM | Admits / 1,000 | ER / 1,000 | Average IB Score |
|---|---|---|---|---|---|---|---|---|---|
| 2014 | 2,065,888 | 22,155,204 | $9,147,278,541 | $412.87 | $355.71 | $103.40 | 56.4 | 203.6 | 1.04 |
| 2015 | 2,077,107 | 22,402,954 | $9,800,833,845 | $437.48 | $371.57 | $117.99 | 54.9 | 200.0 | 1.04 |
| 2016 | 2,040,609 | 22,080,828 | $8,388,843,031 | $449.81 | $379.92 | $126.91 | 54.0 | 190.7 | 1.05 |

The most common episodes of addiction each year are due to alcohol while opioid addiction is the second most common. Over 2,000 Members identified each year have episodes for multiples types of drug addiction.

**Part VI, Figure 51: Summary Of Addiction Members By Episode Type**

| Year | Alcohol Only | Opioid Only | Other Drug Only |
|---|---|---|---|
| 2014 | 7,800 | 4,290 | 5,582 |
| 2015 | 8,186 | 4,252 | 4,715 |
| 2016 | 8,287 | 5,125 | 4,328 |

[42] *Lloyd Sederer; http://www.usnews.com/opinion/blogs/policy-dose/2015/06/01/america-is-neglecting-its-addiction-problem; A Blind Eye for Addiction, June 1, 2015*

**Integration between Primary Care and Specialty Behavioral Health**

Since many patients with addiction have co-occurring medical and Behavioral Health disorders, PCMH Primary Care Physicians, LCCs, Complex Case Managers, BHCCs, psychiatrists and other Behavioral Health providers as well as Members and their families are a major source of identification and referral for those addicted.

Because Behavioral Health issues exacerbate medical conditions if not identified and treated, communication between PCPs and Behavioral Health providers are critical to improve the outcomes of patients with addiction behaviors, especially with regard to related medical conditions such as AIDS, Hepatitis C, pneumonia, accidental injuries, cirrhosis of the liver, pancreatitis and systemic infections.

**Principles of Effective Treatment for Addiction**

Committing to treatment and maintaining sobriety is extremely difficult for those Members suffering from addiction. The goal of treatment is to help individuals to stop using, stay alcohol or drug free and lead a full, productive life.

The following are principles of effective treatment:

- Addiction is a complex but treatable disease that affects brain function and behavior.
- No single treatment is right for everyone.
- People need to have quick access to treatment.
- Effective treatment addresses all of the patient's needs, not just his or her drug use.
- Staying in treatment long enough is critical.
- Medications are often an important part of treatment, especially when combined with behavioral therapies.
- Treatment plans must be reviewed often and modified to fit the patient's changing needs.
- Treatment should address other possible mental disorders.
- Medically assisted detoxification is only the first stage of treatment.
- Treatment doesn't need to be voluntary to be effective.
- Drug use during treatment must be monitored continuously.

**Types of Addiction Programs**

Treatment programs are typically organized into two categories: inpatient treatment and outpatient treatment. A Member may go through multiple types of therapy – there is no standard order or one treatment over the other. In these programs, Cognitive Based Therapy ("CBT") and Medication Assisted Therapy ("MAT") may be used. These specific programs and related therapies are explained more fully below.

Inpatient treatment, also known as Residential Treatment, typically lasts 28 days and removes the patient from the community and the triggers of their addiction. Members are not usually admitted unless there are indications of alcohol or drug use on admission. Licensed residential treatment facilities offer 24-hour structured and intensive care, including safe housing and medical attention. Residential treatment facilities may use a variety of therapeutic approaches typically focusing on detoxification as well as providing initial intensive counseling and preparation for treatment in a community-based setting.

Community-Based outpatient programs are usually the next step in recovery treatment after completing a residential program. However, many patients begin treatment in an outpatient program because they do not require a higher intensity of treatment or are not able to pay the higher costs of residential programs.

Intensive Outpatient Programs ("IOP") provide treatment four to five days a week in group and individual counseling sessions. Instead of isolating the Member from the community and the triggers that cause relapse, the Member returns to the community each day while working with a counselor to overcome the temptations Members are actively experiencing.

The cost of an IOP is far less than residential treatment. Treatment is highly individualized and great attention is placed on communication with the Member's Primary Care Physician.

IOP Treatment phases include:

4) An outpatient detoxification phase for those needing withdrawal management.
5) A rehabilitation phase which typically lasts eight weeks and includes individual and group sessions-using psychiatrists where needed.
6) A continuing care phase consisting of clinician-led group therapy sessions that may last a year or more. Family services and groups sessions are also typically offered.

Outpatient therapy is commonly the next step in the recovery process after IOP. Regular outpatient treatment meets one to two days per week for usually a year or more. In order to achieve treatment goals, long term engagement of usually a year or longer in outpatient sessions is critical. During this time, the brain heals, coping strategies are strengthened, and relationships are solidified in therapy groups.

**Cognitive Behavioral Therapy (CBT)**

Cognitive Behavioral Therapy (CBT) is useful in a number of ways in the treatment of addictions and relapse prevention. CBT is a goal-based psychological treatment designed to analyze and change how patients view challenging situations. Patients can be taught to make behavioral changes such as avoiding people, places, and things that trigger their desire for alcohol or drugs. People in early recovery are often also in need of skills training in assertive communication, stress management and refusal skills.

Equally important is the need to recognize and address maladaptive cognitive patterns. This can take the form of identifying a faulty belief or expectation. For example: “I won’t be able to stay sober”, or “I’m a chronic relapser”. Through CBT, patients are taught to challenge and correct these behaviors with positive thinking; “I’ve had trouble staying sober in the past but I’ve been learning new skills.” CBT also includes a number of exercises designed to improve the likelihood of sustained recovery. These tools include exercises listing the advantages and disadvantages of substance use, and exercises designed to identify relapse warning signs such as isolation and dishonesty.

**Medication Assisted Therapy (MAT)**

Medication Assisted Therapy (MAT) is particularly effective at preventing relapse while the brain is healing, helping to restore normal decision making. It is common for the healing process to take one year or more with greater risk of relapse without medication therapy. MAT is individually tailored and has proven to significantly reduce the need for inpatient services.

MAT treatment and counseling have been shown to:

- Reduce relapse rate post treatment
- Improve patient survival
- Decrease illicit opiate use and other criminal activity
- Increase patients’ ability to gain and maintain employment
- Improve birth outcomes among women who have substance use disorders and are pregnant

Despite this success, MAT is greatly underused. Reasons for the slow adoption include lack of training for physicians and a lack of understanding, even among health care professionals, of the biological basis of addiction in the community at large.

**Relapse**

Despite strong programs and evidence-based therapies for addiction, relapse is very common. People may go in and out of programs multiple times in phases of stability and relapse. The National Institute on Drug Abuse (NIDA) reports the relapse rate for drug addiction is 40 to 60 percent. Approximately 90 percent of alcoholics will experience one or more relapses during the four years after treatment, according to a publication from the National Institute on Alcohol Abuse and Alcoholism.

Due to the high risk of relapse, those undergoing treatment are encouraged to stay in outpatient programs for up to one year or more. Therapy groups can cultivate peer pressure to stay clean. Strong relationships develop with therapy groups connecting both in and outside of therapy. Many times, someone who has relapsed can be reached through other members of the group.

In an IOP or outpatient program, having a relapse is not viewed as a failure but an opportunity to identify the cause and establish a plan to manage the trigger.

One of the most effective ways to prevent a relapse is to establish new, healthy habits in the course of treatment. Recovery Centers have nutritionists on staff and counselors who focus on assisting those recovering with identifying emotions and stressors that cause relapse. Recommended lifestyle changes include the following:

- Changing diet
- Starting an exercise program
- Paying more attention to mental health
- Managing stress
- Modifying sleep habits
- Spending more time around people who do not use drugs

**Collaboration with Intensive Outpatient Programs**

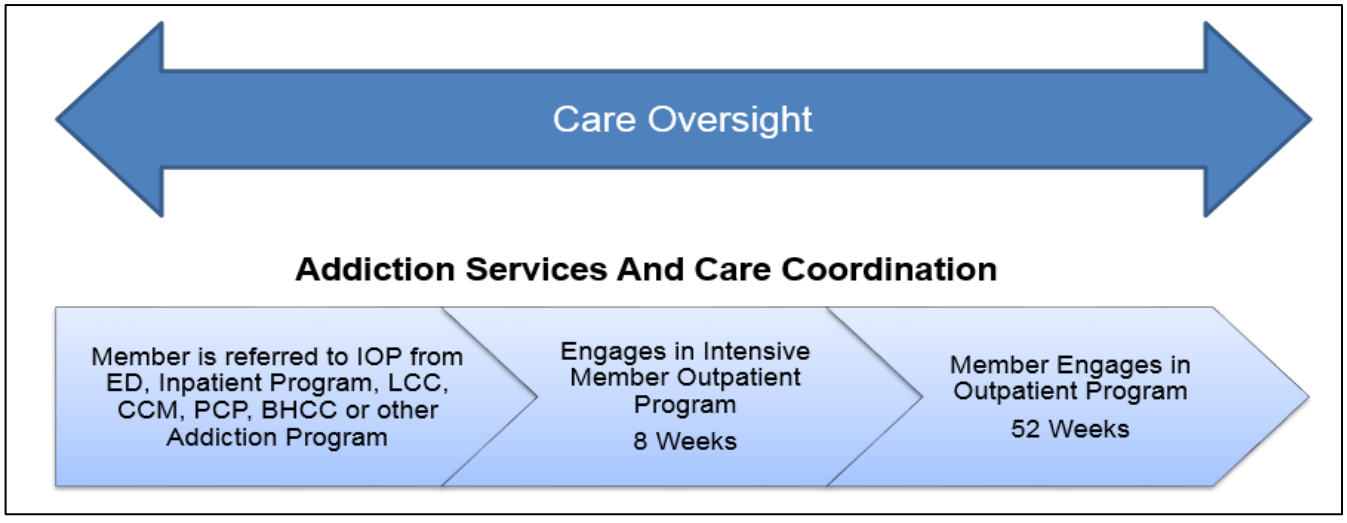
In developing the Addiction Program, CareFirst has partnered with high performing Addiction Recovery Centers and specialists throughout MD, DC and Northern VA who are leaders in the provision of Intensive Outpatient Programs (IOP), which consists of individual evaluation and MAT therapy, as well as group therapy.

Many people engaging in IOP do not require residential treatment or are moving from residential treatment to a step-down program. The foundation of the Addiction Community-Based Program is to begin actively managing and tracking the Member's progress on admission to IOP and throughout follow-up treatment. Documentation is entered in iCentric at 30, 90, 180, 270 and 365 days after IOP treatment is completed. By doing so, Members maintain their engagement in the appropriate programs and prevent or address relapse with greater likelihood for continued stability.

The diagram below shows the Program's timeline and process flow to guide Members as they graduate from IOP and move into less intensive outpatient treatment. The diagram also depicts the CareFirst Addiction Care Oversight monitoring of Member progress and the weekly updates provided by the addiction recovery centers. The Addiction Care Oversight staff is responsible for routinely analyzing patterns of care and with working closely with the addiction recovery center to increase Program compliance and improve the likelihood of each Member's sustained recovery.

**Process Flow for Addiction Program**

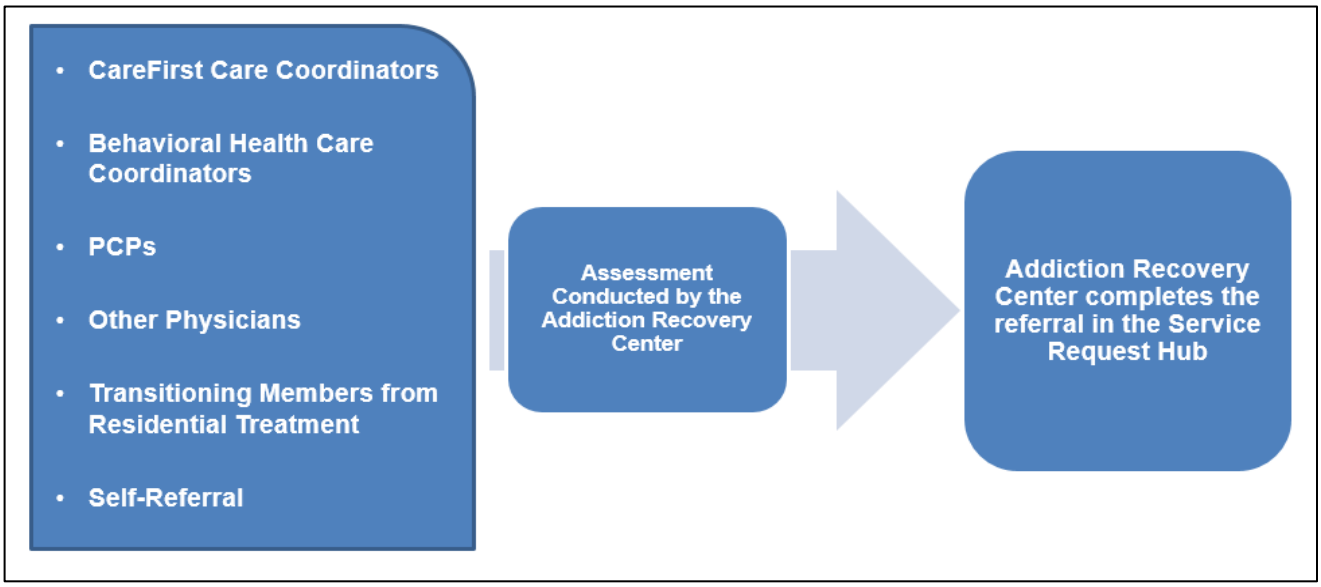
**Part III, Figure 52: Care Coordination And Compliance Oversight**




A CareFirst Member who is identified with an alcohol or drug addiction may be referred to one of the regional Addiction Recovery Centers through the following sources:

- CareFirst LCCs or Complex Case Managers after a diagnosis is made by a PCP or specialist
- Direct referral from a PCP or specialist
- BHCCs
- Case reviews conducted by CareFirst and CVS pharmacists and medical directors through which substance abusers are identified
- A residential treatment center
- Voluntary enrollment by the Member

**Part III, Figure 53: Referral Sources**




- The Addiction Recovery Center receives a service request through the Service Request Hub. The service request is addressed by the center's admissions staff with a notation in iCentric identifying the referral source, condition(s) and date of admission.

- An initial evaluation appointment takes place within one business day of admission. The assessment is conducted by the Recovery Center's licensed/certified staff. A treatment plan is then developed for the Member. The service request is activated on the date the assessment and plan are uploaded to iCentric and treatment begins.

- The Member's out-of-pocket costs under this benefit plan design are waived while the member is engaged in an Intensive Outpatient Program and during the subsequent 12 months in an Outpatient Program as long as the Member remains in compliance.

- The recovery center uploads progress notes weekly to iCentric throughout the course of treatment. The center will work with CareFirst Addiction Care Oversight team monitoring Member progress.

- Upon Member consent, the Addiction Recovery Center collaborates with the Member's PCP throughout treatment and provides ongoing progress notes and a summary of treatment to the PCP periodically and upon completion.

- If a Member does not remain engaged, the recovery center will seek assistance from therapy group members, LCC, PCP, BHCC or the initial referral source to re-engage the Member.

- If a Member drops out of the program prior to completion, the recovery center contacts the PCP, LCC or BHCC making every effort to re-engage with the Member. If unable to re-engage the Member, the Member's treatment plan is canceled in iCentric with the appropriate cancellation reason and notice.

- After completing the eight-week IOP Program, the Addiction Recovery Center uploads a summary of treatment in pdf format to the Member MHR in iCentric. The summary includes primary and secondary conditions, assessment results, plan of care, summary notes and member State-of-Being at the end of treatment.

- Upon IOP completion, the Addiction Recovery Center motivates and encourages the Member to consistently attend outpatient sessions. The center continues to update Member progress in iCentric for the 12 months' post IOP graduation. At a minimum, the recovery center contacts the Member 30-, 90-, 180-, 270- and 365 days after IOP treatment and documents each Member outreach in iCentric.

- The recovery center reaches out to the Member when ER visits, hospital admissions or other breakdowns have occurred. The CareFirst addiction oversight team works with recovery centers to reveal these occurrences in the claims data.

In the case of relapse, the Addiction Recovery Center will attempt to re-engage the Member at an appropriate level of treatment. Relapse treatment may be a referral to a residential treatment facility or re-entry into the IOP.

**Graduation from IOP and Follow on Care**

A Member must demonstrate continued Engagement throughout the eight-weeks in IOP and remain in further treatment for one year (one to two sessions per week) in order to graduate from the program. The Member must demonstrate the capability to remain independently drug or alcohol free during this one-year period.

Follow on care, also known as after care, is of vital importance to Members with addictions. The longer someone with an addiction remains engaged in a program, the greater the likelihood of continued success in remaining drug or alcohol free. The relationships that develop in group oriented programs become part of the Members lifestyle and sustained focus on continued recovery.

Follow on care programs are focused on encouraging participants to seek reintroduction into treatment at the earliest sign of slippage or breakdown. Many addiction recovery centers hold programs on site to promote this message. After completing treatment in an outpatient setting, evening and weekend programs such as SMART (Self Help Addiction Recovery), Celebrate (Spiritual Recovery), Alcoholics Anonymous, Narcotics Anonymous and IOP alumni meetings offer ongoing support and play a critical role after formal treatment has concluded.

**Recovery Center Standards**

Each partner in CareFirst's Alcohol and Drug Addiction Program maintains the following standards:

- Accreditation by NCQA (National Committee for Quality Assurance), CARF (Commission on Accreditation of Rehabilitation Facilities) or Joint Commission.

- Use of evidence based treatments.

- Capability for ambulatory detoxification or close relationships with other providers in the network that provide this service.

- Capability for assessing/diagnosing co-occurring mental health disorders.

    - Medicating and treating in the center or
    - Referral relationships to other network providers with this capability

- Use of therapy groups led by licensed or certified staff.
- Clinical staff who meet regularly to discuss patient and treatment issues.
- Staff training that enables staff to remain current on developments in the field and reinforce best practices.
- Reporting of Member progress to referral sources and other treating providers including PCP's.
- Ability to report to CareFirst through a standard interface (iCentric) the weekly progress of all Members in the Program.
- Discharge planning that includes transition/referral to a step-down level of treatment and other wrap around services.
- Follow-up care 30, 90, 180, 270 and 365 days after IOP graduation to assess and measure Member progress.

**Partner Incentives for Continued Engagement**

To promote long term Member Engagement and increased opportunity for success, CareFirst offers outcome incentive performance awards to recovery center partners. The three elements upon which outcome incentives are based include:

1. Graduation from the IOP and post IOP after care for one year.
2. Rapidity and effectiveness of follow-up with a Member when breakdowns, ER visits or inpatient admissions occur as measured by a reduction in or no inpatient admissions and ER visit rates.
3. The quality, consistency and completeness of the data and encrypted text on Members in treatment that is sent to iCentric on a timely basis.

The first-year results of the Addiction Program (2017) will be the baseline for these three levels of performance. In the second year of the Program, all recovery centers become eligible for performance incentives. All results reported are subject to a CareFirst audit including iCentric notes and Member claims.

**Conclusion**

Addiction disorders have dramatic and detrimental effects on personal relationships, the family, health care costs and society at large. The purpose of the Addiction Community-Based Program is to quickly connect CareFirst Members to trusted providers of Intensive Outpatient Treatment who understand the neurobiological underpinnings of the disease and provide best practice, individualized evaluation and treatment.

## Hospice And Palliative Care Services Program

Each year, over one million patients in the United States die in hospice care, representing approximately 44 percent of all US deaths. Over the past decade, hospice providers have seen substantial growth in the number of patients served. While these numbers are significant, they are largely driven by the Medicare population.

There is a significant opportunity to expand services and to lengthen the time in hospice and palliative care for the under 65 population. In the event of serious illness, most Americans indicate that they strongly prefer supportive care that addresses pain and discomfort as well as emotional, social and spiritual needs. Many studies have shown that most individuals would prefer to have greater autonomy regarding their end-of-life care options. Notwithstanding this, most terminally ill patients under the age of 65 die in intensive care settings undergoing often futile, invasive procedures not in keeping with the patient's express wishes.

Hospice is a key way of providing high quality, compassionate care for people facing a life-limiting illness or injury. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well.

Palliative care is specialized medical care for people with serious illnesses who may be experiencing persistent pain or other debilitating effects. Although it is often provided in the latter stages of illness or disease, it can be provided at any stage of illness and in both inpatient and outpatient settings. Palliative care treats suffering from serious and chronic illnesses such as cancer, cardiac disease, Congestive Heart Failure ("CHF"), COPD, Alzheimer's, Parkinson's and Amyotrophic Lateral Sclerosis ("ALS").

More specifically, palliative care focuses on alleviating such symptoms as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression. It helps the Member to carry on with daily living despite their health challenges. It also helps Members to have more control over their care by improving communication so that they can better understand their choices for treatment and the course or path of their disease(s) or condition(s).

Hospice is best understood as a form of palliative care specifically designed for Members who are terminally ill. Hospice focuses on caring, not curing. Palliative care is often part of hospice care but can, and often does, stand-alone especially for people without a terminal condition.

### Medicare and Carrier Policies

Carrier reimbursement policies influence and shape access to hospice and palliative care services. Since the establishment of the benefit in 1983, many hospice and palliative care benefits are based on the rules governing the Medicare Hospice Benefit which has long dominated how providers view access to hospice and palliative care. Medicare limits access to hospice and palliative care in two ways:

- The benefit explicitly limits access to hospice care to patients with a prognosis of six months or less to live.
- It compels beneficiaries who choose hospice care to forgo "disease-modifying treatment".

As a result, many patients who might benefit from hospice and palliative care services do not receive them unless they have a short life expectancy and agree to give up on further treatment, causing many to delay enrollment in hospice and palliative care until the last few days of life.

Another impediment is the cultural mindset that is associated with hospice benefits. Many health care providers and Members view advancing illness and death as failures of medicine or of themselves, inhibiting progression to hospice or palliative care because it is seen as giving up.

The CareFirst Hospice and Palliative Care Program advances well beyond the traditional Medicare limits of hospice and palliative care. CareFirst has created a model in which palliative and ongoing disease treatments can be managed con-currently, encouraging the Member to enter Hospice/Palliative Care earlier in advanced disease progression thus improving quality of life as it nears its end. At the heart of the CareFirst Hospice and Palliative Care Program is the belief that each Member has

the right to die pain-free and with dignity, with the necessary services for both the Member and their family. In this context, it is the goal of the entire health care team to provide an extra degree of support to these most vulnerable Members.

In the CareFirst Hospice and Palliative Care Program, the care team is supportive, not prescriptive. Palliative care and hospice services are generally provided in the home setting, with a higher level of quality, patient/family satisfaction and lower cost than intensive services provided in acute inpatient settings.

**Impact**

In 2016, CareFirst had over 1,500 Members per year who have received home or inpatient hospice services. Total spending for these services was approximately $12 million per year with an average duration of 32.7 days. Roughly, 67 percent of hospice patients received services in the home and 73 percent of hospice cost is in the home setting.

It is estimated that the total number of CareFirst Members who could benefit from Hospice and Palliative care services far exceeds those who actually receive these services suggesting far greater use of the benefit could be made.

By increasing Member and caregiver awareness of palliative and hospice care, coupled with a strong, carefully selected network of hospice providers, CareFirst seeks to increase the length of time in palliative and hospice care services used by CareFirst Members.

**The Hospice Palliative Care Program**

To provide a foundation of the Hospice and Palliative Care Service Program, CareFirst has entered into a strategic alliance with five top flight hospice and palliative care providers in its core service area to support patients who are in CCM or CCC Care Plans. In addition, CareFirst has identified an additional 15 hospice providers (out of over 35 hospice providers) in the regions surrounding the core CareFirst service region to fill out a network of top performing hospice and palliative care providers covering the entire CareFirst Service Area.

These providers have been selected based on an extensive review of their capabilities, including such factors as clinical quality, geographic access, and financial/contractual considerations, as well as a track record with CareFirst that demonstrates excellent staff relationships, and the willingness to use CareFirst's iCentric technology in creating integrated Care Plans for those CCM and CCC Members referred for Hospice and Palliative Care services.

In this way, the Hospice and Palliative Care Service Program offers Members support in addressing treatment choices and planning end-of-life care from the most capable of the Hospice and Palliative Care service providers in the area. The LCC or CCM works with the Member, caregiver and certified hospice provider to develop a comprehensive Care Plan to relieve or reduce pain and improve the quality of life and to ensure that the Member's decisions and treatment choices are followed.

**Guidelines for selection of Members and the responsibilities of the Hospice and Palliative Care Program**

While Medicare guidelines strictly limit the timeframe for hospice services to six months or less with no further disease/condition treatments, the CareFirst guidelines for a referral to the Hospice and Palliative Service Program do not have such a limit and are intended to expand earlier access to hospice and palliative care. Accordingly, services are not limited to those with a life expectancy of six months or less to live. Each Member is clinically evaluated and some Members may be under hospice care for nine months or more. Further, Members need not cease disease treatments although the course of treatment may very well follow a different course after entry into the Program due to the ongoing communication that occurs following entry into the Program.

Giving Members information about their options leads to increased autonomy regarding end-of-life decisions, which can provide dignity and a sense of meaning and satisfaction with one's choices. This allows Members to consider alternatives to aggressive, often futile, medical procedures that subject patients to a quality of life few want during the last stages of their illness.

LCCs and CCMs work with the Hospice/Palliative Care Team to develop a Care Plan that meets each Member's individual needs for pain management and symptom control. Only Members in a CCM or CCC Plan are eligible for the special CareFirst Hospice and Palliative Care Program that is part of the larger CareFirst TCCI Program Array.

The Care Coordination Team usually consists of the Member's physician, the Hospice/Palliative Care physician, nurses, home health aides, social workers, clergy or other counselors, trained volunteers, and therapists if needed. The focus is on minimizing the symptoms, pain, and stress of a serious illness. The goal is to improve quality of life for both the Member and the family. The Program offers both high touch and high-tech support as needed.

Among its major responsibilities, the interdisciplinary Hospice/Palliative Care Team:

- Manages the Member's pain and symptoms.
- Assists the Member with the emotional, psychosocial and spiritual aspects of having a serious illness/dying.
- Provides needed drugs, medical supplies, and equipment.
- Coaches the family on how to care for the Member.
- Delivers special ancillary services like speech and physical therapy when needed.
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time.
- Provides bereavement care and counseling to surviving family and friends.

**Cost Share Waiver**

As noted, hospice/palliative care services are most often provided in the home setting and thus can be identified as eligible for a CSW. Hospice services are covered benefits under most CareFirst benefit plans. Palliative care services are typically not specifically delineated in most benefit plans. However, once enrolled in the TCCI Hospice and Palliative Care Program, hospice and palliative care services are covered and out-of-pocket expenses are waived in accordance with the CareFirst Cost Share Waiver that is offered for as long as the Member cooperates with the elements of their specific Care Plan.

**Program Goals**

There are five specific Program goals:

- Facilitate access earlier in the health care continuum.
- Relieve or reduce pain, provide comfort and improve the quality of life of Members.
- Provide transitional services between curative treatment and end-of-life care.
- Reduce preventable hospital readmissions and ER visits.
- Change the "mindset" regarding hospice and palliative care within the CareFirst region.

Key measures of the Program's success include:

- A measurable increase in the number of Members enrolled in the Hospice and Palliative Care Program.
- An increase in the number of LCC and CM referrals through the iCentric Service Request Hub.
- An increase in the stabilization of the Member and improvement in their quality of life.
- Earlier enrollment into the Program leading to longer duration in the Program.

The Program tracks the number of acute hospitalizations and ER visits in the last 30 days of life as well as on any attempts at aggressive last minute treatments and analyzes the efficacy of these efforts as guides to those who follow.

**Service Components**

The professional hospice/palliative team develops a Hospice or Palliative Care Plan, which is incorporated into the larger CCM or CCC Care Plan that already exists for the Member that is documented in iCentric. The LCC or CCM maintains oversight of the implementation of the Care Plan, working hand in hand with the certified hospice and palliative care providers.

Just as in the HBS Program, there are two key components of a Hospice/Palliative Care Plan: The initial/subsequent assessment and ongoing Care Coordination. As with HBS, each Hospice/Palliative starts with a comprehensive assessment. The Comprehensive Hospice/Palliative Care Assessment includes:

**Environmental and Psychosocial Assessment:** This is intended to increase Member understanding of their disease process, home assessment, safety review, identification of a primary caregiver, spiritual /cultural assessment, and to provide a review of Advance Directive and Durable Power of Attorney and development of a transitional End-of-Life Care Plan.

**Clinical Assessment:** This involves evaluation of the type and stage of disease, symptoms and pain assessment**,** review of medications and treatment, Behavioral Health Assessment, review of functional limitations and activities of daily living.

**Community Resources:** This is intended to help with a review of the Member's financial situation, spiritual/pastoral care, bereavement services, community Programs, support groups, transportation and volunteer assistance available in the community.

**Services Needed:** This identifies items such as durable medical equipment, skilled services, social work needs, home health aides, and Behavioral Health services that may be needed.

**Overall Situation Analysis:** This results in a recommended course of action based on key observations.

Thus, the Comprehensive Hospice Assessment entails an analysis of the overall situation of the Member and recommends a clear plan that is documented in the iCentric Hospice and Palliative Care portion of the Care Plan template that is applicable to the Member. The Comprehensive Assessment indicates the level and type of service needed by the Member and their expected prognosis. Each Member managed under palliative care is strongly encouraged to work with their PCP for ongoing care needs.

**Care Plan Process**

CCMs and LCCs always coordinate palliative and hospice care in collaboration with the Member's treating physicians. The Hospice and Palliative Care Services Program begins with a referral from a CCM or LCC assigned to a Member who is already in an active Care Plan. The referral request must be made through the CareFirst Service Request Hub in iCentric, which then directs the request to the CareFirst palliative or hospice care partner agency covering the geographic area in which the Member lives, or where the Member has chosen to receive the services.

Just as in HBS, the Care Coordination Team has access to iCentric, which provides real-time access to the Member Health Record and the larger, detailed CCM or CCC Care Plan. iCentric is used to connect patients, families and their caregivers with a variety of Community-Based resources, including meals, transportation, respite care, and various entities involved in serving the needs of terminally ill Members such as cancer support, caregiver support, bereavement and survivor group support.

**Process for Referral through the iCentric Service Request Hub**

- The Member must be referred to the Hospice and Palliative Care Program by a CCM or LCC.
- The referral must have the appropriate level of service defined (palliative or hospice or both).
- The referral must be sent to the CareFirst select agency in the region where the Member lives, or will receive services, via a Service Request through the Service Request Hub.
- The agency or facility must accept or reject the Service Request within 72 hours of receipt of the Service Request (with full explanation in the case of rejection).
- The agency or facility must complete a Comprehensive Assessment.
- The agency or facility must upload the completed comprehensive assessment, treatment plan and ongoing findings in the iCentric System within 48 hours of its completion.

- The Hospice/Palliative Care Nurse who conducted the Comprehensive Assessment must discuss the case and decide on the course of action jointly with the referring LCC or CCM. This must be jointly agreed to before a course of action is commenced.

- There must be communication between the palliative and hospice team, and the CCM or LCC, at a minimum of once a week, and documentation of all follow up in the iCentric System.

- The palliative and hospice provider must monitor and carry out services for the Member in accordance with the approved Hospice/Palliative Care Plan.

Overall Member satisfaction is measured by an ongoing survey arranged by CareFirst through which overall Member Satisfaction with the Hospice/Palliative Care Program and agency is measured. This is reported to the LCC or CCM who made the referral and, through them, to the Member, PCP, and treating provider and is included in the Member Health Record.

**Special Reimbursement**

Hospice/Palliative Care agencies who participate in the Hospice and Palliative Care Program receive additional reimbursement for each Member in the Program to reflect the additional Care Coordination activities they undertake in the Program.

## Skilled Nursing Facility Program (SNF)

Most Members hope to go directly home from the hospital after surgery or illness. But even if a Member plans to go home, the recovery may be slower than expected or additional services may be needed to meet recovery goals. As a result, the Member may need to be transitioned to a skilled facility for intensive nursing or rehabilitation services. The TCCI Skilled Nursing Facility (SNF) Program provides care for Members who are not yet able to care for themselves at home, even with home care support. In 2016, over 1,500 CareFirst Members were transferred from acute inpatient hospitals to skilled facilities.

In the SNF Program, a physician supervises each Member's care. Skilled nursing care is available 24 hours a day. Other medical disciplines, such as physical and occupational therapists, are also available at the facility. This allows for the delivery of medical procedures and therapies at one location with 24-hour oversight and monitoring that would not be possible in a home setting.

Members typically spend three to four weeks in a Skilled Nursing Facility. The Skilled Nursing Facility Program acts as a bridge to continued-home or outpatient care.

Currently, one in four persons admitted to a Skilled Nursing Facility from a hospital is readmitted to the hospital within 30 days of their stay. In addition to being very costly, this has negative physical, emotional and psychological impacts on the Member. Many readmissions from Skilled Nursing Facilities to the acute hospital are preventable, particularly when the facility attends to wound care, fall prevention and infection control. The SNF Program – as part of CBP – seeks to reduce these hospital readmissions through the use of selected high-quality facilities, with a focus on Member and physician Engagement and the development of an actionable Care Plan with specific, agreed upon goals.

**TCCI Skilled Nursing Facility Program Goals**

There are three specific Program goals for the SNF Program:

- Provide a bridge between acute inpatient care and the home setting for those Members needing intensive skilled nursing and/or rehabilitative services.

- Facilitate the Member's return to their pre-injury/pre-illness baseline by providing the multiple services needed on a daily basis in one location.

- Reduce preventable hospital readmissions and ER visits.

Ultimately, the purpose of the Program is to safely return Members to their homes with the highest possible level of functioning as soon as they are clinically stable.

**Skilled Nursing Facility Services Criteria**

Most Members are identified for the SNF Program as a result of an acute inpatient admission. Therefore, Members needing SNF services are almost always first identified by a HTC. Members who require three or more hours of combined professional services daily are candidates for the SNF Program and are evaluated by the HTC.

SNF Program services include:

- Continuous IV therapy (hydration)
- Multiple infusions (IV antibiotics)
- Frequent suctioning
- Extensive wound care
- Pain Management
- Multiple rehabilitative services (PT, OT, SP)

- Ventilator weaning

Professional services include nursing and rehabilitative services, which cannot be adequately performed by a non-skilled individual (family Member, caregiver) or by a home care agency.

When these types of services are identified during hospitalization, the HTC completes a Skilled Nursing Facility Service Request via the iCentric Service Request Hub, which is then sent to a select Skilled Nursing Facility after speaking with the Member and acute care facility team. In this Service Request, the HTC specifies the service sought according to the following four service levels:

Level 1: Three hours of professional services daily. Care includes such services as extensive dressing changes or wound care three times per day, IV antibiotics, or three hours of rehabilitative services daily.

Level 2: Up to six hours of professional services daily. Care includes such services as Stage 3/Stage 4 wound care, post-cerebrovascular accident care, including rehabilitation, total parenteral nutrition, complex hydration, and respiratory services.

Level 3: Over six hours of professional services daily, which include care for multiple injuries post motor vehicle accident/trauma, skeletal traction, or severally deconditioned Members requiring frequent monitoring.

Level 4: Ventilator weaning with defined short and long-term goals.

**Process for Referral through the iCentric Service Request Hub**

After completing a Service Request, through the iCentric Service Request Hub, the HTC or LCC transitions the Member to a CCM who specializes in Skilled Nursing Facility Care. SNF services are almost always managed and arranged through the Complex Case Management Program. The CCM develops a detailed Case Management Plan with short and long-term goals against which the Member's progress is monitored. The CCM frequently discusses the plan and ongoing progress and treatments with the SNF team, which consists of SNF case managers, social workers, therapists and a lead physician as needed.

The following process is followed in requesting and arranging SNF care:

- The Member must be referred to the SNF Program by a HTC, CCM or LCC (as previously noted, often the HTC will initiate the referral).
- The referral must have the appropriate Level of Service defined (Level 1-4).
- The referral must be sent via a Service Request through the iCentric Service Request Hub.
- The preferred facility must accept or reject the Service Request within 48 hours of receipt of the Service Request (with full written explanation in the case of rejection).
- The facility must then complete a Comprehensive Assessment and Plan within 48 hours of accepting the Service Request.
- The facility must upload the completed Comprehensive Assessment, treatment plan and ongoing findings in the iCentric System within 48 hours of completion.
- The SNF nurse from the selected facility who conducted the Comprehensive Assessment must discuss the case and decide on the course of action jointly with the referring HTC, LCC or CCM. This must be agreed to by the HTC, CCM or LCC before starting the recommended course of action.

- There must be communication between the SNF Nurse and the CCM or LCC at least once a week.
- All documentation of care must be complete and kept up to date in the iCentric System.
- The SNF must monitor and carry out services for the Member in accordance with the approved Skilled Nursing Facility Care Plan.

For those Members in PCMH, the CCM coordinates with the referring source as discharge from the SNF nears, ensuring early LCC and PCP Engagement post discharge.

Skilled Nursing Facility services are covered benefits under most CareFirst benefit plans. Only Members in a CCM or CCC Plan are eligible for the special CareFirst SNF Program that is part of the larger TCCI Community-Based Services Program. Custodial/residential nursing home care is not covered and these services are not a component of the SNF Program.

**Skilled Nursing Facility Assessment and Goals**

The Skilled Nursing Facility care team develops a treatment plan, which is incorporated into the larger CCM Plan that already exists for the Member that is documented in iCentric. The CCM maintains oversight of the implementation of the Care Plan, working hand in hand with the SNF care team/providers.

Just as in the HBS Program, there are two key components of the SNF Program: the initial/subsequent assessment and ongoing Care Coordination. Each SNF Plan starts with a comprehensive assessment.

The Comprehensive Skilled Nursing Facility Services Assessment includes an overall evaluation of the Member's condition, their understanding of their condition/disease process, medications, functional capabilities and limitations, equipment needs, cultural and spiritual needs, and advanced directives. The Assessment serves as the foundation to identify clear and specific short term and long-term goals for the Member as well as a targeted length of stay. Each week, the SNF Nurse will update iCentric and the CCM on the Member's progress toward their goals and will identify key milestones that have been met or are to be met. The CCM maintains oversight of the implementation of the CCM Plan, working hand in hand with the SNF Nurse.

Thus, the Comprehensive Assessment entails an analysis of the overall situation and recommends a clear plan that is documented in iCentric. The Comprehensive Assessment will confirm and modify, as appropriate, the level of service needed by the Member. Each Member managed under the SNF Program is strongly encouraged to meet with their PCP for ongoing care needs as soon as they are discharged from the facility. For those Members in PCMH, the CCM directly transitions the Member to the LCC for continued Care Coordination ensuring early PCP Engagement post their SNF stay.

**Skilled Nursing Facility Partners**

To provide a foundation for the SNF Program, CareFirst has entered into strategic alliances with four select Skilled Nursing Facility providers in its core service area to support patients who are targeted for the Program. These carefully selected SNF providers cover the region with multiple sites allowing Members to choose the closest local facility for their SNF stay. SNF providers were selected based on an extensive review of the capabilities of these facilities, including such factors as clinical quality, geographic access, and financial/contractual considerations, as well as a track record with CareFirst that demonstrates excellent staff relationships, and the willingness to use CareFirst's iCentric technology in creating integrated Care Plans for those CCM and CCC Members referred for SNF services.

**Ongoing Oversight and Monitoring**

Overall Member satisfaction is measured by an ongoing survey arranged by the CCM through which overall Member Satisfaction with the SNF Program and facility is measured. This is reported to the HTC or CCM who made the referral and, through them, to the LCC, PCP (if the Member is in the PCMH Program) and treating providers.

## Chronic Kidney Disease Program (CKD)

Chronic Kidney Disease (CKD) is a medical condition that has serious effects on health status, quality of life and total cost of care. Despite the availability of nationally-endorsed, evidence-based guidelines for screening and treatment, CKD is often undiagnosed until it reaches more advanced classes, when complications begin to occur. By this point, total cost of care is double that of persons with uncomplicated CKD. [43]

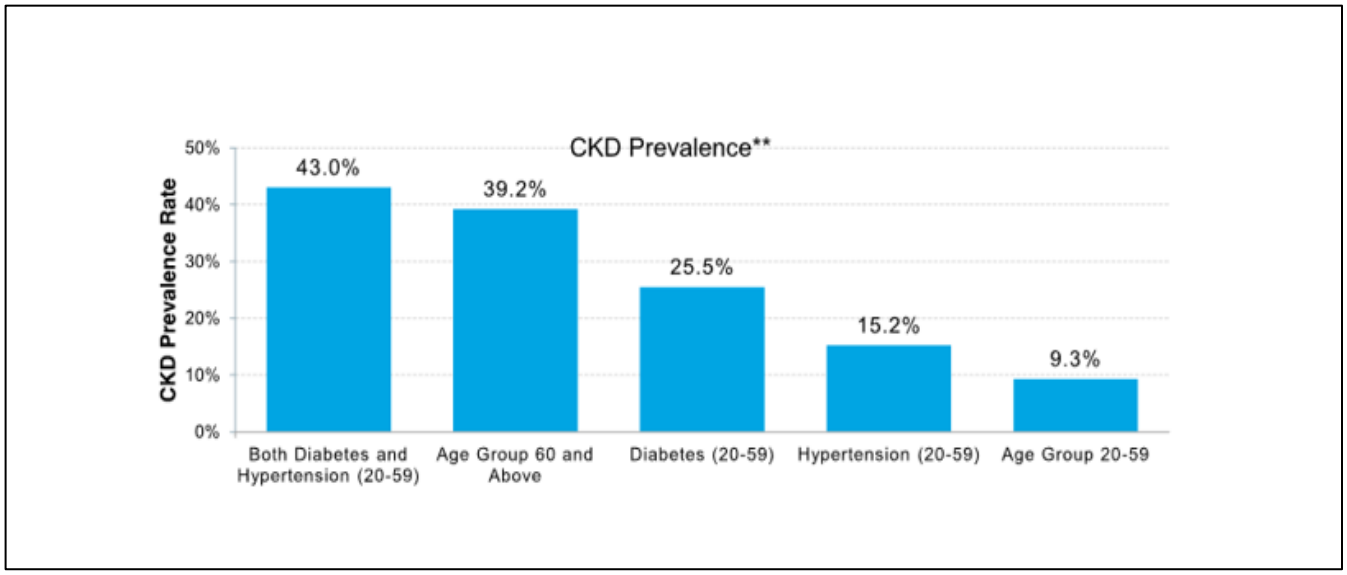
Therefore, it is vitally important to diagnose and treat persons with CKD early. Recently-updated expert Chronic Kidney Disease guidelines include the following recommendations:

- Higher risk populations, including all persons with diabetes and/or hypertension, and all persons over age 60 years should be screened for CKD;
- Two lab test results (estimated glomerular filtration rate (eGFR) and albumin-to-creatinine ratio (ACR) should be used to screen persons with risk for CKD;
- Patients diagnosed with CKD should be monitored at specified intervals depending on CKD class; and
- Members with advanced classes of CKD should be referred to nephrologists at the right time.

### Prevalence and Cost of CKD

Approximately one in 10 adults in the U.S. has some level of CKD[44], with greater prevalence associated with comorbid conditions and increasing age. Persons with both diabetes and hypertension have the highest prevalence of CKD (four to five times the general adult population under age 60), closely followed by all persons' age 60 years and older, then those under 60 with either diabetes alone or hypertension alone, as indicated in **Figure 54** below:

**Part VI, Figure 54: Chronic Kidney Disease (CKD) Prevalence Rates Vary On Different Disease States And Age Ranges[45]**




[43] *Honeycut t AA, Segel JE, Zhuo XH, Hoerger TJ, Imai K, Williams, D: Medical Costs of CKD in the Medicare Population. J Am Soc Nephrol 24.*

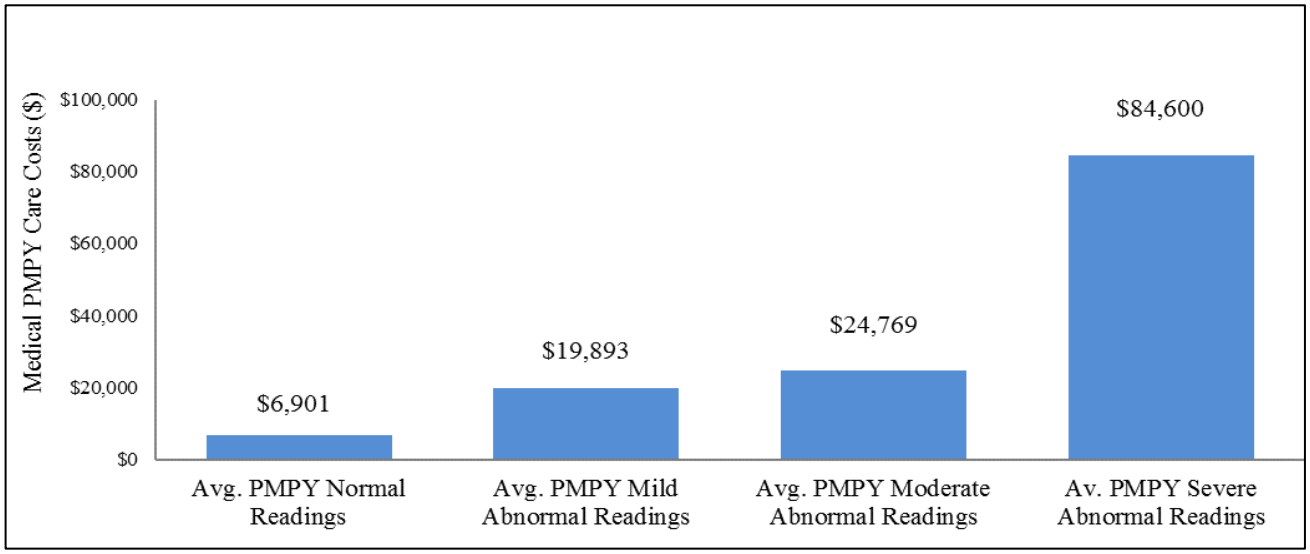
[44] *Report from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).*

[45] ***Collins AJ, Vassalotti JAA, Changchun W, et al: Who should be targeted for CKD screening? Am J Kidney Dis 53 (Suppl 3): S71 – S75, 2009*

CKD has enormous impact on well-being, health status, and economic cost. A recent study estimates that spending by Medicare, Medicaid and private insurers on persons with CKD reached approximately $350 billion in 2014, and that early detection and treatment could reduce these costs substantially. [46]

Medicare spending for CKD patients at any class is higher than for non-CKD patients and up to 3.0 times higher for Class 4 CKD. An analysis of CareFirst members who had lab tests in 2014 showing reduced kidney function demonstrated similar findings, with annual costs rising dramatically with worsening kidney function, as indicated in **Figure 55** below.

**Part VI, Figure 55: Average Per Member Per Year (PMPY) Costs For CareFirst Members Increases With Worsening Renal Function[47]**




**Definition of Chronic Kidney Disease (CKD)[48]**

According to the guidelines: Kidney Disease: Improving Global Outcomes ("KDIGO"), CKD is defined as "abnormalities of kidney structure or function, present for at least three months, with implications for health." CKD is classified into one of five classes, based on two laboratory tests: a simple blood test (eGFR) and a urine test (ACR). Both tests are required for this classification system.

Creatinine is a normal waste product of muscle activity, which is cleared by a normally-functioning kidney. When there is kidney damage, the serum creatinine rises in proportion to the degree of damage. The creatinine lab value is used to estimate kidney function, the eGFR. The eGFR takes into account serum creatinine level, as well as age, race and gender.

With kidney damage, albumin (protein) spills into the urine, also in proportion to the degree of damage. The ACR lab results, the second laboratory test used to calculate the CKD class clusters into three categories, based on the degree of kidney damage. Thus, the two lab test results are used in concert, as indicated on the following three charts. These charts illustrate the appropriate determination of a Member's CKD class and the appropriate intensity of recommended treatment, which forms the basis of CareFirst's Program.

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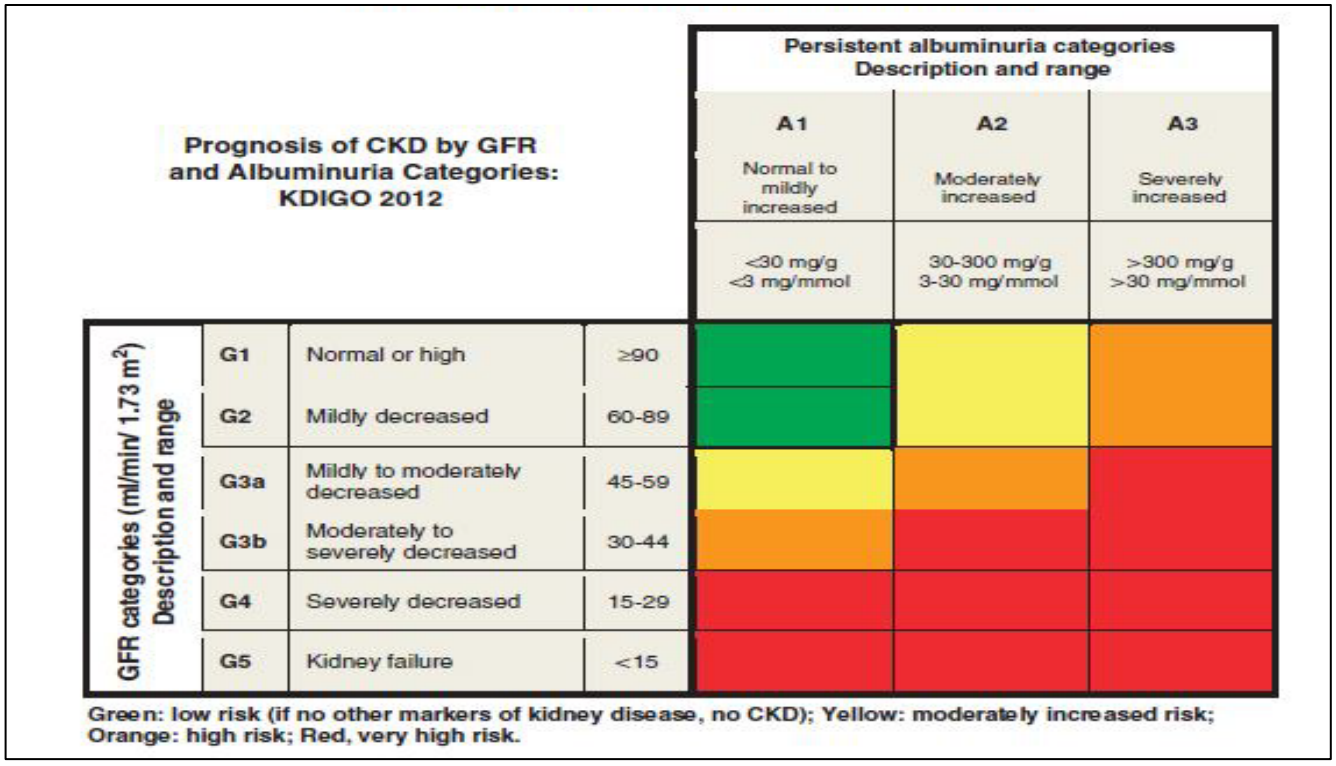
[46] *Avalere, Modeling the Impact on Payers from Early Detection and Treatment of CKD (Draft) Prepared for the National Kidney Foundation, November 2013.*

[47] *Source: Lab data and claims for CareFirst Members 2014*

[48] *Kidney Disease Improving Global Outcomes (KDIGO) 2012 Clinical Practice Guidelines for the evaluation and management of Chronic Kidney Disease. This document includes matrices with recommendations for monitoring and referring, as indicated on the following pages.*

**Part VI, Figure 56: Prognosis Of Chronic Kidney Disease (CKD) According To Class Determined By eGFR And Albuminuria Values**



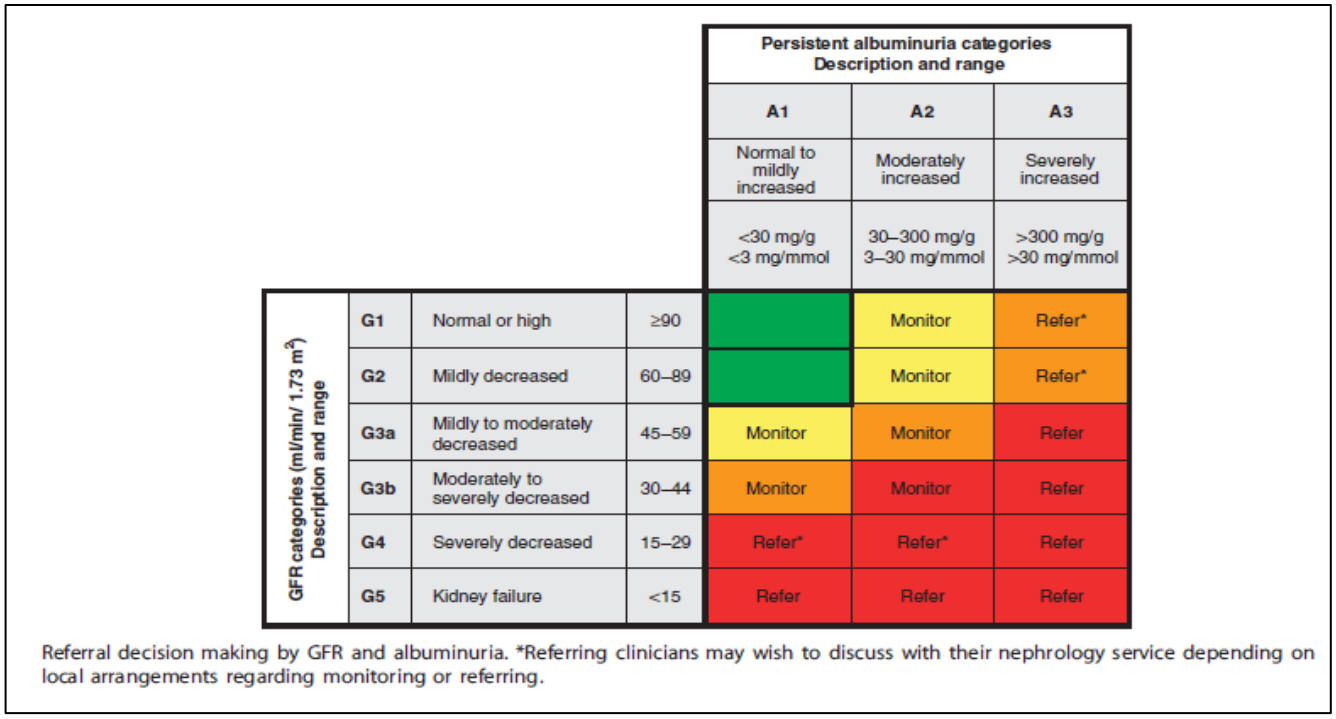

**Part VI, Figure 57: Recommended Frequency Of Kidney Function Monitoring Per Year By Chronic Kidney Disease (CKD) Class**

Guide to Frequency of Monitoring (number of times per year) by GFR and Albuminuria Category

| GFR categories (ml/min/1.73 m²) Description and range | | | | Persistent albuminuria categories Description and range | | |
|---|---|---|---|---|---|---|
| | | | | A1 Normal to mildly increased <30 mg/g <3 mg/mmol | A2 Moderately increased 30–300 mg/g 3–30 mg/mmol | A3 Severely increased >300 mg/g >30mg/mmol |
| | G1 | Normal or high | ≥90 | 1 if CKD | 1 | 2 |
| | G2 | Mildly decreased | 60–89 | 1 if CKD | 1 | 2 |
| | G3a | Mildly to moderately decreased | 45–59 | 1 | 2 | 3 |
| | G3b | Moderately to severely decreased | 30–44 | 2 | 3 | 3 |
| | G4 | Severely decreased | 15–29 | 3 | 3 | 4+ |
| | G5 | Kidney failure | <15 | 4+ | 4+ | 4+ |

GFR and albuminuria grid to reflect the risk of progression by intensity of coloring (green, yellow, orange, red, deep red). The numbers in the boxes are a guide to the frequency of monitoring (number of times per year).

**Part VI, Figure 58: Recommendations On Timing Of Referral To Nephrologists By Chronic Kidney Disease (CKD) Class**



| GFR categories (ml/min/ 1.73 m²) Description and range | | | | Persistent albuminuria categories Description and range | | |
|---|---|---|---|---|---|---|
| | | | | A1 | A2 | A3 |
| | | | | Normal to mildly increased | Moderately increased | Severely increased |
| | | | | <30 mg/g <3 mg/mmol | 30–300 mg/g 3–30 mg/mmol | >300 mg/g >30 mg/mmol |
| | G1 | Normal or high | ≥90 | | Monitor | Refer* |
| | G2 | Mildly decreased | 60–89 | | Monitor | Refer* |
| | G3a | Mildly to moderately decreased | 45–59 | Monitor | Monitor | Refer |
| | G3b | Moderately to severely decreased | 30–44 | Monitor | Monitor | Refer |
| | G4 | Severely decreased | 15–29 | Refer* | Refer* | Refer |
| | G5 | Kidney failure | <15 | Refer | Refer | Refer |

Referral decision making by GFR and albuminuria. *Referring clinicians may wish to discuss with their nephrology service depending on local arrangements regarding monitoring or referring.

The CKD Program enables PCPs who identify higher-risk Members to refer them for appropriate monitoring and treatment by community-based kidney care specialists. The CareFirst CKD Program has been designed in collaboration with national and regional kidney care experts, including representatives from the National Kidney Foundation ("NKF").

In addition to referrals from PCPs, the CKD Program relies on laboratory data and medical claims data to identify Members with CKD who could benefit from the Program. The Program identifies Members with CKD as early in their course as possible with the goal of delaying or preventing migration to higher CKD classes.

The Program relies on the involvement of a dedicated network of community-based nephrologists who have agreed to support PCPs with Care Plans for these Members and who agree to timely see those Members with advanced CKD. It also relies on specialized Home-Based Monitoring services to enable Members with CKD to manage their disease and related comorbidities.

In short, the Program is designed to retard the progression of CKD to advanced classes, when lifetime dialysis or kidney transplant becomes necessary to preserve life.

**Awareness of PCMH Panels**

Most Members who have early-class CKD are not aware they have the disease (up to 90 percent, according to the NKF) and many PCPs report they are unsure how best to treat such Members once diagnosed. To successfully delay the progression of CKD, local nephrologists in the CKD Program meet with PCMH Panels to educate them on the proper diagnosis and treatment of CKD. Regional Care Directors coordinate these education sessions during which recommended treatment guidelines are reviewed and guidelines are discussed as to how to appropriately identify potential Members with early class CKD.

**Identifying Potential Members for the CKD Program**

There are nearly 17,000 CareFirst Members at any point in time with a diagnosis of CKD with an average IBS of over eight. While inpatient admits/1,000 in the general CareFirst population are 52/1,000, those Members diagnosed with CKD show over 375/1,000 admits with medical costs of approximately $30,000 per year.

All of CareFirst's Care Coordinators actively seek to identify patients with abnormal kidney function and work with PCPs in the development of Care Plans, when appropriate. Selection criteria for the CKD Program includes both Members who have full expression of CKD as well as those at higher risk for developing CKD who are at earlier class.

There are three processes through which Members are identified for the Program based on analyses of laboratory and/or medical claims data.

- LCCs use the CKD smart filter in iCentric to view the Members with CKD. The LCC reviews all identified Members with their assigned PCPs to determine if the CKD Program is appropriate.

- HTCs flag all Members with CKD/ESRD who are admitted to the hospital for any reason, using a unique category designation (Level 1H), and through the Service Request Hub to notify the LCC of any attributed Members who may benefit from the CKD Program.

- CCMs also identify all advanced/complex Members with CKD/ESRD and notify the LCC of any attributed Members who may benefit from the CKD Program.

In addition, the Program identifies Members who are at higher risk for developing CKD/ESRD but do not yet have screening laboratory results. LCCs and PCPs identify Members who should have received nephropathy (kidney damage) screening tests through systematic review of Members at risk for CKD (those with diabetes and/or hypertension) who have not had recommended screening tests. These Members are flagged for PCP attention.

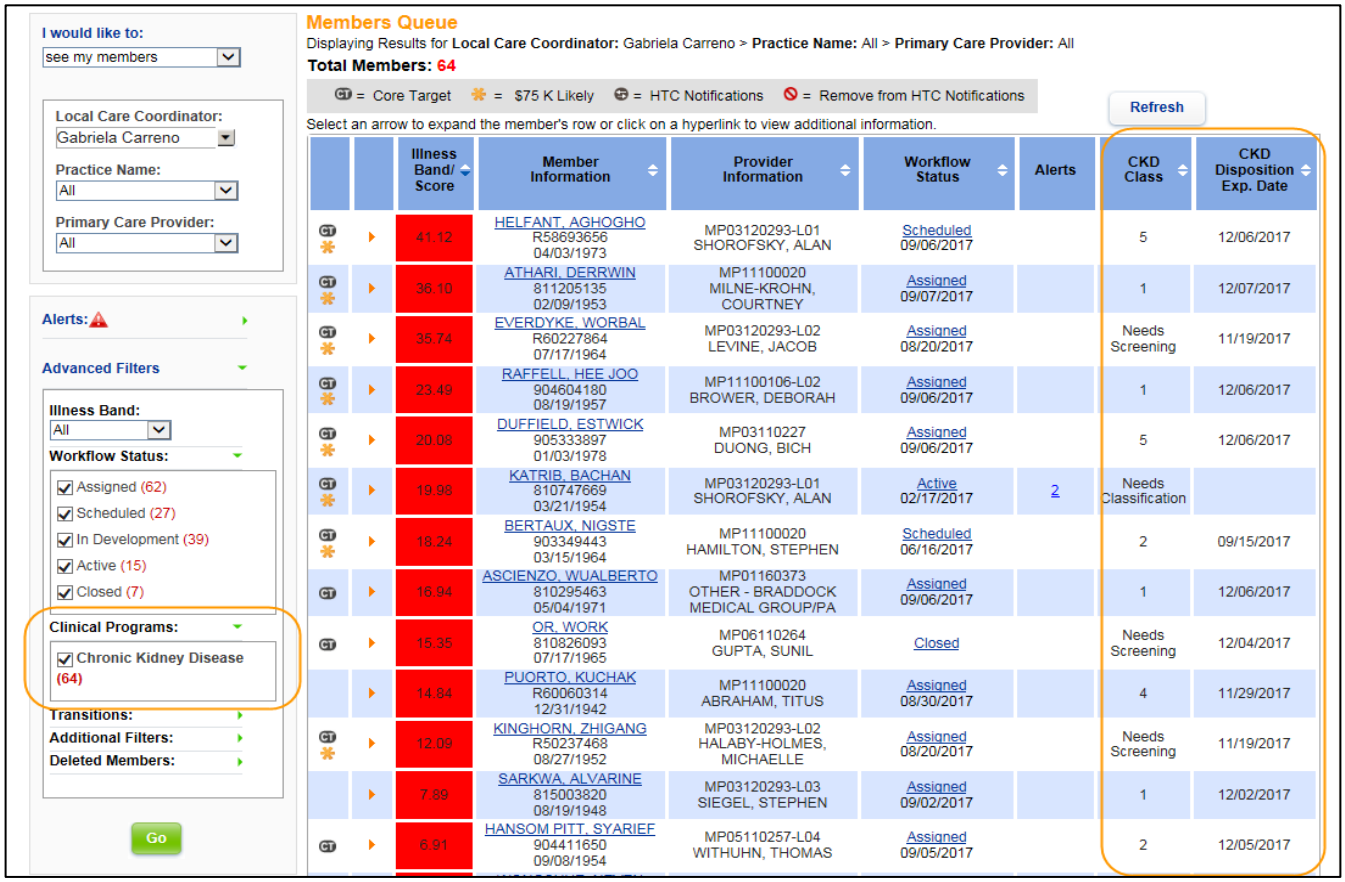
**Assigning CKD Class**

Each LCC reviews the lab results of identified individuals with the PCP to assign the appropriate CKD class, as defined in the Kidney Disease Improving Global Outcomes ("KDIGO") guidelines (represented in **Figure 53)**. The assigned CKD class aids the PCP to decide on an appropriate course of treatment, the need for a Care Plan, the frequency of kidney function monitoring and the timing of referral to kidney care specialists and other related community-based resources (e.g., renal nutritionists).

Local nephrologists who are recognized leaders in kidney care by the NKF (and who constitute the CareFirst dedicated network) are available via telemedicine consultation with the PCP to confirm the treatment course and to help decide whether a Member should be referred to a Nephrologist at that time or continue to undergo monitoring by the PCP. The use of such consultations ensures access to experts for those who specifically need timely in-person consultation with renal care specialists.

Once the CKD class is determined, the information becomes available in iCentric. The LCC filters for Members on the roster or finds new Members with CKD. The LCC can sort the Members by CKD class and identify when a CKD disposition is expiring. The figure below shows the LCC view of the CKD filter and roster columns.

**Part VI, Figure 59: LCC View Of CKD Filter, Class, And Disposition Expiration**




**Determining Appropriate Interventions**

CareFirst, in collaboration with the NKF and a local nephrology practice, created a tool to help PCPs and LCCs identify resources to support the early identification of CKD and to slow progression in Members diagnosed with CKD. The interventions are based on national guidelines for CKD management. Based on the clinical assessment of the Member, the PCP decides which interventions to implement.

The interventions are progressive, each class building upon the previous class. For Members in Class 0, the PCP orders the albumin to creatinine ratio and the estimated glomerular filtration rate to determine the class of CKD.

- Class 1 indicates minimal to no kidney disease. The PCP educates the Members about the risk of CKD progression and works with the Member to manage underlying chronic conditions such as Diabetes or hypertension.

- For Class 2, CKD has progressed. The PCP can implement automated appointments and testing reminders. The PCP considers a comprehensive medication review (CMR), a nutrition consultation, enhanced monitoring, and smoking cessation as appropriate to the Member.

- By Class 3, the kidneys have sustained moderate deterioration. The PCP considers placing the Member in a Care Plan and increases the screening frequency rate. Expert Consult and Enhanced Monitoring are value Programs the PCP may incorporate into the Member's treatment plan. At this class, the PCP starts collaborating with the consulting nephrologist about the Member's status. The nephrologist advises the PCP on current treatment best practices. A formal nephrology referral is often obtained when the albumin to creatinine ratio is severely increased.

- By Class 4, the Member's kidney function is significantly impaired. The PCP increases kidney function screening to three times per year. The PCP co-manages the Member with the nephrologist and begins the discussion of kidney replacement preparation with the Member.

- When the Member's CKD has progressed to Class 5, the PCP orders Kidney function screening four times per year. The PCP supports ongoing dialogue between the Member and the nephrologist regarding kidney replacement options and establishes access early to avoid emergency dialysis access placement.

- From time to time, Member laboratory findings are not available to CareFirst. For these Members, the PCP reviews the laboratory results in their electronic medical record, classifies the Member based on the results, and submits a diagnosis code for the appropriate CKD class.

**Part VI, Figure 60: Class And Treatment Recommendations For CKD**

| Class | Category | Treatment Recommendations |
|---|---|---|
| **0** | **Needs Screening** | • Set up an appointment with the Member<br>• Order lab work:<br>- Albumin to Creatinine Ratio (ACR)<br>- Estimated Glomerular Filtration Rate (eGFR)<br>- Determine the Member's classification based on the lab values |
| **1** | **Green** | • Provide Member education<br>• Schedule annual follow-up visits for regular kidney function testing<br>• Manage the underlying risk factors for CKD, such as Diabetes and hypertension<br><br>*In addition to:* Recommendations listed in **Class 0**. |
| **2** | **Yellow** | • Schedule annual follow-up visits for regular kidney function testing<br>• Consider instituting automated appointments and testing reminders<br>• Consider a Comprehensive Medication Review (CMR)<br>• Order the following services as necessary:<br>- Nutrition Consultation<br>- Home-Based Assessment (only if in an active Care Plan)<br>- Smoking Cessation<br>- Diabetes Management Program<br>- Enhanced Monitoring (blood glucose, hypertension)<br>- Wellness and Disease Management<br><br>*In addition to:* Recommendations listed in **Class 1** and **Class 0**. |

**Part VI, Figure 60: Class And Treatment Recommendations For CKD (continued)**

| Class | Category | Treatment Recommendations |
|---|---|---|
| 3 | Orange | • Conduct Semi-annual kidney function screening<br>• Initiate a PCMH Care Plan<br>• Consider an Expert Consult<br>• Consider Enhanced Monitoring<br>• Begin PCP-to-nephrologist consultations about the Member's status and collaborate on best practices<br>• Referral to nephrologists if the urine albumin to creatinine ratio (ACR) is severely increased<br><br>*In addition to:* Recommendations listed in **Class 2**, **Class 1** and **Class 0**. |
| 4 | Red | • Kidney function screening three (3) times per year<br>• Refer Member to a nephrologist or a nephrology group.<br>- Expect preferential appointments for these referrals and additional Member support programs (nutrition, emotional support, community resources).<br>• Use the LCC to coordinate communication with the nephrologist<br>• Collaborate with the nephrologist and Member to discuss kidney replacement preparation.<br><br>*In addition to:* Recommendations listed in **Class 3**, **Class 2**, **Class 1** and **Class 0**. |
| 5 | Brown | • Kidney function screening four (4) times per year.<br>• Work jointly with a nephrologist to manage the Member's care.<br>• With nephrologist and Member, discuss peritoneal dialysis/home dialysis, hemodialysis access, and transplant options.<br>• Establish kidney replacement access early to minimize the need for emergent dialysis access placement.<br><br>*In addition to:* Recommendations listed in **Class 4**, **Class 3**, **Class 2**, **Class 1** and **Class 0**. |
| -- | Gray | Needs classification<br><br>• Review the medical record for lab values<br>• Determine the Member's classification based on the lab values |

**Documenting the Disposition**

After the PCP clinically assesses the Member and determines the treatment plan, the LCC documents the decision of how to treat the Member. The decision is called the disposition. There are several dispositions the PCP and LCC can select:

- Engaged in/could benefit from Care Coordination. PCP is actively monitoring Member's CKD status.

- CKD screening completed. Member has CKD Class 1, CKD Class 2, or no evidence of CKD. PCP will monitor Member's status.

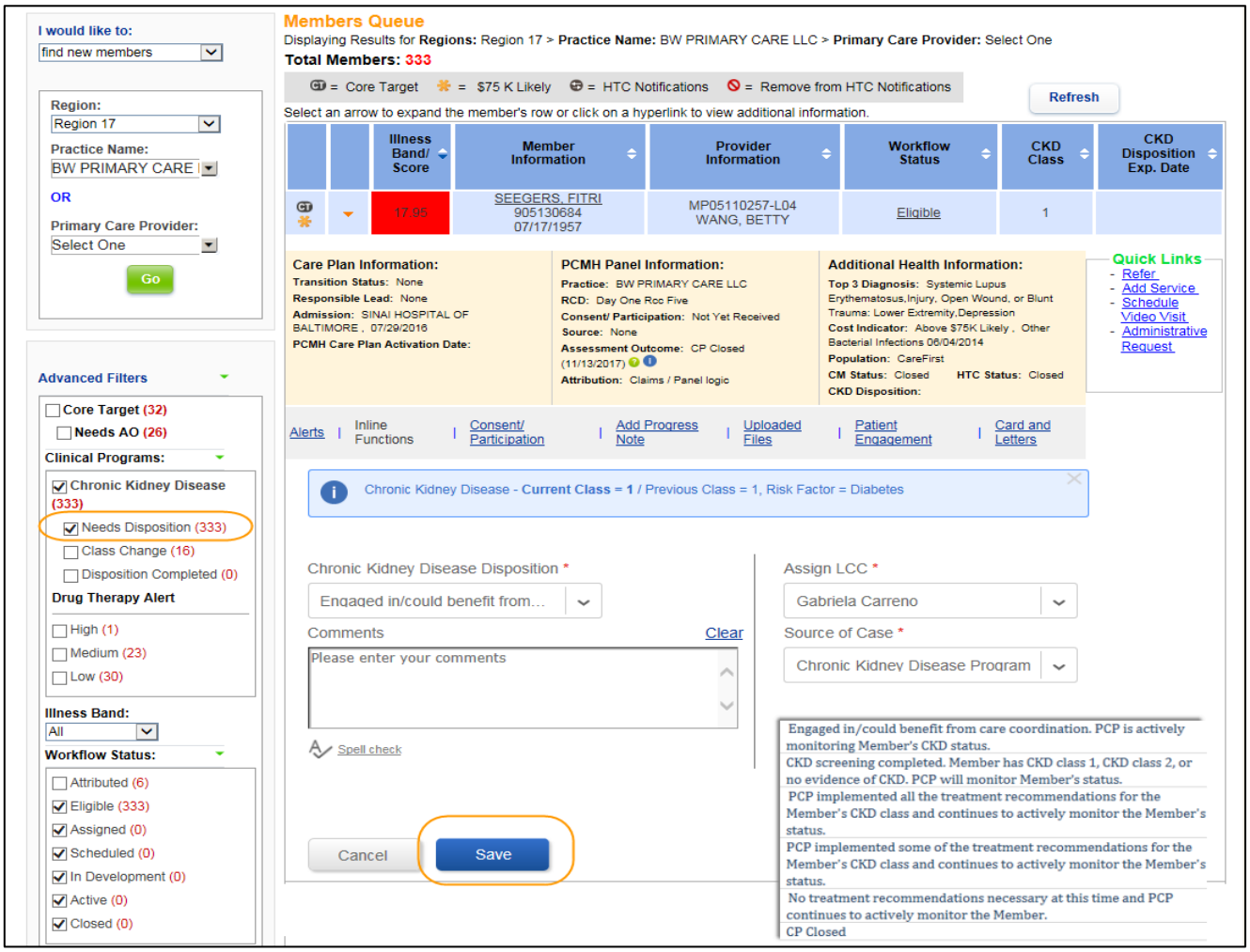
- PCP implemented all the treatment recommendations for the Member's CKD class and continues to actively monitor the Member's status.

- PCP implemented some of the treatment recommendations for the Member's CKD class and continues to actively monitor the Member's status.

- No treatment recommendations necessary at this time and PCP continues to actively monitor the Member.

The disposition for "engaged in/could benefit from care coordination" remains in place until a Care Plan closes. For Members with CKD class 1, class 2, or no evidence of CKD, the disposition expires in 365 days, aligning with national guidelines so as to prompt an annual screening for early detection of CKD. The remaining dispositions expire every 90 days, prompting frequent review and treatment management by the PCP and LCC. The figure below displays the LCC view for entering the CKD disposition into iCentric.

**Part VI, Figure 61: View Of LCC CKD Disposition Entry Options**



**Developing Specialized Care Plans**

Once identified as having CKD, PCPs work with their LCC to develop chronic condition Care Plans for Members consistent with Kidney Disease Outcomes Quality Initiative ("KDOQI") guidelines. Such Members have access to all TCCI Programs and are eligible for the Cost Share Waiver. Elements of a Care Plan at a minimum include:

- Pharmaceutical treatment of kidney disease to delay its progression, including a CMR to ensure the avoidance of medications associated with acute kidney injury as well as promote adherence to kidney-sparing medications;
- Management of underlying conditions, most often diabetes and/or hypertension;
- Prevention of cardiovascular disease progression and other metabolic abnormalities; and
- Nutritional management, provided by renal nutritionists, in person or by telemedicine.

The Care Plan identifies the appropriate intervals for kidney function monitoring through standard laboratory tests, as indicated on **Figure 57.** KDIGO guidelines recommend performing these tests one to four (or more) times per year, depending on the CKD class. Based on clinical judgment, for selected Members who have poor control of underlying comorbidities or who are otherwise fragile and would benefit from intensive virtual coaching, the care team also considers the use of Home-Based Monitoring services.

The EMP is often used in conjunction with the Care Plans of Members in the CKD Program. Specific monitoring protocols are used in collaboration with the NKF and CareFirst clinicians. These protocols monitor Members' key biometric data (weight, blood pressure, glucose) using in-home electronic devices and provide targeted CKD adherence and self-management information and education on a daily basis. Each Member receives tailored messaging daily - depending on their response to brief questionnaires - that helps them with:

- Medication adherence
- Avoidance of potentially dangerous medications (such as those that are associated with acute renal injury)
- Renal-specific nutritional information (calorie, salt and protein intake)
- Reminders for monitoring tests and visits
- Screening for Behavioral Health issues

This messaging reinforces and supports the very same information that the care team provides to the Member during weekly Care Coordination visits (in person, video or telephone calls).

For Members with advanced CKD (eGFR < 30 or severe albuminuria), the care team ensures timely referral to a Nephrologist, consistent with KDIGO guidelines represented on **Figure 58**. Referral to a nephrologist at the appropriate time is associated with significantly improved clinical and economic outcomes by allowing for careful planning and preparation for Renal Replacement Therapy (including dialysis and kidney transplantation). The dedicated CareFirst nephrology network includes credentialed board-certified nephrologists of whom approximately 160 are considered high-volume nephrologists in the service area.

LCCs, working in consultation with the PCP and during weekly interactions with the Member, continue to monitor Members' progress (biometrics, laboratory tests, medication adherence, office visits) based on KDIGO guidelines. For Members who meet criteria (eGFR less than 30 and/or severe albuminuria) for referral to the nephrology team, the LCC works to ensure timely appointments and that care is comprehensive and coordinated with other community-based resources, including specialized renal dieticians, vascular surgeons, dialysis centers, transplant services, and advanced Care Planning/palliative care as appropriate. LCCs track glucose and blood pressure improvements for these Members.

Member tracking is conducted through data collection of medical claims data and laboratory data. The data file captures the following set of outcomes metrics to evaluate overall impact of the Program:

- Utilization of inpatient and ED services related to renal disease, comorbidities or complications, with expected decreases over time;

- Total cost of care decrease for Member with any class of CKD;

- Use of prescription medications (ACE and ARB inhibitors) increase;

- Measures of migration from one CKD class to another, with less migration to advanced classes;
- Glucose and blood pressure levels;

- Timeliness of fistula/graft placement;

- Timeliness of referral (between nephrologist referral and Renal Replacement Therapy ("RRT") initiation), with goal of nephrology referral at least six to 12 months prior to RRT initiation; and

- Utilization of RRT modalities (peritoneal or hemodialysis) and site of service (home or dialysis center), expecting increasing use of the home setting where clinically appropriate.

All of this information is kept current in the Member Health Record in iCentric.

**Conclusion**

While nearly 20,000 CareFirst Members have a known diagnosis of CKD or End class Renal Disease, it is very likely that this number represents only a portion of CareFirst Members who actually have CKD.

CareFirst's comprehensive CKD Program includes screening of high risk individuals, treatment of underlying diabetes and/or hypertension with special attention to medication adherence, and collaboration with select community-based renal care providers.

The best possible health and economic outcomes result when CKD is diagnosed and treated early using two readily available screening tests (eGFR and ACR). The results of these two tests provide the basis for categorizing Members with CKD into classes to determine the risk of disease progression, the frequency of periodic monitoring and the timing for referral to kidney care specialists.

Most patients with CKD have relatively mild expressions of the disease and can be managed by the PCMH PCP with medications, dietary advice and promotion of healthy lifestyle behaviors, including regular exercise and smoking cessation. Periodic kidney function monitoring uncovers the trajectory for Members who are more rapidly deteriorating and need more aggressive intervention. As some Members move to more advanced CKD classes, their care is co-managed by their PCMH PCP and a selected nephrologist practicing in a multi-disciplinary setting who is the most appropriate health professional to manage the Member, including preparing the Member for RTT (dialysis or kidney transplant).

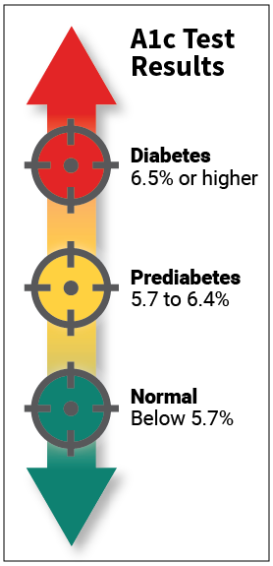
## Diabetes Management Program

Diabetes has a devastating impact on society due to the sheer volume of individuals who have the condition or are on the path toward it. According to the American Diabetes Association, more than 30 million (9.4 percent) Americans have diabetes, with nearly 1.5 million Americans diagnosed with diabetes every year.[49] Strikingly, approximately a quarter of those with diabetes are undiagnosed.[50] In the CareFirst population, over 200,000 Members have diabetes with as many as 50,000 additional Members undiagnosed. If trends persist, by the year 2050, one in three Americans will suffer from diabetes.[51]

### *Clinical Impact*

Serious, long-term complications, including heart attacks, strokes, blindness, kidney failure, and blood vessel disease can occur when diabetes is left unmanaged or untreated.[52] Diabetes is the leading cause of new cases of blindness and end stage kidney disease in adults. 70 percent of those with diabetes have nerve damage. Diabetes is also responsible for over half of all amputations of legs and feet.[53]

### *Diabetes is Treatable, Yet Too Few Control Their Diabetes*




Better control of glycated hemoglobin (A1c) levels can help reduce the risk of complications associated with diabetes. A1c levels reveal the average level of glucose in the blood over the eight to 12 weeks preceding the test and are used to measure diabetes control – generally, having an A1c lower than seven is deemed to be in tight control and an eight or higher to be uncontrolled. Reducing A1c levels by just one point has far-reaching implications, including reducing the rate of microvascular complications (i.e., eye and nerve damage) and potentially reducing the risk of other major diseases.[54] Unfortunately, it is estimated that as many as 50 percent of those with diabetes do not maintain recommended A1c targets.[55]

### *Economic Impacts and CareFirst Population Characteristics*

The incidence of diabetes is one of the main drivers of increases in health care costs. The American Diabetes Association in 2012 concluded that diabetes and related complications accounted for $245 billion in total medical costs and lost productivity. Stunningly, this is a 41 percent increase from $174 billion reported just five years earlier in 2007.

Medical costs for those who have diabetes are 2.3 times higher than the general population at an average cost of approximately $13,700 per year.[56] Further, 40 percent of costs attributable to diabetes are from hospital admissions, a result of poor control and the end-organ damage that follows it.[57] The CareFirst population mirrors these national statistics. The table below identifies CareFirst Members who are diagnosed with diabetes. As can be readily seen, rates of hospital admission and ER

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[49] *"Statistics About Diabetes." American Diabetes Association, 12 Dec 2016. http://www.diabetes.org/diabetes-basics/statistics/?loc=db-slabnav*

[50] *"Statistics About Diabetes." American Diabetes Association, 12 Dec 2016. http://www.diabetes.org/diabetes-basics/statistics/?loc=db-slabnav*

[51] *John Anderson et al. "How Proven Primary Prevention Can Stop Diabetes." Clinical Diabetes 2012 April, no. 2, 76, 76.*

[52] *"An Overview of Diabetes." Joslin Diabetes Center. http://www.joslin.org/info/an_overview_of_diabetes.html*

[53] *"Diabetes: What Is It?" Centers for Disease Control and Prevention, Jun 2017. http://www.cdc.gov/diabetes/diabetesatwork/pdfs/DiabetesWhatIsIt.pdf*

[54] *Irene M. Stratton et al. "Association of Glycaemia with Macrovascular and Microvascular Complications of Type 2 Diabetes (UKPDS 35): Prospective Observational Study." The BMJ 2000 Aug. 405, 409. http://www.bmj.com/content/321/7258/405*

[55] *Chrvala, Carole, Sherr, Dawn, and Lipman, Ruth, "Diabetes self-management education for adults with type 2 diabetes mellitus: A systematic review of the effect on glycemic control." Patient Education and Counseling 99 (2016) 926-943.*

[56] *"The Cost of Diabetes." American Diabetes Association, 22 June 2015. http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html*

[57] *"Diabetes Complications Severity Index (DCSI) – Update and ICD- 10 Translation." Journal of Diabetes and Its Complications, 17 February 2017.*

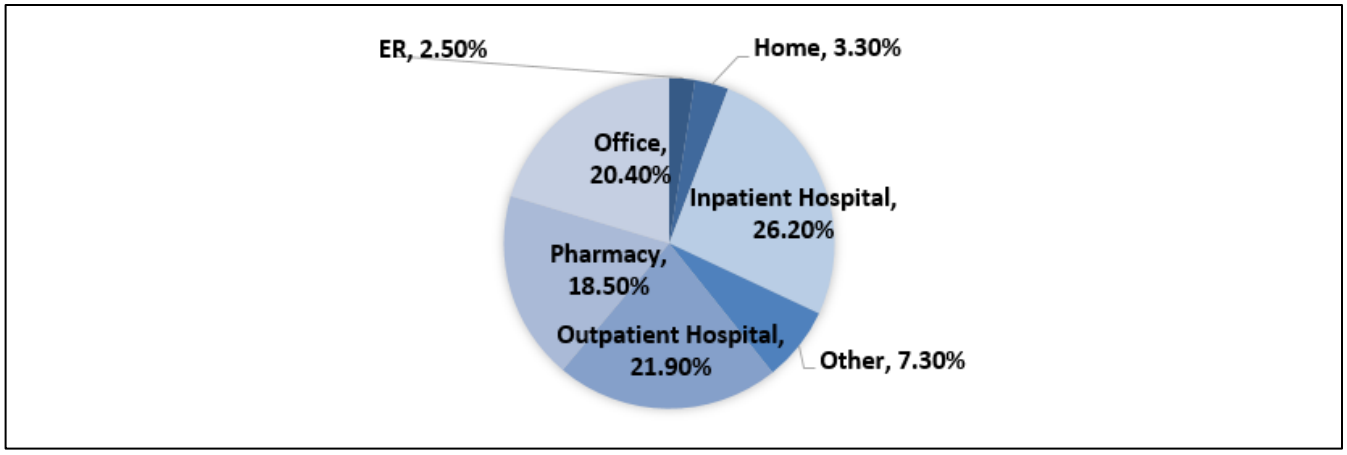
visits are nearly triple those for the general CareFirst population and this is reflected in the far higher cost for diabetic Members. Total medical cost for Members with diabetes accounts for an estimated $2 billion annually. Hospital costs account for nearly 50 percent of all spend for these individuals higher than the general population, and more than double of the average cost.

**Part VI, Figure 62: Summary of Members with Diabetes Episodes**

| Year | Members | Total Spend | Medical Spend PMPM | Rx Spend PMPM | Admits / 1,000 | ER / 1,000 | Average IB Score |
|---|---|---|---|---|---|---|---|
| 2014 | 184,970 | $1.79B | $718.43 | $289.69 | 142 | 321 | 2.45 |
| 2015 | 198,731 | $2.02B | $743.91 | $329.24 | 135 | 316 | 2.40 |
| 2016 | 200,612 | $2.1B | $726.04 | $352.30 | 117 | 299 | 2.36 |

Additionally, individuals with diabetes frequently face significant comorbidities. In fact, 80 percent of these Members have other conditions with over 50 percent diagnosed with hypertension. Nearly 10 percent have three+ related conditions and are associated with even greater costs (typically four times average per-Member costs).

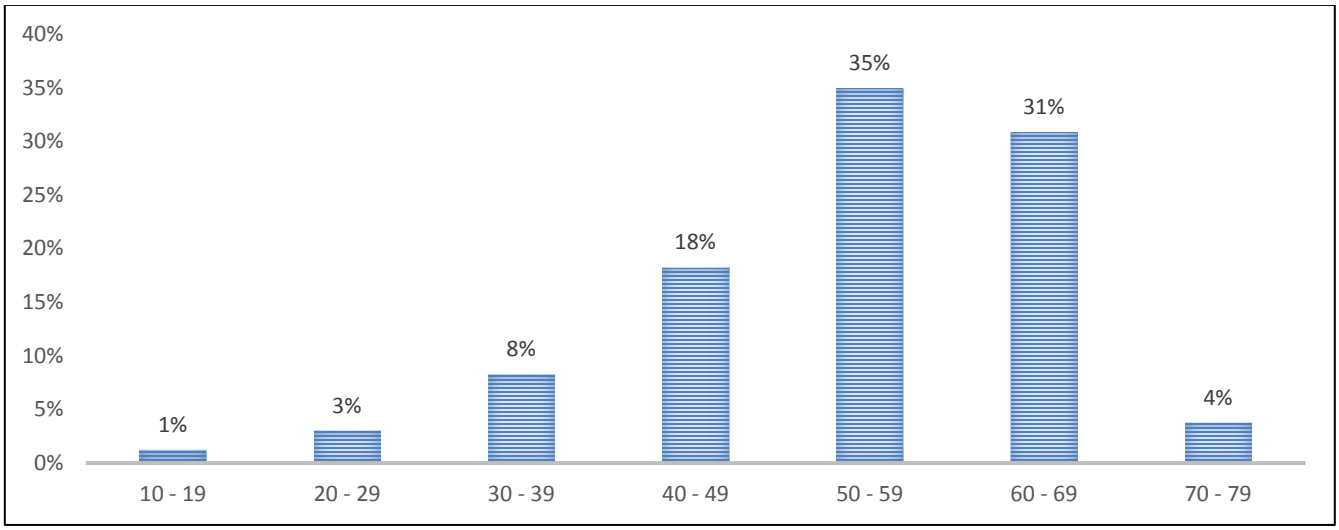
**Part VI, Figure 63: Overall Spend by Place of Service**




*Average CareFirst spend for Members with diabetes by place of service from 2013-2015.

Diabetes incidence is often associated with age. This holds true with the CareFirst population, where 84 percent of the population with diabetes is between the ages of 40-69, with the largest percent, over one third, from 50-59. The 70-79 population does not make up a large percentage of CareFirst's population with diabetes. This is due to the average age of a commercial population. The 70-79 population is covered by Medicare not commercial insurance. While those under 30 represent only four percent of Members with diabetes, ER visits per 1,000 are the highest of all populations for these cohorts, at 460 per 1,000 for 20-29 and 409 per 1,000 for 10-19, compared to an average of 302 per 1,000 for the overall population.

**Part VI, Figure 64: Members with Diabetes by Age, 2016**




**Understanding Diabetes**

When someone has diabetes, they have too much sugar (glucose) in their blood stream. In an individual without diabetes, insulin, the primary hormone in the body for regulating sugar from the bloodstream to the surrounding cells, is produced in the pancreas. With diabetes, either the pancreas does not produce insulin, produces very little, or the body does not respond appropriately to it, known as insulin resistance. This can result in dangerous levels of sugar in the blood if not treated appropriately. Left untreated, high blood glucose levels lead to serious life-threatening conditions as severe as ketoacidosis (a diabetic coma) and even death. There are three main categories of diabetes: Type 1, Type 2, and Gestational.[58]

Type 2 diabetes is the most common, accounting for 95 percent of all cases. Type 2 occurs when the cells in the body do not respond to insulin properly and usually develops over several years.[59]

Type 1 diabetes is less common, accounting for only five percent of all cases. It is caused by an autoimmune disease where the body attacks the pancreas, rendering it unable to produce insulin. Type 1 diabetes must be treated through insulin therapy. As with any form of diabetes, diet and exercise are encouraged to manage the disease.[60]

Gestational diabetes occurs during pregnancy and is caused by placental hormones that lead to a buildup of sugars in the blood. Healthy eating and activity help manage gestational diabetes, but medication can be prescribed if necessary.[61]

**The Value of Certified Diabetes Education**

A key, but often unavailable as well as underutilized resource that can help Members self-manage their diabetes, is Certified Diabetes Education. It is estimated that fewer than seven percent of those with private insurance use a Certified Diabetes

[58] *"About Diabetes." Center for Disease Control and Prevention. https://www.cdc.gov/diabetes/basics/diabetes.html*

[59] *"Type 2 Diabetes." Center for Disease Control and Prevention. http://www.cdc.gov/diabetes/basics/type2.html*

[60] *"Type 1 Diabetes." Center for Disease Control and Prevention. https://www.cdc.gov/diabetes/basics/type1.html*

[61] *"Gestational Diabetes." Center for Disease Control and Prevention. https://www.cdc.gov/diabetes/basics/gestational.html*

Educator ("CDE"), in the first year after diagnosis.[62] In the CareFirst service area, physicians across the region have often noted this is a service at the top of their list of needs.

Certified Diabetes Education enables individuals with diabetes to be taught the skills needed to self-manage their disease, often through the modification of their behavior.[63] Through better self-management, an individual becomes an active participant in their treatment, engaging in decision making and improving communication with healthcare practitioners. A CDE is a health professional with specialized knowledge in diabetes who understands the many ways to successfully manage the disease. In addition to a rigorous exam, the practitioner must meet strenuous professional practice requirements including a minimum of two years of practice in a discipline such as a registered nurse or registered dietician as well as a minimum of 1000 hours working with diabetes patients on self-management. Certification is administered by the National Certification Board for Diabetes Educators.[64]

While there are some diseases in which medication alone may be a successful form of treatment, there are many complex factors that must come together to successfully manage diabetes. These factors include nutrition, physical activity, medication adherence, glucose monitoring, and psychosocial adjustment. Diabetes Education enables individuals to become more aware of consequences of diabetes, the many factors that go into treating it and how to control it.[65]

Certified Diabetes Education is also strongly correlated with an increase in quality of life. It is associated with increased knowledge, clinical outcomes, self-efficacy, and compliance with screening for complications. A key outcome is A1c reduction. A1c is the key predictor of disease progression and development of microvascular and macrovascular complications.[66]

There is considerable support in the literature on the efficacy of Diabetes Education. Studies associated with Diabetes Education generally show a positive ROI or cost savings/decreased costs. It is clear in the literature review that "behavior change, lifestyle modification, and self-management are crucial elements to the cost-effective management of chronic illnesses such as diabetes. The benefits associated with Diabetes Education are positive and, based on the literature, outweigh the costs associated with the intervention.[67]"

Recognizing the importance of CDEs in helping Members manage their diabetes, CareFirst started with the recognition that there are too few locally-based CDEs to effectively provide Diabetes Education to CareFirst Members. Within the region, there are 2,000 individuals with diabetes for every one CDE.[68] Most of these CDE's work in hospitals and are not readily available as a community-based resource.

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[62] *Powers, Margaret. "2016 Health Care & Education Presidential Address: If DSME Were a Pill, Would You Prescribe it?" Diabetes Care 2016 Dec; 39(12): 2101-2107. http://care.diabetesjournals.org/content/39/12/2101?etoc*

[63] *"What is a CDE." National Certification Board for Diabetes Educators. http://www.ncbde.org/living-with-diabetes/whatisacde/*

[64] *"What is a CDE." National Certification Board for Diabetes Educators. http://www.ncbde.org/living-with-diabetes/whatisacde/*

[65] *"What is a CDE." National Certification Board for Diabetes Educators. http://www.ncbde.org/living-with-diabetes/whatisacde/*

[66] *Chrvala, Carole, Sherr, Dawn, and Lipman, Ruth, "Diabetes self-management education for adults with type 2 diabetes mellitus: A systematic review of the effect on glycemic control." Patient Education and Counseling 99 (2016) 926-943.*

[67] *"Costs and Benefits Associated with Diabetes Education: A Review of the Literature." The Diabetes Educator 2009; 35; 72. https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/Costs_and_Benefits.pdf*

[68] *"Count by State of Health Professionals Holding the Certified Diabetes Educator® Credential." National Certification Board for Diabetes Educators. http://www.ncbde.org/assets/1/7/StateCount0317.pdf*

**Scaling Certified Diabetes Education through the TCCI Diabetes Management Program**

Therefore, to help Members better manage their condition, CareFirst has developed a CDE capability – through a partner - to meet the needs of a large uncontrolled population. Members are paired with an expert CDE, who through telephonic coaching and online support, that helps the Member to better control their diabetes. This service, which forms the core of the Diabetes Management Program, is being piloted in 2018 in partnership with select PCMH PCPs and Fit4D, a firm which provides the CDE's in the Program.

The Diabetes Management Program is a covered preventive benefit at no cost to the Member. It is a specialized, intensive intervention, that delivers Diabetes Education directly to the Member through a qualified CDE who remains assigned to the Member throughout the Program and teaches them how to manage and control their disease with an emphasis on medication adherence, nutrition, and exercise. Coaching is reinforced through the offering of a diabetes self-management mobile application that provides blood sugar tracking capabilities.

***Target Population***

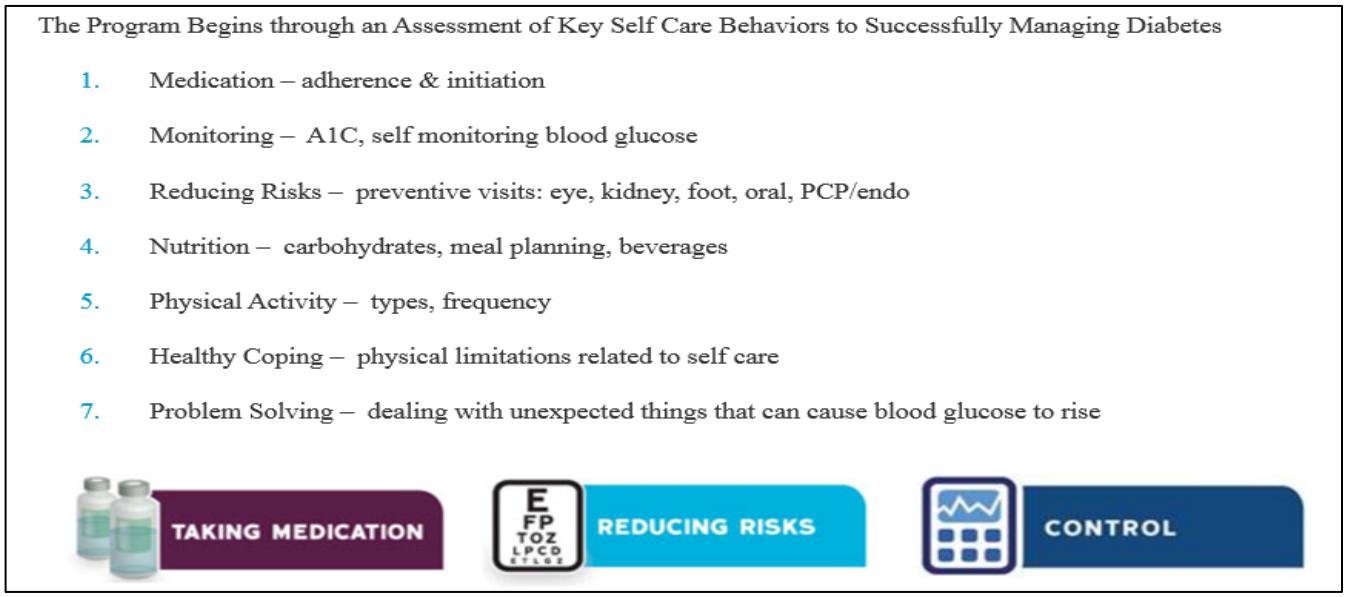
The CDE Program is intended for Members whose diabetes is uncontrolled or who are newly diagnosed. While referred Members are best identified by the clinical judgment of their doctor, typically, members entering the Program will either be those with an A1c of eight or higher (uncontrolled) or someone who was recently diagnosed with diabetes. This population ranges from those at an early state of the disease to those who have a more complicated stage of the disease and may be in Care Coordination.

***Diabetes Management Program***

Members are engaged in the Program via telephonic interaction, text, email, and group webinars and are offered access to a diabetes self-management mobile application. The mobile application enables Members to more effectively track daily sugar levels and provides easily discernible trends and insights over time. The Member can share these results with their spouse, doctor, or others at their discretion.

Diabetes Education plans, which are developed by the assigned CDE in conjunction with the Member, are highly tailored to individual Members. Initially, an assessment is conducted, focused on core self-care behaviors necessary to successfully manage diabetes. Through this assessment, gaps and barriers to care are identified and SMART goals (Specific, Measurable, Attainable/Achievable, Relevant, and Timely) are set.

**Part VI, Figure 65: Key Self Care Behaviors**




***Program Length and Graduation***

The Program typically runs for three to six months, depending on Member need. The Member graduates from the Program after three months if they have met their goals. Those who have not will continue for an additional three months. During the entire three to six months, as well as for six months following graduation, the diabetes self-management mobile application is available to Members.

Graduation from the Program is based on several factors indicating the Member's stronger understanding of the key self-care behaviors necessary to successfully self-manage diabetes. In proceeding toward graduation:

- The Member and their CDE review progress made in the Member's Diabetes Education plan.
- The CDE assesses Member confidence for their confidence in their ability to manage their diabetes.
- Outcome measures such as A1c level are assessed.

At graduation, the mobile application remains available for six additional months to reinforce self-management skills and behaviors. During this six-month maintenance period, the Member's dedicated CDE will check in on them at the three-month and six-month mark to ensure there is not a change in therapy or a setback. If additional support is needed, they may be reenrolled for a final three-month period.

***Referral Pathway and Engagement with the Member's PCMH PCP and Care Team***

PCMH PCPs identify Members and refer them to the Diabetes Management Program provider. LCCs work with their assigned PCMH PCP to assess members and refer them to the Program through the Service Request Hub. Throughout, progress status is provided back to the PCP and Care Coordinator, including escalation if there are concerns and potential suggestions regarding medication and therapy. This includes general medical considerations as well as behavioral health.

**Diabetes Management Program Goals and Outcomes**

The three goals of the Program are to:

1. Expand the availability of CDEs across the CareFirst service area following a successful pilot in 2018.

2. Improve quality outcomes and reduce risk factors primarily through the reduction of A1c and management of blood sugar levels.

3. Empower Members to self-manage their diabetes (medication adherence, coping skills, exercise, healthy eating habits, etc.).

Program success is measured according to four dimensions:

1. Quality Outcomes: A1c reduction, blood sugar control, medication adherence, blood pressure control, cholesterol (total, HDL, LDL), gaps in care (percent increases in foot exams, eye exams, and Chronic Kidney Disease screenings), and percent of time blood glucose is in range.

2. Member Metrics: Member satisfaction, engagement, etc.

3. Goals Met: The number of Members who achieve successful completion of the Program.

4. Utilization: Program impact on admissions to the hospital/ER and related cost savings realized. Change in PCP visits, prescription fills, and testing of A1c.

Members whose diabetes and other chronic conditions have become very complicated are supported through Care Plans set up for the Member by LCCs. As part of a Care Plan, a Member who is particularly unstable may also be offered the Enhanced Monitoring Program to help in the stabilization of their blood sugars as well as blood pressure and other factors. CareFirst also offers wellness and disease management coaching to help Members make appropriate lifestyle changes via the Wellness and Disease Management Services Program.

**Conclusion**

Diabetes has reached epidemic proportions. It remains one of the most common diseases among CareFirst Members. Without action, it will continue to have an increasing impact on CareFirst's population of Members. In 1921, Dr. Elliot Joslin, a pioneer in diabetes management warned, "there are entirely too many [patients with diabetes] in the country. Statistics for the last thirty years show so great an increase [if not for] better recognition of the disease, the outlook for the future would be startling." Dr. Elliot Joslin's quote still rings true today.

**Pain Management**

**UPDATE PENDING**

**Congestive Heart Failure**

**UPDATE PENDING**

**Cardiac Rehabilitation**

**UPDATE PENDING**

## Sleep Management Program

Obstructive Sleep Apnea ("OSA") is a common chronic disease prevalent in approximately 20 percent of the U.S. adult population. The incidence of OSA increases with age from 18 to 45 years and plateaus at 55 to 65 years of age[69] with a predisposition for African Americans and Asians possibly related to facial structure[70]. However, the overwhelming majority of people with OSA go undiagnosed until they are being evaluated for some other co-morbid condition.

OSA involves partial collapse or repetitive collapse of the airway during sleep. The resulting disrupted sleep leads to daytime sleepiness and diminished cognitive performance, often times leading to chronic diseases, catastrophic motor vehicle accidents, and even death. Major defined risk factors for OSA include obesity (BMI >35), craniofacial abnormalities, and upper airway soft tissue abnormalities. Other risk factors include smoking, nasal congestion, and heredity.

OSA is associated with multiple chronic medical illnesses, such as coronary artery disease and heart failure, stroke, hypoventilation syndrome, chronic obstructive pulmonary disease, pulmonary fibrosis, and mental illness. Increasingly, OSA is being considered a predisposing factor for the development of diabetes, systemic hypertension, cardiovascular diseases, and other chronic conditions. Numerous trials have reported that effective Continuous Positive Airway Pressure ("CPAP") therapy reduces systemic blood pressure and improvements in other comorbidities have also been noted.

Given the demographics of CareFirst Members and the myriad of diseases associated with OSA, proactive diagnosis and early intervention for members with undiagnosed OSA present an opportunity to reduce long-term morbidity, curtail avoidable cost and even prevent mortality.

**Economic Impact of OSA**

In the United States, the economic cost of unmanaged OSA (moderate-to-severe) is estimated to be between $65 and $165 billion, which is greater than the cost associated with asthma, heart failure, stroke, and hypertension. Members with unmanaged OSA are known to incur higher rates of hospitalizations, contacts with healthcare specialists and increased medication use.

In 2014, CareFirst Members received 25,000 sleep studies costing nearly $34 million, the vast majority of which (~90 percent of total sleep studies) were performed in a sleep lab, clinic or outpatient facility. Sleep studies performed in a clinical setting are known as polysomnography or PSG. During that same period, claims for CPAP machines/supplies for treatment of OSA cost $29 million. Members on CPAP therapy were managed by over 30 different vendors/providers.

Beginning January 1, 2016, CareFirst required that attended sleep studies performed in a lab, office, clinic or hospital setting undergo Prior Authorization. Unattended sleep studies performed at home do not require such authorization. Implementation of this policy yielded a drop in the portion of sleep studies done in a facility, producing approximately $9 million in cost savings in 2016.

During this time period, the number of facility based tests dropped from almost 25,000 in 2014 to 18,700 in 2016 while the number of home sleep studies increased from 2,900 in 2014 to over 7,600 in 2016, indicating a wide adoption of home based testing. CareFirst's total savings in 2016, compared to 2015, is over $7.6M, which factors in the reduction in average cost due to the movement towards the home-based setting as well as an overall decrease in the volume of requested tests. Starting on January 1, 2017, the Federal Employee Health Program joined this Prior Authorization as well. It is expected that the volume of facility based sleep studies will continue to decrease while the portion of sleep studies performed in the home will steadily increase. This is expected to produce a better Member experience and increase the likelihood of effective treatment thereafter.

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[69] *Jennum P, Riha RL. Epidemiology of sleep apnoea/hypopnoea syndrome and sleep-disordered breathing. Eur Respir J 2009; 33:907.*

[70] *Dempsey JA, Veasey SC, Morgan BJ, O'Donnell CP. Pathophysiology of sleep apnea. Physiol Rev 2010; 90:47.*

**New Technology and Approaches**

Technology has advanced considerably in the last five years and now, for Members whose conditions are not complicated by certain comorbidities, Home Sleep Tests ("HST") have proven effective, while proving to be a much more convenient and comfortable alternative than tests performed in a lab or hospital setting.

While sleep studies in a lab, office or facility typically have ranged from $2,000-$4,000 per study, the equally effective HST costs from, on average, $225 for the same actionable diagnostic results.

Thus, there is tremendous opportunity to reduce diagnostic cost while also providing early intervention measures that have been proven effective. It is further thought that by making HST more accessible and convenient, more of the population suffering from OSA may be reached resulting in downstream cost savings and improved overall health.

**Sleep Management Program Goals**

CareFirst's Sleep Management Program provides a straightforward approach to identifying, diagnosing, and engaging Members for sleep studies and appropriate follow-up management.

The two goals of the Sleep Management Program are to:

1. Ensure a more cost effective, yet clinically appropriate, setting for sleep studies by shifting unnecessary facility based sleep tests and outpatient testing to home settings resulting in lower cost and improved Member experience.

2. Intensively monitor and improve Member compliance with CPAP equipment provided by selected equipment vendors to promote better outcomes following a sleep study.

**Prior Authorization for Facility Based Sleep Studies**

CareFirst has collaborated with local board-certified Sleep Medicine physicians to develop a clear, comprehensive medical policy based upon sound clinical judgment for sleep management services that clearly indicates the diagnoses/conditions that are appropriate for attended sleep study in a lab and unattended sleep study at home. This medical policy is available to all Members and providers online at www.carefirst.com.

As with other services, providers submit authorization requests via iCentric. Requests are reviewed by the CareFirst clinical team and Prior Authorization is given when medical necessity criteria are met. Individual clinical circumstances not meeting the criteria are always reviewed by a CareFirst Medical Director.

For most Members, a lower copayment of $20 applies for sleep studies done in the Member's home. For Members who undergo a freestanding sleep study in a lab, a higher copayment of $100 applies in addition to a copayment of $200 for hospital-based tests. The Prior Authorization requirement combined with the site of service differential in Member cost sharing is meant to encourage medically necessary care in the most appropriate setting.

**Member Access to the Sleep Management Program**

Specialization in sleep medicine is generally found in two medical specialties – Neurology and Pulmonology. To ensure visibility and access to the best possible network of sleep medicine specialists, CareFirst has established a credentialing category of "Sleep Medicine Specialist". To be considered a Sleep Medicine Specialist, physicians must be credentialed by the American Board of Medical Specialties ("ABMS") in Sleep Medicine. Members needing sleep studies or sleep management services are not required to use a designated Sleep Medicine physician. However, these credentialed sleep medicine physicians are separately listed in the CareFirst Provider Directory that is available online under the specialty category "Sleep Medicine".

When sleep services are needed for a Member in a Care Plan, the LCC works with the Member's PCP to identify and select a credentialed sleep provider. Members without a PCMH PCP can access the list of credentialed sleep medicine physicians using CareFirst's online Provider Directory through a simple query. In addition, any provider can access the listing of

credentialed sleep services specialists. Providers and Members are advised of the Sleep Management Program through the CareFirst website and targeted communications in BlueLink and Member newsletters.

Once sleep study results are reviewed by the PCP or Specialist and OSA is diagnosed, a treatment plan is developed based upon the clinical and physical findings. In cases where CPAP services are ordered by the physician, a referral is sent to one of CareFirst's designated CPAP vendors through the iCentric Service Request Hub.

CareFirst has selected five preferred sleep service equipment vendors to support the Sleep Management Program. These vendors not only supply the needed equipment, but provide ongoing monitoring and hence, are part of the TCCI Enhanced Monitoring Program. Each vendor has been thoroughly evaluated by CareFirst for access, timeliness, quality, oversight and Member satisfaction. The preferred vendors provide stringent oversight, continuous monitoring and preferred pricing for CareFirst Members in the Sleep Management Program.

Although Members are not required to use a preferred vendor for CPAP equipment, PCMH PCPs and Sleep Medicine Specialists connect the Member to a preferred CPAP vendor whenever possible. The preferred vendors provide a higher level of Member service, reaching out to Members to assess compliance, barriers to compliance, and equipment related issues. They also provide follow up OSA and CPAP coaching and devise ongoing plans to address barriers.

**Initiation, Oversight and Monitoring Process for Members on CPAP Therapy**

The service standards set forth below guide the work of these preferred vendors:

1. The preferred vendor receives an order from a provider for a Member requiring CPAP therapy.

2. The vendor completes a Service Request (SR) in iCentric within 72 hours of receiving the order.

3. CareFirst requires that CPAP equipment have auto titration functionality and an internal modem. The vendor delivers this CPAP equipment to the Member's preferred address or provides a convenient office location for equipment pick up, if that option is preferred by the Member.

4. A licensed respiratory therapist or registered nurse thoroughly reviews the CPAP equipment set up in person with the Member and trains the Member on the use and maintenance of the equipment including the overall health benefits of CPAP compliance.

5. The CPAP device must be equipped with an internal wireless modem to monitor therapy daily and feed the results back to the vendor each morning.

6. The vendor must contact the Member after the first night of therapy to review the Member's progress and address Member questions/concerns.

7. If therapy is initially successful, the Member is contacted on days 7, 30, 60, and 90 from the date of setup. If the Member continues to be compliant with therapy, the Member is contacted every six months, thereafter, for the duration of therapy.

8. The preferred vendors will ensure that 100 percent of the CareFirst Members on service are compliant with therapy a minimum of four hours/night 75 percent of each month.

9. At any point, if an individual Member's compliance drops below 70 percent for five or more consecutive nights, as measured electronically by the device, the vendor must contact the Member to address barriers to compliance. Members are provided with options that improve compliance including appropriate mask-fitting education; tubing, filter replacement, or water chamber replacement; or other appropriate device related issues.

10. The vendor must develop an action plan to address compliance barriers. If compliance continues below 70 percent and/or the Member does not comply with the action plan, the vendor must notify the ordering physician for further evaluation and recommendation.

11. The vendor must staff a 24-hour on-call line with Customer Service Technicians/Respiratory Therapists available to address Member questions and concerns regarding the functionality of the equipment.

The Service Request Hub tracks activity metrics/outcomes such as the number of Members on service, number of Members compliant vs. non-compliant, barriers to compliance such a mask leakage, and improvements in quality of life.

**iCentric Integration with Sleep Monitoring Devices**

On a monthly basis, each of the designated equipment vendors send monitoring data directly to iCentric to enable CareFirst's Care Coordination teams and other providers to view Member compliance and progress on the CPAP machine. The Hub monitors the monthly data feeds and alerts the Care Coordination team as needed to any problems, untimeliness or unavailability of data.

**Conclusion**

With the advent of the Sleep Management Program, CareFirst seeks to provide a comprehensive approach to identifying, diagnosing, and engaging Members for sleep studies and appropriate follow-up management. By shifting unnecessary facility-based CPAP sleep tests to the home setting, costs are reduced and Member experience is improved. Through preferred equipment vendor arrangement, ongoing CPAP services are intensively monitored to improve Member compliance with needed equipment. The Sleep Management Program connects Members with the most cost-effective site of service and trusted equipment vendors to minimize cost for Members and Accounts, ensuring the best possible health outcomes.

## Program #9: Network Within Network Program (NWN)

**(Update Pending)**

## Program #10: Pharmacy Coordination Program (RxP)

### Preface

There are five key elements in the TCCI Pharmacy Management Coordination Program (RxP) that confer substantial value in controlling pharmacy spend and improving quality outcomes for Members. Pharmacy costs are among the most rapidly growing costs borne by health benefit plans and taken as whole, now account for the single greatest portion of the medical dollar for CareFirst Members.

There are five elements of the Pharmacy Coordination Program (RxP) that are described in this section:

**RxP Element #1:** **Drug Pricing And Ingredient Cost Control**

**RxP Element #2:** **Formulary Offerings**

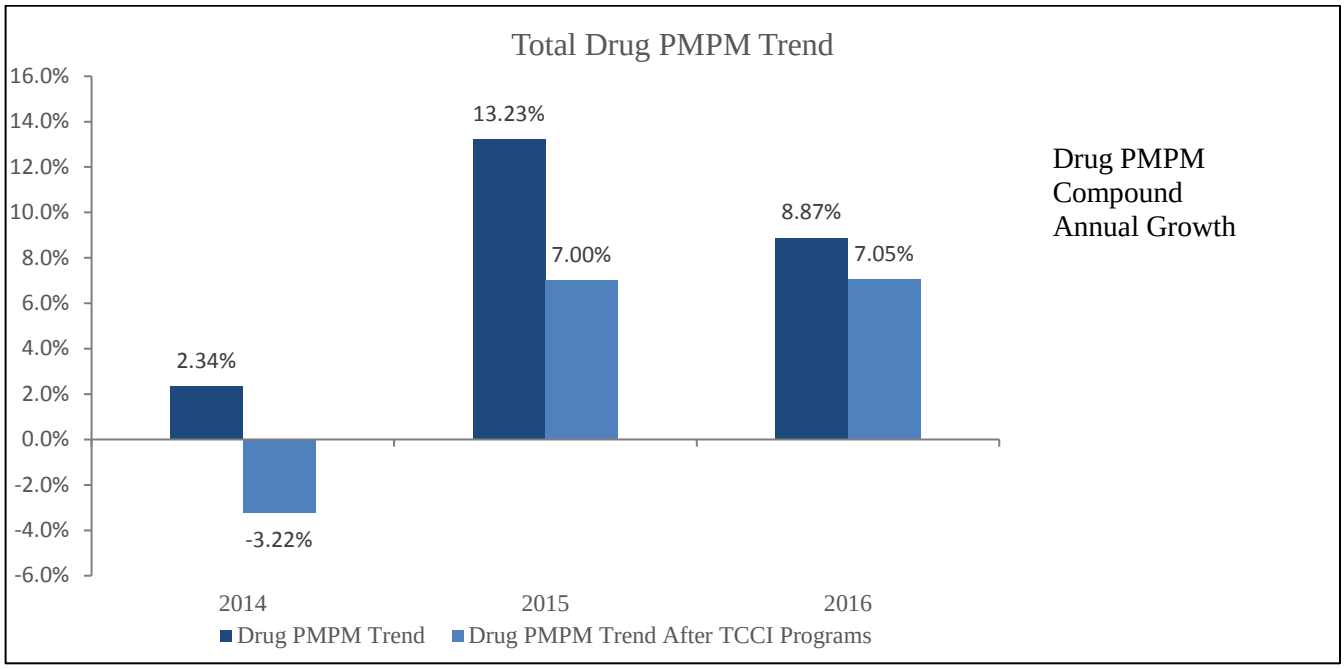
**RxP Element #3:** **Pre-Authorization And Case Management For Specialty Drugs And Compounds**

**RxP Element #4:** **Behavioral Health Pharmacy Coordination**

**RxP Element #5:** **Comprehensive Medication Review and Drug Advisories**

These five Elements, when taken together, have a significant impact on the level of drug spending as well as on the efficacy of this spend through enhanced Member compliance/adherence. As **Figure 66** below shows, the total billed drug costs to CareFirst have rapidly increased since 2013 from $3.1 billion to approximately $5 billion in 2016. Yet, the allowed drug cost has risen more modestly during the same period from $1.8 billion to $2.3 billion due to the impact of the RxP Programs.

**Part VI, Figure 66: TCCI Program's Effect On Drug Spend, 2013-2016**




It is well to keep in mind that the most explosive portion of pharmacy spending is for specialty drugs which are expected to continue to grow as a portion of all pharmacy related spending in the coming decade. For CareFirst, the portion of all pharmacy spending that is dedicated to specialty drugs (generally infusible or injectable drugs) is now approximately forty-one percent – and this is expected to rise to 50 percent over the next five years.

Hence, strategies and capabilities cannot be limited to the usual undertakings of maximizing generic use, encouraging mail order for maintenance drugs or tuning the tiering of drugs in model formularies as a way of steering Member use to preferred (cost effective) drugs as important as these initiatives are. These strategies are important but do not sufficiently address the full spectrum of needed capabilities. This is discussed in the pages that follow.

In the end, the integration of all elements of the TCCI Pharmacy Coordination Program with the rest of the Programs in the TCCI Program Array is critical to achieving better outcomes and cost results. This is so because drugs are the single most important means used in treating disease and chronic conditions.

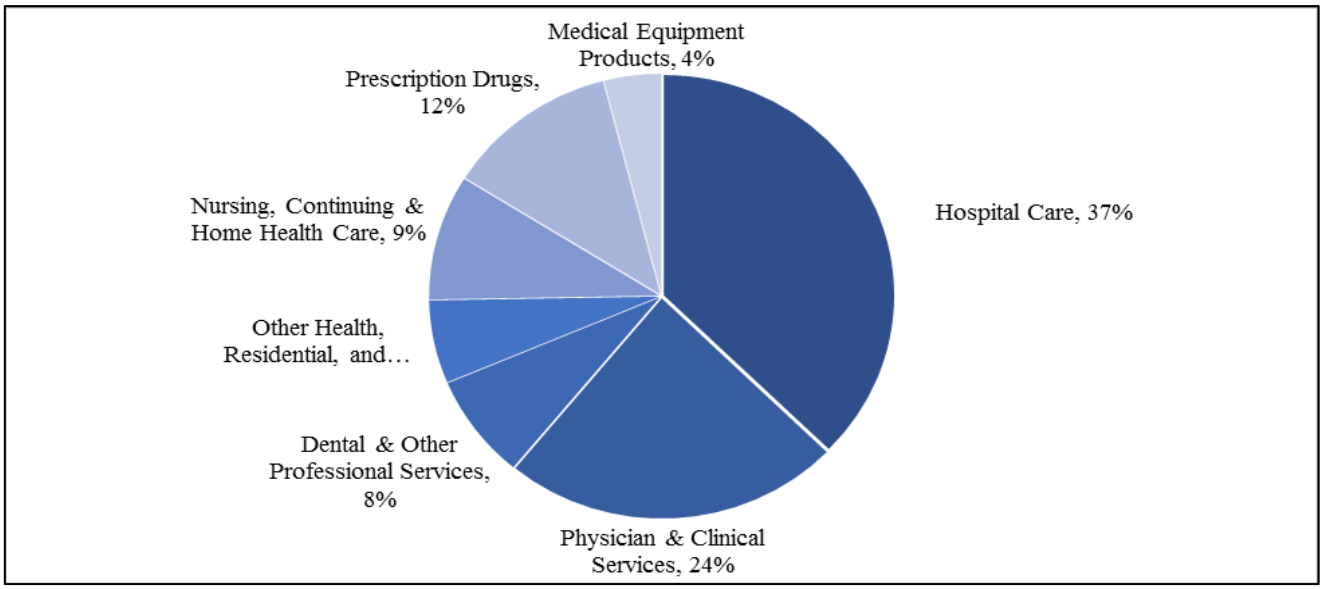
To this must be added the observation that we are entering a new era in which medications will be finely tuned to the genetic map of individual Members and, in so doing, will deliver ever more effective treatments that either protect or enhance the duration and quality of life in a way that was never before possible. This will come at very considerable cost even after considering offsets in the costs associated with less advanced therapies and approaches in use today.

## RxP Element 1: Drug Pricing And Ingredient Cost Control

Cost control of prescription drug spend is central to the RxP. CareFirst spent approximately $1.67 billion in 2016 on pharmacy benefit costs under its Members' pharmacy benefits and another $600 million under their medical benefits. Changes in benefit design, formulary structure, rebate contracting and pharmacy network pricing can result in changes amounting to hundreds of millions of dollars in savings. An integrated approach to management of the complex elements of pharmaceutical services is required to maximize outcomes while holding down growth in costs.

According to the Centers for Medicare and Medicaid Services (CMS), prescription drug spending represents the third largest spending category behind hospital care and physician and clinical services. Of the $3.2 trillion spent on health care in the United States in 2015, prescription drug spending, flowing through the pharmacy benefit alone, accounted for approximately $324.6 billion representing 12 percent of overall healthcare spend as shown in **Figure 67**. This figure includes all populations (Medicare, Medicaid, Commercial, Veterans, etc.).

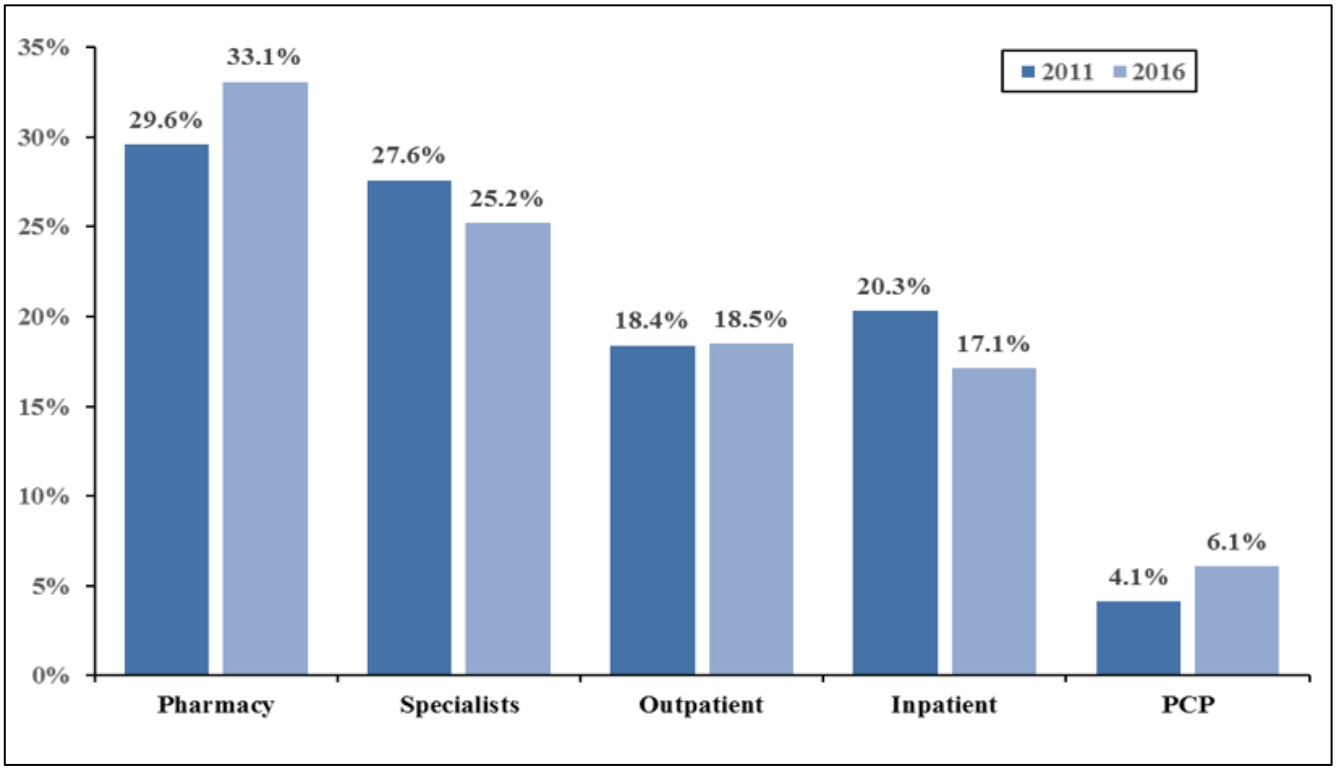
**Part VI, Figure 67: Portion Of U.S. Healthcare Spending By Category, 2015**[71]




By analyzing drug spend, regardless of whether the medication is covered under the medical or pharmacy benefit of a Member, CareFirst has identified that pharmacy is the single greatest contributor to the overall medical dollar at approximately 33 percent of total health care spend, as shown in **Figure 68** on the next page. These figures, as compared to 2011, show a significant increase in pharmacy contribution to total spending. The only other material increase is for PCP spend, which is intentional as integral to the CareFirst PCMH Program.

[71] *Centers for Medicare & Medicaid Services. "National Health Expenditures 2015 Highlights." Department of Health & Human Services. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf.*

**Part VI, Figure 68: CareFirst Medical Spend By Category, 2011 vs 2016[72]**




**CareFirst Pharmacy Benefit Management ("PBM") Bidding Process – Systematically Testing the Market**

In formulating its strategy to contain the expected growth in pharmacy trend, CareFirst sought superior manufacturer rebates, competitive ingredient costs and a high level of service that could be integrated into the PCMH Program and TCCI Program Array. By bidding the pharmacy program out through market checks and Requests for Proposals ("RFPs"), CareFirst has been able to drive the ingredient cost and pharmacy spend down significantly. This systematic testing through competitive bidding has proven to be the single most impactful way to achieve this goal for Members and employee groups.

In early 2017, CareFirst had 1.2 million Members with a pharmacy benefit as part of their health care coverage with the company. These Members fill 12 million prescriptions per year (33,000 per day) at some 65,000 pharmacies across the United States and account for approximately $1.67 billion in prescription drug spending.

**PBM RFP Process – A Competitive Result**

In order to test the market and ultimately maximize the value to CareFirst, its Members and self-funded groups, CareFirst put its Pharmacy Benefit Administration Program out for bid in early 2013. This followed a period in 2012 during which CareFirst collected important market data to assure the release of the most incisive Request for Proposal possible.

Five leading PBMs submitted RFP proposals in early 2013, which included the four industry standard price components of Ingredient Cost, Manufacturer Rebates, Dispensing Fees, and Administrative Fees, with each variable relating to drug classification (i.e., brand or generic), dispensing method (i.e., retail or mail order), and prescription length (e.g., 30-day or 90-day).

[72] *Source*: *CareFirst Health Care Analytics, 2016 Data.*

Since the eventual price, Members pay for their prescription drugs depends on which pharmacy they frequent and the mix of brand and generic drugs they use, pricing terms (Ingredient Cost) provide the first line of cost savings to CareFirst. Therefore, CareFirst requested that each PBM respondent perform a re-pricing exercise based on eight calendar quarters of historical CareFirst pharmacy claims data. These historical claims were re-priced by each PBM reflecting what would have been paid for the specific drug, on the specific date of fill, at the pharmacy where the drug was obtained had the PBM role been with them. These analyses were then compared to determine which PBM had the lowest administrative fees, the strongest rebate contracts, and the best actual pharmacy network pricing. CareFirst took great care in evaluating the proposals by conducting multiple levels of analysis of the data supplied.

To maintain competition in the negotiation all the way through contract execution, contracts were negotiated with the two finalists simultaneously. When each contract was ready for signature, CareFirst awarded the business to CVS Caremark which distinguished itself on all pricing elements below:

- Superior ingredient costs across a large pharmacy network
- Superior manufacturer rebate levels and guarantees
- Waived dispensing fees for all 90-day and mail-order fills
- Competitive dispensing fees for 30-day prescription fills
- Aggressive performance guarantees

In addition to securing these preferable contractual terms, a process was established to set up various formulary optimizations and Care Coordination activities to increase Member adherence to complex drug therapies as well as enhance coordination and support of specialty drug use as described further in the Pharmacy Coordination Program (RxP) section of the PCMH/TCCI Program Description and Guidelines.

Again in January, 2017, CareFirst released an RFP to ensure that, market leading prices services and programs offer CareFirst Members the most cost-effective therapies to manage illness. CareFirst expects significant improvements in three key areas through this RFP process:

- Deeper ingredient cost discounts for brand and generic drugs in retail, mail, and specialty channels.
- Improved rebates with stronger rebate guarantees created.
- More dedicated focus by the PBM partner working through CareFirst; not in isolation or separation in the CareFirst service area.

**Market Checks: Scanning the Market**

Because the RFP process occurs at fixed intervals and is a laborious process to thoroughly check all facets of CareFirst Pharmacy Programs, a less intensive market check occurs throughout the contract years to scan - market competitors. The market check is also a tool for driving down ingredient cost, raising rebate guarantees, and identifying other Program enhancements. The process mimics the RFP in that CareFirst releases a year of pharmacy claims to competitive bidders and asks them to price the claims as if they were our PBM. This process is expedited through a financial analysis only, without analyzing all the operational metrics of each PBM. If a significant variance in pricing is seen from the competition, CareFirst is in a better position with the incumbent PBM partner to strengthen pricing competitiveness.

The market check also allows CareFirst to keep up with the ever-changing pharmacy market. Pricing terms secured in an RFP for a three to five-year contract can become stale within 18 months. The market check can also benefit the PBM partner if it leads to a contract extension without the need for an RFP.

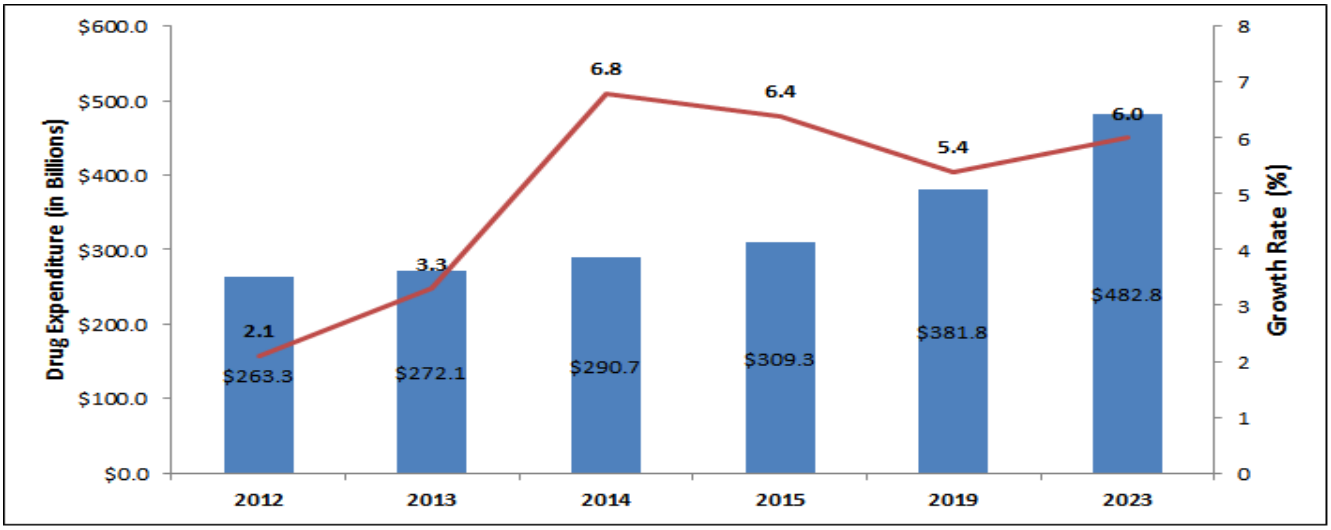
**Historical Context of Pharmacy Trend: Value of Generics**

The average annual growth of retail prescription drug spending (i.e., excluding inpatient spending) from 1992 to 2012 was nine percent, as reported by the Centers for Medicare and Medicaid Services (CMS). **Figure 69** shows pharmacy trend continuing to grow at an average annual rate of six percent through 2025.

A focus on utilization of generic drugs in the early 2000s was the main driver in containing prescription drug spending growth to less than 10 percent after 2004. The trend has continued to decline and reached a historic low of 0.4 percent in 2012 when six of the 10 top-selling brand prescription drug products on the U.S. market faced their first generic competition. It is estimated that generic competition eroded $67 billion in top drug companies' annual sales in the U.S. between 2007 and 2012.

Prescription drug spending growth slowed during 2007 to 2012, primarily due to the recession and several blockbuster brand prescriptions drugs going off patent. In 2014 drug expenditures started to rise when the ultra-expensive Hepatitis C medications Sovaldi and Olysio hit the market and as millions of Americans took advantage of insurance offerings authorized under the Affordable Care Act. This trend is expected to continue, with CMS projecting average annual drug spending growth of nearly six percent.

**Part VI, Figure 69: Growth Of Prescription Drug Spend**[73]




While the increase in broad availability of generic drugs has helped to mitigate inflation increases over the past few years, the rate of brand patent expirations will ebb going forward and the "patent cliff" in the pharmaceutical industry will ebb with it. Between 2014 and 2020, it is estimated that $259 billion in worldwide pharmaceutical sales are due to experience patent expiration, with $70 billion of this in 2016 and 2017.[74] Other estimates predict $26.5 billion in annual revenue reductions for manufacturers from patent expiration in 2017 alone.[75]

**Market Impact of Brand Drug Patent Expirations**

When a new drug therapy is released, it can have a dramatic effect on the market. For example, when brand name drug Sovaldi was introduced to treat hepatitis C in early 2014, the treatment options changed dramatically from a chronic blend of shots

[73] *Source: CMS, National Health Expenditure Projections, 2013–23: Faster growth expected with expanded coverage and improving economy (Health Affairs, September 2014) from https://www.ihs.com/country-industry-forecasting.html?id=1065994900.*

[74] *Pharmaceutical Executive Vol 36, Issue 11, Nov 9, 2016*

[75] *http://www.fiercepharma.com/pharma/big-pharma-faces-26-5b-patent-loss-threats-year-analyst-says*

(interferon) and pills that came with unpleasant side effects, to the much milder Sovaldi. While the reported cure rate of Sovaldi is 90 percent, the cost of $84,000 for a full 12-week course of treatment dramatically increased costs for payers in the short term. This cost is being included in premium rates in 2015 and onward.

The price at which Gilead Sciences, Inc. introduced Sovaldi provides evidence of a pattern of higher prices in the pharmaceutical industry for specialty drugs. As drugs become more specialized and face less competition, drug manufacturers are able to command a higher price due to the perceived value the drug brings to patients and the cost savings expected to be realized by preventing further disease-related deterioration and complex medical procedures (e.g., Hepatitis C-related Cirrhosis and Liver transplants) over the long term. No longer are drug manufacturers claiming markups solely to cover expensive Research and Development ("R&D") activities. Instead, more recent pricing decisions appear to be based on the estimated value the drug brings and what "the market can bear."

Conversely, when a novel drug reaches expiration of its patent and generic equivalents or alternatives are introduced, the price of the brand drug usually declines dramatically with increased competition. Typically, patients are directed by their health plans to the lower cost generic versions. When the cholesterol-lowering drug Lipitor, reputed as the best-selling prescription drug in world history, began being widely manufactured and sold in its generic form (atorvastatin) in May 2012, the out-of-pocket price for most consumers dropped from the brand level co-pay cost of $25 to the co-pay level of other generics, which is $10 or less for a month's supply.

Pfizer, the manufacturer of Lipitor, used a variety of techniques to maintain revenue levels. These included effectively blocking the sale of the generics from pharmacies in exchange for rebate offers to PBMs and insurance plans to increasing the retail price just prior to the patent expiration. These and other tactics have become common practice by brand drug manufacturers, and ultimately lead to higher costs through increased premiums for publicly funded pharmacy programs, such as Medicare Part D.

The savings resulting from a generic launch can be substantial. The introduction of a generic equivalent for Aciphex in 2013 dropped the daily ingredient cost from $12.56 to $1.31. Even with only 1,000 Members on Aciphex, the savings resulting from the generic launch were close to $3 million for CareFirst.

The top drugs expected to lose their patent in 2017 are shown in **Figure 70** on the next page which lists brand drugs that have or are expected to have generic competition in the coming years.

**Part VI, Figure 70: Brand-Name Drugs With Patent Expirations In 2017 And 2018**[76]

| Brand | Generic Name | Manufacturer | Therapeutic Category | Generic Availability |
|---|---|---|---|---|
| RELPAX | Eletriptan | Pfizer | Antimigraine agents | 2017 |
| MINASTRIN 24 FE | Norethindrone Acetate and Ethinyl Estradiol/ Ferrous Fumarate Capsules | Warner Chilcott/ Allergan | Combination Contraceptives - Oral | 2017 |
| VYTORIN | Ezetimibe/simvastatin | Merck/Schering | Antihyperlipidemic combinations | 2017 |
| STRATTERA | Atomoxetine | Eli Lilly | CNS stimulants | 2017 |
| VIAGRA | Sildenafil | Pfizer | Impotence agents | 2017 |
| VIREAD (300 MG) | Tenofovir | Gilead | Nucleoside reverse transcriptase inhibitors | 2017 |
| REYATAZ | Atazanavir | BMS | Protease inhibitors | 2017 |
| SUSTIVA 600 MG | Efavirenz | BMS | Non-nucleoside reverse transcriptase inhibitors | 2017 |
| SOLODYN (65 & 115 MG) | Minocycline | Valeant | Tetracyclines | 2017 |
| NUVARING | Ethinyl Estradiol, Etonogestrel | Organon | Contraceptives | 2018 |
| ADCIRCA | Tadalafil | United Therapeutics | Agents for pulmonary hypertension | 2018 |
| CIALIS | Tadalafil | Eli Lily | Impotence agents | 2018 |
| REMODULIN | Treprostinil | United Therapeutics | Agents for pulmonary hypertension | 2018 |
| SENSIPAR | Cinacalcet | Amgen | Miscellaneous uncategorized agents | 2018 |
| ACANYA | Benzoyl peroxide/clindamycin | Valeant | Topical acne agents | 2018 |
| CANASA | Mesalamine | Forest Allergan | 5-aminosalicylates | 2018 |

**Recent Generic Drug Pricing Surges**

While the availability of generic forms of drugs has helped to contain pharmaceutical spending, recent data suggests that drug manufacturers and distributors are sharply increasing costs for certain generic drugs by as much as 9,000 percent over a six-month period. Some of the most notable increases are highlighted in the table below:

**Part VI, Figure 71: Generic Drug Price Surges 2015-2016**[77]

| Drug | AWP Prior | AWP Post | Change |
|---|---|---|---|
| Metformin ER | $1.44 | $15.19 | 952% |
| Omeprazole/bicarbonate | $18.26 | $84.57 | 363% |
| Theophylline ER | $0.68 | $1.92 | 181% |
| Norgestrel/ethynyl Estradiol | $1.40 | $3.81 | 171% |

[76] *Source: CVS Health Generic Prospective Pipeline Summary - Launch Expected 2017 to 2018 - Sorted by Year and Quarter. Updated 03/03/17.*
[77] Source: CareFirst Claims Data. All priced represent cost/unit (e.g., tablet, capsule).

The market introduction of generics is generally thought to induce downward price pressure. However, studies have shown that for competition to bring price down significantly, at least four or five companies need to be making the drug. Recent industry consolidation and changes in supply due to temporary factory closures are driving the rise in generic drug prices, which is reportedly impacting patients, healthcare providers, and hospitals across the country considerably and will surely have significant impact on CareFirst Members and self-insured accounts if left unaddressed.

CareFirst is working with CVS Health to monitor large upswings in generic drug pricing and to optimize dosage to minimize costs while maintaining clinical efficacy. Furthermore, CareFirst will keep a close eye on developments of the aforementioned investigation, particularly when opportunities arise to provide input into potential cost reduction measures.

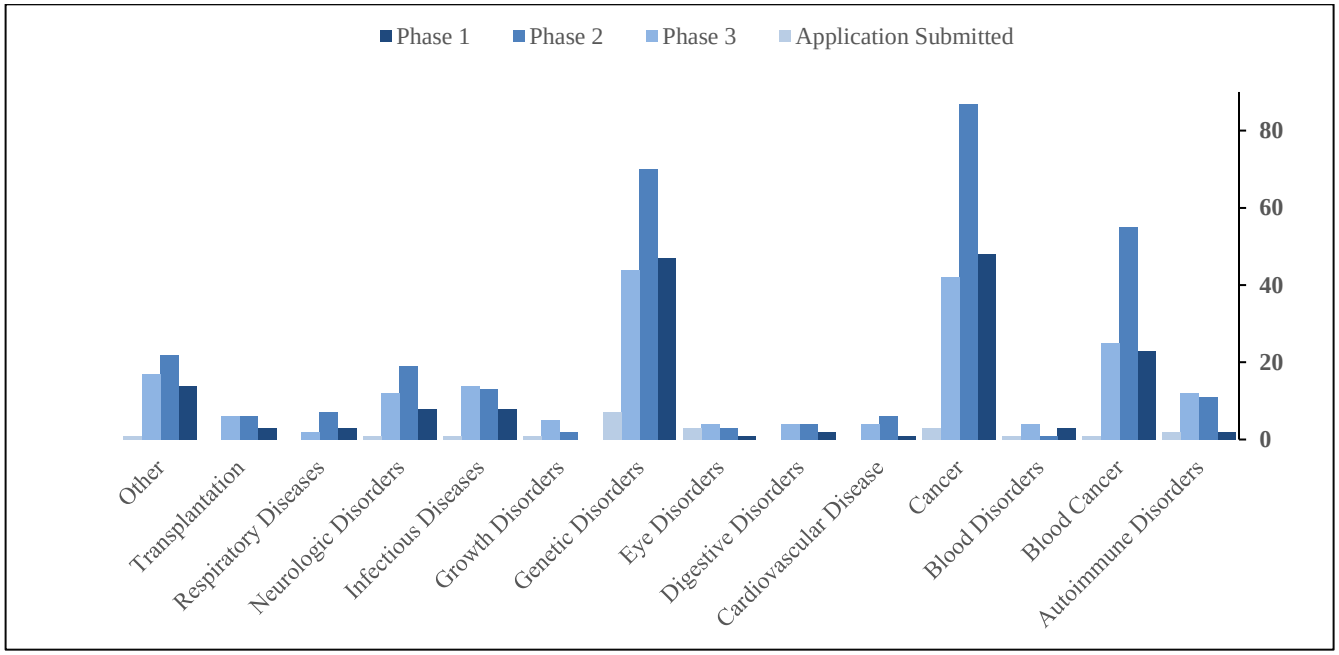
**Pharmaceutical R&D Competition and Outlook**

While forecasting the level of generic competition is important in evaluating cost savings opportunities, it does not tell the whole story. It is critical to also monitor the pipeline of drugs in development to foresee how potential new therapies might impact Members.

Development of new treatments is a long and rigorous process, and it has become costlier and complex over the last decade. Even among the new drug candidates reaching Phase III trials (the last phase before submission for FDA approval), about one-third fail. Companies "race" to bring the first medicine in a class to market, and just two in ten approved drugs are commercial successes.

Complicating the pipeline further, over the past decade more than 230 new orphan drugs were approved by the FDA. The Orphan Drug Act (ODA) provides special status to a drug or biological product to treat a rare disease or condition. This status is referred to as orphan designation (or sometimes "orphan status"). For a drug to qualify for orphan designation, both the drug and the disease or condition for which the drug is intended must affect fewer than 200,000 people in the United States. Additionally, orphan drug sponsors qualify for seven-year FDA market Orphan Drug Exclusivity (ODE), tax credits of up to 50 percent of research and development costs, waived FDA fees, research protocol assistance, and may be eligible for clinical trial tax incentives. In 2015 alone, nearly half of novel new drugs approved were for rare diseases such as cystic fibrosis, enzyme deficiency disorders and cancer. Rare diseases are increasingly a focus of the biopharmaceutical industry and will bring costly medications to the market. **Figure 72** represents the 566 medicines in development globally by phase.

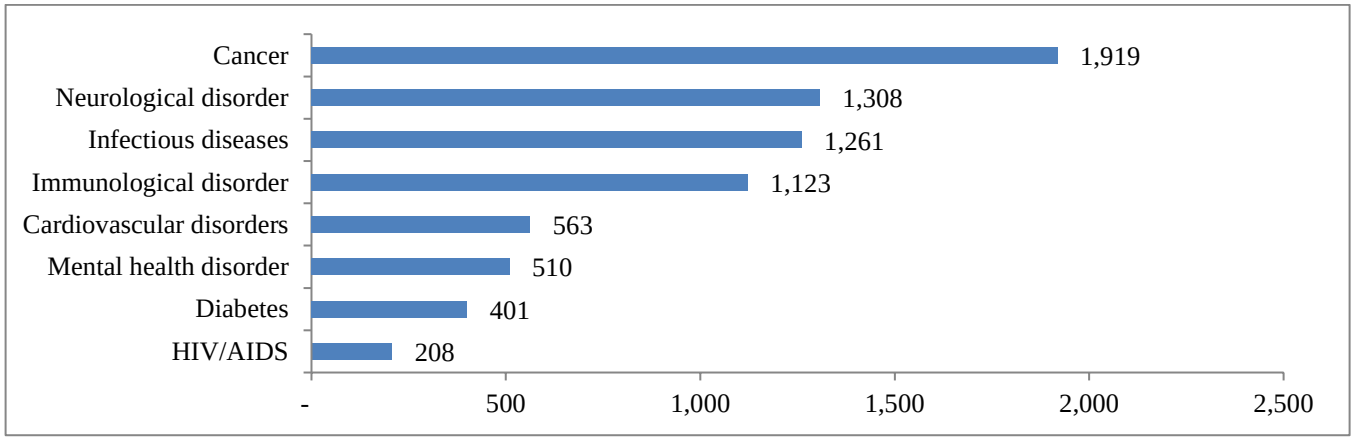
**Part VI, Figure 72: Rare Disease Medicines in Development by Condition Type**[78]




**Innovation in Specialty Drugs**

The pipeline of drugs in development is increasingly filled by specialty drugs. These are biologics that typically require infusion, injection or other special handling or compounding. By 2018, it is expected that specialty drugs will make up six of the top ten drugs in terms of overall use. In 2015, nearly 400 of the 7,300 drugs in development by biopharmaceutical companies were biotechnology drugs. Of these, seventy percent are first-in-class strategies. The breakdown of these new medicines by therapeutic area is shown in **Figure 73** below.

**Part VI, Figure 73: More Than 7,000 Medicines In Development In 2016**[79]




[78] Source: http://phrma-docs.phrma.org/sites/default/files/pdf/medicines-in-development-drug-list-rare-diseases.pdf
[79] *Source: PhRMA Industry Report pg. 63, 2016 (Adis R&D Insight Database: Accessed March 2016).*

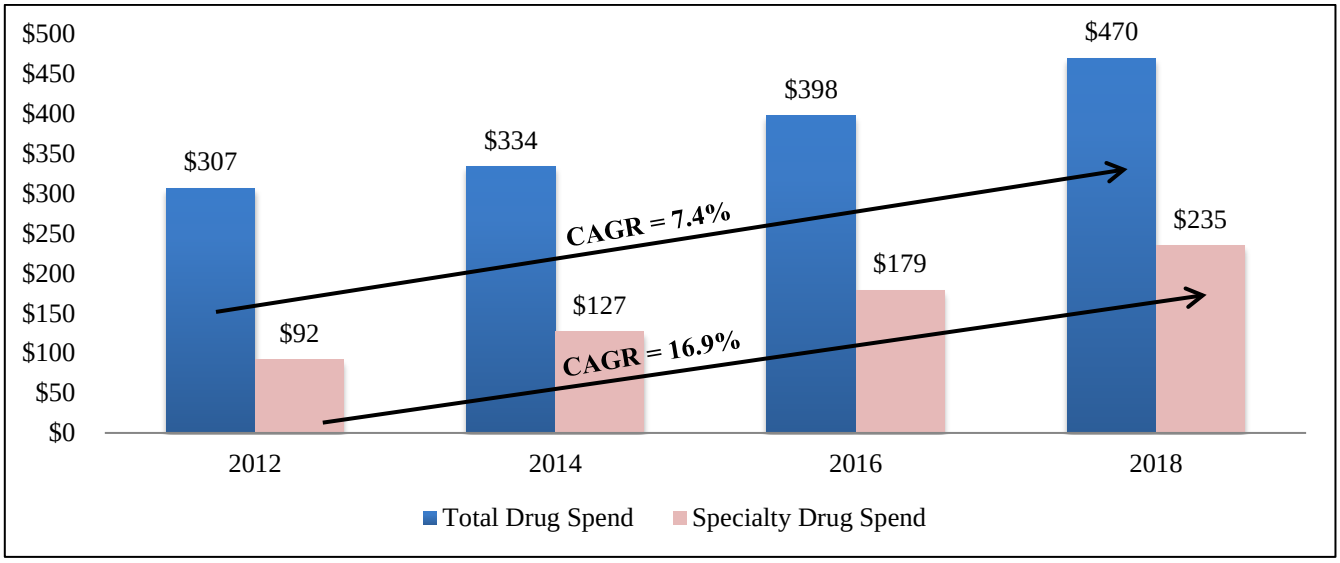
Further, biopharmaceutical companies have increased research and development investment in personalized medicine by ninety-seven percent between 2000 and 2015. Personalized medicine is treatment that is based on the molecular characteristics of the individual patient. These investments are primarily concentrated in oncology and infectious diseases and conditions that are chronic and complex in nature. While the field of personalized medicine continues to develop, the expectation is that the ability to preemptively assess and manage an individual's predisposition or reaction to a particular disease and associated treatment will lead to better outcomes than current standard approaches and medications.

Therefore, the overall rise in prescription drug trend will continue to be driven mainly by specialty drugs, which are typically classified as those drugs:

- used to treat chronic, complex and/or rare disease states.
- requiring special handling, storage, inventory and/or administration.
- that are part of an FDA-mandated Risk Evaluation and Mitigation Strategy Program (REMS).
- requiring clinical assessment to optimize safety and adherence.
- that are in limited distribution.
- that are high cost.

The Specialty drug cost trend has exhibited double digit levels for years and is expected to continue to rise rapidly into the future. As shown in **Figure 74**, overall drug spend is expected to rise at a Cumulative Average Growth Rate (CAGR) of over seven percent from 2012 to 2018, while specialty drug spend is expected to grow at a CAGR of seventeen percent over the same period.

**Part VI, Figure 74: Total Industry Drug And Specialty Drug Spend (Billions of Dollars)**[80]




Several states are considering enacting laws to limit the level of Member cost sharing for specialty drugs. For example, Maryland has limited Member cost sharing for specialty drugs to $150. It is essential that health plans and PBMs develop new strategies to ensure responsible spending, reduction in waste, and high levels of Member adherence to their specialty medications. This is the primary impetus for **RxP Element #3** within the Pharmacy Coordination Program described in the pages that follow.

[80] *Source: CVS Caremark. "INSIGHTS-Trend2014".*

**Biosimilars**

In the past, large molecule biologic medications were not subject to generic competition when patent protection expired. This is mainly due to the intricate process to synthesize biologic products. Since manufacturers are unable to make an identical copy of biologics that would meet FDA standards for small molecule generic drugs, the industry turned to biosimilars, which are highly similar molecules that create a bioequivalent effect when compared to the parent molecules. Biosimilars were available through a separate approval process in Europe since 2004, and produce discounts of twenty-five percent or more compared to the reference products.

In 2010 one of the provisions of the Affordable Care Act provided the regulatory framework for the development, approval, and sale of biosimilars. A 2014 RAND Corporation study estimates that biosimilars could produce an estimated savings of $44.2 billion on biologic drugs from 2014 and 2024. The FDA has approved four biosimilar products. Zarxio (reference Neupogen), Inflectra (reference Remicade), Erelzi (reference Enbrel) and Amjevita (reference Humira). To date, only Zarxio and Inflectra have launched to market with discounts approximately fifteen percent compared to the reference product. Erelzi and Amjevita launch dates are still to be determined. It is estimated that Biosimilars could produce overall savings of $44.2 billion between 2014 and 2024.

**Forecasting Trend for the Next Three Years**

The growth in prescription drug spend is driven by rising utilization and price inflation across brand, specialty, and generic drugs. In 2013, the Average Wholesale Price (AWP) trend was 14.4 percent, 10.5 percent, and 2.6 percent for brands, specialty, and generics respectively, which equates to an overall ingredient cost increase of 7.6 percent year-over-year, as reported by CVS Caremark (“Insights 2014: 7 Sure Things”). This was in addition to an increase in utilization of over two percent and was mitigated by a decrease in the proportion of brand vs. generic drugs being dispensed. Overall drug cost trend in 2013 increased approximately five percent when all these factors are taken into account.

Thus, the prescription drug market is characterized by a number of factors, including the sheer number of market participants, the fluidity of new products entering the market, and the overall lack of transparency in product cost and pricing. Hence, no single strategy or set of tactics is sufficient and constant. Vigilant attention to changes and emerging trends as well as upcoming events is required.

**TCCI Approach to Managing Prescription Drug Trend**

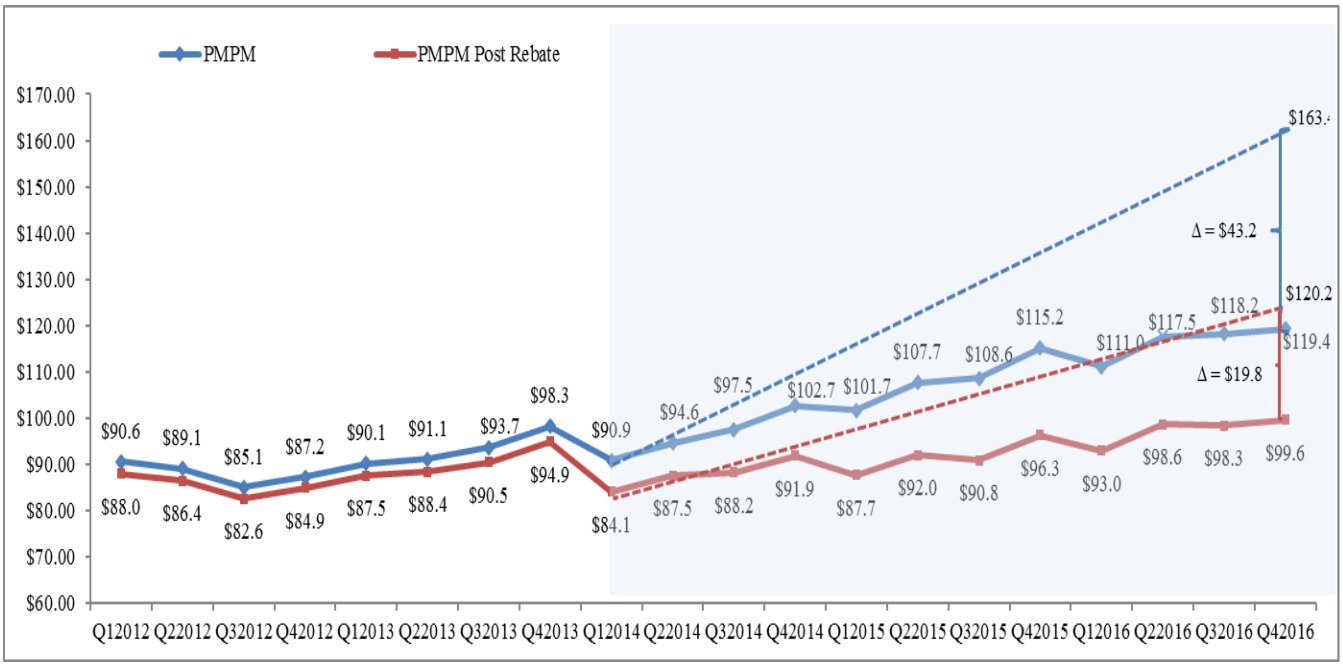
Against this background, CareFirst’s approach to pharmacy management is multifaceted and offers options to self-insured employers as to the degree of aggressiveness with which they wish to pursue control of prescription drug costs. These include the implementation of new formulary designs, extensive support for Care Coordination, and an exclusive, cost effective source of specialty drugs.

Of note, a key aspect of specialty drug management is the fact that many specialty drugs are covered under the medical benefit portion of a Member’s coverage plan, not the pharmacy benefit (some are covered under both). The cost of a specialty medication depends on a number of factors, such as site of service and who administers the service (e.g., self-administered at patient home or administered by a NP with careful physician oversight). This means that Care Coordination efforts and formulary strategies must span both the medical and pharmacy benefit portion of coverage.

**Value of Ingredient Cost Control**

Through the strategies in the RxP Program and the Program’s various Elements, CareFirst has seen a moderation in drug PMPM costs in recent years. **Figure 75** on the next page shows how the PMPM pharmacy cost changed from 2010 through the fourth quarter of 2016. Without the RxP Programs, CareFirst would have likely proceeded on the steep upward climb in costs evident through 2013. If left unmanaged, it is estimated that the trajectory for CareFirst’s PMPM cost would have been $163.40 by the end of 2016, a difference of $43.20 PMPM (or 26 percent) before rebates. This delta would undoubtedly have made healthcare premiums and pharmacy costs more unmanageable for both CareFirst and its Members.

**Part VI, Figure 75: Pharmacy Per Member Per Month (PMPM) Allowed Amount Including Impact Of Rebates 2012-2016**



## RxP Element #2: CareFirst Formulary Offerings

There are approximately 5,000 drugs (including brand, generic and specialty) on the market in the U.S. The U.S. Food and Drug Administration (FDA) categorizes all of these drugs into 158 Therapeutic Classes ranging from Analgesics to Skeletal Muscle Relaxants. There are typically multiple drug choices – often a mix of Brands and Generics – in each Therapeutic Class.

Health plans typically organize these choices into benefit coverage tiers with different cost sharing in an attempt to encourage Members and Providers to choose the least expensive option in each therapeutic class when the differences in clinical efficacy are negligible as determined by the Food and Drug Administration. As pharmaceutical manufacturers lose their patents on drugs and generics become available, major changes in pricing occur and drive large market shifts in utilization to less costly medications.

**Equivalent and Alternative Drug Choices Drive Formulary Design**

When the active ingredient in a Generic and Brand name drug is the identical molecule, the FDA considers the compounds to be therapeutically equivalent. In other cases, there are drugs with different molecular structures but with similar therapeutic effects. These are classified by the FDA as generic or brand alternatives.

For example, when the brand cholesterol drug Crestor lost its patent, it was immediately replaced on most formularies with the therapeutically equivalent generic drug rosuvastatin. Other well-known brands with generic equivalents include Ambien (equivalent zolpidem), Prilosec (equivalent omeprazole), and Prevacid (equivalent lansoprazole).

**Common Formulary Structures in the Market**

The key goal of a tiered formulary is to provide financial incentives to Members to direct demand to specific, cost effective drugs within a therapeutic class. Essentially, tiering is a strategy to drive Member and prescriber behavior by encouraging the selection of the most cost-effective medication(s) in a therapeutic class by varying cost sharing levels through copayments or coinsurance. Formularies generally consist of three to five-tiers. There is often a "Tier 0" reserved for $0 copay drugs which are generic drugs used to manage chronic diseases. **Figure 76** below provides an example of a typical four tier design.

**Part VI, Figure 76: Model Four-Tier Structure**

| Tier Number | Tier Name | Copay Amount | Drug Example |
|---|---|---|---|
| Tier 0 | Preventive / Maintenance | $0 Copay | Chantix |
| Tier 1 | Generics | $0 Copay | metoprolol |
| Tier 2 | Preferred Brand | $25 Copay | Bystolic |
| Tier 3 | Non-Preferred Brand | $45 Copay | Lopressor |
| Tier 4 | Specialty | $150 Copay | Humira |

Five tier designs generally divide generics into preferred and non-preferred categories. Some generics have multiple competing manufacturers and are purchased from pharmacies at a Maximum Allowable Cost (MAC). These drugs are said to have "MAC Pricing" or appear on the "MAC List." Other generics have less competition and are able to command a higher price, thus leading to an additional tier for generics as shown in **Figure 77** on the next page.

**Part VI, Figure 77: Model Five-Tier Structure**

| Tier Number | Tier Name | Copay/Coinsurance Amount | Drug Example |
|---|---|---|---|
| Tier 0 | Preventive/Maintenance | $0 Copay | Chantix |
| Tier 1 | Generics | $10 Copay | olmesartan |
| Tier 2 | Preferred Brand | $30 Copay | Benicareprosartan |
| Tier 3 | Non-Preferred Brand | $60 Copay | Teveten |
| Tier 4 | Preferred Brand Specialty | $100 Copay | Enbrel |
| Tier 5 | Non-Preferred Specialty | $150 Copay | Humira |

In the fourth quarter of 2016, CareFirst's average cost per brand name drug fill was $455 per fill vs. an average cost of $36 for a generic fill. This $419 difference illustrates the importance of encouraging Members and providers to select the option that provides the desired therapeutic effect at the lowest cost.

Studies have shown that a 100 percent increase in out of pocket cost for a Member (e.g., $20 copay to $40 copay) can cause significant reductions – ranging from twenty-two percent to sixty-five percent – in the use of higher cost drugs within as little as one calendar quarter. This shows how powerful tiering can be. Furthermore, seventy percent of Members who choose a lower-cost drug say they do so to save money.

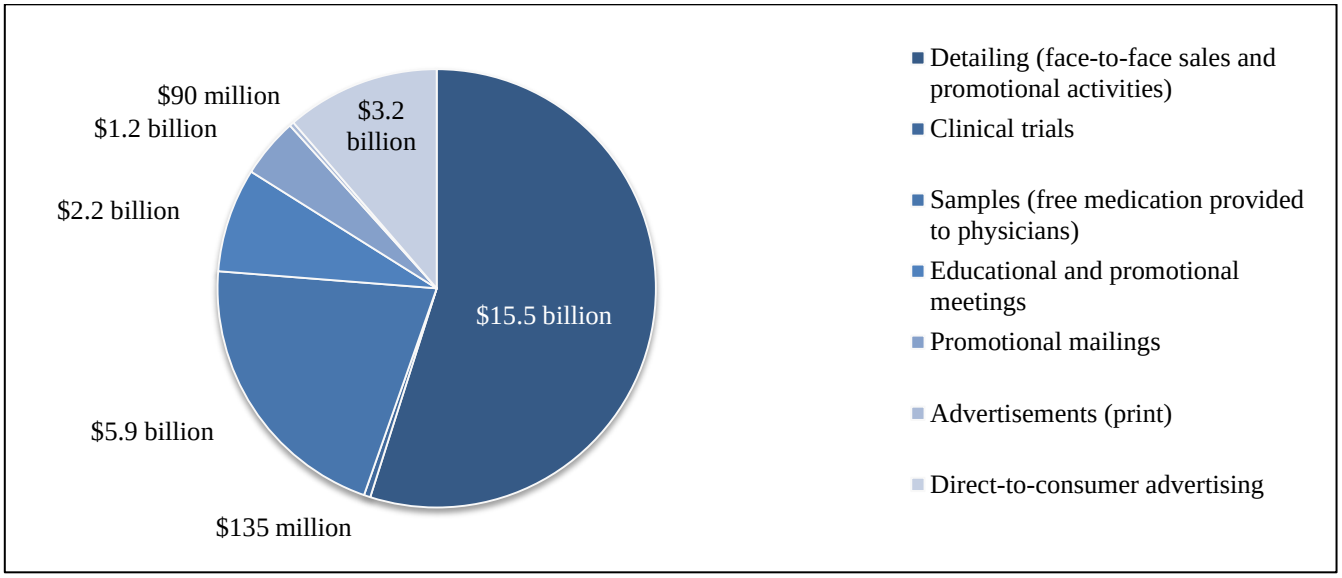
Hence, a well-constructed Formulary can drive use toward preferred products and result in substantial savings. Driving greater generic use nearly always makes sense. A formulary can also be "tuned" to encourage the maximization of rebates on brand drugs. Striking the right balance of generic utilization and rebate maximization, while minimizing Member disruption, is the hallmark of a thoughtful formulary. Utilization management techniques (i.e., prior authorization, step therapy, quantity limits, etc.) can then be added to assure that certain drugs are used only when medically necessary and only when less expensive options have been attempted first.

Improving access to cost effective drugs through benefit design also has a key clinical benefit. There are many documented barriers to medication adherence, including cost. By minimizing or eliminating this barrier to access, Members may be more adherent to their prescribed medications because of lower out of pocket expense. Maximizing adherence to chronic condition medications will limit disease progression and reduce the downstream medical spending associated with breakdowns.

**Pharmaceutical Manufacturers Endeavor to Thwart Formulary Strategies**

In response to payers' efforts to direct drug use through benefit design and utilization management programs (prior authorization, step therapy, quantity limits, etc.), pharmaceutical manufacturers have developed a number of strategies to thwart these efforts. See **Figure 78** on the next page for a breakdown of marketing expenditures by pharmaceutical manufacturers.

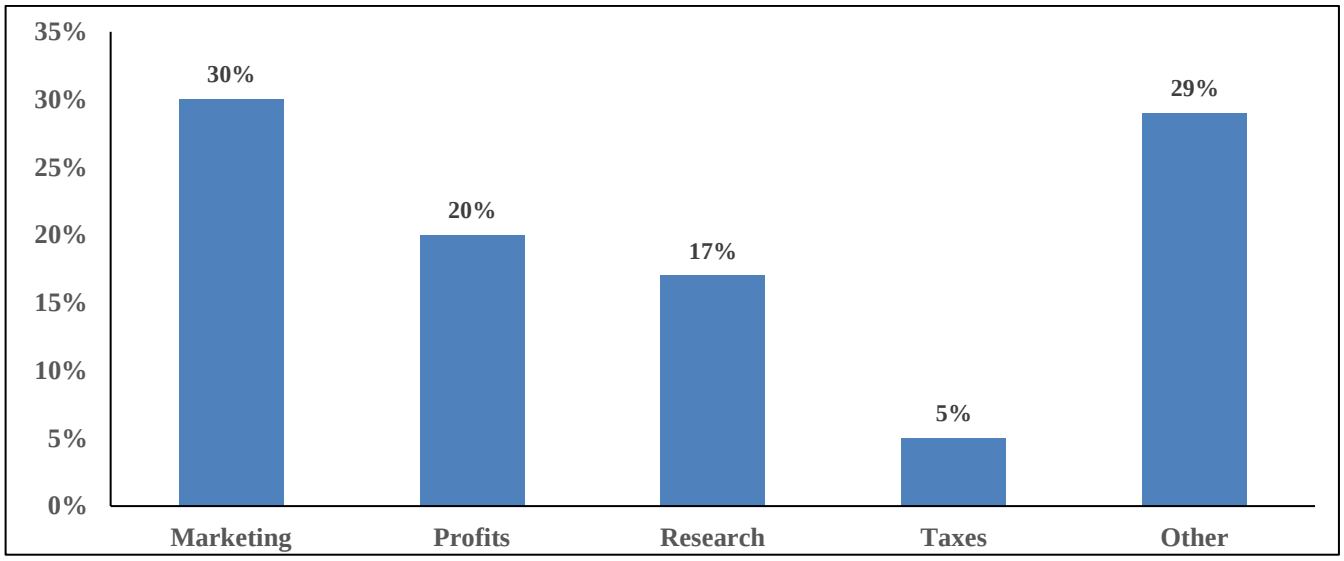
**Part VI, Figure 78: Pharmaceutical Manufacturer Marketing Expenditures, 2013**[81]




The strategies shown in **Figure 78** above are designed to create demand for specific brand products. Prescribing behavior has been correlated with the relative spending levels of pharmaceutical companies in targeted therapeutic classes. Direct to Consumer advertising has also been effective in getting up to twenty percent of patients to request an advertised drug.

As seen in **Figure 79** below, shows pharmaceutical manufacturers in the U.S. spend more on sales and marketing than on research and development. In order to thwart benefit design and tiering approaches, manufacturers have created coupons, copay cards, direct-to-Member rebates, and other financial assistance programs to steer demand for their product in their direction.

**Part VI, Figure 79: Proportional Allocation Of Revenue 2003-2015**[82]




[81] *Source: Cegedim Strategic Data, 2012 U.S. Pharmaceutical Company Promotional Spending, 2013.*

[82] *Source: http://www.washingtonpost.com/news/wonkblog/wp/2015/02/11/big-pharmaceutical-companies-are-spending-far-more-on-marketing-than-research/.*

Given the above, there are two necessary elements for effective Formulary design:

- Getting the right mix of brand and generic drugs in all Therapeutic Classes so that Members' needs can be met.
- Determining on which tier a particular drug is to be placed to properly encourage cost effective use.

**ACA Impact on Formulary Design**

Formulary designs have been greatly impacted by the introduction of the Affordable Care Act (ACA). The ACA defines how formularies should be constructed by introducing the concept of a "benchmark formulary." CareFirst's formulary is the benchmark formulary in Washington, DC and Maryland and Anthem holds the benchmark in Virginia. The CareFirst formulary is considered an open formulary with coverage for virtually every drug on the market. Anthem's benchmark formulary in Virginia is similarly open. These generous benchmarks exceed what is typical across the United States.

ACA requires that a plan must cover at least the greater of one drug in every therapeutic class or the same number of drugs in each category and class as the Essential Health Benefit (EHB) benchmark plan. Plans may go beyond the number of drugs offered by the benchmark. CMS has clarified that if the EHB benchmark plan in a state does not cover drugs in a specific category, the health plan must cover at least one drug in each class. However, health plans do not have to cover drugs on a particular tier merely because that was the tier identified in the EHB benchmark plan.

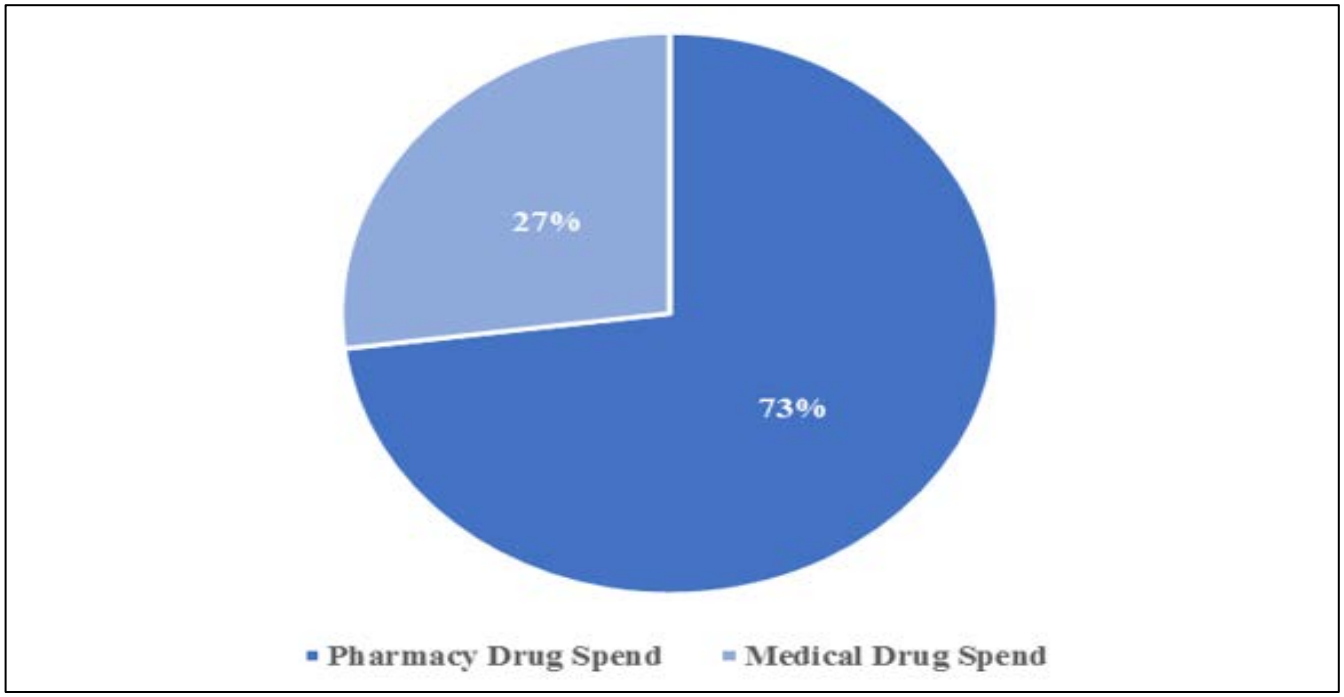
In determining which drugs to cover, a health plan's benefit design may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Insurers may, however, use reasonable medical management techniques to prevent waste or excessive usage. These typically include step therapy, prior authorization and quantity limits. The states and health benefit exchanges are responsible for monitoring health plans for their compliance with these requirements as part of their enforcement and certification responsibilities.

**CareFirst's Formulary 2006-2014**

For many years, CareFirst managed its own formulary and rebate negotiations with pharmaceutical manufacturers. At that time, the company believed that based on its scale in the region, it could negotiate the best rebates. CareFirst's scale, however, is small in comparison to a national PBM with millions of covered lives. While CareFirst's formulary was open – covering all 5,000 drugs – the rest of the industry (PBMs and CareFirst competitors) was moving in a different direction toward more restrictive formularies, including the outright exclusion of certain drugs from formulary coverage.

By 2013, CareFirst spent approximately $1.6 billion on pharmaceuticals pursuant to its open formulary. Of this, $1.2 billion was covered under the drug portion of benefit coverage and $400 million was covered under the medical benefit (mostly for certain oncology and specialty drugs). Drugs covered under the medical benefit typically are those medications that cannot be self-administered by the patient, such as injectable or infusible drugs. In 2016, CareFirst spent $2.3 billion on pharmaceuticals with 73 and 27 percent under the prescription and medical benefit, respectively.

**Part VI, Figure 80: Portion Of Spending On Pharmaceuticals In The Medical And Pharmacy Benefits, 2016**[83]




**CareFirst's Current Formulary Options**

As of January 1, 2017, CareFirst offers three formulary options for its subscribers and employer group customers. The three options are:

**Formulary 1: Open Formulary (offers coverage for the highest number of available drugs)**

This open formulary continues to offer broad, open access to over 5,000 drugs with optimized tiering to drive Member behavior and attain rebate value without the introduction of brand drug exclusions. This formulary adjusts the tier positions of some drugs to leverage CVS Caremark's manufacturer rebate contracts to the benefit of CareFirst risk and non-risk accounts. Less than 15 percent of the CareFirst's book of business still uses this completely open Formulary as of year-end 2016.

**Formulary 2: Rebate and Generic Enhanced Formulary**

This formulary is similar to Formulary 1 except that certain brand drugs and high-priced generics (for which alternatives are available) are excluded to drive higher rebates from the manufacturers whose drugs remain on the formulary. Formulary 2 is now the standard formulary for CareFirst with approximately 65 percent of Membership on this formulary. The formulary is available to ASO accounts that wish to be more aggressive in their pursuit of rebates, so the share of all CareFirst membership on this formulary is expected to grow.

This formulary excludes approximately 130 brand drugs for which therapeutic alternatives exist. All other features of Formulary 1 (e.g., tiering, number and range of cost-effective generics available, etc.) are the same. It should be noted that exclusions are only made when there are ample alternatives within the same therapeutic class.

[83] *CareFirst Health Care Analytics, 2016 Data.*

The decision to exclude products is made only after reviewing several factors, including drug class categories with several clinically interchangeable options, price inflation, manufacturer share shift strategies (including copay cards), and the ability to negotiate improved pricing for preferred product placement. When the conditions exist to consider drug exclusion, these are used in negotiations with pharmaceutical manufacturers to procure improved rebates. A higher rebate payment from one manufacturer can result in another manufacturer with an alternative drug being excluded from the formulary. This can result in increased generic utilization when compared to Formulary 1 as well.

Formulary 2 increases rebates by nearly 25 percent over Formulary 1, thereby reducing the effective level of overall spend by nearly 4.5 percent when compared to Formulary 1. The net effect on cost varies by market segment or employer group based on the starting point for generic dispensing rate, brand drug utilization, preferred vs. non-preferred utilization, etc. Approximately 85 percent of the CareFirst book of business is on this Formulary as of yearend 2016.

**Formulary 3: Generic and Rebate Maximization Formulary (Lowest Net Spend)**

Formulary 3 captures additional value by expanding brand drug exclusions to approximately 200 (from approximately 130 in Formulary 2) but maintains sufficient coverage in each therapeutic class to assure appropriate clinical care. This formulary aims to further improve utilization of generic drugs and focuses on maximization of rebate value through exclusions and tier design.

Beginning January 1, 2018, CareFirst will offer all three formulary options in a five-tier structure. This new formulary structure will be comprised of the following tiers:

- Generic
- preferred brand
- non-preferred brand
- preferred specialty
- non-preferred specialty

The new ACA Health Benefits Exchange formulary will also be aligned to a five-tier structure.

**Key Formulary Statistics**

The CareFirst formulary contains approximately 1700 brand name drugs, of which 700 have a generic equivalent. Of the nearly twelve million pharmacy claims CareFirst processed in 2016, nearly 83 percent were for generic medications. The tiering breakout above incents this generic utilization through differential cost sharing to encourage Member selection of generics. This is critically important since the average cost per generic fill in 2016 was $35.93 as compared to a branded counterpart for the same medication of $367.04.

**Evolving Formulary Strategies**

In 2017, two additional enhancements to formulary management were introduced:

- **Hyperinflation Strategy**: The first enhancement employs a hyperinflation strategy aimed at identifying drug products that have experienced significant price inflation over a specified time. Those products with readily available, clinically appropriate and more cost-effective alternatives will be targeted for either a tier change or prior-authorization requirement. Factors assessed for targeted products include: pricing, prescription volume, member impact, clinical applicability, and existing utilization management strategies. For example, if a drug price inflates by 100 percent or more when alternatives exist for the same drug, that drug will be excluded from the formulary. In the first quarter of 2017, seventeen products were targeted that had an average three-year inflation rate ranging from 160 percent to 1,531 percent. The anticipated reduction in average unit price through this strategy is 67 percent for these seventeen products.

- **Indication-based Strategy**: The second enhancement is an indication-based formulary preference that offers a more precise management strategy related to a drug's treatment indication or diagnosis and the value that therapy delivers to each individual patient. Given the growing number of new indications for currently approved drugs, using

indication-based criteria allows selection of preferred formulary options for the most cost-effective therapy to treat a given condition.

- Currently, this strategy applies to treatments for hepatitis C treatment and auto-immune drugs (specifically those used to treat psoriasis). Additional indication-based opportunities and categories will be evaluated as they emerge over time. For example, a drug like Humira is FDA approved for various arthritic conditions as well as Crohn's disease. The indication based strategy allows us to only prefer Humira for one indication, rather than both, because other less costly alternatives exist in the other indications. This forces the manufacturers to provide the deepest discounts and best prices on a granular, indication by indication level.

**Review Available for Members on Drug Choices/Needs**

Each of the three formularies provides a "safety valve" for Members who may need a certain brand drug. Any Member and their physician can point out facts related to medical need that may require them to take a particular brand name drug.

Once this information is received, the facts will be reviewed by a pharmacist. If the pharmacist deems the drug to be medically necessary, an exception is granted and the Member and physician are notified. However, if the pharmacist does not approve, the review will proceed to a physician. If the physician does not grant an exception, the Member can seek a further review via appeal up to 180 days after the determination. If the Member appeals, the subsequent review is conducted either by a different physician or an Independent Review Organization ("IRO").

**Credibility in Formulary Governance**

CareFirst uses CVS Caremark's Pharmacy and Therapeutics ("P&T") Committee to keep current with new medications. The Committee consists of 19 independent health care professionals (including 16 physicians, one of whom is a medical ethicist) practicing in a broad array of specialties and three pharmacists as the first line in formulary decisions. No member of the P&T committee is an employee of CVS Caremark.

The P&T Committee makes decisions in a non-biased, quality driven and evidence-based way. The clinical merit of each drug, not the cost, is the primary consideration. The Committee also reviews and approves how and to what extent prior authorization, step therapy and quantity limits are applied.

The Committee conducts drug reviews in a structured way. Drugs recently approved by the FDA are reviewed along with all clinical trial evidence and FDA labeling information to determine eligibility for the formulary. Prior formulary decisions are reviewed in light of the ever-changing environment and updated information. Periodically, a full review of a therapeutic class of drugs is conducted to assure the right mix of clinical options exist and to identify opportunities for ingredient cost savings or maximizing rebates. The composition of therapeutic classes is reviewed at a minimum of every eighteen months.

CareFirst maintains oversight of the P&T decision-making process through its Senior Medical Director and pharmacy team who monitor and review the actions of CVS Caremark's P&T Committee meetings and provide periodic reports to CareFirst's Pharmacy Oversight Committee. The Pharmacy Oversight Committee is composed of CareFirst physicians, community physicians, and pharmacists. This Committee reviews the actions of the CVS Caremark P&T Committee on a quarterly basis to assure alignment with local medical practice. This CareFirst review governs all decisions affecting CareFirst pharmacy benefits.

**Managing the Opioid Crisis**

It is estimated that 1.9 million people in the United States suffer from substance abuse related to opioid prescriptions. These substance abusers cost approximately $15,500 more than non-abusers. As a result, an estimated $78.5 billion is spent annually on medical and substance abuse treatment, lost work productivity and criminal justice costs. A State of emergency has been declared in Maryland due to a rise in opioid-related deaths throughout the state. CareFirst has implemented a pharmacy utilization management strategy that is designed to deter excessive opioid prescribing and inappropriate utilization. This is based on the Centers for Disease Control Guidelines for Prescribing Opioids:

- **Dose limit strategy on all opioids:** Dose limits are based on morphine milligram equivalents ("MME"), which is a method to compare the different strengths of opioid medications. This approach provides a standard way to identify

patients that may be at a greater risk for abuse or overdose. Initial limits are set at 90 MME/day, with higher doses requiring prior authorization.

- **Duration limit strategy of immediate-release opioids intended to treat acute pain:** Evidence suggests that limiting initial opioid use to the fewest number of days possible greatly reduces the likelihood of addiction. Therefore, CareFirst limits initial immediate-release opioid prescriptions to a duration of seven days. A lookback ensures this limit does not impact cancer patients, or those being treated for chronic pain.

## RxP Element #3: Pre-Authorization And Case Management For Specialty Drugs And Compounds

### Sharply Rising Cost Trends, Promising Therapies

As noted in the **Preface** to the **RxP**, specialty drugs are typically used to treat conditions that are complex, genetically caused, chronic, progressive and life-threatening. The definition of a "specialty drug" varies but is often a large molecule protein requiring injection or infusion or oral drugs that are very expensive or require special handling. Members using them often need expert clinical support. Specialty drugs are almost always prescribed by specialists.

Members taking specialty drugs often take a number of other drugs as well. In 2016, only 1.2 percent of all CareFirst Members were taking specialty drugs yet this small population accounted for over 40 percent of all drug spending. Specialty drugs are covered under both the Members' pharmacy benefit plan as well as the medical benefit plan. A complete picture of spending necessitates combining these two portions of coverage.

Introductions of new specialty drugs can cause dramatic shifts in cost over short periods of time. CareFirst's spending on specialty drugs covered under Members' pharmacy benefit jumped over 14 percent between Q1 and Q2 2014, largely due to the introduction of one new drug to treat Hepatitis C (Sovaldi). This trend persisted with the introduction of Harvoni in 2015. It has since begun to ebb in 2016 as the initial wave of demand was satisfied.

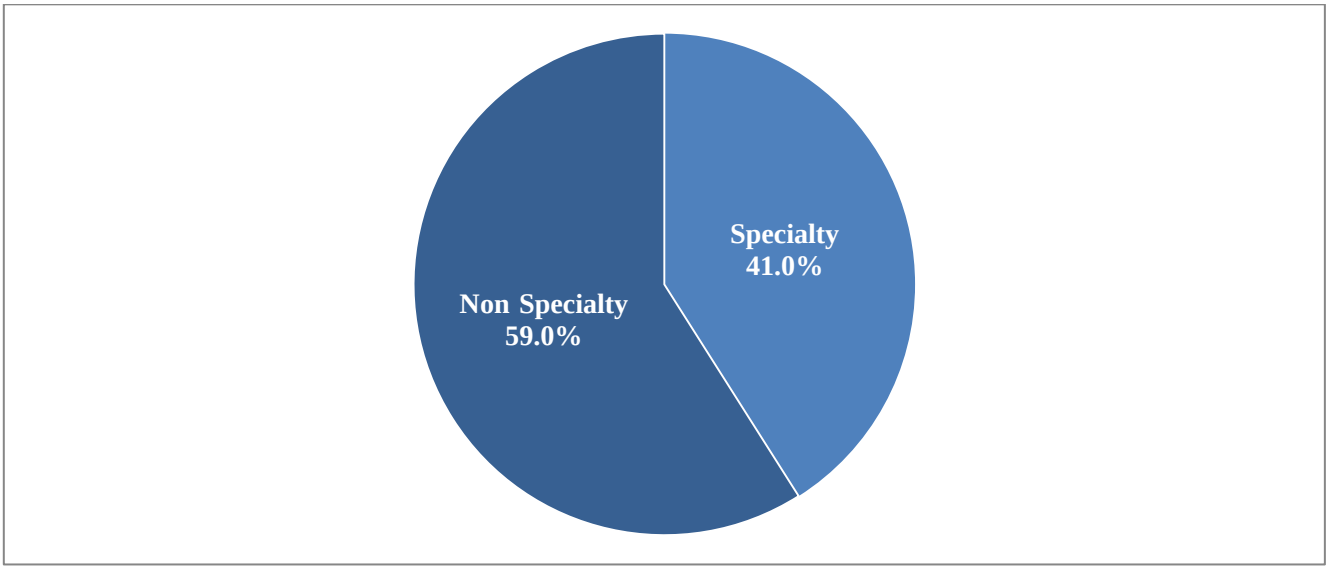
An increasing portion of specialty pharmacy costs are covered under the medical benefit portion of coverage. When taken together, the percentage of spending on specialty drugs as a percentage of all spending on drugs is shown in **Figure 81** on the next page. However, the specialty pharmacy spend is now greater under the medical benefit portion of coverage than the pharmacy portion of coverage, as shown in **Figure 82**.

Because the medical benefit portion of coverage now accounts for 53 percent of specialty spend, CareFirst expanded the RxP program to manage spend in the medical benefit. Drug requests are prospectively validated for appropriateness of use according to nationally accepted, evidence-base medical guidelines to ensure that the right therapy is being prescribed for the right patient, for the right medication and at the right time. Through an electronic PA system, drug requests are clinically reviewed in an efficient manner with auto-approval capabilities for quicker responses to providers.

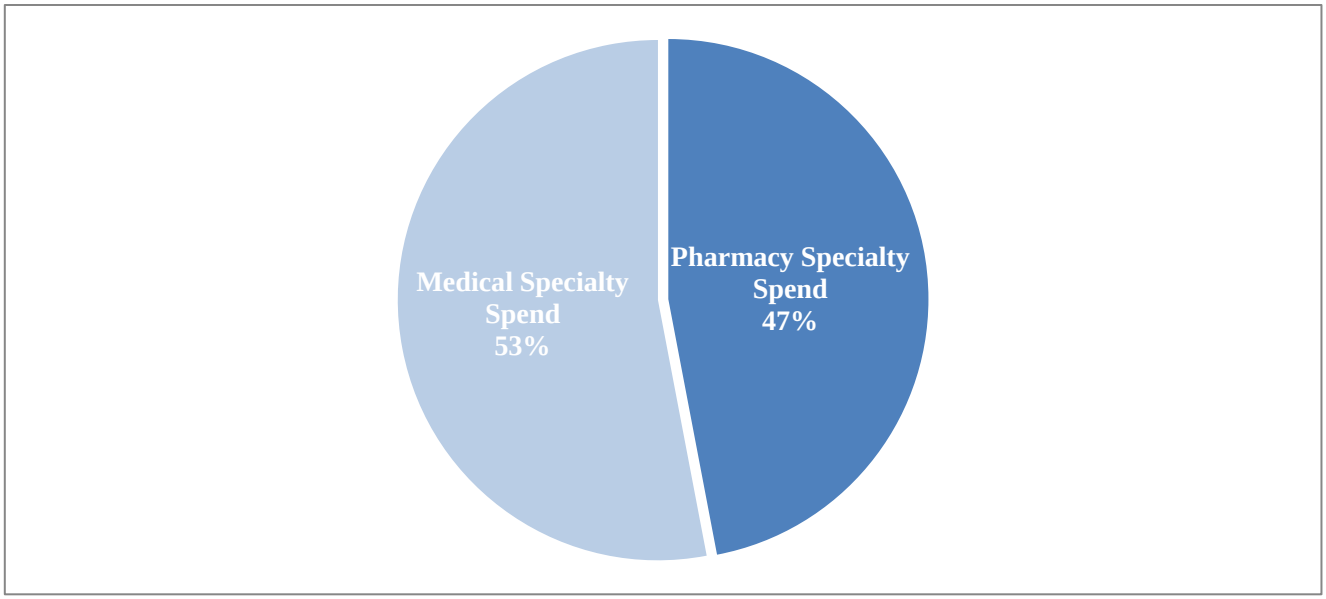
After a drug has been administered and a claim is submitted for payment, medical claims are reviewed to ensure the dose administered and the quantities billed are in accordance with FDA-approved labeling. The application of claims review and editing reinforces the PA and helps manage drug claims that are billed above clinically appropriate quantities to control overall costs and utilization.

Providers who believe they should be covered for a specific claim that has been changed during review can submit an appeal with additional documentation supporting their case.

**Part VI, Figure 81: Specialty Spending As A Share Of Total Drug Spending, 2016**[84]




**Part VI, Figure 82: Portion of Specialty Spending Under The Medical Benefit vs. Pharmacy Benefit Coverage, 2016**[85]




For many self-insured employer groups, the era of the carved-out pharmacy benefit (i.e., where pharmacy benefits are with a different carrier or PBM than the medical benefit) may be coming to an end due to the combination of increasingly costly specialty drugs and the need to manage them across both Pharmacy and Medical benefits. In order to assure the best cost and quality outcomes, the artificial separation between these two benefits must be removed.

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[84] *CareFirst Pharmacy Management, 2016 Data.*
[85] *Healthcare Analytics, CareFirst, 2016".*

As costly as specialty drugs can be, it must be recognized that Members who use them also use the overall health care system at higher rates and are among the costliest to treat. Yet, these new specialty drugs offer enormous promise for those struggling with certain diseases. Specialty drugs can help to slow disease progression, and improve the quality of life for Members beyond what is possible without them. The diseases treated with specialty medications are estimated to affect five percent of the world's population. This relationship is shown in **Figure 83** below which displays a representative list of conditions commonly treated with specialty medications.

**Part VI, Figure 83: Total Annual Cost Per CareFirst Member Using A Specialty Drug, 2016** [86]

| Disease State | Annual Cost Per Member (Medical and Rx)* |
|---|---|
| Hemophilia | $162,462 |
| RSV | $144,306 |
| Renal Disease | $112,558 |
| Hepatitis C | $96,010 |
| Cancer | $82,569 |
| Multiple Sclerosis | $69,295 |
| Crohns / Colitis | $57,508 |
| Rheumatoid Arthritis | $46,195 |
| Growth Hormone | $44,845 |
| Fertility | $24,846 |
| **Members may be receiving multiple specialty drugs and may appear in more than one condition summary.* | |

The promise of specialty drugs is only realized if they are used properly. If not, the Member will almost certainly experience a breakdown incurring the cost of both the drug and the breakdown. Avoiding this scenario requires substantial support, often beyond the support offered by the prescribing physician. This is the impetus for the creation of the **Pre-Authorization and Case Management and Compounds, RxP Program Element#3** for specialty drugs.

It is important to note that pre-authorization can serve a dual purpose: to monitor and to control. In many instances, the pre-authorization is required to help control the use of unnecessary medications when clinically efficient, less costly alternatives exist. The pre-authorization in these instances drives utilization to less costly agents. More often, pre-authorization is a tool to help monitor the use, since less costly alternatives may not exist. By requiring a pre-authorization for the medication, CareFirst can then outreach to the Member and ensure the right care management is provided to aid the Member through their condition.

**Specialty Drugs in the Pipeline**

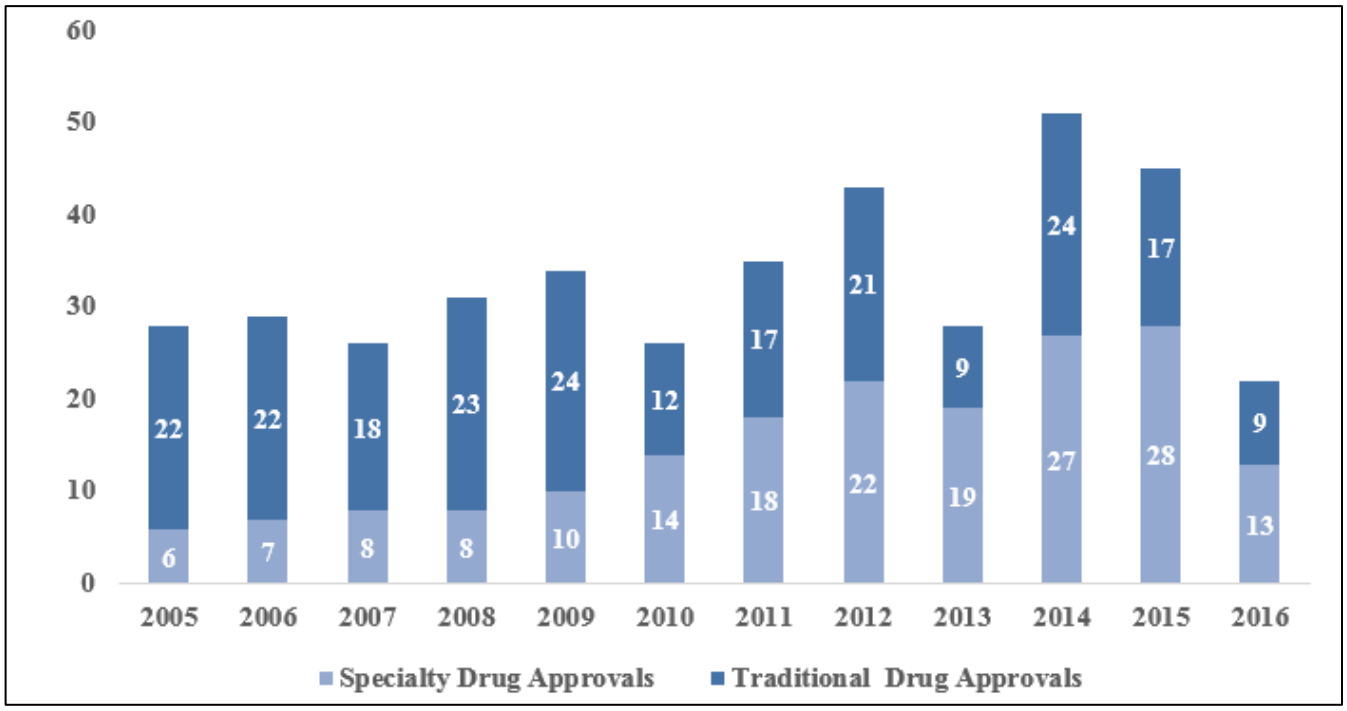
In placing specialty drugs in perspective, it is useful to recall – as noted earlier – that we are only just at the beginning of the specialty pharmacy era. As **Figure 84** shows, the number of specialty drug approvals as compared to traditional drug approvals has steadily risen since 2005. Currently, more specialty drugs are approved by the FDA annually than traditional drugs and this trajectory is expected to continue.

As shown in **Figure 84**, specialty drug approvals have surpassed traditional drugs in the past five years and, based on the FDA pipeline, this will continue. From 2017 to 2019, there are 541 anticipated new drugs, of which 220 are specialty, covering 101 specialty indications. This signifies not only an increasing pipeline of drugs, but also a growth in the percentage of specialty

[86] *CareFirst Health Care Analytics, 2016 Data: Members with both a Medical and Pharmacy benefit.*

medications. Furthermore, as drugs are designated for specific clinical indications, roughly 30 percent of supplemental indications were added for specialty from 2005 - 2014.

**Part VI, Figure 84: Specialty Drug Approvals vs. Traditional Drug Approvals – 2005 to 2016**[87]




**Specialty Spending Today is Concentrated in 10 Disease States**

To place the cost of specialty drugs in fuller perspective, a focus on one area – the drug costs for CareFirst Members with Rheumatoid Arthritis – is illuminating. All CareFirst Members are paying $5.68 more each month in their premiums just to cover Specialty Medications for the 0.002 percent of Members with this disease. If there ever were a case to be made for providing broad-based support to a small, identifiably ill population, this would be it.

In this vein, it is useful to understand that 10 diseases account for 94 percent of the overall CareFirst specialty pharmacy drug spend. These are shown in **Figure 85** on the next page.

[87] *PriceWaterhouseCoopers. Medical Cost Trend: Behind the Number 2016, Chart Pack. Available at:* https://www.pwc.com/us/en/health-industries/behind-the-numbers/assets/pwc-hri-medical-cost-trend-chart-pack-2016.pdf. *Accessed on May 25, 2017.*

**Part VI, Figure 85: Total CareFirst Specialty Drug Cost Of Top 10 Diseases**[88]

| Disease State | Pharmacy Drug Cost | Medical Drug Cost | Total Specialty Drug Cost |
|---|---|---|---|
| Oncology | $64,399,544 | $84,708,463 | $149,108,007 |
| Rheumatoid Arthritis | $123,007,668 | $0 | $123,007,668 |
| Multiple Sclerosis | $80,351,230 | $13,175,245 | $93,526,475 |
| Hepatitis C | $54,713,918 | $0 | $54,713,918 |
| Biologic Disease Modifying Agents | $0 | $52,421,454 | $52,421,454 |
| Psoriasis | $23,208,862 | $4,306,423 | $27,515,285 |
| Immune Deficiencies and Related Disorders | $168,997 | $25,636,580 | $25,805,577 |
| Neutropenia | $3,235,452 | $20,053,991 | $23,289,443 |
| Hemophilia | $29,534 | $21,255,981 | $21,285,515 |
| IVIG | $0 | $16,856,054 | $16,856,054 |
| **Total** | **$349,115,205** | **$238,414,191** | **$587,529,396** |
| *** HIV, Transplant, and Renal Disease Drugs are excluded.** | | | |

Given this concentration, **RxP Element #3** consists of Care Coordination processes tailored to the unique needs of Members within each of these disease categories. The top 10 disease states are monitored quarterly for any changes in cost. These tailored efforts have been purposefully designed to be integrated with CareFirst's PCMH Program and other relevant TCCI Programs.

**Identifying the Specialty Rx Population**

**RxP Program Element #3** begins with timely identification of CareFirst Members who have been prescribed a specialty drug.

The two means of identification are as follows:

- **Analysis of pharmacy and medical claims data:** CareFirst evaluates claims data to identify Members who may benefit from the Program. When a Member is so identified, the Member is referred to the Program through the Service Request Hub.

- **Service requests placed by CareFirst Care Coordinators (LCCs and CCMs)**: A Service Request from an LCC or CCM through iCentric's Service Request Hub will refer these Members.

**Case Management Provided to Identified Members**

CVS Health provides dedicated specialty pharmacy case managers who are trained in the diseases and specialty drugs that are preauthorized through the CareFirst website or that are referred through the iCentric Service Request Hub. This offering is separate from, but complementary to, case management services provided by CareFirst to Members in the general medical field. The individualized Care Coordination provided by CVS Health case managers occurs after a detailed initial phone assessment with the Member and incorporates monitoring health status, education and joint goal setting. This includes:

- A comprehensive assessment at Program initiation
- Enhanced access via convenient mail order shipping or pick-up at dedicated local pharmacies
- Injection training coordination
- Disease-specific and co-morbidity education
- Enhanced disease self-management skills
- Disease complication prevention

[88] *CareFirst Health Care Analytics, 2016 Data.*

- Drug optimization
- Medication and dosing appropriateness determination
- Education on medication adherence and side effects
- Inventory coordination to reduce drug waste
- Drug to drug interaction review
- Refill reminders
- 24x7 telephonic access to a specialty pharmacist to provide support for Member questions

Members with the most complex diseases or therapies receive these additional services including:

- A uniquely tailored Care Plan incorporating all clinical factors.
- Integration of the Care Coordination Team with the PCP via iCentric to assure continuity of care in all settings.
- Linkage to CCMs, BHCMs, or LCCs as needed for Members managing other comorbidities in addition to the condition requiring specialty medications.
- 24 x 7 telephonic access to a specialty pharmacist or nurse to provide support for Member questions or help with the management of side effects to reduce the possibility of ER visits or hospitalizations.

Up to date documentation on each Member in this Program is available within the iCentric Member Health Record based on daily updates made by the CVS Case Management system.

The Care Coordination plans for each of the top 10 disease conditions above are designed to provide the right level of support for the disease condition and therapy used. In some cases, a pharmacist with expertise in the drug being used is sufficient. In other cases, the pharmacist is supplemented with a registered nurse with expertise in the disease.

***Continuous Monitoring***

A pharmacist (or pharmacy support representative) contacts Members prior to the fill of their initial specialty drug prescription, and regularly (typically every thirty days, depending upon need) thereafter to reassess the safety, appropriateness and efficacy of therapy, as well as the Member's ability to manage their therapy. The frequency of this contact is tailored to the specific disease and therapy of the Member. Regular check-ins focus on the following areas:

- Side effects and Member concerns
- Challenges with self-injection, including injection site reactions
- Difficulty adhering to the therapy regimen

***Specialty Rx Care Coordination with Condition Specific Management Registered Nurses***

In order to achieve the best outcomes, some diseases and therapies call for a broader skill set to support the Member. This involves teaming a CVS registered nurse trained in the Member's disease condition with the pharmacist. This allows for a focus not just on the Member's set of prescribed drugs, but on the specific needs of the Member that must be addressed to assure the highest possible level of adherence and therapeutic value.

A CVS RN is involved in situations in which an assessment and ongoing monitoring can make a significant positive impact on Member health outcomes, compliance with their prescribed plan of care and knowledge about their condition. Members receive a description of the Program and are asked when they are available to speak with an RN. Since the Program requires Member consent, the Member can opt out. If the Member opts out, they are reminded of the Program's availability at the time of their next specialty medication refill.

To assure coordination with other TCCI Programs, CVS RNs have 24 x 7 access to the Member's full CareFirst CCC or CCM Plan (if there is one) as well as the Member Health Record. This enables timely and coordinated clinical intervention to further improve medication and Care Plan adherence, to reduce ER visits and hospitalizations, resulting in an improved quality of life and overall decrease in health care costs for the Member. When CVS RNs interact with Members, notes of their interactions are visible to all treating providers and to others on the Member's care management team via the Member Health Record.
When a Registered nurse is involved in the case, additional elements are considered including:

- The Member's psychosocial status and other disease-specific and general wellness topics.
- The Member's enhanced understanding of the signs and symptoms of disease progression.

Based on the interaction with the Member, the Nurse:

- Augments the coaching available and points the Member to additional training / educational resources.
- Collaborates with and informs CCC and CCM Care Coordinators.
- Adds additional notes and documentation to the Member Health Record of the Member.

Upon completion of the assessment, the Registered nurse will create a Disease Management Plan (DMP) and define the outreach frequency based on the patient's clinical condition, severity of the disease, and current medication regimen. Clinically-relevant information from the DMP will be integrated into the Member's overall Care Plan. The Member will then be stratified into one of three disease-specific levels of intervention categories: High, Medium or Low.

- **High:** Calls may occur as frequently as daily, based on case complexity.

- **Medium:** Calls occur intermittently in addition to scheduled risk assessments (for example, Member who is not as stable as he or she has been in the past may require an additional outreach call before the next scheduled risk assessment). Outreach frequency may be weekly or multiple week intervals, depending on individual patient needs and the duration of therapy.

- **Stable (Low):** Calls are made at least once every six months as long as the Member is stable.

Updates resulting from calls are uploaded into the iCentric Member Health Record on a daily basis.

***Specialty Pharmacy Care Coordination for Members Diagnosed with Cancer***

Patients diagnosed with cancer often have a complex course of disease that can be further exacerbated by the medications used to treat the disease. Many chemotherapy medications used to cure or slow the progression of cancer can cause debilitating side effects that may destabilize the Member and possibly increase ER visits and hospitalizations. In particular, there is a cohort of chemotherapy drugs that have severe side effects. Patients on these drugs can benefit from a high touch Care Coordination Program.

In this Program, specially trained Oncology nurses coordinate with other TCCI Programs to provide longitudinal case management that will augment the Member's overall Care Plan. The Oncology Specialty Coordination Program provides an array of supportive services that include:

- Providing an additional avenue for Members to discuss and ask questions about their diagnosis, treatment and possible side effects with a specially trained nurse.
- Assisting with medication management of side effects to help prevent costly ER visits or hospitalizations.
- Addressing individual treatment-related needs.
- Helping manage co-morbid conditions that overlap with side effects of chemotherapy.
- Assisting with Member support/coping skills.
- Providing emotional support of spouse/caregiver.
- Coordinating resources with treating Oncologist.
- Promoting active communication between the Member and Oncologist.
- Discussing palliative care, end of life and hospice options, if needed.

The Oncology Care Management Program has shown that aggressive outpatient support for Members with side effects caused by certain chemotherapy can change the pattern of ER/hospital utilization and achieve better treatment outcomes.

**Total Chronic Myeloid Leukemia Care Program ("CML") with Enhanced Digital Communication**

Members newly diagnosed with CML and starting treatment for the first time require high touch to ensure that they make their follow up appointments and take their medication as prescribed. The Total CML Care Program is designed to reduce costs by encouraging the use of generics and enhanced care through patient-centric clinical services. Patient-centric services include an Oncology Pharmacist Care Team to provide drug management and ongoing patient support in addition to care management nurses to help patients overcome barriers to therapy and achieve durable remission on therapy.

**Coordination with CCM, CCC, BHCC**

If a Member is on a Specialty Drug and has other complicating factors requiring attention, such as a Behavioral Health issue, the likelihood of breakdown is far greater. Thus, a more holistic approach to the Member's overall needs is required.

In such cases, the CVS RN will directly contact the CareFirst CCM or LCC, where appropriate, with condition information and patient health or compliance concerns, to provide a two-way feedback loop enabling the sharing of critical and/or proactive information with other Members of the health care team.

Members with one or more co-morbidities are typically enrolled in other CareFirst TCCI Programs. Based on need, the CVS RN may refer Members to the full array of TCCI Programs via a dedicated referral line. This includes:

- direct telephonic warm transfer to Behavioral Health Support (Magellan) for urgent situations;
- direct telephonic transfer to the TCCI intake Complex Case Management group; and
- alerts through iCentric to the Member's PCP and LCC.

**Tracking and Reporting on Progress and Results**

Pharmacy and medical claims data on each Member in the Specialty Pharmacy Coordination Program ("SPC") is incorporated into the SearchLight Reports that are available to the PCP, and Panels and treating specialist(s) of the Member. This gives treating providers the ability to see what treatment course is being followed and what results are being obtained for each Member.

Over time, SearchLight data enables the tracking and monitoring of results for cohorts of Members with specific diseases or conditions. This is critical to evaluating the larger patterns associated with emerging results.

**Exclusive TCCI Integrated Specialty Pharmacy**

Since specialty drugs are expensive and their effectiveness depends on Member adherence to the prescribed regimen, the best possible arrangement for specialty drug management is to coordinate their use and to assure that the total care needs of the Member are coordinated as parts of a comprehensive plan that is monitored closely by qualified professionals as described above. In order to benefit from the value of these coordinative services, all prescriptions for specialty drugs must be filled at a set of exclusive (to CareFirst) designated CVS Caremark pharmacies that are integrated with the TCCI Program Array.

Better outcomes (both clinical and financial) are derived from the avoidance of breakdowns. This is accomplished through the actions of the highly-engaged pharmacists and nurses described above who are an integral part of the operation of the exclusive CVS specialty pharmacy. These professionals enhance the Member's understanding of their medication, anticipate problems, assess psycho-social issues that could impact adherence, support the management of side effects, and are available to answer the Member's questions. Improved adherence results in a reduction of costly breakdowns.

In contrast, if a Member receives their specialty drug from multiple or alternative sources (separate from the exclusive CVS pharmacy) the effectiveness of **RxP Element #3** is greatly reduced. Engagement statistics through 2016 show Members are three times as likely to engage with the care management nurses described above when filling a prescription through the exclusive CVS specialty pharmacy.

The laws governing the use of an exclusive specialty pharmacy vary by State and, in some cases, by product line. For example, Maryland PPO contracts must maintain an open specialty network until 2016, regardless of the benefits of concentrating Care Coordination activities in one specialty pharmacy. Nevertheless, Maryland HMO contracts may use an exclusive specialty

pharmacy and this is already reflected in the TCCI Program. In the District of Columbia, all risk groups use the CVS designated exclusive pharmacy. Virginia prohibits the designation of exclusive specialty pharmacies for risk groups.

**Standards Related to Member Engagement and Frequency of Contact**

Upon receipt of a prescription for a specialty drug by the CVS Health exclusive Specialty Pharmacy, a pharmacy technician specializing in Member Engagement (Engagement Specialist), nurse or other pharmacy team Member will attempt to seek to call the Member up to six times within a twelve-week period to secure their Engagement. This occurs before the prescription is filled for the Member. After the 12-week period, the SPC Program staff member will call every three to four weeks for up to six months until the Member makes a decision regarding participation.

Members not referred through the Specialty Pharmacy (i.e., those identified through other methods) are sent an introduction letter. Once identified, an Engagement Specialist or nurse initiates calls seven days after the letter is sent. From that time onward, the call pattern and timing/cadence mirrors that described above.

Upon receipt of the prescription for a specialty drug by the CVS Health exclusive Specialty Pharmacy, a Pharmacy Services Representative introduces the Program when speaking with the Member about the delivery of the medication. The RN is notified of the introduction and begins outreach to the Member within days of notification or at a time specified by the Member. If the RN does not reach the Member on the first attempt, additional attempted calls are made by an Engagement Specialist. Once the Engagement Specialist reaches the Member, the call is transferred to a nurse. Six attempts to reach the Member are made proactively.

Once engaged, the RN interacts with the Member based on the acuity level established in the previous call. Call frequency typically occurs two to four weeks after the prior call but can be as long as six months after the previous call, if warranted. The RNs refer Members to the CareFirst CCM or CCC Programs, based on nursing judgment. At the time of the referral, the RNs collaborate with an LCC or CCM, as necessary, regarding additional follow up. In addition, Members are reminded during refill interactions that the RN is available to speak with them. A warm transfer is offered, if desired.

**Additional Considerations for Specialty Drugs Covered by the Medical Benefit**

Care management services provided to Members through the **RxP Program, Element#3** are the same regardless of whether the services are covered under the Member's Medical or Pharmacy benefit. But, there are two additional considerations for management of specialty drugs under the Medical benefit that are addressed by CareFirst's approach to specialty drug management. These are described below.

***Site of Care Alignment for Infusion Services***

In most cases, infusions can be administered in a physician's office, patient's home, or ambulatory infusion center. This is far less expensive and usually more convenient for the Member than the outpatient setting. The hospital outpatient setting is recognized as one of the costliest options for specialty infusions with costs up to three times higher compared to non-hospital outpatient settings. Site of service management is one of the proven solutions for controlling these costs.

Often, administration of intravenous immune globulin ("IVIG") and select autoimmune infusions can be carried out in a non-hospital based setting. Hospital based setting is approved only if medical necessity criteria are met at the time of prior authorization. In addition, CareFirst benefit designs encourage the use of the most cost effective settings – with less cost sharing for non-hospital based sites.

Upon receipt of a prior authorization, a nurse contacts the provider to discuss the various options for the Member's infusion therapy. Outreach is then conducted to educate the Member about the benefits available to them for an alternative site of care and help with the transition to a lower cost setting. The transition is made in concert with the provider and Member, facilitating the best cost, convenience, and clinical outcome. CareFirst and Member savings are generated when the Member chooses a more cost-efficient location.

**A Holistic Approach to Specialty Drug Case Management**

In summary, Members beginning a course of specialty drugs are most reliably identified through pre-authorization. This process not only assures that the Member is a good candidate for the therapy based on available medical evidence, but also collects information about the Member that helps to assure accurate, effective support.

Pre-authorization also provides notice to the specialty drug case managers that a new Member will require outreach. This allows a pharmacist and nurse to become involved in the case at the time of the first treatment, rather than waiting to be notified when the claim arrives sometime later and therapy is already under way.

Further, with use of an exclusive specialty pharmacy where permitted by law, CareFirst is able to assure an integrated experience for the most at-risk Members which starts with the preauthorization of their drugs to all aspects of their compliance and adherence through ongoing monitoring.

Finally, through pre-established daily data feeds that populate the Member Health Record and CCC/CCM Care Plans with timely data from CVS Health, the progress of Members on specialty drugs can be carefully monitored and made available to all treating providers.

**Combating Inappropriate Drug Compounding Through Prior Authorization**

Drug compounding is a process in which a pharmacist alters or combines multiple ingredients to create a distinct drug or dosage. These "designer" compounds are outside of the usual bounds of clinical appropriateness or regulatory oversight.

Compounded drugs make up one to three percent of the $300 billion prescription drug market.[89] There is growing concern in the industry with compounding pharmacies that mail large numbers of prescriptions to individual patients or facilities in multiple states without the same good manufacturing practices (GMP) that drug manufacturers must follow.

Drug compounding is regulated by state boards of pharmacy, which have varying laws from state to state. There are several reasons for concern with compounded medications including:

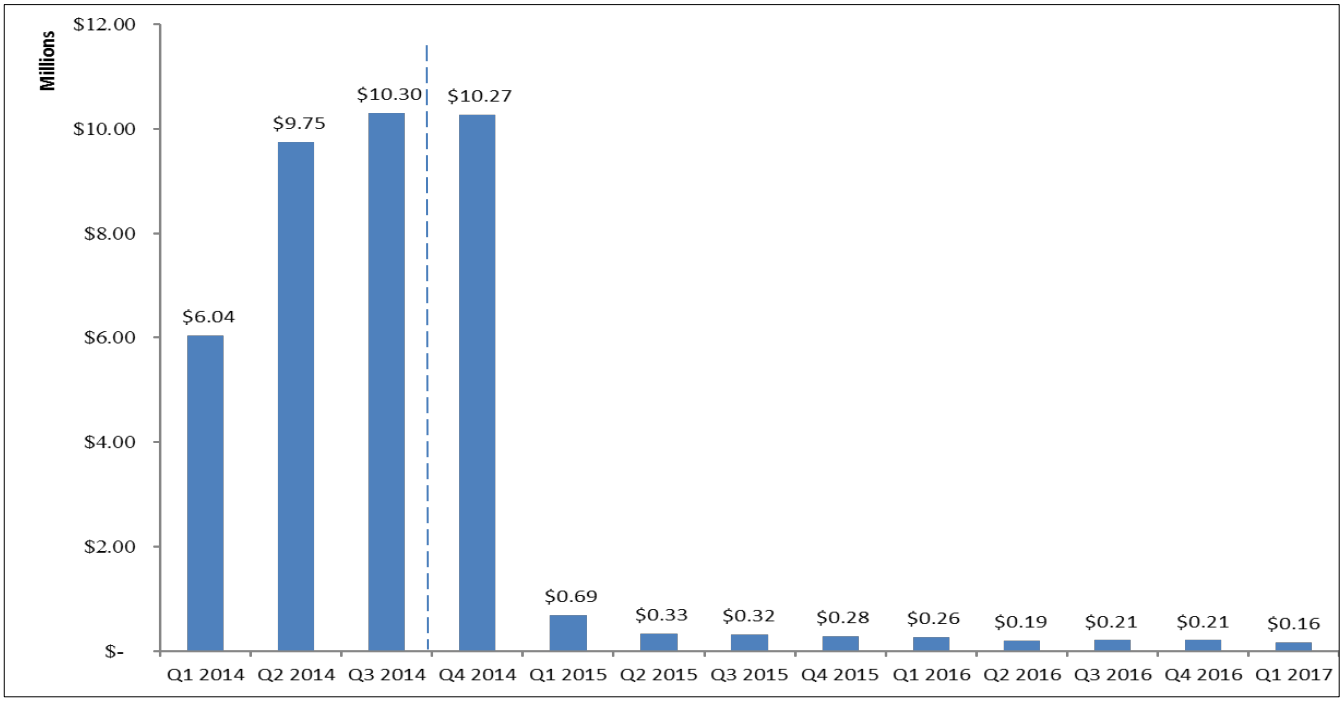
- No clinical trials to prove the compound is safe or effective
- No FDA requirement for stability testing
- No requirement to provide patient information on appropriate use
- Higher blood levels of active ingredients compared to commercially available products
- No post-manufacture monitoring requirements

There has been an unprecedented increase in the dispensing of compounded drugs despite these safety concerns. From 2007 to 2014 a five-fold increase in compounded prescriptions[90] occurred. Similarly, CareFirst experienced a rapid rise in compound prescription spend during the same period. In an effort to combat these unprecedented expenses, CareFirst adopted a compound drug strategy in December 2015 that resulted in drastic reduction in utilization, as well as, expense (see **Figure 86** on the next page).

[89] *(n.d.). Retrieved from http://www.amedisys.com/assets/pdfs/care_transitions_amedisys.*

[90] *CompPharma. "Compounding is Confounding Worker's Compensation." White Paper. 2014. http://comppharma.com/CompoundDrugResearch.pdf.*

**Part VI, Figure 86: CareFirst Prescription Compound Spend 2014-2017[91]**




Historically, much of the cost associated with these compounds was attributed to bulk powders, which can increase the ingredient costs considerably. Many of the compounds submitted to CareFirst in 2014 had three or more ingredients, further increasing the overall cost of the product. During 2014, compound prescription claims had an average cost of $3,534.76, compared to $86.80 in 2016 with the most expensive compound submitted costing $16,667.63 in 2014 versus $3,010 in 2016.

Many of the ingredients in these compounded prescriptions are available in commercially available products that have been tested and approved by the FDA at a significantly lower cost. Safety concerns, together with these exploding costs, have prompted CareFirst to develop a strategy for controlling the use of compounded drugs.

CareFirst excludes all compounds containing:

- Drugs with no FDA approved indication
- Drugs for cosmetic use
- Drugs for performance enhancement
- Hormone therapy for Menopause or Androgen decline

In late 2014, CareFirst began to require a Prior Authorization for all compounds greater than $300. To combat pharmacies trying to split bill the compound and get around this limit, CareFirst also limits Members to one unique compound per month. The compounding strategy was integrated with the Fraud, Waste, and Abuse Program to monitor the top compound prescribers for troublesome prescribing patterns.

Based on results through 2017, CareFirst's prior authorization program continues to effectively shield accounts and Medical Care Panels from the vast majority of the prior annual spend for compounded drugs. In 2016, the average compound spend

[91] *Source: CareFirst Pharmacy Management, 2016.*

per month was only $72,500. Yet, the strategy continues to allow access to compounds with safe and effective ingredients. CareFirst believes this strategy will keep compound spending at appropriate levels going forward.

In response to a new trend seen in the marketplace like compounding, CareFirst developed a prior authorization strategy to address increasing use of topical lidocaine products. Over the past year there was a 120 percent rise in utilization and quantities of lidocaine or lidocaine-containing medications. This is cause for concern for both safety and financial reasons. Because lidocaine can cause life-threatening heart arrhythmias, the increase in use and quantity is of significant clinical concern. The prior authorization will impose a quantity limit on the amount of lidocaine that is covered by CareFirst.

## RxP Element #4: Behavioral Health Pharmacy Coordination

Medication coordination for Members who have Behavioral Health disorders is intended to promote the safe and effective use of their medications. This coordination requires close alignment among the Member, treating physician, pharmacist and BHCCs to connect Members to the appropriate TCCI Program to best meet their needs.

Currently, more than 260,000 CareFirst Members have a Behavioral Health or Substance Abuse diagnosis and 17,000 pharmacy Members use psychiatric medications in a given year. Effective and systematic medication management is a key part of the recovery process and/or on-going support for people who have Behavioral Health disorders.

Medications used to treat behavioral disorders, such as Depression, Schizophrenia, Bipolar Disorder, Anxiety Disorder, and Attention Deficit Hyperactivity Disorder (ADHD) are among the most complicated pharmaceuticals on the market today due to unpleasant side effects, importance of adherence, potential for abuse, and the individualized dosage of these medications. Effective management requires each Member and his/her care team to determine the right medication, right dose, and ideal treatment plan to ameliorate symptoms effectively while meeting the Member's individual needs and medical situation.

Careful oversight of medications used to treat these conditions can have a positive impact on outcomes, helping Members and physicians avoid costly hospital encounters and fragmented care that ultimately reduces costly breakdowns. Members with Behavioral Health conditions often suffer from co-morbid medical conditions and demonstrate a higher overall Illness Burden Score, higher average costs, and higher utilization of costly hospital services (ER visits, admissions and readmissions) than the overall CareFirst population.

For example, among Members with ADHD, nineteen percent had an ER visit and ten percent had a hospital admission in the last year. Some of the key characteristics of this population compared to the CareFirst population without a Behavioral Health or Substance Abuse diagnosis are shown in **Figure 87** below and **Figure 88** on the next page.

**Part VI, Figure 87: Analysis Of CareFirst Population With Behavioral Health And Substance Use Disorder (BSD) Diagnoses, 2016**[92]

| All Behavioral Health Categories | Members | | Average IB Score | Debits PMPM | Admits Per 1,000 | 30-Day Readmits |
|---|---|---|---|---|---|---|
| **Illness Band** | **#** | **%** | **#** | **$** | **#** | **%** |
| Advanced/Critical Illness | 14,516 | 5.5% | 11.66 | $4,569 | 1,246 | 34.4% |
| Multiple Chronic Illnesses | 46,456 | 17.5% | 2.98 | $1,243 | 244 | 17.2% |
| At Risk | 60,666 | 22.9% | 1.44 | $592 | 79 | 22.6% |
| Stable | 119,248 | 44.9% | 0.58 | $250 | 12 | 18.7% |
| Healthy | 24,471 | 9.2% | 0.18 | $126 | 4 | 8.6% |
| **Total** | **265,358** | **100.0%** | **1.77** | **$718** | **134** | **26.7%** |

[92] *CareFirst Health Care Analytics, 2016 Data.*

**Part VI, Figure 88: Population Without Behavioral Health And Substance Use (BSD) Diagnoses, 2016[93]**

| All Behavioral Health Categories | Members | | Average IB Score | Debits PMPM | Admits Per 1,000 | 30-Day Readmits |
|---|---|---|---|---|---|---|
| **Illness Band** | **#** | **%** | **#** | **$** | **#** | **%** |
| Advanced/Critical Illness | 50,673 | 2.3% | 11.47 | $4,360 | 702 | 17.2% |
| Multiple Chronic Illnesses | 173,352 | 7.9% | 2.93 | $1,085 | 152 | 2.5% |
| At Risk | 265,263 | 12.0% | 1.43 | $482 | 44 | 0.8% |
| Stable | 685,817 | 31.1% | 0.54 | $179 | 3 | 1.4% |
| Healthy | 1,028,115 | 46.7% | 0.09 | $39 | 0 | 2.2% |
| **Total** | **2,203,220** | **100.0%** | **0.89** | **$322** | **35** | **8.9%** |

In addition to ensuring that Members are effectively being treated by prescription drugs, CareFirst has an interest to address issues of prescription abuse, worrisome prescribing patterns that do not align with treatment guidelines, Member adherence problems, or "drug seeking" behavior from Substance Abuse patients that is often difficult to recognize and avoid.

The combination of these Member and physician challenges spurred the creation of the **Behavioral Health Pharmacy Coordination Program RxP Element #4**. The Program relies on pharmacy claims data and Member medical history to identify patterns or triggers that place Members or physicians at risk of medication mismanagement. Once identified, BHCCs work with these Members and their physicians to connect these Members to the most appropriate care management programs or other interventions.

**Drug Triggers for Behavioral Health Conditions with Medication Treatment**

A small number of conditions make up the majority of Members with Behavioral Health diagnoses as illustrated in **Figure 89** on the next page. Of these, the Behavioral Health Pharmacy Coordination Program focuses on five persistent conditions where medications are highly used.

Medications work differently for different individuals, often with varying duration of treatment, drug choice, dose, combination, and side effects. Many patients require treatment with several of these medications to achieve symptom relief. For these conditions, BHCCs and Case Managers can play a valuable role in evaluating the treatment plan, monitoring compliance, avoiding unpleasant side effects, and ultimately increasing the likelihood of medication effectiveness.

[93] *Source: CareFirst Health Care Analytics, 2016 Data.*

**Part VI, Figure 89: Members With Behavioral Health Conditions By Condition, 2016**[94]

| Condition | Total Members | |
|---|---|---|
| | Number | Pecent |
| Depression | 107,496 | 40.5% |
| Anxiety Disorder | 86,300 | 32.5% |
| Neuroses | 66,019 | 24.9% |
| Substance Abuse | 17,953 | 6.8% |
| Bipolar Disorder | 17,049 | 6.4% |
| Antisocial Personality Disorder | 5,016 | 1.9% |
| Psychoses | 4,636 | 1.7% |
| Obsessive Compulsive Neurosis | 3,941 | 1.5% |
| Autism | 3,224 | 1.2% |
| Schizophrenia | 1,831 | 0.7% |
| Eating Disorders | 1,134 | 0.4% |
| **Total** | **265,358** | **100.0%** |

CareFirst has identified a list of Behavioral Health and Substance Abuse medications that typically indicate a need for intervention. A sample list of these drugs is represented here:

**Depression** is most commonly treated with antidepressant medications. The most popular types of antidepressants include: fluoxetine (Prozac), citalopram (Celexa), sertraline (Zoloft), paroxetine (Paxil), and escitalopram (Lexapro), venlafaxine (Effexor), duloxetine (Cymbalta), and bupropion (Wellbutrin). Side effects such as headache, nausea, and sleeplessness or drowsiness are common in the first few weeks of use and safety risks arise when Members are not compliant with their treatment plan.

**ADHD** occurs in both children and adults and is commonly treated with stimulants such as methylphenidate (Ritalin), amphetamine (Adderall), and dextroamphetaime (Dexedrine, Dextrostat). Side effects are often minor, but can be dangerous in rare cases among young adults. Prescription abuse is also a growing concern with this class of drugs.

**Substance Abuse** treatment medications are helpful during detoxification and can also become an essential component of an ongoing treatment plan for opioid addiction. Effective medications include methadone (Dolophine or Methdose), buprenorphine (Subutex), and naltrexone (Depade, Revia, and Vivitrol). As a general class of drugs, opioid addiction medications are tightly controlled and have a high potential for abuse.

**Bipolar Disorder**, also called manic-depression illness, is commonly treated with mood stabilizers, sometimes in combination with antidepressants or antipsychotics. Common medications to treat Bipolar Disorder include lithium, olanzanpine (Zyprexa), aripipraxole (Abilify), risperidone (Risperdal), clozapine (Clorazil) and lurasidone (Latuda). Side effects are strong, and a Member's treatment plan often needs to be frequently changed or adjusted to be effective. Treatment works best when it is continuous, and Member adherence is critical.

**Schizophrenia** is treated with antipsychotic medications, and some of the more commonly used medications include chlorpromazine (Thorazine), haloperidol (Haldol), risperidone (Risperdal), olanzapine (Zyprexa), and clozapine (Clozaril). Long-term medication use is typically required for Members with Schizophrenia, sometimes triggering a relapse where symptoms return or get worse.

**Pharmacy Data Enables Rapid Identification**

Pharmacy claims data is timely, very actionable and reveals a great deal about the conditions and diagnoses of Members. Pharmacy data can identify Members needing treatment for Behavioral Health and Substance Abuse that are also in other

[94] *CareFirst Health Care Analytics, 2016 Data. IB score as of December 2016. / Excludes Medicare Primary Members.*

TCCI Programs. CareFirst monitors pharmacy claims and Behavioral Health and Substance Abuse diagnoses – effectively serving as an early warning system for the identification of emerging risks in the population.

The Behavioral Health Pharmacy Management Program uses criteria-based flagging of Member or provider medication use patterns that indicate a high risk of breakdown and seeks to apply corrective measures proactively. The Program draws on clinical understanding of the integration between medical, mental health and pharmacy in order to develop appropriate criteria resulting in referrals to other TCCI Programs designed to address these risks.

Additionally, CVS Health and CareFirst scan pharmacy claims data to identify Members and providers for possible intervention by the following patterns as defined by CareFirst and its care partners. These include:

1. **Side Effect Management and Drug-Drug Interactions**

    - Combinations of drugs likely to exacerbate side effects of antidepressant medications
    - Polypharmacy drug-drug interactions for Members being treated with behavioral health medications

2. **Adherence Concerns**

    - Missed refills, particularly for Member with newly prescribed drugs
    - Dose checks for newly prescribed Members to minimize side effects
    - Back-to-back scripts for similar drugs suggesting change in treatment plan due to adherence or drug effectiveness concerns

3. **Prescription Drug Abuse**

    - Multiple scripts for the same or similar drugs from different prescribers and different pharmacies
    - High refill frequency outside of recommended guidelines

4. **Vulnerable Populations**

    - Contra-indicated medications for women during and after pregnancy
    - Injectable and oral antipsychotic use
    - Antidepressant use in young adults
    - ADHD medication abuse in young adults
    - High risk medication use among older adults with potentially many co-morbid chronic conditions in addition to Behavioral Health condition

5. **Prescriber Non-compliance with Established Guidelines**

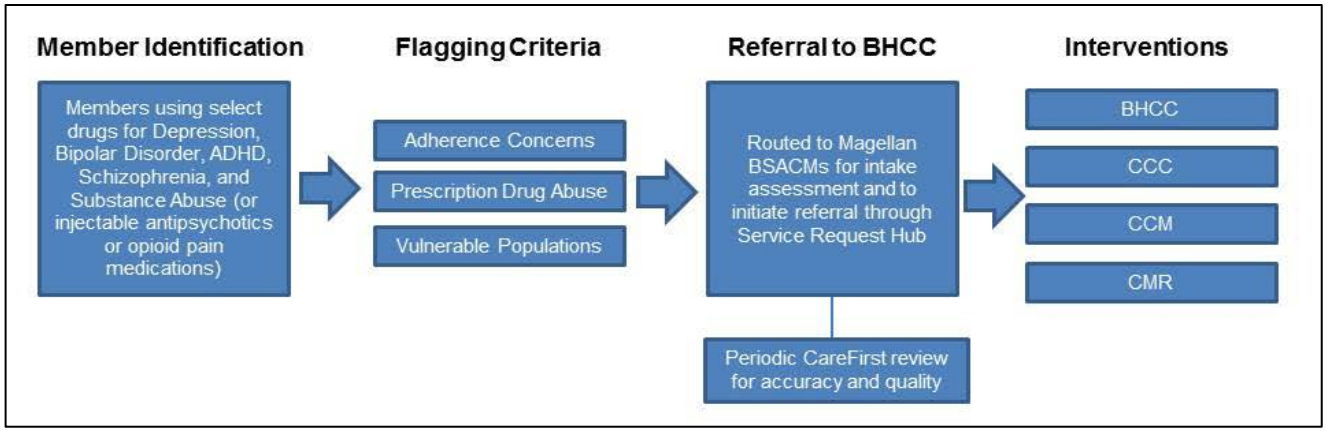
    - Providers who demonstrate prescribing patterns outside of evidence-based guidelines for ADHD medications

**Referral to TCCI Programs**

The Behavioral Health Pharmacy Program serves as the central source for identifying Members, who could benefit from TCCI Programs through targeted use of the CCC, CCM, and BSD TCCI Programs as illustrated in **Figure 90**.

Once identified, Members whose use patterns have been flagged for further attention are submitted for evaluation by Magellan BHCCs where Members are evaluated via an intake assessment, and are connected with the right TCCI Program to meet their needs. BHCCs in turn, initiate referrals through the iCentric Service Request Hub to the appropriate TCCI Program, as necessary. The documentation included as part of the Service Request details the reason why the Member was identified (e.g., presence of medical drug prescription likely to exacerbate side effects of anti-depressant).

**Part VI, Figure 90: Making The Connection - Identification And Referral Of Members To TCCI Programs**

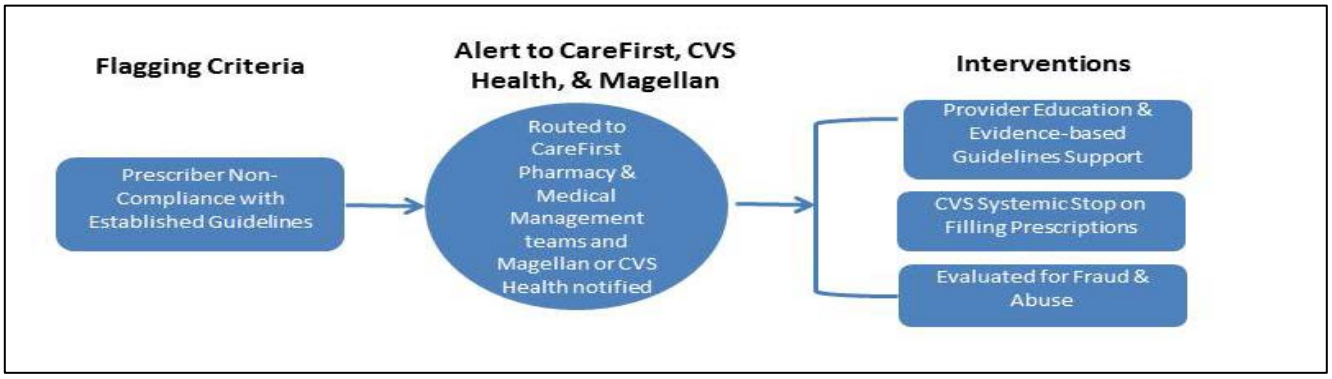



**Prescriber Tracking and Interventions**

Prescribers of substance abuse, opioid, and ADHD medications described above are tracked and trended to identify outliers. Pharmacy claims are scanned for worrisome prescribing patterns not in compliance with established guidelines. Once identified, CareFirst Pharmacy and Medical Management teams work closely with LCCs, CCMs, as well as BHCCs to respond to these alerts through provider education and intervention as a first step, or may recommend a systemic stop on filling prescriptions from a prescriber in the case of opioid medications.

**Figure 91** below shows the possible interventions used when errant prescribing patterns are identified.

**Part VI, Figure 91: Identifying Non-Compliant Prescribing Patterns For Intervention**




***Prescription Drug Abuse***

In an effort to reduce prescription drug abuse in the behavioral area, an analytical approach to identify "pill mill" prescribers, identifies physicians and other prescribers who prescribe an extremely high number of controlled substances relative to other practitioners with similar listed specialties. Once identified, CVS Health reviews the case and may put a systematic stop on filling prescriptions from these clinics, or institute provider education to expose the patterns to the provider as a "first warning".

Through the CMR Tier II program, pharmacy claims data is monitored for high numbers of controlled substances, multiple prescribers, multiple pharmacies, excessive use and high total claims cost for these medications. Cases that require heightened attention are referred from CVS Health to CareFirst and reviewed by an interdisciplinary team comprised of CareFirst medical directors, pharmacies, and Magellan healthcare team members. These Members are referred to Magellan for behavioral health coordination, CareFirst case management, or their prescribers are notified of the Member's controlled substance utilization.

### *ADHD Medication Abuse*

Data profiling in the area of ADHD identifies physicians with prescribing patterns outside of accepted guidelines for medications used to treat ADHD in adolescents. CareFirst sends letters to these prescribers encouraging them to follow current guidelines for ADHD medication use. Medications used to treat ADHD can, like any medication, be abused in a variety of ways, particularly among young adults. Responsible prescribing among physicians plays an important role in reducing the likelihood of ADHD medication abuse.

### *Medication Assisted Therapy for Substance Abuse*

Medication Assisted Therapy (MAT) for the treatment of substance abuse disorders is effective in helping Members sustain recovery from opioid addiction. Educational material on the identification and management of substance abuse disorders, along with Magellan resources are sent to providers at least annually. Prescribing trends are assessed by tracking the number of providers utilizing buprenorphine for the treatment of opioid addiction. Magellan may reach out to buprenorphine prescribers for inclusion into their network.

### *Adherence for Behavioral Health Medication and Management of Antipsychotic Medications*

A Member-focused service carried out by Magellan works with Members who are taking high risk antipsychotics are non-adherent to their behavioral health medication, especially for classes of drugs where stopping a medication without notifying the prescribing physician can be dangerous. Members are engaged by Magellan's BHCCs who with prescribing physicians as necessary and appropriate.

## RxP Element #5: Comprehensive Medication Review And Drug Advisories

**Understanding the Need for a CMR**

Prescriptions are the most important treatment method in healthcare today. In 2016, over, thirty two percent of all CareFirst coverage spending was for prescription drugs – the highest category of spending and for more than is separately spent on inpatient or outpatient hospital care. Prescription drug use has increased steadily for the past decade, and four out of five Americans who visit the doctor leave with a prescription. Many people do not consult adequately with their doctor or pharmacist about how to safely take their over-the-counter and prescription medications resulting in millions of preventable medicine errors each year.

CareFirst's Comprehensive Medication Review and Drug Advisories Element offers two Tiers of review to support safe and cost-effective medication use as outlined below:

**CMR Tier I**: Reviews Members with complex medication related issues through direct pharmacist interventions. This is a case specific, highly involved intervention with a pharmacist and a physician, engaging to assess the most complex Members' needs.

**CMR Tier II**: Identifies on an automated basis, Members with evidence of possible gaps in care, medication adherence, and appropriateness of drug regimen issues. These are flagged as drug advisories to the attention of the Member's PCP. Unlike CMR Tier 1, the CMR Tier 2 program operates on the high volume of claims. With 33,000 pharmacy claims per day at CareFirst, the CMR Tier 2 program is able to improve quality and yield significant savings without the involved process required of the Tier 1 program.

**Comprehensive Medication Review Program (CMR) Tier I**

The effectiveness of prescription drug treatment is heavily contingent upon a Member's adherence. Yet, the average medication adherence rate is fifty percent or less and is even lower for individuals on multiple medications. Over 145,000 CareFirst Members are on eight or more prescriptions at the same time, often prescribed by as many as six or more specialists as well as their PCP. Major consequences of poor adherence to medication regimens are poor health outcomes and increased health care costs. The CMR Program (Tier I) aims to serve Members who are on multiple medications prescribed by multiple providers and, therefore, place the Member at risk due to a lack of knowledge about why and how to take their medications.

Designed for Members with the highest potential medication-related issues, CareFirst's Comprehensive Medication Review Program (CMR) Tier I engages a specialized pharmacist to address the question, "What medications should the Member be on?" While the CMR Tier 1 program does not operate to produce savings (and may increase cost due to greater adherence and eliminating gaps in drug therapy), the importance of prescription management for the chronic or multi-chronic Member warrants a distinct focus that is tightly integrated with the PCMH Program to assure their drug treatments are optimized. For identified Members on large numbers of medications or on medications that create instability in the Member, the CMR Program reviews and seeks to mitigate the issues that arise when multiple medications are prescribed for a single Member, including:

- Poor compliance and confusion
- Duplicative prescribing patterns across multiple providers (PCPs, specialists, ER physicians)
- Dangerous drug-to-drug interactions
- Adverse side effects from multiple prescriptions
- Compounding effects of using medications to treat the effects of other medications

Perhaps the most important focus is on Members who have been prescribed medications that when taken as directed, make them unstable, depressed or psychotic.

**Figure 92** below shows the number of CareFirst Members on eight or more drugs at any given time over a three-month period, along with their average Illness Burden Score (IBS) and total spend.

**Part VI, Figure 92: Member Multi-Drug Use And Costs In 2016[95] (Data Spans A Three-Month Interval)**

| Number of Prescribed Drugs | Number of Members | Avg IBS | Total Medical Cost | Total Pharmacy Cost | Total Cost | Total Cost PMPY |
|---|---|---|---|---|---|---|
| 8+ Drugs | 145,526 | 4.36 | $2,024,411,817 | $864,657,016 | $2,889,068,833 | $19,852.60 |
| 9+ Drugs | 110,697 | 4.75 | $1,760,914,236 | $747,049,047 | $2,507,963,283 | $22,656.11 |
| 10+ Drugs | 84,221 | 5.17 | $1,518,215,854 | $637,625,257 | $2,155,841,110 | $25,597.43 |
| 11+ Drugs | 64,289 | 5.61 | $1,309,301,184 | $543,465,547 | $1,852,766,730 | $28,819.34 |
| 12+ Drugs | 49,057 | 6.09 | $1,125,501,724 | $456,585,907 | $1,582,087,631 | $32,249.99 |
| 13+ Drugs | 37,417 | 6.58 | $956,546,014 | $381,646,614 | $1,338,192,628 | $35,764.30 |
| 14+ Drugs | 28,809 | 7.07 | $814,331,065 | $319,637,873 | $1,133,968,938 | $39,361.62 |
| 15+ Drugs | 22,017 | 7.63 | $696,173,267 | $262,544,947 | $958,718,213 | $43,544.45 |

Members who are prescribed multiple medications generally have multiple chronic conditions and diseases. They often experience frequent breakdowns, resulting in hospital-based care and suffer complications due to the side effects of the medications they take. For Members with Behavioral Health or Substance Abuse issues along with chronic or severe medical issues (which is common), lack of compliance is a heightened concern. Additionally, adverse interactions are more likely to occur when a Member takes a number of medications concurrently. For example, the prescription drug Nexium, used to treat acid reflux, has been shown to reduce the effectiveness of Plavix, an anti-blood clot medication, when the two are taken together.

Further complicating the situation is the fact that the prescribing physician often lacks knowledge of the medications other physicians are prescribing for the Member, potentially resulting in overdosing or the triggering of dangerous drug-to-drug interactions. The combination of these factors creates a compelling need to conduct a medication review for those Members whose sheer number or type of medications heightens the dangers of complication, breakdown and non-compliance.

**Finding the Right Members for a CMR**

Members are identified as needing a CMR based on the clinical judgement of LCCs and CCMs who interact with a Member and the Member's PCP. Upon activation of every care plan, LCCs and CCMs evaluate each Member for a CMR referral. Factors such as the number of medications, number of prescribing providers, high DVS, multiple unstable conditions, presence of adherence problems, potential drug-drug interactions, and financial barriers are some of the considerations used when selecting Members for a CMR.

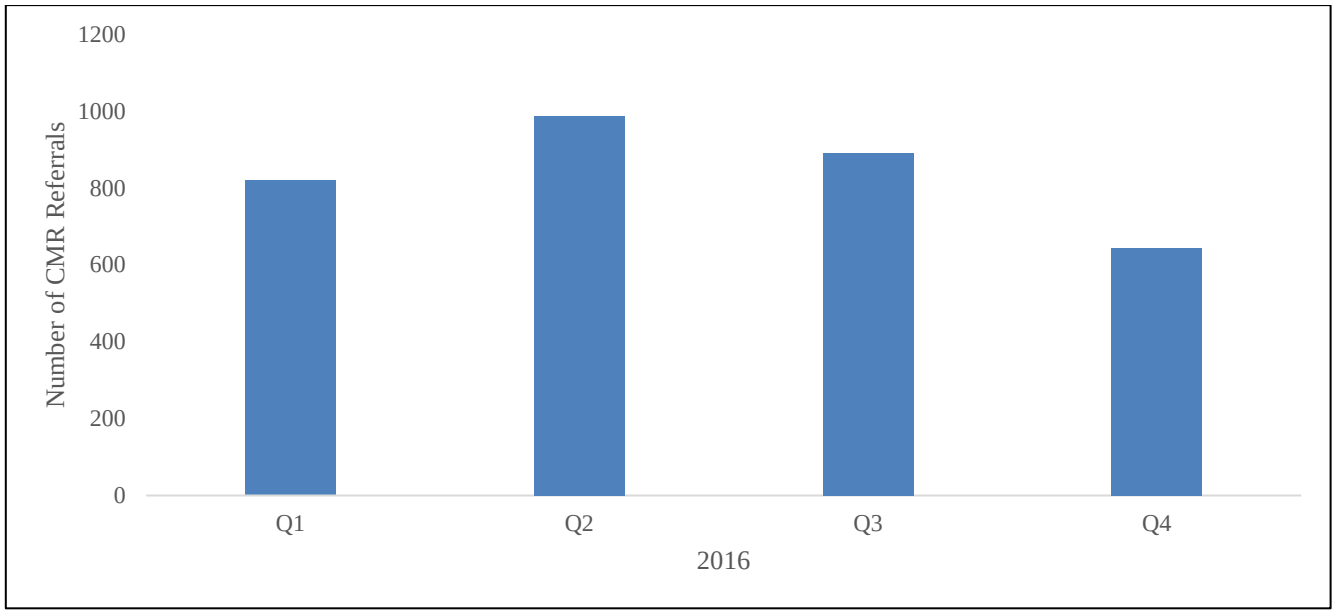
Identifying Members with a high level of likely instability requiring heightened review, monitoring, and possible intervention is a core goal in selecting Members for a CMR. Through the first quarter of 2017, Members referred for a CMR had an average of more than 12 prescriptions. This signifies that the referral process through the LCCs and CCMs is identifying the most complex Members who could benefit from a high touch service like the CMR.

LCCs use clinical judgement to bring forward potential CMR candidates for discussion with the PCP. Upon the PCP's review and agreement, a Member is referred for a CMR. In addition, CCMs identify Members in Complex Case Management plans that could benefit from a CMR.

[95] *Source: Healthcare Analytics, CareFirst, 2014.*

In 2016, LCCs and CCMs referred a total of 3,343 Members for a CMR. **Figure 93** represents the volume of CMR referrals by quarter for 2016.

**Figure 93: Number of CMR Referrals by Quarter in 2016**




**Finding the Right Mix of Drugs and Dosages**

As already noted, the central question for the Members who are selected for a CMR is, "What should they be taking?" To properly answer this question, a CMR is conducted by a pharmacist who systematically reviews all the medications the Member is taking.

The CMR Program recognizes that often the most frequent interaction people have with the health care system is with their pharmacist. This interaction forges a trusting relationship between Members and pharmacists, positioning the pharmacist as the best party to conduct a CMR and to provide clarity into the total list of drugs prescribed by the various physicians who are the prescribers for a Top 50 list Member. Furthermore, a pharmacist's point of view spans and is complementary to the specific medical knowledge of each of the various prescribing physicians involved.

**Sending Lists of Members for CMR**

Members selected for a CMR are routed through the iCentric Service Request Hub to CVS Caremark on a daily basis where specialty trained, dedicated pharmacist conduct each CMR. All CMR referrals are tracked through the Service Request Hub to assure completion and proper follow up action.

Members in a high-deductible health plan are typically not targeted until they have met their deductible. This is to ensure these Members are not charged for the cost of a CMR which cannot be waived (under IRS rules) for Members in high deductible plans. For all other Members, CareFirst uses the Cost Share Waiver to provide this service at no cost to the Member.

**The Tier I CMR**

The first step in a CMR is for the pharmacist to understand what medications the Member is on. Claims history helps clarify most of the Member's medication list. However, since Members may take over-the-counter (OTC) medications or pay for prescriptions without using their coverage benefit, claims history alone cannot completely reveal the Member's medications. Therefore, medication reconciliation is necessary. In the case of Members in CCC, CCM or BSD Care Plans, this reconciliation

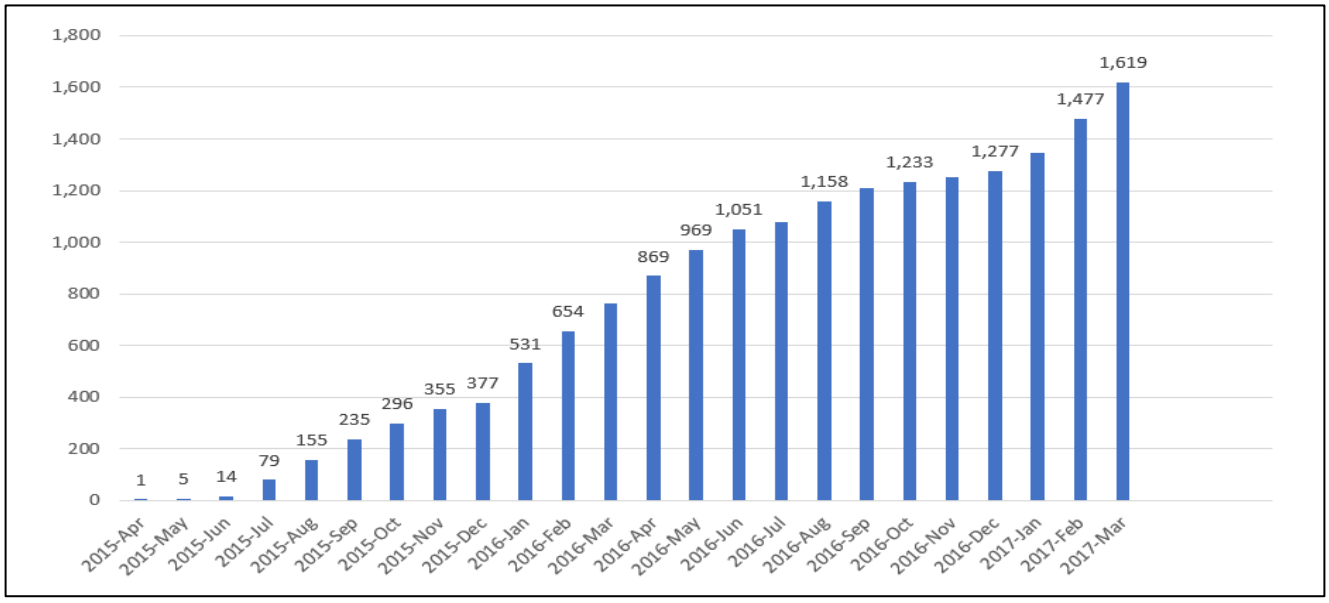
is performed by the LCC, CCM or BHCC before referral for a CMR. For all other Members who are selected for a CMR based on trigger criteria, this reconciliation is performed by the dedicated CMR CVS pharmacist with the Member.

The medication list for each Member is sent with the Service Request to the pharmacist responsible for the CMR. The pharmacist views the Member's profile online by accessing to the Member Health Record, clinical notes (if the Member is in a Care Plan) and claims history.

The Pharmacist reviews all information made available online through iCentric and collected from the Member when applicable and communicates with the prescriber(s) regarding the dosages, duration, drug combinations and any other pertinent issues called for by the unique circumstances of each Member. At any time during the process of conducting a CMR, at the pharmacist's discretion, the Member may be interviewed to gain additional insight.

Phone calls are the primary mode of communication for the pharmacist to discuss medication recommendations with the prescriber(s). Occasionally, the pharmacist's review yields recommendations that do not warrant a phone conversation with the prescriber. In those instances, faxes are used in place of the phone calls to minimize disruption to the prescriber. As the CMR Tier 1 Program has grown since inception in 2015, providers are increasingly engaging with the pharmacist and using them as a resource for the provider's practice. **Figure 94** below shows the referral volume increasing month over month, with over 1,100 Providers submitting a CMR in August of 2016, including 490 Providers submitting multiple CMRs.

**Figure 94: Number Of Primary Care Providers (PCPs) Submitting Comprehensive Medication Reviews (CMRs)**




After the appropriate consultations occur, the pharmacist will recommend the overall package of drugs and dosages that best fits the Member's needs and circumstances. No change is made in prescriptions by the pharmacist without the express authorization of the prescribing physicians. It is important to note that nearly 70 percent of the medications Members are prescribed by the PCP. This enables most recommendations to be readily implemented once the PCP agrees. The objective during the pharmacist's conversations with PCPs, specialists, and Members is to gain insight into:

- Current medication regimen to assure that:
    - Medications taken (including OTC or other supplements) are appropriate;
    - Dosages are appropriate and effective;

    - Administration method is correct; and
    - Dosing times are correct for maximum effectiveness.

- Adherence history

- Whether side effects associated with medications are understood and accounted for

- Whether Members are taking high-risk medications for their age and health status that may create instability or harm

The reviewing pharmacist communicates any and all recommendations based on the items above with all prescribing physicians. If any prescribing physician is inaccessible for phone consultation, the pharmacist refers this to the PCP for direct follow up by the PCP with the specialists involved. The LCC may assist in seeking contact with the PCP as needed.

As the pharmacist discusses the recommendations with prescribing physicians, there may be particular issues identified that indicate cause for concern. A CMR is not considered complete until open questions of significance, as judged by the pharmacist, are acted upon by the prescribing providers.

CVS pharmacists are matched to specific PCMH regions to gain familiarity with prescribers and build a clinician-to-clinician relationship encouraging direct communication through enhanced relationships with the PCPs. The pharmacists and PCPs may also use video conferencing capabilities to virtually connect during the CMR process.

**Conduct of the CMR**

Because the Members selected for a CMR have the highest potential medication related issues, it is critical that initiation of a CMR happens in a timely manner. The reviewing pharmacist initiates a CMR that has been referred through the iCentric Service Request Hub within three business days of its receipt by CVS Caremark. This is evidenced by the pharmacist's attempt to contact one or more parties (Member or a prescribing physician) involved in the CMR.

Once all prescriptions for a Member have been reviewed and any questions or concerns of a material nature have been resolved in the judgment of the reviewing pharmacist, the completed CMR is transmitted back to CareFirst for display in iCentric. The pharmacist sends both fixed field information and free form notes for a complete summary of the CMR.

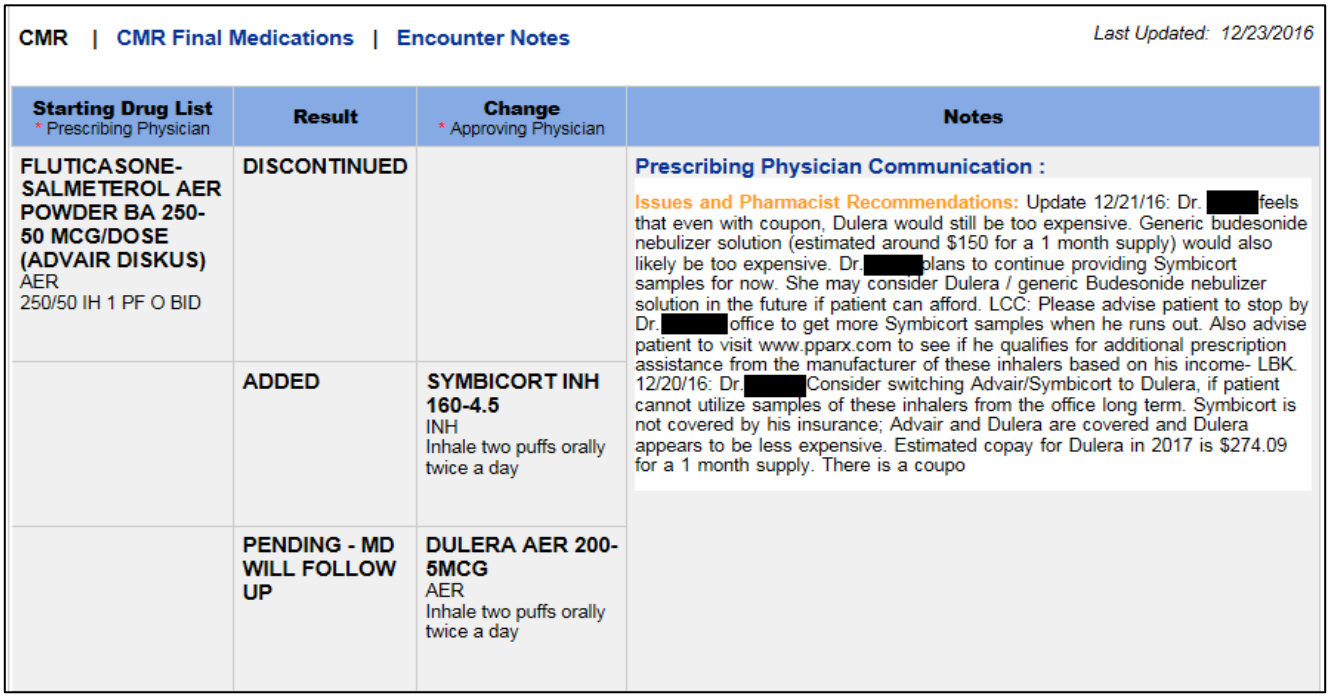
Any potential medication related problems (MRPs) are noted in an explanation column as are inappropriate dosing or duplication of drugs, adherence issues, inadequate efficacy, or safety concerns. In addition, the pharmacist provides free form text that outlines the recommendations made and the reason(s) for these changes. The recommendations range from a drug being discontinued, changed, confirmed as is, or left pending due to a physician needing to meet with the Member for further discussion.

When these recommendations are compared to the original medication list sent with the Service Request, the result shows a "before and after" view of the Member's prescriptions and dosages at a National Drug Code level, as shown in **Figure 95**. This is placed in the Member Health Record and allows all caregivers to view what medications the Member should be on.

Measurable outcomes are tracked to show the value of a CMR. The main value of Tier I CMR is in the enhanced therapeutic value of a Member's drug regimen leading to long term overall improved outcomes. A secondary value in in financial savings due to changes recommended and acted upon through the CMR process. Sometimes a CMR may actually increase drug spend when, for example, there is the addition of a prescription due to a gap in care. In addition, the following metrics are reviewed to validate the CMRs positive effects:

- Increase in adherence
- Reduction in breakdowns and ED visits
- Medical cost savings

**Part VI, Figure 95: Before And After View**



CMR | CMR Final Medications | Encounter Notes — *Last Updated: 12/23/2016*

| Starting Drug List<br>* Prescribing Physician | Result | Change<br>* Approving Physician | Notes |
|---|---|---|---|
| **FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/DOSE (ADVAIR DISKUS)**<br>AER<br>250/50 IH 1 PF O BID | **DISCONTINUED** | | **Prescribing Physician Communication :**<br>Issues and Pharmacist Recommendations: Update 12/21/16: Dr. [redacted] feels that even with coupon, Dulera would still be too expensive. Generic budesonide nebulizer solution (estimated around $150 for a 1 month supply) would also likely be too expensive. Dr. [redacted] plans to continue providing Symbicort samples for now. She may consider Dulera / generic Budesonide nebulizer solution in the future if patient can afford. LCC: Please advise patient to stop by Dr. [redacted] office to get more Symbicort samples when he runs out. Also advise patient to visit www.pparx.com to see if he qualifies for additional prescription assistance from the manufacturer of these inhalers based on his income- LBK. 12/20/16: Dr. [redacted] Consider switching Advair/Symbicort to Dulera, if patient cannot utilize samples of these inhalers from the office long term. Symbicort is not covered by his insurance; Advair and Dulera are covered and Dulera appears to be less expensive. Estimated copay for Dulera in 2017 is $274.09 for a 1 month supply. There is a coupo |
| | **ADDED** | **SYMBICORT INH 160-4.5**<br>INH<br>Inhale two puffs orally twice a day | |
| | **PENDING - MD WILL FOLLOW UP** | **DULERA AER 200-5MCG**<br>AER<br>Inhale two puffs orally twice a day | |

**CMR Communications**

The success of a CMR is dependent on an effective communication process among PCP, Specialist and Pharmacist. The foundation of the process relies on the successful Engagement of the prescribing physician(s) by the pharmacist. Successful engagement is prioritized as a phone conversation, and is only replaced with a fax when non-critical recommendations are made and a phone call would be disruptive to the prescriber's workflow.

All communications:

- Use an actively engaged model with direct provider contact, when applicable.
- Are conversational with understandable content.
- Reiterate the importance and benefit of the Program to the prescribers and Members.
- Seek to increase awareness of the provider and/or Member on medication related issues.

The pharmacist engages prescriber(s) in a phone conversation when recommendations of high clinical concern are identified that would yield an immediate impact to care. Examples of recommendations requiring a phone conversation include:

- Safety concern (e.g. drug-drug interaction, adverse drug effect)
- Unnecessary drug therapy (e.g., Member is taking a medication that is not indicated)
- Product substitution (e.g., more cost-effective therapy is available, therapeutic alternative to stabilize a condition)

When the medication review yields recommendations that are non-critical in nature, a phone conversation with the prescriber is not required and the recommendations are communicated by fax. Examples of recommendations that do not require a phone conversation include:

- Addition of an over-the-counter medication (e.g., when aspirin therapy is recommended)
- Addition of therapy based on clinical guidelines (e.g., when diabetic Member is not on an ACEI or ARB)

For CMRs that are submitted for Members in active Care Plans, the LCC indicates the preferred contact date and time for the pharmacist to reach the PCP. If the pharmacist is unable to speak with the prescribing providers on their initial outreach they will attempt to schedule a specific appointment time for the pharmacist to call back.

The pharmacist makes, at a minimum, three attempts to reach the prescribing providers. These attempts to contact and speak by telephone with prescribing providers are documented through systematic daily data feeds to iCentric. If the pharmacist is unsuccessful in reaching a specialist, they make this known to the PCP for direct follow up by the PCP with the specialist. If the pharmacist is unsuccessful in reaching a PCP for a CMR, the pharmacist seeks assistance from the LCC in contacting the PCP.

In an instance where the prescriber wishes to meet with the Member prior to acting upon a CMR recommendation, the pharmacist notes this in the system so that the need for follow up with the prescriber is known to all parties. A subsequent fax to the prescriber summarizing the recommendations and serves as a supplement to a phone conversation but never in place of a call.

After successful PCP Engagement, the pharmacist may seek to call the Member. The pharmacist uses this opportunity to provide medication education and among other things, judge the Member's understanding and comfort with the medication they are taking and with any recommended changes.

When the pharmacist's review yields non-critical recommendations, a fax to the prescriber(s) may replace the need for a phone call. In these instances, a call coordinator will reach out to the prescriber(s) office to confirm receipt of the pharmacist's fax. An example would be: combining 2 individual medications into a combination therapy to reduce the Member's pill burden.

For CMRs that are submitted for Members not in an active Care Plan, the pharmacist first reaches out to the Member to perform the medication reconciliation. Three attempts are made to reach Members. For Members unreachable via telephone, the pharmacist may ask for assistance from the CCM or LCC in connecting with the Member.

After successful Member Engagement, the pharmacist reaches out to the prescribing physicians to communicate any changes in the drugs used by Members in accordance with the process outlined above.

If the pharmacist believes a Member's lack of understanding may deter positive outcomes from the CMR, the Member will be flagged for a follow up phone call during which the Member may receive additional counseling to review misunderstandings and gaps in knowledge of the Member. All Members that are successfully engaged by the pharmacist will be mailed a personal medication list and medication action plan. These two documents aid the Member in understanding the outcome of the CMR and having actionable material to engage with providers.

**Completion of the CMR**

A CMR is considered complete when all prescribers have been successfully contacted and when any pending review of a specific drug ordered by a prescriber is not considered to pose a likelihood of material change and/or risk/concerns for the Member. In addition, a CMR is considered complete when the Member has been successfully contacted by the reviewing pharmacist to confirm their understanding and consent to the recommended/confirmed regimen of drugs resulting from the CMR.

**The Tier II CMR**

Nearly eighty percent of CareFirst Members use their pharmacy benefit each year. This leads to approximately 33,000 prescriptions claims processed every day for CareFirst members. In such a large pool of activity, there is a multitude of opportunities to create better clinical outcomes and manage unnecessary cost. The CMR Tier II program provides this exact service looking, for example, at an entire days' claims for gaps in therapy, safety issues, and opportunities to switch a brand product to a generic.

At any point in time, CareFirst supports hundreds of thousands of Members on maintenance medications for conditions like high blood pressure, cholesterol, and diabetes that are in the early stages of their disease progression. It is startling that approximately fifty percent of these Members do not take their prescribed medications as directed. This leads to disease progression at a much faster rate resulting in major downstream breakdowns.

Thousands of other Members are prescribed a medication regimen that can be delivered more efficiently. An example is a high-cost brand drug that can be changed to a generic reducing cost for both the plan sponsor and the Member. A dose of 10mg twice a day can, in some cases, be changed to a dose of 20mg once a day again reducing cost for all parties. These interventions also simplify the Member's daily regimen in a way that increases adherence.

Still other Members are taking one kind of medication while common medical practice generally requires a companion therapy that is missing – a gap in care. These gaps in care can result in serious complications for the Member and tremendous downstream cost. For example, failure to take a statin after a heart attack can result in a second heart attack and death.

**Drug Advisories**

Under CMR Tier II, continuous monitoring of the flow of pharmacy claims data for all Members is accomplished. Pharmacy claims data is run through clinical targeting analyses that identify "Drug Advisories" intended to help improve Member compliance and the correctness of their prescriptions. These Drug Advisories are delivered to Members and prescribers via the three components of the CMR Tier II program as outlined below:

- Pharmacy Advisor - Improving adherence and reducing gaps in care
- Drug Therapy Alerts - Evidence-based therapy optimization
- Safety and Monitoring - Identification of possible fraud, waste and abuse

CareFirst further prioritizes these advisories for the Providers based on cost, clinical, and workflow priority. This eases the potential burnout from Providers receiving numerous advisories for CareFirst Members. Providers are able to focus on the most impactful interventions from a clinical and/or cost perspective.

**Pharmacy Advisor - Drug Advisories to Improve Adherence and Reduce Gaps in Care**

Drug Advisories are designed to improve adherence and to close gaps in care are forwarded to a pharmacist for follow-up and intervention. This is often simultaneous with the prescription fill at the pharmacy. Intervening at these "teachable moments" increases the effectiveness of the Program and yields good closure rates.

These advisories are divided into the following categories:

- Gap in Medication Therapy counseling
- Adherence counseling
    - New to Therapy/First Fill education
    - Late to Refill counseling
    - Ongoing Adherence Counseling, as needed

- Health Management Program referral (e.g., Member with a diabetes medication is informed of the plan sponsor's Diabetes Management Program)

Drug Advisories focus on issues related to particular disease states and issues related to certain therapeutic classes of drug. The disease states included in the Program encompass the ten most common and costly chronic conditions, the progression of which can be slowed or stopped with effective medication therapy. These include:

- Diabetes
- Hypertension
- High Cholesterol
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Osteoporosis
- Breast Cancer
- Benign Prostatic Hypertrophy (BPH)
- Parkinson's Disease
- Behavioral Health

**Interventions to Improve Adherence and Close Gaps in Care**

Approximately forty percent of CareFirst Members fill their prescriptions at CVS retail pharmacies. CVS retail pharmacists automatically receive advisory messages in their point of sale system that flags Members who were identified for intervention through one of the Drug Advisories listed above. Given that Advisories derive from the CVS system, appropriate intervention is seamlessly integrated into the pharmacists' workflow. Below is a list of the approaches used at CVS retail locations:

- Face-to-face first-fill counseling with condition-specific educational materials.
- Follow-up calls to address common reasons for non-adherence and help ensure timely refills.
- Face-to-face counseling addresses non-adherence, gaps in medication therapy and Member questions.
- Phone-based non-adherence counseling from Members' local pharmacist if a face-to-face opportunity does not arise.
- Coordinated physician communications, as needed based on the type of intervention, by fax or phone to close gaps in care and improve adherence.

Members filling prescriptions via mail order or at other retail pharmacies are contacted directly by CVS via telephone by a program pharmacist to complete the identified intervention based on CareFirst's clinical criteria. This ensures all Members are receiving monitoring and advice, irrespective of their source of fill. If telephone contact proves difficult, the Member is contacted by mail.

The nature and frequency of an intervention is carefully tuned to each Member. To successfully engage Members and modify behaviors, pharmacists focus conversations on targeted interventions. For example, one month, a Member may be contacted about an adherence issue. At the next refill, the Member may be engaged to address possible gaps in medication therapy. Some Members with a targeted condition may not have a gap or adherence opportunity during the Program period and will only receive the welcome communication. The level of Engagement varies for each Member, based on his or her needs.

**Impact of Pharmacy Advisor - Adherence and Gap Closure Interventions**

As already noted, in a population of one million Members, hundreds of thousands of Drug Advisories are identified in a year's time. A subset of these result in changes in prescribed therapy. Results of each intervention are, therefore, measured in terms of annual savings from avoided adverse medical events. These savings are netted against any increased cost of additional

utilization (improved adherence to therapy, addition of needed companion drugs to close gaps) to determine the overall effect of the Program on cost of care.

Savings from increased adherence to prescribed therapy is shown in **Figure 96** below by disease state.

**Part VI, Figure 96: Annual Savings From Optimal Adherence By Top Disease States**[96]

| Disease State | Estimated Annual Savings per Conversion to Optimal Adherence |
|---|---|
| Asthma / COPD | $1,038 |
| Diabetes | $3,756 |
| Heart Failure | $7,823 |
| High Cholesterol | $1,258 |
| Hypertension | $3,908 |

Savings from Drug Advisories which reveal gaps in care are shown below in **Figure 97** below.

**Part VI, Figure 97: Annual Savings Resulting From Closure Of Gaps In Care**[97]

| Gap | Estimated Annual Savings per Gap Closure |
|---|---|
| Diabetes: No ACE, ARB or Antihypertensive | $527 |
| Diabetes: No Antihyperlipidemic | $310 |

Annual estimated savings for optimal adherence and gap closures are derived from a Pharmacy Care Economic Model (PCEM). PCEM is a mathematical model that answers the question "How much do I save if a non-adherent Member becomes adherent?" It estimates the annual savings from improvement to optimal adherence in an insured population considering reduced medical spend, gaps in care closure, improved productivity, and improved GDR. Evidence from peer reviewed literature on the economic impact of improvement from suboptimal to optimal adherence is used to derive saving estimates. The PCEM methodology and data sources are validated by Milliman, an independent internationally respected actuarial firm.

**Drug Therapy Alerts - Drug Advisories to Encourage Evidence-based Therapy Optimization**

Evidence-based Therapy Optimization Drug Advisories identify opportunities for improved prescribing and utilization (for prescriptions filled at mail and retail) according to accepted evidence-based prescribing criteria. Clinical pharmacists help maximize savings and improve clinical outcomes while minimizing Member disruption.

Claim review of mail order prescriptions occurs before a prescription is dispensed. Retrospective review of the retail prescriptions occurs within 72 hours of adjudication and triggers a follow-up physician touch point if no response is received from the initial outreach. Physician outreach is thru fax and letters.

Drug Advisories fall into the categories listed below:

- Age-Appropriate Therapy (e.g., Member on a medication not appropriate for their age group).
- Alternative Cost-Effective Therapy (e.g., Member on a drug where therapeutic alternatives have been shown in the evidence to be just as effective but less costly).
- Inappropriate Therapy for Condition (e.g., Member taking a medication that may intensify an existing disease state).

[96] *CVS Health, Pharmacy Care Economic Model (PCEM).*

[97] *CVS Health, Pharmacy Care Economic Model (PCEM).*

- Dose Optimization (e.g., Member taking a medication twice-daily that can be simplified to once daily or multiple medications that can be combined into one tablet).
- Duration of Therapy (e.g., Member taking a medication beyond the duration indicated by the evidence).

- Gastrointestinal (GI) Therapy (e.g., Member taking GI therapy: longer than recommended, duplication of therapy, higher than recommended doses, and more cost-effective therapy).

- Duplicate Therapy (e.g., Member two anti-anxiety medications).

**Impact of Drug Therapy Alerts – Evidence-based Therapy Optimization**

The impact of changes to therapy based on clinical evidence is typically measured in reduced prescription drug cost for the Member receiving the successful intervention. Success is determined by a change to the recommended alternative and may be measured by discontinuation of therapy, change in therapy (new drug), reduction in daily dose, reduction in days on therapy or a reduction in doses per day. Savings are based on the difference between the pre-intervention drug cost and post-intervention drug cost during the tracking period.

**Safety and Monitoring - Drug Advisories that Identify Possible Fraud, Waste and Abuse**

In addition to disease states listed above, certain therapeutic classes of medications, prone to abuse or misuse that create safety concerns are also monitored by the CMR Tier II Program. The Program identifies these by looking at high numbers of controlled substance claims, multiple prescribers, multiple pharmacies, excessive use or high total claim cost. A pharmacist reviews flagged profiles and verifies the need for prescriber intervention. This not only reduces the costs associated with prescription fraud, misuse and abuse but also protects Members from overdose and other serious health consequences.

Claims data is analyzed to identify Members for:

- Total number of controlled substance claims
- Total number of controlled substance prescribers
- Whether prescriptions are filled at multiple pharmacies
- Excessive utilization
- Geographic distribution of prescribers and pharmacies
- Excessive claim cost

The following drug classes are targeted:

- Narcotic/narcotic combination drugs
- Anti-anxiety and sedative/hypnotic agents
- Non-benzodiazepine sedatives/hypnotics
- Muscle relaxants (Flexeril and Soma are included)
- CNS stimulants

**Impact of Safety and Monitoring – Identification of Possible Fraud, Waste and Abuse**

Pharmacy claims data is monitored for a reduction in utilization of controlled substances for targeted Members. Savings are evaluated based on a reduction of pharmacy costs and medical cost avoidance due to unnecessary physician visits, ER visits, and laboratory fees. In 2016, this program yielded $950,000 in pharmacy savings and $10M in medical cost avoidance.

**Interventions and Savings**

The Tier II CMR program results in a high volume of prescriber and Member interventions and significant savings as described above. **Figure 98** on the next page summarizes the 2016 interventions and savings from CMR Tier II.

**Figure 98: CMR Tier II Intervention Count and Total Savings In 2016**

| 2016 | Drug Therapy Alerts | Safety and Monitoring Core and Enhanced | Pharmacy Advisor Adherence | Pharmacy Advisor Gaps In Care | Total |
|---|---|---|---|---|---|
| Number of Interventions (Prescriber & Member) | 218,285 | 9,553 | 492,570 | 23,882 | **744,290** |
| # of Successes | 90,234 | 970 | 295,430 | 7,273 | **393,907** |
| **2016 Total Savings** | $47,945,117 | $13,716,593 | $83,987,402 | $3,161,819 | **$148,810,931** |
| ***Type of Savings*** | *Hard Pharmacy Savings* | *Hard Pharmacy Savings and Medical Cost Avoidance* | *Medical Cost Avoidance* | *Medical Cost Avoidance* | |

**Prescribing Physician Involvement**

Since pharmacists cannot change a prescription without the authorization of the prescriber, all Drug Advisories are communicated to prescribers along with clinical recommendations which are made regarding a drug class, not a specific drug.

Physicians are notified via fax when Members are late to fill a medication and/or when Members have gaps in medication therapy. If a Member remains non-adherent after the initial fax is sent, the pharmacist will call the prescribing physician to discuss the Member's adherence. If the gap in medication therapy remains open after the initial fax is sent, a second fax will be sent. If the second fax receives no response, the pharmacist will call the prescribing physician. If the gap remains open after all three attempts to reach the physician, the physician will be re-targeted again six months later in an attempt to close the gap in medication therapy again.

Physicians are also notified via fax regarding actionable Member-specific drug therapy recommendations based on appropriateness of therapy and drug safety. If a physician ignores the initial outreach and prescribes the same medication, another fax is sent to notify the physician about safety and savings opportunity. In more serious situations, such as drug-drug interactions, a prescriber will be contacted via phone. If there is no fax information available for physicians, they are notified by letter.

Finally, when a reviewing pharmacist determines that physician intervention is necessary regarding possible fraud and abuse, the physician is contacted via fax. A fax is sent to each prescriber of targeted drugs and contains a Member profile, including all prescriptions for targeted drugs by physician and pharmacy. There is also a return request included whereby the physician is asked to indicate whether the patient is theirs and whether they prescribed the medication.

**Integration with iCentric**

iCentric receives a daily feed of all Drug Advisories for the Drug Therapy Alert program, which generates Drug Therapy Recommendations for the PCP. At any time, the PCP can view these Drug Therapy Recommendations in iCentric.

Each Drug Therapy Recommendation results in an alert for the PCP and their assigned LCC. In addition, the PCP may filter their attributed population to see all Drug Therapy Recommendations for their Members. This information is also displayed in the Member Health Record of each impacted Member so that any other treating provider or Care Coordinator can see the Drug Therapy Recommendations and have an opportunity to act in coordination with the pharmacist.

LCCs will perform a monthly review of Drug Therapy Alerts with their assigned PCPs to ensure a Provider response is documented within iCentric. The PCP, with support from the LCC, will review all high and medium priority Drug Therapy Recommendations and enter a Provider response.

When an intervention is completed, the disposition is documented and imported into the iCentric System so that the activity can be tracked by those on the care management team. Through CareFirst's integration of the drug advisories into iCentric, Providers have a one stop solution to respond to the advisories and allow CareFirst to track success of the program.

The future of the CMR Tier II program includes integration of the drug advisories into the Provider's electronic prescribing and prior authorization web portals. This will allow the Providers to act instantly on any interventions recognized from the Tier II program and increase action on the recommendations.

## Program #11: Expert Consult Program (ECP)

Many CareFirst Members, particularly those in Risk Bands 1 and 2 of the Illness Burden Pyramid, suffer from serious conditions that are costly to manage and are often characterized by uncertainty in diagnosis, treatment and prognosis. It is not surprising that these Members become frustrated by relentless severe symptoms and seek definitive diagnosis and treatment by obtaining multiple medical opinions from varieties of specialists. Inevitably these Members are subjected to costly and sometimes questionable diagnostic procedures and treatments, with unclear clinical and financial outcomes.

The Expert Consult Program (ECP) is tailored to those Members who find themselves in these challenging situations. The purpose of the ECP is to provide the best possible clinical review and recommendations to Members and their treating provider(s), who are at a key decision point, facing major diagnostic or treatment options or whose choices may be unnecessarily risky, extremely costly or of questionable value. This review is called a Level 1 review.

The ECP – delivered in partnership with Best Doctors, a key strategic partner of CareFirst – provides an expert physician review of an entire case by nationally-renowned physicians in the appropriate medical and surgical subspecialties. The roster of expert physicians is selected using a "peer polling" process, which, in essence, identifies the "physician's physician," or those experts to whom physician would turn themselves for a family Member. Through the peer polling process, which is repeated regularly, the top five percent of practicing physicians throughout the United States have been identified.

In many cases, the Expert Consult process results in affirmation of the proposed diagnostic and/or treatment plan, providing reassurance to both Member and treating provider. In other cases, the Expert Review results in a changed diagnosis or the presentation of alternative options to the Member and treating provider. Either way, it gives peace of mind to the Member and his/her caregiving team that all options/paths of what could be considered are being given full consideration.

The Program categorizes Member profiles into two levels of review, one more complicated and intensive than the other. Level 1 is the most complicated, while Level 2 is focused on conditions related to certain elective surgeries.

As a result of the ECP, those CareFirst Members who have experienced Level 1 reviews have realized positive clinical impacts. Additionally, significant cost savings have been realized by enhancing the correctness of diagnoses and efficacy of treatment. A brief summary of results is as follows:

- The Level/Case volume has grown to over 1,000 cases a year resulting in an average reduction in medical costs of $10,000 per case.

- Level 1 reviews, on average, have resulted in substantial changes in diagnoses and in recommended treatment pathways for the Members involved as is shown in **Figures 99 and 100** in the next several pages.

- Four out of five treating providers have found the Expert Consult Report findings to be useful in their management of the Member, and as a general rule, adopt them. The specialties where the greatest clinical impact has been observed are oncology, gastroenterology, neurology, rheumatology and orthopedics.

- 95 percent of Members that responded to satisfaction surveys have given the ECP Program the highest rating regarding meeting their needs and would recommend the Program to their family or friends.

The Level 2 Program is a Condition Specific Expert Consult Program that addresses conditions for which there are elective surgeries or discretionary treatments, such as orthopedic (knee, hip, back, neck, shoulder) and benign uterine conditions. The Condition Specific Expert Consult Program includes an Informed Decision Making (IDM) element in which the Member is educated on the elective procedure prior to scheduling surgery. This includes a detailed description of the procedures and treatments including the risks, benefits and potential outcomes. This model provides the Member with the detail necessary to make an informed decision regarding their elective procedure.

The Level 2 Program shows evidence of potentially significant clinical and financial impact for the targeted conditions (knee, hip, back, neck) with a realized savings of $6,500 per case. The reviews have shown a 53 percent change in diagnosis and a 79 percent change in recommended treatment pathway.

**Measurement of Clinical Change/Impacts:**

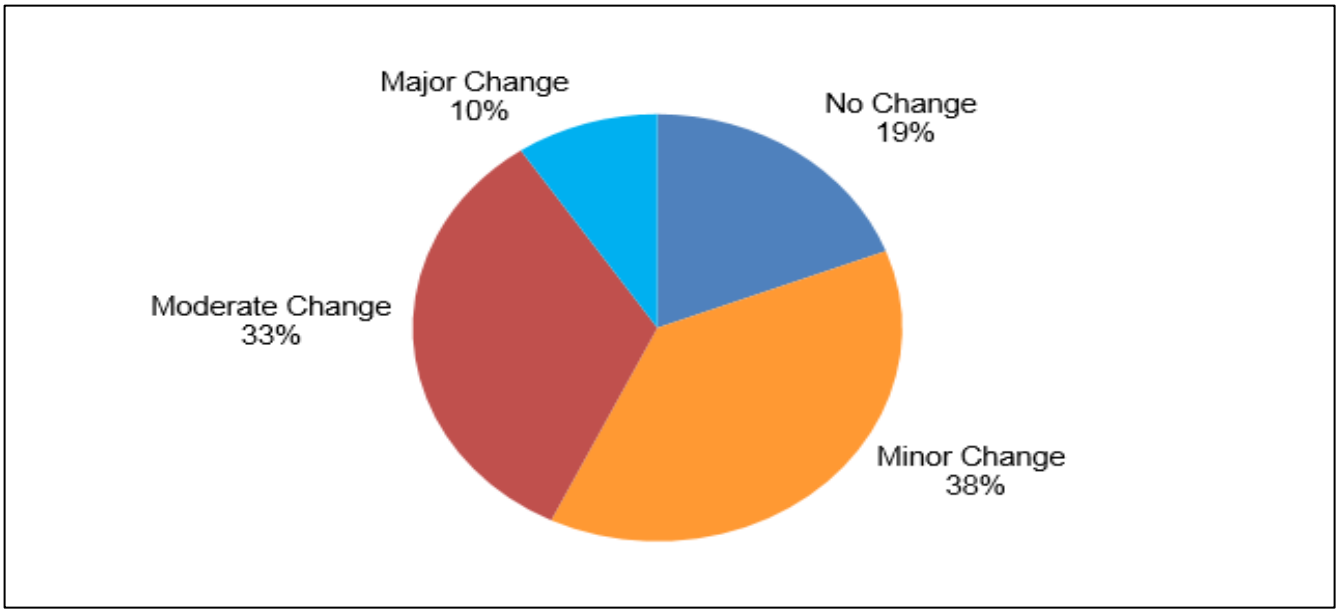
The measurement of the diagnosis and treatment impacts of Level 1 and Level 2 reviews is as follows:

**Major Change -** The review changes an incorrect core diagnosis or offers a diagnosis to include other critical possibilities.

**Moderate Change -** The review broadens the possible diagnoses to include important possible diagnoses not considered by the treating provider.

**Minor Change -** The review refines the diagnosis to be more specific or clear.

**Part VI, Figure 99: Diagnostic Rating Category**




**Treatment Change Clinical Impact Definitions:**

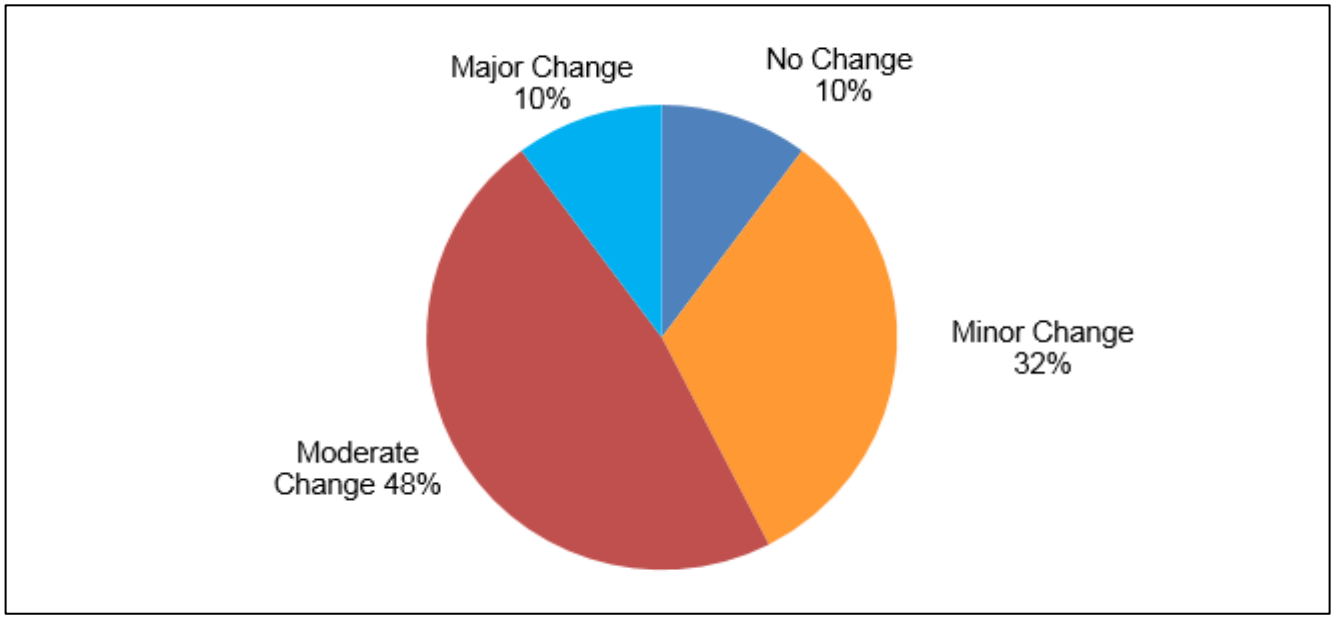
The measurement of changes in treatment resulting from Level 1 and 2 reviews is as follows:

**Major Change -** The review recommends major treatment modalities that will dramatically change the course of the Member's current care.

**Moderate Change -** The review recommends significant additional or different treatment modalities that will somewhat change the course of the Member's current care.

**Minor Change -** The review recommends small changes in treatment modalities that will enhance the Member's current care.

**Part VI, Figure 100: Treatment Rating Category**




**Expert Consult Member Selection Process**

CareFirst CCMs and LCCs – in collaborative discussion with a Member's PCP and other treating providers, identify Members likely to benefit from the Program. These Members must have serious, complex conditions and be at a crossroads or decision point regarding diagnostic testing and/or treatment options. In many cases the diagnosis may be unclear despite severe symptoms (such as gastrointestinal or neurological symptoms, among others). In other cases, there may be multiple differing opinions from various providers regarding the best course of treatment for the Member.

The Members selected must be in an active Care Plan (either CCC or CCM). There are no limits on diagnoses or conditions for selection to the Program, although the CareFirst clinical team has developed a list of "trigger" diagnoses to be considered for referral to the Program. The most important factors for selection consider the severity of symptoms, uncertainty of diagnosis, and/or the risk and cost of anticipated diagnostic testing or treatment. The cases selected are either already high cost cases or are expected to be so.

A CCM or LCC initiates the process by creating a Service Request via the Service Request Hub in the iCentric System, which automatically routes the case to a CareFirst Medical Director to be reviewed for appropriateness. Following review and approval by the Medical Director, the Service Request is electronically routed back to the CCM or LCC who then contacts the Member, and introduces and describes the Program to them to make certain that the Member understands all aspects of the Program and consents to go forward.

Once this is accomplished, the CCM or LCC authorizes the Service Request Hub to route the case to Best Doctors who then receives an email notification that a new Service Request is pending. The Cost Share Waiver Program protects eligible Members from out of pocket expenses for this Program.

Generally, only cases that have or are expected to exceed $75,000 in annual spending are considered for a Level 1 review.

**Expert Consult Program (ECP) Process for Level 1**

Best Doctors takes responsibility for providing the review through completion. Following notification, designated staff at Best Doctors access iCentric to accept the request and obtain the Member's contact information which is contained in the Member Health Record and Care Plan. The Member is already aware that a phone call will be made from Best Doctors to engage the Member.

The Best Doctors' Member Advocate (a registered nurse) contacts the Member and affirms that all required consents for

medical record reviews and data sharing are in hand. The Member Advocate reviews the Member Health Record and Care Plan in iCentric, and then conducts a comprehensive telephonic intake directly with the Member to obtain additional information, as well as the detailed Member perspective on their situation.

At the outset, Best Doctors notifies the treating provider(s) to describe the ECP and invite the provider to participate in the process and seek their assessment of the situation.

The next stage is gathering medical records relevant to the Member's clinical situation. This includes all pertinent medical records across all sites of service (inpatient hospital, ED, providers' offices). As appropriate for the individual case, the actual images and pathology specimens (not just the reports) are also requested for individualized case review.

A Clinical Review Team (composed of the registered nurse Member advocate, Case Coordinator, lead physician and associate physician reviewer) then reviews all the clinical information and develops a comprehensive clinical summary. Based on this review and clinical summary, the Clinical Review Team identifies the most appropriate expert physician(s) to perform the review and case analysis. In some cases, this may involve more than one physician in the same or multiple subspecialties. These nationally-renowned physicians are located at leading medical centers throughout the United States, and are expected to provide the best, most thoughtful and unbiased review of the clinical case with actionable recommendations.

After a thorough review of all case materials, the expert physicians submit a detailed case analysis, a set of recommendations and clinical/treatment options, all backed up with relevant published medical literature citations. During the review, the consulting physician experts may talk to the Member's treating providers as necessary or appropriate to gain relevant clinical information.

The entire report is then reviewed by the lead physician on the Clinical Review Team for consistency and understandability, as a part of the quality assurance process. Two report packages are provided, one to the Member and one to the treating providers(s). The report package for the Member includes a Best Doctors Report Summary, written in language easily understood by a non-medical person, and the Expert Report. The report package for the Member's treating provider(s) includes the Expert Consult Report. Both receive detailed biographies of the expert physicians, including medical training, credentials and publications.

Copies of the reports are sent to the Member and their treating provider(s). If there is a significant difference of opinion (diagnosis or treatment) between the expert physician reviewer(s) and the treating provider(s), Best Doctors may arrange a conference call between the two parties. Best Doctors also provides Continuing Medical Education credits for the treating provider(s) review of the Expert Consult Report.

The Member is given the option to receive an encrypted flash drive that contains the entire history, clinical summary, journal references and Expert Consult Report. This allows ready access for any clinician's review, at any time, at the Member's discretion.

When the Expert Consult Report is complete, Best Doctors uploads the Expert Consult Report as a PDF file directly to the Member Health Record in iCentric, where it is available to all treating providers on the Member's care team.

The Clinical Review Team contacts the Member at four weeks and three months, after the report delivery to follow-up on the treatment plan and on the health status of the Member. This follow-up is noted in the Member Health Record in iCentric.

Once Best Doctors has accepted the Service Request, a series of status updates are provided as follows:

**Accepted**: The case has been retrieved from the Hub and is accepted into the Expert Consult Program.

**Medical Records Collection**: Medical records, pathology specimens and/or original images have been requested and are being collected.

**Clinical Summary Delivered**: The Clinical Review Team has reviewed all available records, images and specimens and has identified the appropriate expert physician reviewer(s). All materials are in the hands of the expert physicians for their review and report.

**Expert Report Delivered**: Report has been simultaneously sent to the Member, treating providers and posted to the Member's Member Health Record. Email notification to the CCM or LCC is sent that a report is ready.

**Follow-up Four-week outreach**: Best Doctors contacts Member at four weeks.

**Follow-up Three-month Call**: Best Doctors contacts Member at three months. Observations recorded in Member Health Record.

**Case Closure**: End of Expert Consult process.

**Core Target Members**

As might be expected, the CareFirst Core Target Member population is the most frequent source of case referrals to Best Doctors for Level 1 reviews. However, other cases are identified through data mining or on the recommendation of a PCP, LCC or CCM.

**Additional Program Components**

In addition to the full ECP services offered, Best Doctors provides a dedicated clinical integration specialist. This is a registered nurse who works with CareFirst to make sure that the Program is fully integrated within the TCCI Program Array. Best Doctors also provides a dedicated account executive to ensure that all aspects of the Program are operating in a way to meet high standards.

**PCP Awareness and Consent**

It is the responsibility of the referring LCC or Complex Case Manager to fully inform the Member's PCP of the review, as well as the course of action flowing from it. Prior to undertaking an Expert Consult review, the PCP is asked for their consent and virtually all PCPs take great interest in the outcomes achieved through the Program.

**Reporting**

All Members whose cases are reviewed through the ECP are followed closely in the following weeks and months and their care experience, costs and results are available to the PCP as well as other treating providers as part of the Member Health Record update process as well as in Search Light Reporting.

**Conclusion**

The ECP delivers timely advice to Members at critical decision points in diagnosis and treatment. This ensures that the recommendations resulting from Level 1 and Level 2 reviews are fully considered by Members and their treating provider(s). CareFirst Members who have participated in the Program have overwhelmingly praised its high impact on their overall health. The ECP also provides a reduction in high risk procedures and procedures that are of low value and high cost.

## Program #12: Urgent And Convenience Care Access Program (UCA)

### Background

In many primary care practices, the limited availability of extended evening and weekend hours, combined with a lack of patient knowledge of alternative sites of care, results in patients going to the ED of a hospital when faced with sudden care needs. As a result, the most expensive site of service is often chosen, despite the existence of alternatives that can deliver the same quality of care in a less expensive and more convenient setting.

UCA is designed to help PCPs minimize this problem with flexible and convenient options for their Members. The various elements of the UCA Program offer an array of access choices to Members that support PCPs with back-up care when they are not available, while maintaining and protecting the PCPs central role in the Member's care.

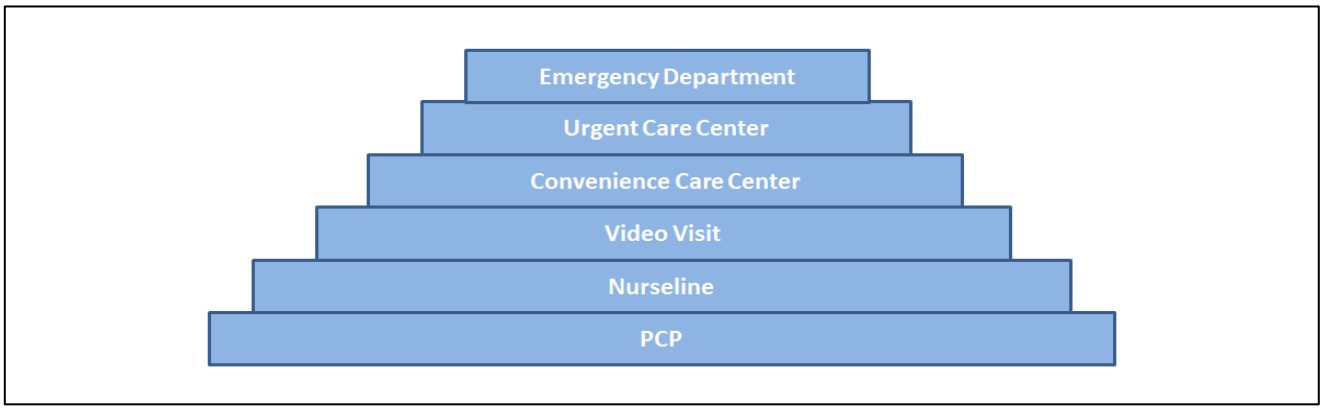
### Six Levels of UCA Care

The UCA Program offers Members six levels of access within different treatment settings based on the type and severity of their health needs as shown in **Figure 101** below.

**The UCA Program six-level system of after-hours care:**

- Emergency Department (ED) for true emergency situations
- Urgent Care Centers (UCC)
- Convenience Care Centers or "Retail Clinics"
- Physician On-Demand Telemedicine
- Nurseline
- PCP

**Part VI, Figure 101: Urgent And Convenience Care Access Program (UCA) Provides Ways To Access Care**




### Benefit Design

CareFirst benefit designs encourage Members, PCPs, and other physicians to choose the most appropriate setting for medical treatment. The average episode cost per ED visit in 2016 was $1,170 compared with $196 for Urgent Care (e.g. Patient First) and $94 for Convenience Care (e.g. CVS Minute Clinic). There is a significantly different cost impact when Members use different sites of service because benefit designs encourage Members to use the most appropriate site of care through differential cost sharing as shown in **Figure 102**.

**Part VI, Figure 102: Benefit Design Encourages Use At The Most Appropriate Site**[98]

| Site of Care | Member Cost Share |
|---|---|
| Emergency Department Visit | $200 |
| Urgent Care Center Visit | $50 |
| Convenience Care Center Visit | $25 |
| Physician On-Demand Telemedicine Encounter | $40 |
| Nurseline Encounter | $0 |

**Cost Impact on Panels**

A typical Panel experiences about $650,000 to $750,000 per year in debits for emergency and urgent care. Much of these costs are for ED services that could have been managed outside of the ED. The average cost for common procedures when delivered in an ED compared to an Urgent Care Center or Convenience Care Center is shown in **Figure 103** below and underscores the potential savings from arranging services in the least costly setting.

**Part VI, Figure 103: Comparison Of Costs For Common Conditions Treated In The Emergency Department (ED), Urgent Care Center (UCC) And Convenience Care, 2016**[99]

| Diagnosis | ED | UCC | Convenience Care | Potential Savings |
|---|---|---|---|---|
| Acute Pharyngitis | $810 | $128 | $83 | 84%-90% |
| Otitis Media (Middle Ear Infection) | $655 | $109 | $74 | 83%-89% |
| Acute Sinusitis | $778 | $125 | $74 | 84%-91% |
| Conjunctivitis | $498 | $96 | $72 | 81%-85% |
| Streptococcal Sore Throat | $882 | $125 | $85 | 86%-90% |
| Cough | $913 | $142 | $81 | 84%-91% |
| Acute Upper Respiratory Infections | $810 | $132 | $79 | 84%-90% |
| Acute Bronchitis | $1,232 | $151 | $103 | 88%-92% |
| Urinary Tract Infection | $1,670 | $161 | $83 | 90%-95% |
| Acute Cystitis | $1,439 | $112 | $92 | 92%-94% |

**Positive Impact on ER Spend Resulting from the PCMH Program**

The ED continues to have a major impact on cost of care, and over time, the average cost per ED visit has increased significantly. However, CareFirst's PCMH model has proven supportive in helping members better use the appropriate settings of care. As presented in **Figure 104** and **105** on the next page, CareFirst members who are attributed to a PCMH PCP use the ED more efficiently than similar members who have doctors not affiliated with the PCMH Program. The Per Member Per Month (PMPM) costs for these cohorts are presented in the figures below. Further, while ED cost has increased across the board, the rate of its increase over time has increased more dramatically for the cohort not attributed to the PCMH Program. Correspondingly, Urgent Care PMPM has shown to be more expensive for the PCMH Attributed population. This may represent more appropriate use of a less costly site of service for this population.

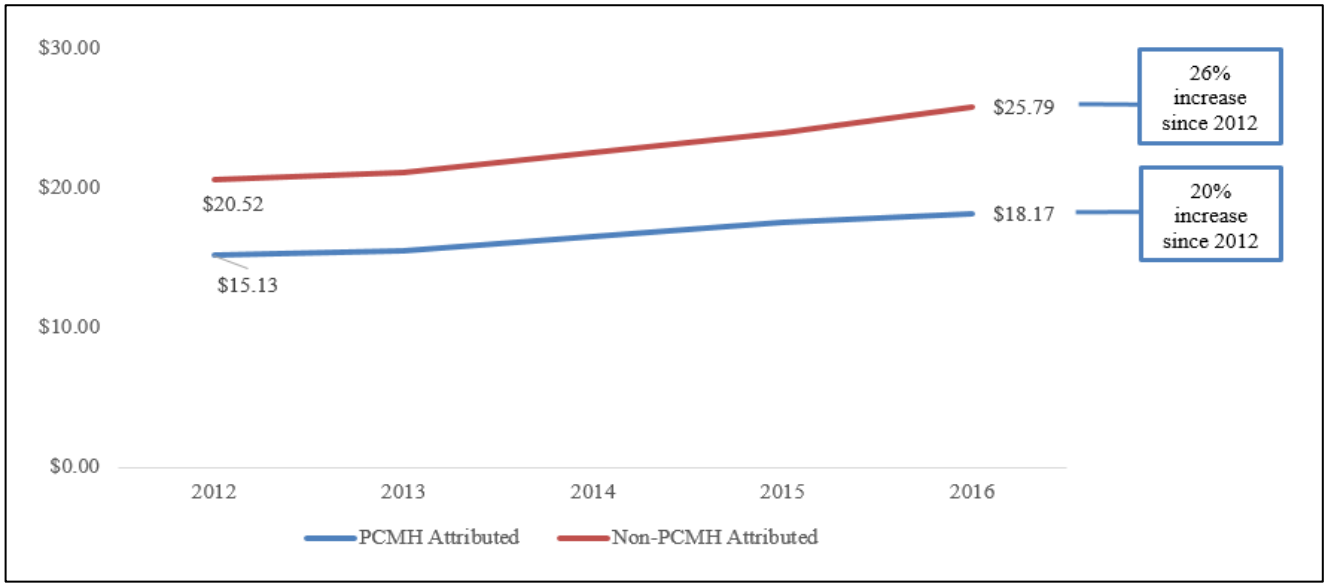
[98] *Copayments vary based on group coverage. Figure presents sample range.*

[99] *This information represents a sample of conditions commonly treated in all three settings and includes all Members with these diagnoses, but does not take into account the severity of their illness. Costs are based on average CareFirst Members in 2016 for top most common conditions and may not represent patient's actual cost of care.*

**Part VI, Figure 104: Comparison Of Costs by Site of Service For PCMH Attributed And Non-PCMH Attributed Members, 2016**[100]

| | PCMH Attributed Members | Non PCMH Attributed Members |
|---|---|---|
| Emergency Room PMPM | $18.17 | $25.79 |
| Urgent Care PMPM | $3.79 | $1.96 |
| Convenience Care PMPM | $0.24 | $0.18 |

**Part VI, Figure 105: Emergency Department (ED) Per Member Per Month (PMPM) Over Time For PCMH Attributed And Non-PCMH Attributed Members, 2016**




The following sections provide further details on the six levels of care in the UCA Program.

**PCP Access**

Members visiting their PCPs provide the greatest continuity of care and allow the PCP to direct the Member to the most clinically appropriate care setting for any health care need. As such, the PCMH Program includes measures of access as part of the quality scorecard Panels must achieve to be eligible for an OIA. Therefore, the PCP should provide access that meets Member needs, both during regular office hours and off hours, including nights and weekends.

Primary Care Practices are supported via PCMH Practice Consultants who play an important support role in helping PCPs with practice transformation, including the development of a strategy to improve Member access. CareFirst has developed guidance on best practices for access, which Practice Consultants will be promoting in **Performance Year #7 (2017)** as outlined below.

- **Online Appointment Scheduling:** Online appointment scheduling should be available for all PCPs.
- **Practice Website:** A Practice website should include the following information:
    - Daily Office Hours
    - e-Mail Addresses

[100] **PMPM represents the costs for services at the site of service and compares PCMH Attributed Members to Non-PCMH Attributed Members.*

- Emergency Contact Phone Numbers
- List of Conditions for Triage
- Patient Education
- Suggested Sites of Care for Symptoms Experienced After Hours
- Nearby Urgent Care Locations

- **Communication with Members:** A Practice should use the following tools to adequately communicate access for Members:

  - New Patient Packets
  - Office Fliers or Signage
  - Voice Mail Message
  - Practice Website

- **Phone After Hours:** PCPs should participate in a call group that provides telephonic advice for Members 24-hours a day/seven days a week. PCPs in smaller Practices can enter into coverage arrangements with other PCPs within their Panel.

- **Provider After Hours:** Telephonic advice after hours should include the option of call back by the PCP or a covering PCP within 15 minutes.

- **Early Morning Appointments:** A PCP or covering PCP should have appointments available before 7:30 A.M. on weekdays.

- **Same-Day Appointments:** A Practice should offer same-day appointments which should not be filled up prior to 12 noon or later.

- **Evening Appointments:** A Practice should offer evening appointments after 5:30 P.M. on weeknights.

- **Video Visits:** Practices should offer and use Video Visits to improve convenience and access for CareFirst Members after hours or when follow-up visits are not required to be in-person.

- **Urgent Care:** Practices should maintain a relationship with an urgent care center for certain situations and communicate this to their Members.

A survey of some of the larger Panels within the PCMH Program was conducted based on these standards to provide a baseline. The results of this survey are shown below in **Figure 106**.

**Part VI, Figure 106: CareFirst Access Standards For PCMH Primary Care Providers (PCPs)**

| | Standard | Practices Currently Meeting Standard |
|---|---|---|
| 1. | Online Appointment Scheduling Available for All Providers | 17.9% |
| 2. | Practice Has a Website Including Required Information | 17.3% |
| 3. | Practice Adequately Communicates Access Options to Members | 20.4% |
| 4. | Phone Answered After-Hours | 82.6% |
| 5. | Provider Available After-Hours within 15 Minutes | 68.2% |
| 6. | Appointments Available before 7:30am on Weekdays | 22.3% |
| 7. | Same-day Appointments Do Not Fill Up until Noon or Later | 75.5% |
| 8. | Appointments Available after 5:30pm on Weekdays | 12.4% |
| 9. | All Providers Make Video Visits Available When Clinically Appropriate | 6.3% |
| 10. | Maintains a Relationship with an Urgent Care Center for Certain Situations | 29.7% |

Optimizing PCPs' relationship with their Members can prevent care that is either unnecessary or being provided at the wrong site of care, such as the ED. In cases where the access strategy does not appropriately retain Members in the office setting, the Practice Consultants can help PCPs identify Members who are frequent users of ED services, both appropriate and potentially inappropriate.

Practice Consultants actively scan the Panel data for these Members and bring the results to the attention of PCPs and LCCs for intervention. Practice Consultants also work closely with each PCMH practice to identify the nearest network of UCA providers and the services available through these providers.

For its part, CareFirst provides services to complement Member access to PCPs as described below, including a Nurseline, Video Visits, Convenience Care Centers, and Urgent Care Centers. Each PCP is encouraged to incorporate these services into their overall access strategy for Members on an as needed basis.

**Nurseline**

All CareFirst Members have free access to a nurse by telephone or web chat 24/7 to answer questions about new or worsening symptoms they may be experiencing. The nurse has instant access (following HIPAA validation) to information about the Member including:

- The Member's web-based Member Health Record through iCentric
- History of earlier calls by the Member to the Nurse Information Line
- The Member's benefits
- Locations of Program options in the Member's area

In addition to text notes of the interactions, structured data Reporting on Nurse Information Line utilization patterns provide information on the following:

- Call volumes
- Call reason
- Intent of caller at beginning of call
- Intent of caller at end of call
- Condition of caller upon follow-up call
- Likely cost avoided by redirection of callers to more appropriate care setting

Nurseline nurses are knowledgeable about CareFirst TCCI Programs enabling appropriate referrals to be made to Care Coordinators for appropriate Program placement through CareFirst's Service Request Hub. Further, the Nurses have access to other UCA providers including CareFirst's telehealth line, the nearest location of CareFirst's preferred Convenience Care Clinics (Minute Clinic) and their hours, the locations of Urgent Care Centers, as well as the locations of the nearest EDs near the Member, if required.

Members identified by Nurses that are clearly in need of a Disease Management Program or who do not have a PCP are advised by the nurse and provided information on the availability of such Programs and a list of PCMH PCPs in their area.

Primary Care practices who participate in CareFirst's PCMH Program are encouraged to provide the Nurse Information Line telephone number for CareFirst Members as a first line of afterhours contact rather than suggesting that their Members seek ED-based services.

**Physician On-Demand Video Visits**

CareFirst's medical policy covers telemedicine visits across various services and specialties to provide Convenience and accessible services to Members. Telemedicine is fully covered by all CareFirst plans at the same billing level as a regular visit so long as the provider has the capability, meets the same requirements as face-to-face consultations, and uses the appropriate codes allowable for telemedicine.

All Members have 24/7 access to on-demand, video consultations ("Video Visits") with physicians licensed and located in their state. Members can seek treatment advice for common conditions such as: bronchitis, sinusitis, upper respiratory

infection, allergies, urinary tract infections, strep throat, etc., and where medically indicated, have a prescription electronically sent to their preferred pharmacy.

To request a Video Visit, Members can contact CareFirst's telehealth line via mobile phone or website to connect with a physician within one hour of request. Typically, a Member connects to a physician much sooner, connecting within five to 10 minutes.

The results of all Video Visits are documented showing various statistics about these visits including:

- Consultation volume
- Consultation time (regular business hours or after hours)
- Consultation reason
- Intent of caller at beginning of consultation
- Intent of caller at end of consultation
- Condition of caller upon consultation follow-up
- Likely cost avoided by consultation

**Convenience Care Centers**

CareFirst contracts with three Convenience Care organizations offering Members over 100 locations within the CareFirst service area. MinuteClinic is the largest with 65 locations. Some examples of conditions suitable for Convenience Care include cold or flu symptoms, ear infections, strep throat, bandaging for minor cuts and scrapes, or common vaccinations.

MinuteClinic also serves as a resource center for Members to visit for educational programs including patient education for smoking cessation, nutrition assessment and weight loss. CareFirst has partnered with MinuteClinic to develop a Program for smoking cessation as described in greater detail in **Program #1: Health Promotion, Wellness and Disease Management Services Program (WDM)**. These patient education services free up valuable PCP time, and PCPs can trust that the education services are delivered through a partner who will share the details of these encounters within iCentric and has an obligation to refer their Members back to them for follow-up.

**Urgent Care Centers (UCCs)**

As a step-up in care from Convenience Care Centers, CareFirst maintains a network of Urgent Care providers in approximately 240 locations within its service area. Urgent Care Centers are distinguished from EDs and Convenience Care Clinics by the scope of conditions treated with on-site diagnostic equipment including phlebotomy and x-ray equipment, as well as exam rooms equipped to perform minor medical procedures. Some examples of conditions suitable for Urgent Care include: sprains; painful sore throats; flu; and, ear or eye infections. While Urgent Care Centers are not typically open 24-hours a day, most centers in the CareFirst region are open seven days a week from 8:00 AM to 8:00 PM with larger organization such as our UCA partners Patient First and Righttime who are often open until 10:00 PM.

**Emergency Departments (EDs)**

The most intensive level of care is the ED of a hospital. EDs are open 24 hours a day/seven days a week (24/7). All EDs in the CareFirst region participate in the CareFirst network of providers. ED care is required for major, life-threatening illness or injury. Examples of medical emergencies include chest pain, trouble breathing, head trauma, bleeding that does not stop when pressure is applied, and loss of consciousness.

**Figure 107** shows the range of illnesses or injuries that can be treated in an ED vs. the other care settings included in the UCA Program.

**Part VI, Figure 107: Treatment Options Among Telemedicine, Convenience Care Centers, Urgent Care Centers And Emergency Departments (EDs)**

| Illness/Injury | Telemedicine | Convenience Care Center | Urgent Care Center | ED |
|---|---|---|---|---|
| **Major Illness or Injury (Broken Bones, Burns, Bleeding)** | | | | * |
| **Chest Pain, Shortness of Breath, and Other Symptoms of Heart Attack or Stroke** | | | | * |
| **Significant, Uncontrolled Bleeding** | | | | * |
| **Abnormal heart rhythms** | | | | * |
| **Spinal Cord or Back Injury** | | | | * |
| **Labor** | | | | * |
| **Poisoning** | | | | * |
| **Minor Fracture** | | | * | * |
| **Animal Bites** | | | * | * |
| **X-rays** | | | * | * |
| **Stitches** | | | * | * |
| **Back Pain** | | | * | * |
| **Sprains and Strains** | | | * | * |
| **Nausea, Vomiting, Diarrhea** | | | * | * |
| **Mild Asthma** | | | * | * |
| **Minor Headaches** | | | * | * |
| **Foreign Object in Eye or Nose** | | | * | * |
| **Blood Work** | | | * | * |
| **Allergies** | * | * | * | * |
| **Bumps, Cuts, and Scrapes** | * | * | * | * |
| **Rashes and Minor Burns** | * | * | * | * |
| **Fevers** | * | * | * | * |
| **Ear or Sinus Pain** | * | * | * | * |
| **Eye Irritation, Swelling, Pain** | * | * | * | * |
| **Vaccinations** | | * | * | * |
| **Minor Allergic Reaction** | * | * | * | * |
| **Coughs and Sore Throat** | * | * | * | * |
| **Cold or Flu Symptoms** | * | * | * | * |

### Many Locations for Easy Access

With approximately 240 Urgent Care and over 100 Convenience Care service locations in the CareFirst service area comprised of Maryland, Washington, D.C., and Northern Virginia, the proximity of these centers is such that Members are effectively able to reach a site easily in most cases with no more than a 10- to 15-minute drive. UCA providers are available in all 20 sub-regions of the CareFirst overall service area. And with back up provided by video-based telemedicine and Nurseline support available on a 24/7 basis, Members have easy, consistent access to Urgent and Convenience Care when they need it and cannot get in to see their PCP.

### System Integration of Urgent Care and Convenience Care Center Partners

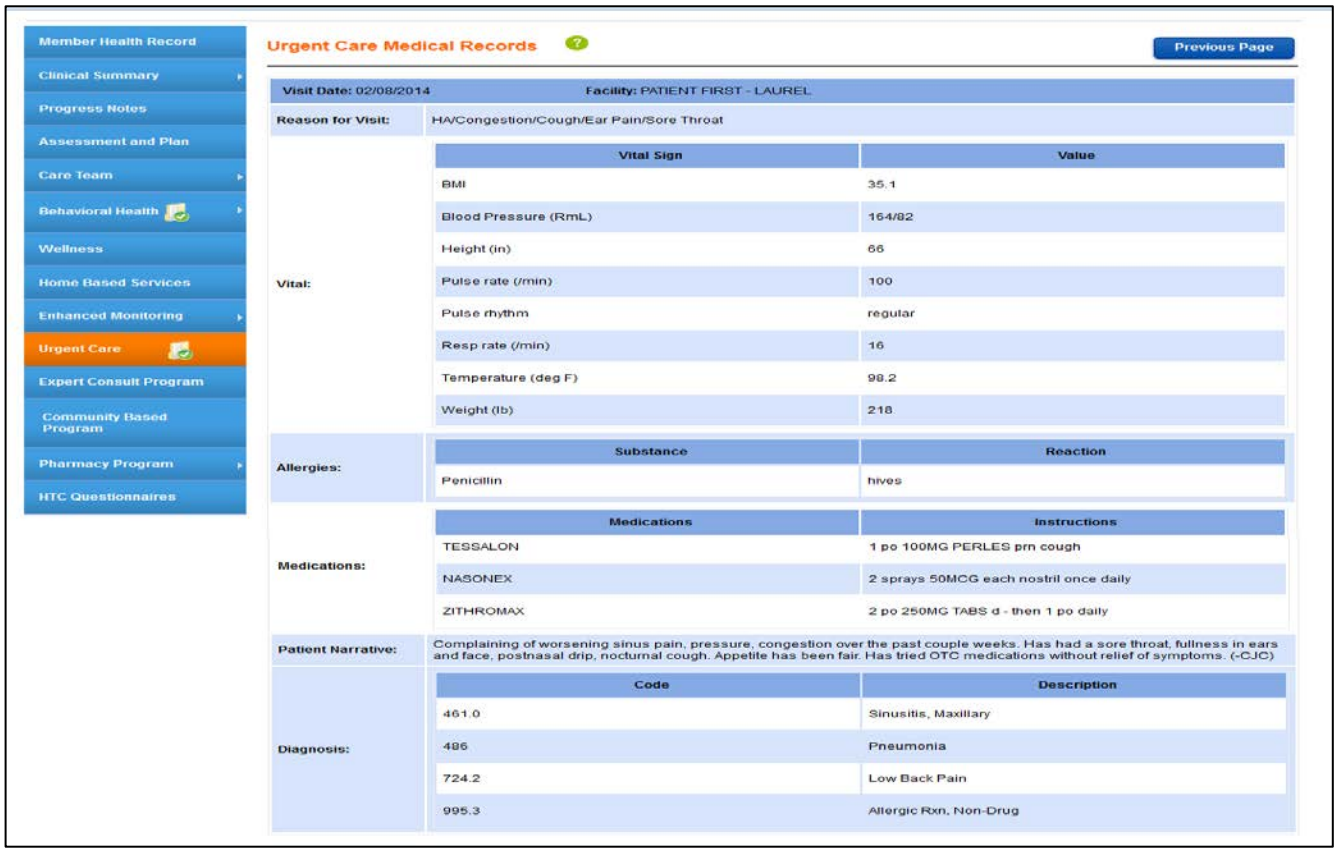
Urgent and Convenience Care providers send treatment information to the iCentric System in order to enhance continuity of care. Patient First and Righttime are the core of the Urgent Care network while CVS MinuteClinic fulfills this role for the Convenience Care network. In return, CareFirst provides its UCA partners access to the Member Health Record of each

Member that is contained within the iCentric System. UCA provider partners' login to iCentric at the point of care to obtain available medical history (including medications) on the Member they are treating.

Following treatment, the UCA providers send CareFirst a record of all Members seen, examined, and treated with complete clinical notes from these encounters. This data is uploaded into iCentric daily where it is easily viewable by PCPs and Care Coordinators. This enables the PCP to maintain visibility into their Members minor and urgent health episodes when rendered by UCA providers. CareFirst also requires UCA partners to refer Members back to their PCPs for follow-up treatment, underscoring the primary relationship with the PCP.

When viewing the iCentric System, providers see the following results from Urgent and Convenience Care partners.

**Part VI, Figure 108: Urgent And Convenience Care Access Program (UCA) Partner Visit Results Documented In iCentric**




**Mobile Enabled Access**

The UCA Program is supported through CareFirst's mobile application for Members. Members can use their mobile devices to access convenient geo-mapping results when searching for Urgent or Convenience Care providers in a prescribed radius around their current location. Once a Member locates a UCA site, driving directions, contact information and facility hours are one click away. The "find a doctor" functionality on the CareFirst website and Member mobile application provides Members with locations and list of services offered by UCA providers.

## Program #13: Centers Of Distinction Program (CDP)

About half of inpatient admissions paid by CareFirst are for a planned procedure, such as knee or heart surgery. Through careful analysis of its claims information, CareFirst has observed distinct patterns in care provided in hospitals throughout the service area. Specifically, the total cost of care for different procedures differs significantly depending on where the specific procedure is performed. For example, in 2014, the average cost of inpatient admission in a high-cost hospital was almost double the average cost of admission in a low-cost hospital. Moreover, certain hospitals have achieved quality distinction through an independent rating process for specific procedures that have high variability in quality and costs.

One of the primary goals of the PCMH and TCCI Programs is to promote the delivery of care at those settings that produce the highest value and quality outcomes for select procedures and categories of care. To further this goal, CareFirst has established the CDP Program to encourage use of the best performing hospitals for certain high volume and/or high cost hospital-based procedures which are typically scheduled in advance by specialists.

Hospitals designated as a BDC hospital are those that meet specified quality criteria as described below, while also meeting cost-effectiveness criteria. CareFirst Members are not required to receive their care at these hospitals but are encouraged to do so because of the better outcomes and higher value care provided for these selective services. In effect, the BDC designation establishes a "network-within-network" for select procedures

Because of their distinction in these services, CareFirst seeks to highlight BCD hospitals to its PCMH Panels and Members by identifying to PCMH Panels the specific physician specialists that perform these selected procedures at BDC hospitals.

**Determination of Blue Distinction Centers (BDC)**

Starting at the most basic level, hospitals that receive the BDC designation must be accredited by a national organization such as The Joint Commission ("TJC") as well as Healthcare Facilities Accreditation Program of the American Osteopathic Information Association ("HFAP"), National Integrated Accreditation Program for Healthcare Organizations of Det Norske Veritas Healthcare, Inc. ("NIAHOSM"), or Center for Improvement in Healthcare Quality ("CIHQ").

To this baseline, three dimensions of capability/quality are added:

- Structural measures—the availability of key clinical services, including diagnostic, medical and multi-disciplinary services and features.
- Process measures—the adherence to evidence-based (or clinically based) care processes.
- Patient outcome measures—including complication rates and lengths of stay.

There are seven categories of BDC hospitals as described below:

- **Bariatric Surgery -** These designated hospitals provide a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. Each selected hospital meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery ("ASMBS"), the Surgical Review Corporation ("SRC") and the American College of Surgeons ("ACS").
- **Cardiac Care -** These designated hospitals provide comprehensive inpatient cardiac services including, Coronary Artery Bypass Graft surgery ("CABG") and/or heart valve surgery and Percutaneous Coronary Intervention ("PCI"). Each selected hospital provides onsite services for Percutaneous Coronary Intervention (PCI) and has 24/7 primary PCI staff coverage, meeting National Cardiovascular Disease Registry® ("NCDR") CathPCI Registry® volume and measuring targets, participating in the Society of Thoracic Surgeons ("STS") Adult Cardiac Surgery Database.

- **"Knee and Hip Replacement -** These hospitals demonstrate superior outcomes for Members of comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement. BDC centers must meet Knee and Hip Replacement Program structure and process, volume and outcome measures standards set such as hospital-level Risk-Standardized Complication rate ("RSCR") following elective primary Total Hip Arthroplasty ("THA") and/or Total Knee Arthroplasty ("TKA") and, hospital-level 30-day, all-cause Risk-Standardized Readmission Rate (RSRR) following elective primary Total Hip Arthroplasty ("THA") and/or Total Knee Arthroplasty ("TKA").

- **Spine Surgery -** These hospitals provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures. BDC centers must meet measures set for Spine Surgery Program structure and process, volume, and Spine Surgery Program complication denominator volume and specific outcome measures such as Readmissions and Surgical Site Infection ("SSI"). BDCs are accredited by at least one of the following: The Joint Commission ("TJC") (without provision or condition) in the Hospital Accreditation Program, Healthcare Facilities Accreditation Program ("HFAP") of the American Osteopathic Information Association ("AOIA"), National Integrated Accreditation Program ("NIAHOSM"), Acute Care of DNV GL Healthcare, or Center for Improvement in Healthcare Quality ("CIHQ") in the Hospital Accreditation Program.

- **Maternity Care -** These hospitals must meet standards set using publicly available data from hospital compare's December 2014 data for Early Elective Delivery ("PC-01"), and selected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS"). Severe Maternal Morbidity ("SMM") Rate from the Centers for Disease Control ("CDC") will be used to further enhance hospital awareness and stimulate quality improvement. BDC hospitals must be designated as Baby Friendly Hospital by Baby Friendly USA or identified as a Mother Friendly Hospital using processes established by the Coalition for Improving Maternity Services ("CIMS").

- **Complex and Rare Cancers -** These hospitals meet structure, process and outcome measures for complex and rare cancer services, including team and volume requirements or be designated through the National Comprehensive Cancer Network ("NCCN"), National Cancer Institute ("NCI") Comprehensive Cancer Center, NCI Clinical Cancer Center, American College of Surgeons' Commission on Cancer Teaching Hospital Cancer Program ("THCP") or a Community Hospital Comprehensive Program ("COMP"). BDC hospitals offer quality care based on patient assessment, treatment planning, complex inpatient care and major surgical treatments for adults; all delivered by teams with distinguished expertise and subspecialty training for the types of complex and rare cancers listed below:

    - Bladder Cancer
    - Bone Cancer – Primary
    - Brain Cancer – Primary
    - Esophageal Cancer
    - Gastric Cancer
    - Head and Neck Cancers
    - Liver Cancer – Primary
    - Ocular Melanoma
    - Pancreatic Cancer
    - Rectal Cancer
    - Soft Tissue Sarcomas
    - Thyroid Cancer – Medullary or Anaplastic
    - Acute Leukemia (Inpatient/Non-Surgical)

- **Blue Distinction Centers Transplants ("BDCT") -** These hospitals are included in a national network of transplant centers that provide comprehensive transplant services through a coordinated, streamlined referral management

program. Each hospital meets stringent clinical criteria, established in collaboration with expert physicians and medical organizations recommendations, including the Center for International Blood and Marrow Transplant Research ("CIBMTR"), the Scientific Registry of Transplant Recipients ("SRTR") and the Foundation for the Accreditation of Cellular Therapy ("FACT"), and is subject to periodic re-evaluation as criteria continue to evolve.

Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.

Each of the BDC Transplant hospitals is designated for one or more of the following types of transplants:

- Heart
- Lung
- Liver (deceased and living donor)
- Pancreas (adult transplants only)
- Bone Marrow/Stem Cell

**Awareness of BDC Hospitals by PCMH Panels**

Promotion of BDC hospitals is made in one of two ways: 1) through working with PCMH Panels; and 2) through the provider directory.

As a condition of being a BDC hospital, the hospital provides the names of all of its specialists that perform the designated procedure in their facility. Those specialists rated by CareFirst as low- or mid-cost are provided to Practice Consultants who educate the PCMH Panels to which they are assigned so that they can make informed referral decisions. The goal is to grow the share of CareFirst Members receiving care at these designated BDC facilities.

PCMH Panels can track how many of their Members receive services at BDC and non-BDC hospitals through monthly SearchLight Reports.

**Provider Directory/Member Portal**

In addition to working closely with PCPs, CareFirst prominently displays BDC designated hospitals in its provider directories. CareFirst Members can find additional information about BDC hospitals at CareFirst's MyAccount Member Portal.

## Program #14: Preauthorization Program (PRE)

**Pre-Authorization of High Cost, High Impact Services Program**

Seeking Pre-Authorization of services often creates a burden for providers and Members and is viewed as an obstacle by Members in receiving needed care or services. In addition, if not structured thoughtfully, pre-authorization can unnecessarily increase administrative costs as well. However, some services are either so expensive or so subject to misuse that they justify the use of a Pre-Authorization requirement.

CareFirst maintains a list of approximately 670 Current Procedural Terminology ("CPT") codes for which Pre-Authorization is required. This is out of the 9,000 or more CPT codes that exist. These Pre-Authorization codes affect a small percentage of CareFirst's overall membership (less than five percent), yet this small population accounts for a high percentage of total health care spending. Members for whom Pre-Authorization applies typically require combinations of authorizations such as medical, drug and Durable Medical Equipment (DME).

Of the more than 670 codes requiring Pre-Authorization:

- Surgical Procedures including Cosmetic and Reconstructive procedures account for 360 codes; and
- DME and Home Care Services account for 190 codes.

Further, there are certain Specialty Medications that also require Pre-Authorization since these medications cost nearly $.5 billion annually with $1.3 billion in associated medical costs for a total of $1.7 billion in annual medical and pharmacy spend for approximately two to three percent of all Members.

Pre-Authorization focuses on services or procedures that are:

- extremely complex
- highly variable and/or potentially unnecessary
- require complex clinical judgment
- experimental or investigational
- extremely high cost
- more effectively provided in an alternative setting (site of service)
- potentially subject to patterns of abuse
- if used inappropriately harm the Member

The procedures and services meeting these criteria listed above are grouped into 10 categories as follows:

1. High Cost DME and Home Care
2. Genetic Testing
3. Air Ambulance
4. Complex Surgeries (e.g. Transplants) and Reconstructive/Cosmetic Procedures
5. Admissions to Skilled Nursing and Acute Rehab Facilities
6. Emerging Technologies
7. High Cost Radiation Therapy such as Proton Beam and Intensity-Modulated Radiation Therapy (IMRT)
8. Out of Network Services (When required by contract)
9. High Cost Specialty Medications and Specialty Infusions
10. End Stage Renal Conditions

The majority of medical services that require pre-authorization are medically necessary and are required for the health and well-being of the Member. The Pre-Authorization Program serves as a check to assure that the right service for the Member in the right setting at the right time is provided. For medical services, Pre-Service Review Nurses ("PSRNs"), apply evidence-based medical policies. The PSRNs have extensive clinical and medical review experience and are extremely knowledgeable in the application of criteria. The nurses also have backgrounds in fraud and abuse, special investigations, medical policy and benefit administration. They have access to Member specific contracts to ensure the Member's benefits are being applied in accordance with the Member's Benefit Contract.

All PSRN's involved on the clinical review team interact with iCentric, documenting clinical notes in the Member Health Record.

If an authorization request does not meet evidence-based criteria, a CareFirst Medical Director provides an additional level of review, with an opportunity for peer-to-peer discussion between the referring physician and the CareFirst Medical Director before an action is taken.

**Sentinel Effect**

The high cost, complex procedures that are subject to pre-authorization are ordered by distinct subsets of providers or specialists, some of whom are employed by the institutions that own the equipment that will be used to administer the treatments. Once the physicians who frequently order procedures on the prior authorization list become familiar with CareFirst's Medical Policy, the number of Pre-Authorization requests usually drops with only requests for Members who actually meet the evidence-based criteria for a procedure or service being submitted. It is not uncommon to see denial rates for Pre-Authorization requests drop below five percent as providers become more aware of evidence-based medical policy.

**Updating Process**

The list of selected services requiring pre-authorization is reviewed on a regular basis by the Medical Directors. This review, which occurs at least twice yearly, includes clinical feedback from the physician community, analysis of denial and appeal data, as well as qualitative feedback from our medical review and appeal nurses. Additionally, the detailed medical policies pertaining to these services are reviewed annually.

**Online Pre-Authorization Request Process**

The CareFirst Provider Portal offers providers access to the specific list of services requiring Pre-Authorization and enables them to enter the request for a specific Member and receive an immediate determination – either an approval or a message indicating further review is required.

The Pre-Authorization Process for Medical Services is as follows:

1. The accesses the Request Authorization tab in iCentric and enters basic Member demographic information and the service being requested. Many services meet criteria and are immediately approved for medical necessity.

2. When a provider requests authorization for one of the identified services or codes on the Pre-Authorization List, a series of condition specific questions must be answered. The provider may attach medical records or any pertinent clinical information.

3. The request, along with all of the submitted documentation, is electronically routed to a Pre-Service Review Nurse for review.

4. The PSRN evaluates every case identified for review referring back to the Member's benefit contract to ensure needed services are covered within the Member's contract. The PSRN documents all findings in the clinical Authorization record within iCentric and communicates with the requesting provider.

5. If the request is approved, the PSRN will issue a Pre-Authorization which will flow through iCentric to the provider, immediately notifying the provider of the approval. The provider can view all of the clinical information and PSRN notes within iCentric.

6. If, after a PSRN review, the request cannot be approved, the PSRN will route the case, including all of the clinical information, through iCentric to the CareFirst Medical Director for a physician level review.

7. The CareFirst Medical Director will assess all of the clinical and contractual information relating to the case, beginning with the provider's initial submission and clinical responses and will render a determination based upon the documentation submitted, clinical judgment, evidence based criteria and national medical policies.

8. If the request cannot be approved, the CareFirst Medical Director will offer a peer to peer review consultation with the requesting provider.

9. The Member and the provider are promptly notified of the determination.

10. All documentation is stored within iCentric and can be viewed by the entire Care Coordination Team.

**Pre-Authorization for Specialty Pharmacy Services**

Medication specific authorizations are a key component of the Preauthorization Program due to the substantial cost and often complex regiments for proper administration of certain medications.

Approximately 120 specific medications require a pre-authorization out of more than 5,000 medications available under CareFirst formularies.

The pre-authorization of these medications allows CareFirst to identify Members who are using these medications. Once identified and authorized, this permits follow up by specially trained nurses who are experts in the proper administration of these medications in support of Members who are taking them (For more, see section titled **Case Management Provided to Identified Members** in **RxP Element #3: Authorization and Case Management for Specialty Drugs in the Medical and Pharmacy Benefits**).

**Coordination with PCMH and TCCI Programs**

At any time, a PSRN or Rx Nurse Case Manager can connect the Member with a LCC or CCM if the Member's condition and/or treatment are appropriate for PCMH or TCCI management.

Due to the nature of the Pre-Authorization process, the PSRN Rx or Nurse Case Manager may become aware of hospitalizations before the HTC. In this instance, the PSRN will route the Pre-Authorization to the HTC, thus engaging the HTC and initiating Care Coordination before the Member is even admitted to the acute care setting.

## Program #15: Telemedicine Program (TMP)

Accessible primary care services are critical to high quality outcomes, reducing ER visits and preventable hospital readmissions. When the availability of many PCPs is limited to regular office hours with little or no back-up and coverage, care is often sought at the local hospital ER.

Telemedicine is emerging as a critical component of an efficient health care system that can improve access to timely, cost-effective care, expanding the accessibility of PCPs and providing a potential alternative to the local hospital ER. Due to advances in technology, telemedicine is spreading rapidly and is becoming integrated into the ongoing operations of physician offices. When performed correctly – in a secure and easy-to-use way that protects privacy – telemedicine can offer Members a convenient way to reach their provider and improve the relationship between Member and physician.

A long standing PCMH Program requirement has been to encourage participating practices to offer extended hours of operation and flexible primary care backup services to their membership. TMP supports this goal by encouraging real-time, integrated audio and video telecommunication between a Member and their PCP or between conferring providers about a specific Member's care.

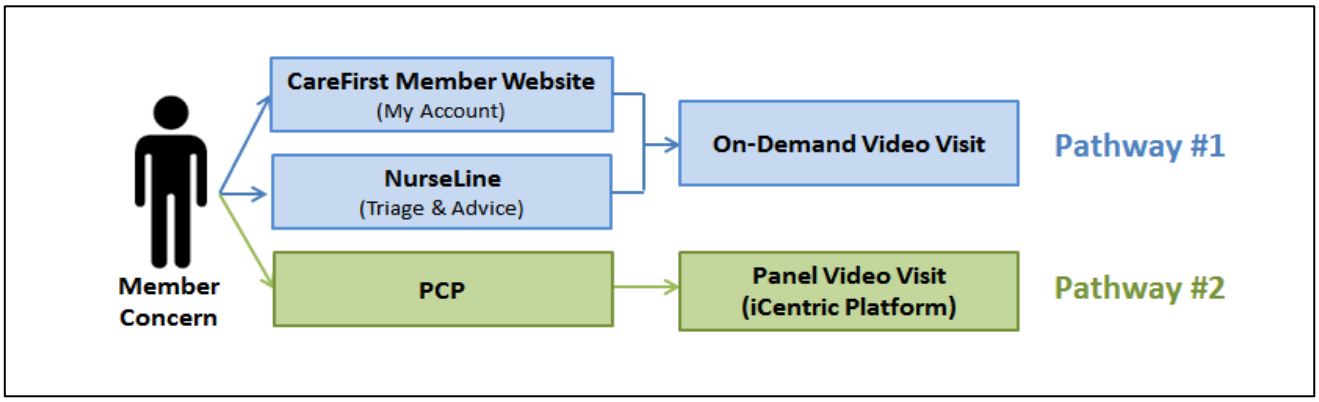
It is a goal of the PCMH Program for all practices to offer telemedicine access to Members. Practices may already be using their own resources to offer telemedicine. If a Practice does not have such resources, CareFirst has developed telemedicine capabilities that are available to participating PCMH practices and all Members. The system is free-of-charge to the provider and enables online video conferencing capabilities as an alternative to in-office visits. Care Coordinators may also access this technology to engage CareFirst Members in Care Plans. In addition, Members themselves can access telemedicine services directly through the CareFirst website when in need of immediate, on-demand physician care.

CareFirst medical policy covers telemedicine visits across various services and specialties to provide convenient and accessible services to patients. Telemedicine is fully covered by all CareFirst plans at the same billing level as a regular visit so long as the provider has the capability, meets the same requirements as face-to-face consultations, and uses the appropriate codes allowable for telemedicine.

### Two Pathways to CareFirst Video Visit Services

To ensure members are able to conveniently and securely access primary care services whenever they need it, CareFirst developed the Telemedicine Program. This Program provides two pathways to access a physician via a Video Visit, the first allows a member to connect with a board-certified physician on a 24/7 basis if their PCP is not available for an in-person visit. The second telemedicine pathway increases a member's access to their PCP. The two pathways are illustrated in **Figure 109** and described below.

**Part VI, Figure 109: Two Pathways To Initiate A Video Visit**



**Pathway #1 – On-Demand Video Visit for all Members**

This pathway is initiated by a Member and can be scheduled to begin immediately. While Members are always encouraged to access the health care system through their PCP, Members seeking treatment advice for common conditions (e.g., allergies, bronchitis, strep throat, eye or ear infections, etc.) have 24/7 access to on-demand video consultations with board certified physicians through a convenient link located on the CareFirst website. This Pathway is used when access to the Member's PCP or back up PCP (in a Panel) is not available.

The link connects Members to a special, secure webpage where they can enter their contact information and reason for a Video Visit. Upon clicking to submit the request, the Member receives an email with a link and instructions for accessing the Video Visit service.

Members can access the link to Video Visits from their home or office anytime and anywhere via mobile device or laptop with sufficient broadband internet access. The link connects Members to a board-certified physician to assist with the treatment of any non-emergency medical conditions. The physician conducting the Video Visit may diagnose symptoms, prescribe medications, and send prescriptions to the Member's pharmacy of choice.

Pathway #1 is considered part of the Urgent and Convenience Care Access (UCA) Program. More information about this Program can be found in the Guidelines under the UCA description contained in this **Part VI** under TCCI **Program #12**. This Pathway is supported by American Well, a CareFirst partner, and by AxisPoint, the CareFirst 24-hour Nurseline.

**Pathway #2 – Video Visits for PCMH Panels Target Population**

This pathway supports PCPs and Care Coordinators in the PCMH Program who do not have their own telemedicine platform with Video Visits delivered through the iCentric platform. iCentric assists with the scheduling of a secure audio-visual connection to enable PCPs to perform routine visits and deliver extended hours of care without regard to physical location, making PCPs generally more available to Members.

Pathway #2 is designed to support a myriad of use-cases as an integral capability provided to Panels that enables them to offer better access to care and improves the quality of care for Members in the PCMH Program. These use-cases are designed to promote stronger relationships and effective care interactions among Members, PCPs, and LCCs. Use-cases for this technology include:

**Medical Follow-up:** A PCP can conduct a Video Visit with a Member to follow-up on a broad range of conditions after an initial diagnosis. The Video Visit platform is particularly effective for reducing the need of a Member to travel for follow up care.

**Maintenance Visit:** During business hours, after hours and on weekends, PCPs can schedule Video Visits with Members and Care Coordinators to review progress and setbacks in achieving Care Plan objectives.

**PCP - Specialist Consult:** A PCP can conduct a consult with a specialist remotely via a Video Visit appointment and involve a Member or an LCC.

**After-hours Care:** A PCP can provide after-hours coverage through a Video Visit with a Member to improve diagnosis and triage urgent conditions to improve coordination of care.

**Remote Location Access:** A PCP in a rural area can use a Video Visit to improve access to medical care for Members who are unable to travel to the office or need the services/consultation of a specialist who would otherwise be unavailable.

**Coordination of TCCI Services:** A Video Visit can be used for all aspects of TCCI Care Coordination, including but not limited to performing Comprehensive Medication Reviews, reviewing results of Expert Consults, conducting pain management review sessions, and evaluating the results of Enhanced Monitoring.

**Hospital Discharge Follow-up:** A PCP can use a Video Visit to perform seven-day and 14-day Transitional Care Management assessments on patients recently discharged from the hospital.

**Chronic Care Management:** A PCP can monitor progress of Members with chronic conditions in a convenient manner by conducting a Video Visit for routine follow-up care of Members.

**Pilot Experience**

CareFirst launched a telemedicine pilot in 2015 to evaluate the use-cases described above and to test the iCentric capabilities built to support real-time audio-visual communication. 33 Panels participated in the pilot with 57 physicians. Early findings showed that Members and participating providers found telemedicine to be convenient and overall would recommend the service to others.

Members enjoyed the ability to connect with their providers in their home environment, and felt they had their providers' undivided attention in this setting. Telemedicine also emerged as a useful capability in urgent care situations. In the cases evaluated in the pilot, Members' symptoms were easy to diagnose and treat, while maintaining the security of the doctor-patient relationship.

Examples of physicians using telemedicine during the pilot are described below:

- A child was seen in the office for a concussion**.** Follow up was required the next day, and the doctor was able to conduct balance testing via telemedicine in the child's home the following day without the child's parents needing to leave home. The CareFirst Video Visit platform enabled the parents of the child to save time, money, and the child did not miss school hours. In this case, the child was also cared for in the security of his home with his parent's right next to him, where he was comfortable with his provider asking him questions about a scary situation.

- During a snowstorm, many Member appointments were being cancelled. Several doctors using the Video Visit platform called their Members and asked if they would like to have a Video Visit rather than cancel their appointments. This eased the minds of the Members as they were still able to follow up with their provider and receive their medical review without delay.

- Following a three-week hospitalization, a medically fragile Member was discharged from the hospital. At the time, the Member was home bound due to their medical condition. Using the CareFirst Video Visit service, the Member's PCP was able to see her within the first week following discharge. This follow up visit would not have been possible for the Member at this time without this service.

- On a Saturday, a Member noticed a concerning wound on his arm that needed his PCPs assessment and he wanted medical advice on how to care for it. In five to 10 minutes the PCP, Member, and his spouse conducted a Video Visit. The Member benefited from talking to a Physician who he already had a relationship with, and stated that he felt that seeing his own PCP expedited his diagnosis and treatment with his own doctor rather than seeing someone new or going to an ED of a hospital.

One of the key insights gained from the pilot was that, to be effective, most physicians require a very simple, intuitive technology interface. They made important suggestions for how to improve the platform's capabilities which are now in place. Further, some Members felt that providing an increased feeling of privacy and data security during the consultation would make them feel more at ease during the consultation.

Members and providers both suggested testing of the technology on their devices prior to the scheduled visit to ensure a smooth connection and sign-on at the time of the Video Visit. The pilot revealed that scheduling needed to be more carefully integrated into the providers' workflow in order to decrease the overall administrative impact of Video Visits on the practice's day-to-day operations. Overall, feedback from the pilot greatly informed the creation of the Telemedicine Program.

**Accessing the Video Visit Program**

As noted earlier, the CareFirst Video Visit capability is available to all PCPs in PCMH practices free of charge from CareFirst. All registered iCentric users in a practice are able to use the Video Visit platform. PCPs have the ability to schedule and

conduct visits. Further, practice administrative staff with iCentric access, gain the ability to schedule and manage Video Visits on behalf of the practitioners in the practice.

When a practice joins the TMP, they receive instructional materials and assistance with accessing and using the Video Visit platform from the PCMH RCD, PC, and the PCMH team. The instructional materials indicate how to schedule and manage Video Visits within iCentric, and instructions on conducting Video Visits with the Member.

Before beginning the Telemedicine Program, participating practices consider how to best accommodate the Video Visit capability into the usual work flow of their office. The iCentric Video Visit platform offers features designed to seamlessly integrate Video Visits, including a scheduling tool, access to the Member Health Record, email notifications to providers and Members, and a virtual waiting room with messaging.

These features are available to support the provider as they consider how best to:

- assist practices with verifying Member insurance eligibility.
- collect cost-share when appropriate.
- coordinate with PCP appointment schedules to ensure timeliness.

**Scheduling a Video Visit with a PCP**

PCMH practices can choose to use the Video Visit platform on a pre-scheduled or on-demand basis. In situations where the appointment is pre-scheduled, scheduling is conducted within iCentric. The scheduling process involves confirming the Member's eligibility, providing the Member's contact email address, selecting a date and time for the appointment, and optionally, including notes on the reason for the appointment.

Once an appointment is scheduled, iCentric automatically sends a schedule reminder email to both the PCP, and the Member, indicating the time of the appointment, including instructions for the Member to set up the software, log in, and use the Video Visit capability. To ease future scheduling needs, the Member's contact information and email address are stored within the iCentric Member Health Record after the first appointment is made.

Some PCMH practices may also choose to use the Video Visit platform as an on-demand service for their Members. In these situations, the Panel decides on which of the PCPs are "on call" for which date and times – thereby enabling Video Visit whenever there is coverage.

**Secure Connection**

All Video Visits are conducted through CareFirst secure servers. The Video Visits platform is password protected, encrypted and HIPAA compliant. Each meeting invite is unique to the Member and PCP. To maintain the privacy of the CareFirst Member, Video Visits should be conducted in a quiet, private location, where health information cannot be overheard by unauthorized individuals. CareFirst does not record the contents of a Video Visit, but logs Member and provider contact information for reporting purposes.

**Simple Setup**

PCPs that use the Video Visit platform may use office computers installed with speakers, a microphone and a web camera. Additionally, they may use most tablets or smart phones after installing the CareFirst supplied Video Visit communication tools. Participating Members may also use the same types of equipment. A high-speed internet connection is needed, particularly over Wi-Fi or a cable connection.

**Member Benefits and Billing**

Video Visits occurring through either Pathway 1 or 2 are a covered benefit for the majority of CareFirst Members. Telemedicine is expected to deliver the same level of care as the equivalent face-to-face service. Therefore, all requirements for a face-to-face contact also apply to a Video Visit. Documentation in the medical record must support the services rendered, as is the case with any visit.

Billing for Video Visits is performed in the usual way and uses an appropriate CPT code with the HCPCS modifier "-GT". Billing for appointments that cannot be completed due to scheduling or technical difficulties is forbidden. A successful Video Visit must consist of both an audio and a video connection between the Member and the provider. That is, to be billable, a Member must always be present.

To bill for a Video Visit, eligible PCPs should select the appropriate CPT code for "Outpatient visit for Evaluation and Management" (CPT code range 99211-99215) along with the telehealth modifier "-GT" to signify that the encounter occurred "via interactive audio and video". If more than one treating provider is present for the appointment, each can bill separately.

PCPs who are conducting face-to-face Hospital Transitional Care Management via Video Visit use the standard Transitional Care Management codes, as appropriate to the Member's situation and the jurisdiction in which care is provided.

Jurisdiction specific laws and regulations, as well as provider licensing, for telemedicine apply based on the location where the Member receiving services is physically located at the time service is provided.

## Program #16: Dental-Medical Health Program (DMH)

**UPDATE PENDING**

## Program #17: Detecting And Resolving Fraud, Waste And Abuse (FWA)

**UPDATE PENDING**

## Program #18: Administrative Efficiency And Data Accuracy Program (AEA)

**UPDATE PENDING**

## Program #19: Precision Health Program (PHP)

**UPDATE PENDING**

## Program #20: Healthworx Program (HWX)

**UPDATE PENDING**

CareFirst
Family of health care plans

# VOLUME III

## SYSTEMS AND DATA SUPPORTS FOR PCMH AND TCCI

## (Parts VII-VIII, Appendices)



Q4 2017

# Part VII: HealthCheck And SearchLight Reports: Seeing Cost Trends And Quality Outcomes More Clearly

Q4 2017

## Preface

The online SearchLight Reporting capability that is made available to Panels on a 24/7 basis places an immense treasure trove of data at their fingertips.

The principle source of data is claims data from three different CareFirst claims processing platforms. All such data is entered into the CareFirst data warehouse that supports the SearchLight Reporting process on a post adjudication basis– meaning it has been scrubbed, corrected, checked and cross checked against industry standard coding norms as well as demographic information on individual Members. It is as "correct" to a 99 percent+ accuracy standard.

It is useful to know just how much data is available. CareFirst receives 36 million claims a year for all Members with an average of two to four claim lines per claim. These claims show all services rendered to all Members anywhere by any provider. At least three years of claims data is kept online before being archived in a way that makes older claims data still easy to retrieve.

In addition, non-claims data is stored in the CareFirst data warehouse (called CBI for CareFirst Business Intelligence). This includes LCC and Complex Case Manager notes and data from the Care Plans of Members as well as information from CareFirst select vendor partners in pharmacy review, behavioral health and other ancillary areas. Notes and data from other providers contained in entries made by LCCs and Complex Case Managers in the development and implementation of Care Plans is also included.

In all, CareFirst currently has approximately 3,000 Terabytes of data in the CBI data warehouse. This is the equivalent of 300 times the entire printed collection of the Library of Congress or three million copies of the Encyclopedia Britannica.

A typical online inquiry from a PCP who is part of a Panel would be to seek out one or more of the structured views that are provided in the SearchLight Report and be able to drill down to the Member level to see the Member Health Record that underlies the view(s). The response time to do this varies from sub-second to five seconds depending on the inquiry. Member specific, disease specific and episode specific views are typically derived from larger patterns shown in the reports as well as comparative views with other Panels. The system gathers and presents the views sought – whether highly specific or sweeping in their scope – swiftly, accurately and reliably.

The navigation to any of the hundreds of views in the SearchLight Reporting package is made easy and swift by the organization of the views into a Table of Contents that can be easily searched enabling the PCP to go straight to the view sought in a few clicks of the mouse.

All data in the SearchLight Report is governed from the point of acquisition at its source though various layers of industry standard Audit, Balance and Control processes overseen by a full time team of data governance analysts who perform constant checks. This activity is, in turn, overseen by a Data Stewardship Committee that is consulted when data anomalies arise.

The underlying software used to generate SearchLight Reports is an amalgam of CareFirst developed software and third party developed software in order to calculate all the data constructs needed to perform such functions as Member attribution, determination of Illness Burden Scores, consolidation of all claims data for individual Members in order to build this up from the PCP to Panel and Program wide levels. This constellation of software – nearly 20 software packages in total – facilitates the calculation of Quality Profile Scores and the myriad of other tasks necessary to support the PCMH and TCCI Programs, not the least of which is to calculate OIAs.

Additionally, CareFirst annually conducts internal and external audits on the validity of the processes used to calculate OIAs – building this up from the sources of all data through all processes followed to reach the correct conclusion for each Panel. This extensive audit review tests the validity of the data contained in CBI and how it is used to feed the calculations that undergird the PCMH and TCCI Programs as well as the accuracy of the calculations themselves.

Finally, all CareFirst sensitive information, including SearchLight Reports, is transmitted over the web using industry standard encryption protocols and secured connections. Access to each SearchLight Report is strictly controlled and enforced via role based security which ensures that an individual user can see only those reports for which permission has

to assist Panels with accessing, understanding and using the data contained in SearchLight views, CareFirst has assigned a trained Practice Consultant to each Panel whose role is to guide and assist each Panel in their attempts to effectively use the data and views made available to them in SearchLight. These trained professional analysts become expert in the patterns of cost, use of service, quality of care and demographic characteristics of the Panels to whom they are assigned. Their sole purpose is to help Panels improve their performance by command of the data they gain access to through the SearchLight Reports.

A full SearchLight Report for a Panel is shown in the pages that follow. The data displayed is real but Member identity is masked in order to maintain confidentiality of patient specific data.

# PCMH SearchLight Report

## Medical Panel ABC

## Virtual Panel Composed of:

**Provider Group A**
**Provider Group B**
**Provider Group C**

Bob Blue, MD
Ray Purple, MD
Robin Red, NP
Gary Green, MD
Irene Indigo, MD
Fletch Orange, MD
Ronald Brown, MD
Samuel Yellow, MD
Theodore Lavender MD
Fer Brick-Red, MD

Bonnie Beige, NP
S. Cornflower-Blue, MD
Peter Black, MD
Michael Mauve, MD
Tom Turquoise, MD
Sarah Cobalt, MD
Ace Emerald, MD
Donald Daisy, MD
Shastine Gold, MD
Margaret Orange, MD

# Purpose and Overview of SearchLight Report

## PCMH SearchLight Report for Panel ABC

*The data views that follow present the facts underlying the performance of the PCMH Medical Care Panel that is the subject of this SearchLight Report. These various views are meant, as their name implies, to provide insight into the patterns that matter the most - indeed, to shine a "searchlight" on these patterns so that the Panel can increase its understanding of its own cost and quality results and maximize its chance of earning an Outcome Incentive Award.*

*The report is organized into 10 distinct sections each displaying a different aspect of Panel Performance. A Panel "HealthCheck" summary is also provided up front which serves as a dashboard that is intended to focus Panel attention on the actionable steps it could take to improve its performance.*

*It is useful to keep in mind that an average PCMH Panel of 8-10 primary care provders with between 2,000 and 3,000 CareFirst attributed Members can be expected to experience total care costs for these Members in excess of $10 million per year. These Members can be expected to have over 50,000 service encounters and produce over double this volume of claim lines for all claims filed on their behalf. These Members can also be expected to run the gamut of Members from those in great health to those that are seriously ill. The challenge, therefore, is to make sense of the sheer mass of data that is available – almost all of which is based on detailed claim information that is submitted in an ever more accurate, detailed and timely way through electronic means. For Members in case management and care plans, clinical information is often gathered to supplement the available claims data.*

*Many sections of SearchLight present information on services that are part of CareFirst's Total Care and Cost Improvement (TCCI) program. TCCI is a broad collection of services, elements of which surround and support the PCMH program, often outside of the PCPs view. The report thus acts as a mechanism to connect the Panel with the full experience of Panel Members and to assist PCPs in finding the most appropriate services for its Members.*

*All data is updated monthly by the 15th day of the month following each completed month. It is critical to understand that a 3 month lag is built into certain claim information to allow for a sufficient run out of claims to provide a complete and accurate picture of results. Other information is available more promptly at the end of each month. These different timings are noted throughout the report.*

*It goes without saying, therefore, that when considering and understanding patterns, time becomes an important dimension. The patterns and facts that this SearchLight Report displays are only available with the passage of time. Hence, it is critical to understand that SearchLight is not a clinical support tool, but rather, a way to see a longitudinal emerging picture of a whole population of Members – and then, to enable the reviewer to peer down into sub patterns that help explain what is going on. SearchLight is not intended to serve as an Electronic Medical Record system for tracking the care of individual Members; its purpose is to highlight patterns that an EMR system would not reveal.*

*Certain comparisons are available that allow the Panel to view its own performance over time and in relation to the performance of other Panels – including peers and all Panels in the PCMH Program. Bettering past performance is the essence of quality improvement, if one could only see and understand past performance in its totality and particularity. And, comparing one's performance to others is also instructive, particularly when data is displayed in a way that assures a "like with like" picture to the extent possible.*

*Central to the purposes of the various data views is the display of data that shows aggregate performance in all settings for all Members over time. In effect, every service rendered by any provider at any time in any setting is maintained in the database that supports the views in this report. It is, therefore, designed to show a comprehensive, longitudinal picture of Member treatment patterns well beyond the services rendered by the primary care providers in the Panel. This longitudinal picture of performance helps give perspective on what patterns matter the most and where focus is most important to improve results from both a quality and cost standpoint.*

*Many data views in the report have a drill down feature that permits a more detailed understanding – down to the Member level – of patterns that may be of particular interest or significance.*

*In short, the report makes available data typically never seen by providers. All data is available over the web on a virtually 24/7 basis. In this way, the report is meant to be what its name conveys - a "searchlight" that can be shined on patterns and facts that most help the Panel manage a diverse and complex Member population over time toward a better overall outcome that could not otherwise be so well achieved without the benefits of this penetrating set of views.*

*While extensive when taken as a whole, this SearchLight Report can be easily and quickly navigated by going directly to the section and view that is of greatest interest after reference to the Table of Contents that follows.*

PCMH SearchLight
Patient-Centered Medical Home

CareFirst

# Table of Contents

**PCMH SearchLight Report for Panel ABC**

PCMH SearchLight™ Patient-Centered Medical Home

CareFirst

## Table of Contents

PCMH SearchLight Report for Panel ABC

# Table of Contents

**PCMH SearchLight Report for Panel ABC**

# Table of Contents

**PCMH SearchLight Report for Panel ABC**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## A. Panel Profile by Year

*The view below highlights key information related to Panel performance. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year.*

*For supporting information, refer to the following SearchLight reports:*

**VIII-H. Overall Panel Composite Quality Score**
**IX-C. Detail of Performance Year**
**X-E. Panel Performance Metrics By Year**

| Metric | Panel Results | | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Base Year (2010) | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Average Members | 3,113 | 2,297 | 2,534 | 2,594 | 2,476 | 2,434 | 2,506 | 2,508 | 2,451 |
| Illness Burden Score (Normalized) | 1.64 | 1.79 | 1.76 | 1.78 | 1.67 | 1.35 | 1.39 | 1.39 | 1.43 |
| Medical Credit $ | N/A | $12,847,681 | $14,557,648 | $15,670,532 | $10,946,631 | $9,833,815 | $10,987,619 | $11,548,331 | $9,100,732 |
| Rx Credit $ | N/A | $1,757,323 | $2,244,927 | $2,493,667 | $1,707,940 | $1,686,322 | $2,012,188 | $2,111,066 | $1,615,458 |
| Total Credit $ | N/A | $14,605,004 | $16,802,575 | $18,164,198 | $12,654,571 | $11,310,642 | $12,583,686 | $13,602,464 | $10,459,906 |
| Total Gross Debit $ | $16,827,375 | $14,409,183 | $16,476,029 | $17,685,552 | $12,112,291 | $12,036,813 | $12,673,130 | $14,250,036 | $10,873,149 |
| Individual Stop Loss $ | $1,249,750 | $1,364,554 | $1,492,765 | $1,681,548 | $837,434 | $950,212 | $996,674 | $1,200,596 | $800,590 |
| Medical Net Debit $ | $13,600,710 | $11,574,169 | $13,030,046 | $13,904,691 | $9,733,281 | $9,499,439 | $9,930,007 | $11,131,488 | $8,566,387 |
| Rx Net Debit $ | $1,976,915 | $1,470,460 | $1,953,217 | $2,099,314 | $1,541,577 | $1,587,194 | $1,746,450 | $1,917,953 | $1,573,965 |
| Total Net Debit $ | $15,577,624 | $13,044,629 | $14,983,263 | $16,004,004 | $11,274,857 | $11,086,633 | $11,676,457 | $13,049,441 | $10,140,353 |
| Net Savings/Loss $ | N/A | $1,560,375 | $1,819,312 | $2,160,194 | $1,379,714 | $434,439 | $907,230 | $553,024 | $387,347 |
| Savings Percentage | N/A | 11.2% | 12.3% | 12.6% | 6.3% | 3.3% | 6.9% | 2.8% | 2.6% |
| Engagement Score | N/A | 19.0 | 26.0 | 28.9 | 44.6 | 12.7 | 18.0 | 21.6 | 32.3 |
| Overall Quality Score | N/A | 61.1 | 67.2 | 72.2 | 77.0 | 55.1 | 60.9 | 65.4 | 64.5 |
| Final OIA Percentage Point Award | N/A | 77 | 84 | 79 | 69 | 28 | 31 | 23 | |
| PCP/NP Change | N/A | N/A | N/A | 18.6% | 22.2% | | | 16.1 | 24.1 |

| Metric | Panel - Annual % Change | | | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Average Members | | | 10.3% | 2.4% | -4.6% | | 3.6% | 0.1% | -1.1% |
| Illness Burden Score (Normalized) | | | -1.7% | 1.2% | -5.9% | | 3.0% | 0.0% | 2.9% |
| Savings Percentage | | | 14.9% | 6.8% | -29.5% | | 109.1% | -59.4% | -7.1% |

**Practice Consultant Analysis for Panel Profile by Year:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## B. Panel Profile by Year - PMPMs and Trends

*The view below highlights key information related to Panel performance. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year.*

*For supporting information, refer to the following SearchLight reports:*

**IX-C. Detail Performance Year**

**X-E. Panel Performance Metrics By Year**

| Metric | Panel Results | | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Base Year (2010) | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Medical PMPM | $364.08 | $419.76 | $428.39 | $446.61 | $436.72 | $339.97 | $341.06 | $374.39 | $389.86 |
| Rx PMPM | $52.92 | $53.33 | $64.21 | $67.43 | $69.17 | $56.72 | $59.99 | $64.51 | $71.63 |
| Total PMPM | $417.00 | $473.08 | $492.61 | $514.03 | $505.89 | $396.70 | $401.05 | $438.90 | $461.49 |
| IB Adjusted Medical PMPM | $190.48 | $237.08 | $244.89 | $253.76 | $261.39 | $253.58 | $244.69 | $269.66 | $273.64 |
| IB Adjusted Rx PMPM | $28.31 | $30.11 | $37.09 | $38.62 | $41.65 | $42.31 | $43.04 | $46.46 | $50.28 |
| IB Adjusted Total PMPM | $218.79 | $267.18 | $281.98 | $292.38 | $303.04 | $295.88 | $287.73 | $316.12 | $323.92 |
| IB Adjusted Medical PMPM Rank | N/A | N/A | N/A | 89/277 | 83/296 | N/A | N/A | N/A | N/A |

| Metric | Panel - Annual % Change | | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|---|
| | 2012 to 2013 | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | 2012 to 2013 | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| PCMH Medical Annual Trend | 5.5% | 3.5% | 3.5% | 3.5% | N/A | 3.5% | 3.5% | 3.5% |
| Panel Medical Annual Trend | N/A | 1.6% | 6.1% | -2.1% | N/A | 0.3% | 9.8% | 4.1% |
| PCMH Medical Cumulative Trend | 5.5% | 9.2% | 13.0% | 17.0% | N/A | 9.2% | 13.0% | 17.0% |
| Panel Medical Cumulative Trend | N/A | 3.5% | 8.5% | 6.2% | N/A | 0.3% | 10.1% | 14.6% |
| PCMH Rx Annual Trend | 5.5% | 3.5% | 10.0% | 5.0% | N/A | N/A | N/A | N/A |
| Panel Rx Annual Trend | N/A | 25.2% | 5.1% | 2.4% | N/A | 5.8% | 7.5% | 11.0% |
| PCMH Rx Cumulative Trend | 5.5% | 9.2% | 20.1% | 26.1% | N/A | N/A | N/A | N/A |
| Panel Rx Cumulative Trend | N/A | 18.7% | 23.8% | 38.9% | N/A | 5.8% | 13.7% | 26.2% |
| Total PMPM Trend | N/A | 6.2% | 5.1% | -1.5% | N/A | 1.1% | 9.4% | 5.1% |
| IB Adjusted Medical PMPM Trend | N/A | 1.9% | 3.8% | 4.3% | N/A | -3.5% | 10.2% | 1.5% |
| IB Adjusted Rx PMPM Trend | N/A | 22.6% | 2.9% | 9.0% | N/A | 1.7% | 7.9% | 8.2% |
| IB Adjusted Total PMPM Trend | N/A | 3.3% | 3.4% | 4.4% | N/A | -2.8% | 9.9% | 2.5% |

**Practice Consultant Analysis for Panel Profile by Year - PMPMs and Trends:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## C. Effectiveness of Panel Referral Patterns

*The view below highlights key information related to specialist and hospital referral patterns experienced by the Panel. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year. Cost efficient specialists are those designated as Low or Low Mid in SearchLight reports.*

*For supporting information, refer to the following SearchLight reports:*

**IV-A. Admissions and Readmissions and Gross Debits by Hospital**

**IV-J. Top 10 Procedures in Both ASC and Outpatient Hospital Settings**

**VII-A. Profile of Medical Specialist Referrals**

**VII-D. Profile of Procedural Specialist Referrals**

| Metric | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Percent of referrals to cost efficient medical specialists | 83.4% | 83.0% | 83.3% | 83.1% | 80.9% | 81.4% | 81.4% | 81.5% |
| Percent of referrals to cost efficient procedural specialists | N/A | N/A | 82.1% | 82.7% | N/A | N/A | 80.3% | 80.7% |
| Percent of admissions and outpatient services at cost efficient hospitals | N/A | 81.6% | 82.7% | 80.5% | N/A | 66.1% | 65.7% | 64.2% |
| Percent of procedures in ASC vs. outpatient hospital settings | 61.3% | 61.2% | 62.9% | 65.6% | 58.1% | 59.6% | 58.8% | 61.4% |

| Metric | Panel - Annual % Change | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|
| | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Percent of referrals to cost efficient medical specialists | -0.5% | 0.4% | -0.4% | | 0.6% | 0.0% | 0.1% |
| Percent of referrals to cost efficient procedural specialists | N/A | N/A | 0.5% | | N/A | N/A | 0.5% |
| Percent of admissions and outpatient services at cost efficient hospitals | N/A | 1.8% | -2.6% | | N/A | -0.6% | -2.3% |
| Percent of procedures in ASC vs. outpatient hospital settings | 2.4% | 1.5% | 3.7% | | 2.6% | -1.3% | 4.4% |

**Practice Consultant Analysis for Effectiveness of Panel Referral Patterns:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## D. Effectiveness of Panel Referral Patterns - Consistency Within the Panel

*The view below highlights key information related to specialist and hospital referral patterns of Panel PCPs. Results are shown for the full previous year and the current Performance Year. Cost efficient specialists are those designated as Low or Low Mid in SearchLight reports.*

*For supporting information, refer to the following SearchLight reports:*

**IV-A. Admissions and Readmissions and Gross Debits by Hospital**

**IV-J. Top 10 Procedures in Both ASC and Outpatient Hospital Settings**

**VII-B. Profile of Medical Specialist Referrals by Provider**

**VII-E. Profile of Procedural Specialist Referrals by Provider**

| Metric | % of PCPs Better Than Peer Average | | | |
|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Percent of referrals to cost efficient medical specialists | 93.7% | 85.0% | 72.0% | 77.3% |
| Percent of referrals to cost efficient procedural specialists | N/A | N/A | 65.9% | 78.6% |
| Percent of admissions and outpatient services at cost efficient hospitals | N/A | 0.0% | 0.0% | 98.6% |
| Percent of procedures in ASC vs. outpatient hospital settings | 0.0% | 0.0% | 0.0% | 82.5% |

| Metric | | Prior Year (2015) | | Current Year (2016 YTD) | |
|---|---|---|---|---|---|
| | | Rate | PCP | Rate | PCP |
| Percent of referrals to cost efficient medical specialists | Highest Scored PCP | 88.5% | Ronald Brown | 84.8% | Bonnie Beige |
| | Lowest Scored PCP | 75.9% | Michael Muave | 51.5% | Fletch Orange |
| Percent of referrals to cost efficient procedural specialists | Highest Scored PCP | 95.0% | Theodore Lavendar | 78.9% | Samuel Yellow |
| | Lowest Scored PCP | 50.0% | Gary Green | 50.0% | Sarah Cobalt |
| Percent of admissions and outpatient services at cost efficient hospitals | Highest Scored PCP | N/A | N/A | 99.3% | Gary Green |
| | Lowest Scored PCP | N/A | N/A | 85.2% | Ronald Brown |
| Percent of procedures in ASC vs. outpatient hospital settings | Highest Scored PCP | N/A | N/A | 93.4% | Ace Emerald |
| | Lowest Scored PCP | N/A | N/A | 81.7% | Ronald Brown |

**Practice Consultant Analysis for Effectiveness of Panel Referral Patterns - Consistency Within the Panel:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## E. Extent of Panel Engagement in Care Coordination

*The view below highlights key information related to the extent of Panel engagement in Chronic Care Coordination (CCC). Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year. The number of Members with an Illness Burden Score greater than seven is shown as the general segment of Members likely to benefit from care coordination. The Core Target Population is a separate group of very high cost, high use Members identified for care coordination. While the two population lists are based on different criteria, Members with more complex illnesses are likely to appear on both lists.*

*For supporting information, refer to the following SearchLight reports:*

**V-A. Core Target Members Most Likely in Need of Care Coordination**

**VI-K. Profile of Members in Chronic Care Coordination**

**VIII-I. Overall Panel Engagement Quality Score vs. Provider Peers**

**VIII-I. Engagement Category Ratings and Care Plan Participation by PCP**

**X-F. Year over Year Measures That Matter - Key Metrics and Comparisons**

| Metric | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Members in Core Target Population | N/A | N/A | N/A | 106 | N/A | N/A | N/A | 88 |
| Average IB for Core Target Population | N/A | N/A | N/A | 8.92 | N/A | N/A | N/A | 8.79 |
| Percent of Members in Core Target Population with Care Plans | N/A | N/A | N/A | 23.7 | N/A | N/A | N/A | 16.1% |
| Members with IB >7 | 112 | 130 | 147 | 110 | 66 | 71 | 83 | 74 |
| Care Plans (active and closed) | 47 | 88 | 100 | 96 | 23 | 37 | 53 | 56 |
| Average IB for Care Plan Members | 6.37 | 7.13 | 6.36 | N/A | 6 | 6 | 6 | |
| Percent of Members with IB>7 in Care Plans | 10.4 | 19.1 | 16.8 | N/A | 9.8% | 13.7% | 15.3% | |
| Care Plans per PCP | N/A | 10.7 | 11.8 | 12.2 | N/A | 4.9 | 6.2 | 6.4 |
| Percent of PCPs with Care Plans | N/A | 100.0% | 100.0% | 100.0% | N/A | 69.9% | 78.2% | 79.0% |
| Engagement Score | 19.2/30.0 | 26.5/35.0 | 29.2/35.0 | 44.7/50.0 | 12.7/30.0 | 18.0/35.0 | 21.6/35.0 | 32.3/50.0 |
| Inpatient Admissions Per 1,000 | 103.9 | 103.9 | 95.9 | 87.5 | 75.0 | 72.1 | 70.7 | 70.4 |
| ER Visits Per 1,000 | 256.4 | 249.9 | 252.2 | 248.5 | 220.9 | 218.7 | 219.2 | 217.0 |

| Metric | Panel - Annual % Change | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|
| | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Members in Core Target Population | N/A | N/A | N/A | | N/A | N/A | N/A |
| Average IB for Core Target Population | N/A | N/A | N/A | | N/A | N/A | N/A |
| Percent of Members in Core Target Population with Care Plans | N/A | N/A | N/A | | N/A | N/A | N/A |
| Members with IB >7 | N/A | N/A | N/A | | 7.6% | 16.9% | -10.8% |
| Care Plans (active and closed) | N/A | N/A | N/A | | 60.9% | 43.2% | 5.7% |
| Average IB for Care Plan Members | N/A | N/A | N/A | | 4.6% | -7.4% | |
| Percent of Members with IB>7 in Care | | | | | 39.8% | 11.7% | |
| Care Plans per PCP | N/A | 9.9% | 4.0% | | N/A | 26.5% | 3.2% |
| Percent of PCPs with Care Plans | N/A | 0.0% | 0.0% | | N/A | 11.9% | 1.0% |
| Engagement Score | 23.4% | 19.6% | -52.0% | | 41.7% | 20.0% | 49.5% |
| Inpatient Admissions Per 1,000 | -0.1% | -7.7% | -8.7% | | -3.9% | -1.9% | -0.4% |
| ER Visits Per 1,000 | -2.5% | 0.9% | -1.4% | | -1.0% | 0.2% | -1.0% |

**Practice Consultant Analysis for Extent of Panel Engagement in Care Coordination:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## F. Extent of Panel Engagement in Care Coordination - Consistency Within the Panel

*The view below highlights key information related to the extent of engagement in Chronic Care Coordination (CCC) for Panel PCPs. Results are shown for the full previous year and the current Performance Year. The Core Target Population is a separate group of very high cost, high use Members identified for care coordination.*

*For supporting information, refer to the following SearchLight reports:*

**V-A. Core Target Members Most Likely in Need of Care Coordination**

**VI-K. Profile of Members in Chronic Care Coordination**

**VIII-I. Overall Panel Engagement Quality Score vs. Provider Peers**

**VIII-I. Engagement Category Ratings and Care Plan Participation by PCP**

| Metric | % of PCPs Better Than Peer Average | | | |
|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Percent Core Target Members with an Assessment Outcome (AO) | N/A | N/A | N/A | 70.2% |
| Percent Core Target Members with Care Plans | N/A | N/A | N/A | 71.1% |
| Care Plans Per PCP | N/A | N/A | N/A | 71.1% |
| Engagement Score | 0.0% | 100.0% | 100.0% | 100.0% |

| Metric | | Prior Year (2015) | | Current Year (2016 YTD) | |
|---|---|---|---|---|---|
| | | Rate | PCP | Rate | PCP |
| Percent Core Target Members with an Assessment Outcome (AO) | Highest Scored PCP | N/A | N/A | 28.0% | Shastine Gold |
| | Lowest Scored PCP | N/A | N/A | 11.0% | Multiple PCPs |
| Percent Core Target Members with Care Plans | Highest Scored PCP | N/A | N/A | 8.0% | Shastine Gold |
| | Lowest Scored PCP | N/A | N/A | 1.0% | Multiple PCPs |
| Care Plans Per PCP | Highest Scored PCP | 7 | Theodore Lavendar | 14 | Fletch Orange |
| | Lowest Scored PCP | 0 | Peter Black | 4 | Bonnie Beige |
| Engagement Score | Highest Scored PCP | 88.0% | Ronald Brown | 85.0% | Margaret Orange |
| | Lowest Scored PCP | 75.0% | Michael Mauve | 72.0% | Samuel Yellow |

**Practice Consultant Analysis for Extent of Panel Engagement in Care Coordination - Consistency Within the Panel:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## G. Impact of Care Coordination Program - Pre and Post Comparisons

*The view below highlights the impacts of care coordination via four key measures for the reporting periods noted. PMPMs are based on full Member debits, including pharmacy. Results are shown for the 12 months prior to care plan activation, and for periods 3, 6, 9, and 12 months after activation. The Post Activation time periods include three months of claims runout.*

*For supporting information, refer to the following SearchLight reports:*

**VI-L. Members in Chronic Care Coordination (CCC) - Key Measures / Outcomes**

| Metric | Activation Year | CCC Care Plans | Pre Care Plan Activation | Post Care Plan Activation | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 12 Months | 3 Months | % Chg | 6 Months | % Chg | 9 Months | % Chg | 12 Months | % Chg |
| Average Illness Burden Score | 2013 | 84 | 6.57 | 7.0 | 7.2% | 7.1 | 7.5% | 6.8 | 2.7% | 6.7 | 2.0% |
| | 2014 | 115 | 8.09 | 8.2 | 3.1% | 8.4 | 5.2% | 7.8 | -0.6% | 6.4 | -20.0% |
| | 2015 | 135 | 6.02 | 6.3 | 3.9% | 5.9 | -3.0% | 5.7 | -5.1% | 4.5 | -24.8% |
| | 2016 YTD | 93 | 9.70 | 9.6 | -0.8% | 8.6 | -11.6% | 5.2 | -46.8% | 0.0 | 0.0% |
| Inpatient Admissions Per 1,000 | 2013 | 84 | 567.1 | 739.0 | 32.0% | 889.7 | 56.0% | 812.1 | 36.8% | 786.5 | 33.1% |
| | 2014 | 115 | 726.2 | 250.9 | -65.1% | 436.8 | -40.0% | 384.2 | -46.7% | 398.6 | -44.4% |
| | 2015 | 135 | 528.8 | 505.9 | 8.8% | 425.7 | -15.3% | 441.2 | -10.4% | 397.5 | -18.1% |
| | 2016 YTD | 93 | 890.4 | 424.0 | -54.0% | 853.5 | -7.6% | 678.8 | -27.8% | 0.0 | 0.0% |
| Emergency Room Visits Per 1,000 | 2013 | 84 | 1,447.8 | 1808.1 | 42.1% | 2244.6 | 60.2% | 2150.8 | 47.1% | 2071.1 | 39.8% |
| | 2014 | 115 | 1,154.7 | 433.0 | -62.4% | 534.1 | -52.8% | 551.1 | -51.5% | 695.8 | -39.0% |
| | 2015 | 135 | 1,305.8 | 1070.8 | -6.0% | 1045.3 | -10.2% | 1073.1 | -7.5% | 1036.9 | -8.8% |
| | 2016 YTD | 93 | 1,801.1 | 857.1 | -52.3% | 2313.2 | 26.8% | 1212.5 | -33.2% | 0.0 | 0.0% |
| PMPM $ | 2013 | 84 | $1,900.61 | $2,051.42 | 9.4% | $2,421.64 | 29.5% | $2,285.06 | 21.1% | $2,400.88 | 28.6% |
| | 2014 | 115 | $1,778.43 | $1,150.71 | -32.6% | $1,696.80 | -5.5% | $1,725.83 | -2.1% | $1,896.30 | 7.1% |
| | 2015 | 135 | $1,524.54 | $1,433.84 | -3.9% | $1,515.49 | 1.8% | $1,563.43 | 5.2% | $1,598.72 | 7.6% |
| | 2016 YTD | 93 | $3,665.42 | $1,810.68 | -52.0% | $2,510.29 | -29.1% | $3,380.54 | -11.8% | $0.00 | 0.0% |

**Practice Consultant Analysis for Impact of Care Coordination Program - Pre and Post Comparisons:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## H. Chronic Care Coordination Program Profile

*The view below highlights measures related to active or closed CCC Care Plans for the Panel over the trailing 12 months. Results are shown by the illnes burden sub-band for the Members at the same time of care plan activiation.*

*For supporting information, refer to the following SearchLight reports:*

**VI-L. Members in Chronic Care Coordination (CCC) - Key Measures / Outcomes**

| Illness Burden Sub-Band | CCC Care Plans | Average Age | Average Pre-IB Score (At Active) | Average Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM |
|---|---|---|---|---|---|---|
| 25.000 and Above | 3 | 62.0 | 40.60 | 30.18 | $19,730.26 | $8,733.47 |
| 10.000 to 24.999 | 9 | 55.0 | 15.52 | 14.87 | $5,850.98 | $4,336.80 |
| 5.000 to 9.999 | 18 | 58.3 | 7.23 | 7.14 | $2,309.45 | $3,080.14 |
| 3.500 to 4.999 | 10 | 56.7 | 4.13 | 4.18 | $1,015.04 | $2,080.39 |
| 2.000 to 3.499 | 11 | 51.6 | 2.70 | 3.10 | $627.89 | $1,109.31 |
| 1.500 to 1.999 | 2 | 52.0 | 1.81 | 2.93 | $466.15 | $1,143.23 |
| 1.000 to 1.499 | 4 | 56.8 | 1.29 | 1.52 | $271.12 | $535.89 |
| 0.250 to 0.999 | 3 | 50.1 | 0.74 | 1.56 | $226.51 | $967.55 |
| 0.000 to 0.249 | 0 | 0.0 | 0.00 | 0.00 | $0.00 | $0.00 |
| **Total** | **61** | **55.8** | **7.90** | **7.40** | **$2,906.90** | **$2,524.74** |

**Practice Consultant Analysis for Chronic Care Coordination Program Profile:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## I. Effectiveness of Panel Medication Management

*The view below highlights key information related to effectiveness of medication management for the Panel. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year. A Member's Drug Volatility Score (DVS) is derived from claims data and demographic information and ranges from 0 to 10 with higher drug use and cost. The Pharmacy Risk Group (PRG) Score is used to assess a Member's utilization of pharmacy drugs, along with their relative risks and cost. PRG scores are normalized on a scale of 1.0, with higher scores associated with higher drug use and cost. Polypharmacy describes Members taking 12 or more unique drugs in the trailing 12 months. CMR 1 refers to Completed Comprehensive Medication Reviews initiated by an LCC or PCP while CMR 2 refers to those auto-initiated and subject to automated edit/correction on behalf of the panel.*

*For supporting information, refer to the following SearchLight reports:*

**V-E. Drug Volatility Score**

**V-G. High Rx Utilization**

**IV-N. Generic Dispensing Rate for Mail/Retail Pharmacy Drugs**

| Metric | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Members with high Drug Volatility Score (DVS) (8-10) | N/A | N/A | 146 | 163 | N/A | N/A | 115 | 161 |
| Members with high Pharmacy Risk Group (PRG) Score (5.0+) | | | 111 | 114 | | | 111 | 112 |
| Members with high polypharmacy (12+) | N/A | N/A | 166 | 169 | N/A | N/A | 117 | 118 |
| Total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) | N/A | N/A | 136 | 122 | N/A | N/A | 164 | 218 |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 1 | N/A | N/A | 0.9% | 2.7% | N/A | N/A | 1.4% | 1.6% |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 2 | | | 0.4% | 2.1% | | | 1.5% | 1.7% |
| Percent generic drug substitution vs. potential | 80.9% | 79.3% | 82.8% | 83.2% | 79.6% | 79.8% | 82.0% | 83.7% |

| Metric | Panel - Annual % Change | | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|---|
| | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Members with high Drug Volatility Score (DVS) (8-10) | N/A | N/A | N/A | 14.8% | | N/A | N/A | 40.0% |
| Members with high Pharmacy Risk Group (PRG) Score (5.0+) | | | N/A | 2.7% | | | N/A | 0.9% |
| Members with high polypharmacy (12+) | N/A | N/A | N/A | -5.5% | | N/A | N/A | 0.9% |
| Total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) | N/A | N/A | N/A | 15.3% | | N/A | N/A | 32.9% |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 1 | N/A | N/A | N/A | -34.4% | | N/A | N/A | 14.3% |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 2 | | | N/A | 425.0% | | | N/A | 13.3% |
| Percent generic drug substitution vs. potential | N/A | -1.4% | 4.1% | 2.7% | | 0.3% | 2.8% | 2.1% |

**Practice Consultant Analysis for Effectiveness of Panel Medication Management:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## J. Effectiveness of Panel Medication Management - Consistency Within the Panel

*The view below highlights key information related to effectiveness of medication management for Panel PCPs. Results are shown for the full previous year and the current Performance Year. A Member's Drug Volatility Score (DVS) is derived from claims data and demographic information and ranges from 0 to 10 with higher drug use and cost. The Pharmacy Risk Group (PRG) Score is used to assess a Member's utilization of pharmacy drugs, along with their relative risks and cost. PRG scores are normalized on a scale of 1.0, with higher scores associated with higher drug use and cost. Polypharmacy describes Members taking 12 or more unique drugs in the trailing 12 months. CMR 1 refers to Completed Comprehensive Medication Reviews initiated by an LCC or PCP while CMR 2 refers to those auto-initiated and subject to automated edit/correction on behalf of the panel.*

*For supporting information, refer to the following SearchLight reports:*

**V-E. Drug Volatility Score**

**V-G. High Rx Utilization**

**IV-N. Generic Dispensing Rate for Mail/Retail Pharmacy Drugs**

| Metric | % of PCPs Better Than Peer Average | | | |
|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 1 | N/A | N/A | 33.0% | 23.2% |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 2 | | | 30.0% | 21.0% |
| Percent generic drug substitution vs. potential | 0.0% | 76.5% | 78.3% | 76.5% |

| Metric | | Prior Year (2015) | | Current Year (2016 YTD) | |
|---|---|---|---|---|---|
| | | Rate | PCP | Rate | PCP |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 1 | Highest Scored PCP | 82.0% | Bob Blue | 80.0% | Irene Indigo |
| | Lowest Scored PCP | 72.0% | Fletch Orange | 75.0% | Ronald Brown |
| Percent of total Members above with high DVS (8-10), PRG (5.0+), or polypharmacy (12+) with CMR 2 | Highest Scored PCP | 80.0% | Shastine Gold | 82.0% | S. Cornflower-Blue |
| | Lowest Scored PCP | 72.0% | Ray Purple | 75.0% | Peter Black |
| Percent generic drug substitution vs. potential | Highest Scored PCP | 88.8% | Samuel Yellow | 86.2% | Gary Green |
| | Lowest Scored PCP | 75.0% | Sarah Cobalt | 74.2% | Robin Red |

**Practice Consultant Analysis for Effectiveness of Panel Medication Management - Consistency Within the Panel:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## K. Profile of Panel Clinical Quality and Patient Access

*The view below highlights key information related to the high level sections of the Panel's Clinical Quality ScoreCard, as well as the number of Video Visits, an emerging tool in expanding patient access. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year. For each clinical quality measure, the rate is the percentage of goal acheivement met by dividing the panel points by the maximum points.*

*For supporting information, refer to the following SearchLight reports:*

**VIII-J. Overall Panel Clinical Score vs. Provider Peers**

| Metric | | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Care Coordination / Patient Safety (Appropriate Use measures) | Rate | 71.3% | 78.5% | 71.0% | 64.1% | 67.2% | 73.9% | 72.9% | 79.4% |
| | Points | 14.25/20.00 | 15.71/20.00 | 14.2/20.00 | 8.02/12.50 | 13.44/20.00 | 14.78/20.00 | 14.57/20.00 | 9.93/12.50 |
| At-Risk Population (Chronic Care measures) | Rate | 64.1% | 62.1% | 63.6% | 65.8% | 65.2% | 64.1% | 67.0% | 60.8% |
| | Points | 6.41/10.00 | 6.21/10.00 | 6.36/10.00 | 8.23/12.50 | 6.52/10.00 | 6.41/10.00 | 6.7/10.00 | 7.59/12.50 |
| Preventive Health (Population Health measures) | Rate | 64.1% | 62.4% | 69.8% | 69.6% | 61.3% | 61.6% | 65.8% | 64.9% |
| | Points | 6.41/10.00 | 6.24/10.00 | 6.98/10.00 | 8.71/12.50 | 6.13/10.00 | 6.16/10.00 | 6.58/10.00 | 8.11/12.50 |
| Patient and Caregiver Experience of Care | Rate | N/A | N/A | N/A | 59.7% | N/A | N/A | N/A | 53.0% |
| | Points | N/A | N/A | N/A | 7.46/12.50 | N/A | N/A | N/A | 6.62/12.50 |
| Overall Clinical Quality Score | Rate | 67.7% | 70.4% | 68.8% | 64.8% | 65.2% | 68.4% | 69.6% | 64.5% |
| | Points | 27.06/40.00 | 28.16/40.00 | 27.54/40.00 | 32.42/50.00 | 26.09/40.00 | 27.35/40.00 | 27.85/40.00 | 32.26/50.00 |
| Members with Video Visits | # | N/A | N/A | N/A | 3 | N/A | N/A | N/A | 4 |

| Metric | | Panel - Annual % Change | | | | Provider Type Peer - Annual % Change | | |
|---|---|---|---|---|---|---|---|---|
| | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Care Coordination / Patient Safety (Appropriate Use Measures) | | 11.4% | -9.5% | -9.3% | | 10.0% | -1.4% | 8.9% |
| At-Risk Population (Chronic Care Measures) | | -3.4% | 2.0% | 3.5% | | -1.7% | 4.5% | -9.3% |
| Preventive Health (Population Health Measures) | | -2.9% | 12.2% | -0.2% | | 0.5% | 6.8% | -1.4% |
| Patient and Caregiver Experience of Care | | N/A | N/A | N/A | | N/A | N/A | N/A |
| Overall Clinical Quality Score | | 4.0% | -2.3% | -5.8% | | 4.9% | 1.8% | -7.3% |
| Members with Video Visits | | N/A | N/A | N/A | | N/A | N/A | N/A |

**Practice Consultant Analysis for Profile of Panel Clinical Quality and Patient Access:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## L. Profile of Panel Clinical Quality and Patient Access - Consistency Within the Panel

*The view below highlights key information related to the high level sections of the Clinical Quality ScoreCard for Panel PCPs, as well as the number of Video Visits, an emerging tool in expanding patient access. Results are shown for the full previous year and the current Performance Year.*

*For supporting information, refer to the following SearchLight reports:*

**VIII-J. Overall Panel Clinical Score vs. Provider Peers**

**VIII-J. Clinical Category Rating by PCP**

| Metric | % of PCPs Better Than Peer Average | | | |
|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Care Coordination / Patient Safety (Appropriate Use measures) | 100.0% | 100.0% | 100.0% | 13.0% |
| At-Risk Population (Chronic Care measures) | 35.5% | 35.6% | 28.3% | 63.8% |
| Preventive Health (Population Health measures) | 64.4% | 60.8% | 78.4% | 81.7% |
| Patient and Caregiver Experience of Care | N/A | N/A | N/A | 63.5% |
| Overall Clinical Quality Score | 100.0% | 100.0% | 100.0% | 32.6% |
| Members with Video Visits | N/A | N/A | N/A | 0.0% |

| Metric | | Prior Year (2015) | | Current Year (2016 YTD) | |
|---|---|---|---|---|---|
| | | Rate | PCP | Rate | PCP |
| Care Coordination / Patient Safety (Appropriate Use measures) | Highest Scored PCP | 82.0% | Bob Blue | 80.0% | Fletch Orange |
| | Lowest Scored PCP | 72.0% | Lisa Orange | 75.0% | Robin Red |
| At-Risk Population (Chronic Care measures) | Highest Scored PCP | 80.0% | John White | 82.0% | Fletch Orange |
| | Lowest Scored PCP | 72.0% | Lea Rose | 75.0% | Gary Green |
| Preventive Health (Population Health measures) | Highest Scored PCP | 88.8% | Sam Black | 86.2% | Gary Green |
| | Lowest Scored PCP | 75.0% | Roy Gold | 74.2% | Robin Red |
| Patient and Caregiver Experience of Care | Highest Scored PCP | N/A | N/A | 56.0% | Ray Purple |
| | Lowest Scored PCP | N/A | N/A | 0.0% | Robin Red |
| Overall Clinical Quality Score | Highest Scored PCP | 82.0% | Roy Gold | 78.0% | Fletch Orange |
| | Lowest Scored PCP | 75.0% | Jane Rose | 73.0% | Gary Green |
| Members with Video Visits | Highest Scored PCP | 88.0% | Heather Brown | 1.0 | Peter Black |
| | Lowest Scored PCP | 75.0% | Sam Black | 0.0 | Multiple PCPs |

**Practice Consultant Analysis for Profile of Panel Clinical Quality and Patient Access - Consistency Within the Panel:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## M. Panel Profile of Inpatient Admission Measures That Matter

*The view below highlights key information related to inpatient admissions and readmission costs and utilization. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year.*

*For supporting information, refer to the following SearchLight reports:*

**IV-A. Admissions and Readmissions and Gross Debits by Hospital**

**IV-H. Members with Admissions & Readmissions - All Bands**

**X-F. Year over Year Measures That Matter - Key Metrics and Comparisons**

| Metric | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Inpatient Admissions per 1,000 | 126.9 | 120.0 | 114.2 | 103.6 | 75.0 | 72.1 | 70.7 | 70.4 |
| Inpatient Days per 1,000 | 658.7 | 603.9 | 538.6 | 587.5 | 342.4 | 336.8 | 335.0 | 335.0 |
| Cost per Admission | $18,736 | $17,655 | $18,727 | $17,634 | $14,997 | $14,951 | $15,748 | $16,356 |
| Admission PMPM | $167.80 | $150.61 | $152.27 | $130.57 | $93.70 | $89.80 | $92.80 | $96.00 |
| 30 Day Readmission Rate | 19.5% | 14.8% | 17.1% | 19.5% | 11.3% | 11.6% | 12.7% | 12.7% |
| 60 Day Readmission Rate | 27.8% | 22.2% | 23.8% | 29.8% | 17.2% | 17.5% | 18.6% | 18.4% |
| 90 Day Readmission Rate | 30.8% | 25.4% | 27.5% | 34.2% | 19.7% | 20.2% | 21.2% | 20.9% |
| Cost per 30 Day Readmission | $13,752 | $14,612 | $16,972 | $9,910 | $12,823 | $12,254 | $12,285 | $12,010 |

| Metric | Panel - Annual % Change | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|
| | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Inpatient Admissions per 1,000 | -4.3% | -3.3% | -8.9% | | -3.9% | -1.9% | -0.4% |
| Inpatient Days per 1,000 | -6.8% | -9.4% | 15.6% | | -1.6% | -0.5% | 0.0% |
| Cost per Admission | -6.3% | 9.1% | -5.0% | | -0.3% | 5.3% | 3.9% |
| Admission PMPM | -10.0% | 4.6% | -13.6% | | -4.2% | 3.3% | 3.4% |
| 30 Day Readmission Rate | -26.6% | 18.6% | 20.5% | | 2.7% | 9.5% | 0.0% |
| 60 Day Readmission Rate | -24.1% | 10.6% | 37.8% | | 1.7% | 6.3% | -1.1% |
| 90 Day Readmission Rate | -21.5% | 16.0% | 34.4% | | 2.5% | 5.0% | -1.4% |
| Cost per 30 Day Readmission | 7.1% | 20.5% | -39.5% | | -4.4% | 0.3% | -2.2% |

**Practice Consultant Analysis for Panel Profile of Inpatient Admission Measures That Matter:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## N. Panel Profile of Measures That Matter for Outpatient Services

*The view below highlights key information related to emergency room (ER), outpatient hospital, ASC, urgent and convenience care, and video visit costs and utilization. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year.*

*For supporting information, refer to the following SearchLight reports:*

**IV-I. Members with ER Visits - All Bands**

**IV-K. Use of Urgent Care Backup (UCB) - Weekend/Weekday Visits by Illness Band**

**X-F. Year over Year Measures That Matter - Key Metrics and Comparisons**

| Metric | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| ER Visits per 1,000 | 256.4 | 249.9 | 252.2 | 248.5 | 220.9 | 218.7 | 219.2 | 217.0 |
| Cost per ER Visit | $1,073 | $1,079 | $1,226 | $1,209 | $1,097 | $1,166 | $1,248 | $1,329 |
| Outpatient Visits per 1,000 | 1,121.5 | 1,201.9 | 1,045.5 | 1,063.3 | $920 | $888 | 963.7 | 969.8 |
| Cost per Outpatient Visit | $1,129 | $1,160 | $1,220 | $1,238 | $1,069 | $1,089 | $1,109 | $1,164 |
| ASC Visits per 1,000 | 156.2 | 162.5 | 184.5 | 181.0 | 125.7 | 121.4 | 136.2 | 136.1 |
| Cost per ASC Visit | $945 | $988 | $1,043 | $1,085 | $976 | $980 | $1,020 | $1,084 |
| Urgent Care Visits per 1,000 | 183.8 | 236.6 | 222.4 | 235.2 | 117.9 | 128.9 | 135.0 | 148.1 |
| Cost per Urgent Care Visit | $126.33 | $126.06 | $129.38 | $128.01 | $123.00 | $124.00 | $128.00 | $128.00 |
| Convenience Care Visits per 1,000 | 25.5 | 32.2 | 41.1 | 33.1 | 15.0 | 19.7 | 34.0 | 25.5 |
| Cost per Convenience Care Visit | $49.69 | $56.13 | $59.44 | $70.52 | $53.00 | $56.00 | $59.00 | $69.00 |
| Percent of Office, Urgent Care, and Convenience Care vs. ER Visits | 86.2% | 86.7% | 87.3% | 87.3% | 88.2% | 88.8% | 89.7% | 89.7% |

| Metric | Panel - Annual % Change | | | Provider Type Peer - Annual % Change | | | |
|---|---|---|---|---|---|---|---|
| | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| ER Visits per 1,000 | -1.5% | 1.3% | -1.6% | | -1.0% | 0.2% | -1.0% |
| Cost per ER Visit | 0.4% | 14.6% | -1.0% | | 6.3% | 7.0% | 6.5% |
| Outpatient Visits per 1,000 | 7.0% | -7.7% | 3.9% | | -3.4% | 8.5% | 0.6% |
| Cost per Outpatient Visit | 5.7% | 4.6% | 1.7% | | 1.9% | 1.8% | 5.0% |
| ASC Visits per 1,000 | 3.6% | 16.8% | -1.8% | | -3.4% | 12.2% | -0.1% |
| Cost per ASC Visit | 4.4% | 5.8% | 4.3% | | 0.4% | 4.1% | 6.3% |
| Urgent Care Visits per 1,000 | 27.5% | -2.3% | 7.6% | | 9.3% | 4.7% | 9.7% |
| Cost per Urgent Care Visit | 0.0% | 2.8% | -0.9% | | 0.8% | 3.2% | 0.0% |
| Convenience Care Visits per 1,000 | 39.7% | 24.7% | -25.4% | | 31.3% | 72.6% | -25.0% |
| Cost per Convenience Care Visit | 14.9% | 6.1% | 19.0% | | 5.7% | 5.4% | 16.9% |
| Percent of Office, Urgent Care, and Convenience Care vs. ER Visits | 0.6% | 0.6% | -0.2% | | 0.7% | 1.0% | 0.0% |

**Practice Consultant Analysis for Panel Profile of Measures That Matter for Outpatient Services:**

# I. HealthCheck Profile of Panel

**PCMH SearchLight Report for Panel ABC**

## O. Extent of Panel Engagement with TCCI Programs

*The view below highlights key information related to Members engaged with TCCI programs. Results are shown for the Panel and Provider Type Peers for three full prior years and the current Performance Year.*

*For supporting information, refer to the following SearchLight reports:*

**VI-A. Illness Band and TCCI Program Intersection**

**VI-AC. Summary of Care Coordination Costs for Members in TCCI Programs**

| Metric | Panel Results | | | | Provider Type Peer Averages | | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult | 2013 Adult | 2014 Adult | 2015 Adult | 2016 YTD Adult |
| Average Members | 2,297 | 2,534 | 2,594 | 2,476 | 2,419 | 2,506 | 2,508 | 2,481 |
| Hospital Transition of Care Program (HTC) Members | N/A | 82 | 86 | 80 | N/A | 50 | 56 | 58 |
| Complex Case Management Program (CCM) Members | N/A | 33 | 42 | 44 | N/A | 22 | 31 | 39 |
| Chronic Care Coordination Program (CCC) Members | N/A | 20 | 40 | 66 | N/A | 8 | 16 | 33 |
| Behavioral Health and Substance Use Disorder (BSD) Members | N/A | 0 | 10 | 10 | N/A | 0 | 8 | 9 |
| Home Based Services Program (HBS) Members | N/A | 8 | 16 | 14 | N/A | 5 | 8 | 9 |
| Enhanced Monitoring Program (EMP) Members | N/A | 1 | 9 | 10 | N/A | 1 | 5 | 5 |
| Comprehensive Medication Review Program (CMR) Members | N/A | 0 | 0 | 2 | N/A | 0 | 0 | 4 |
| Community Based Program (CBP) Members | N/A | 2 | 3 | 2 | N/A | 0 | 2 | 2 |
| Pharmacy Coordination Program (RxP) Members | N/A | 0 | 0 | 2 | N/A | 0 | 0 | 1 |
| Expert Consult Program (ECP) Members | N/A | 1 | 1 | 2 | N/A | 1 | 1 | 1 |
| TCCI Program Debits | N/A | $52,619 | $123,989 | $209,285 | N/A | $32,300 | $65,957 | $101,593 |
| TCCI Percentage of Total Panel Debits | N/A | 30.0% | 76.3% | 144.1% | N/A | 0.3% | 0.5% | 0.7% |

| Metric | Panel - Annual % Change | | | Provider Type Peer - Annual % Change | | |
|---|---|---|---|---|---|---|
| | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD | 2013 to 2014 | 2014 to 2015 | 2015 to 2016 YTD |
| Hospital Transition of Care Program (HTC) Members | N/A | 16.7% | -1.4% | N/A | 12.0% | 3.6% |
| Complex Case Management Program (CCM) Members | N/A | 41.7% | 4.9% | N/A | 40.9% | 25.8% |
| Chronic Care Coordination Program (CCC) Members | N/A | 120.0% | 77.8% | N/A | 100.0% | 106.3% |
| Behavioral Health and Substance Use Disorder (BSD) Members | N/A | N/A | -3.3% | N/A | N/A | 12.5% |
| Home Based Services Program (HBS) Members | N/A | 108.2% | -6.9% | N/A | 60.0% | 12.5% |
| Enhanced Monitoring Program (EMP) Members | N/A | N/A | 9.1% | N/A | 400.0% | 0.0% |
| Comprehensive Medication Review Program (CMR) Members | N/A | N/A | N/A | N/A | N/A | N/A |
| Community Based Program (CBP) Members | N/A | N/A | N/A | N/A | N/A | 0.0% |
| Pharmacy Coordination Program (RxP) Members | N/A | N/A | N/A | N/A | N/A | N/A |
| Expert Consult Program (ECP) Members | N/A | -10.9% | N/A | N/A | 0.0% | 0.0% |
| TCCI Program Debits | N/A | 173.7% | 65.1% | N/A | 104.2% | 54.0% |
| TCCI Percentage of Total Panel Debits | N/A | 154.5% | 92.5% | N/A | 66.7% | 40.0% |

**Practice Consultant Analysis for Extent of Panel Engagement with TCCI Programs:**

# II. Profile of Members in Panel

**PCMH SearchLight Report for Panel ABC**

*CareFirst Member attribution is run monthly for each Panel. This shows which Members use a primary care provider (PCP) in each Medical Care Panel. Attribution is achieved in one of three ways:*

- *Member selected PCP in the most recent 6 months.*
- *Practice/PCP seen most often during the most recent 24 months of claims filed with CareFirst*
- *Member selected PCP during open enrollment if no claims experience is available*

*Typically, there is considerable stability in a Panel's attributed Members, but the monthly review shows changes and keeps Panel membership current. Data on each Panel's CareFirst attributed Members is shown in a series of "views." Where appropriate, these include comparisons with other PCMH Panels.*

*PCMH Panel comparisons are shown for three categories:*

- ***Panel Type Peers** - These are Panels in one of four categories:*
  - *Virtual Panel*
  - *Independent Group Practice Panel*
  - *Multi-Panel Independent Group Practice*
  - *Multi-Panel Health System*
- ***Provider Type Peers** - These are Panels in one of three categories:*
  - *Adult*
  - *Pediatric*
  - *Mixed*
- ***PCMH All** - All active Panels in the PCMH program.*

*To gain a deeper understanding of Member health and/or illness status, all Members in the Panel are assigned to one of five illness bands and may be referenced in the SearchLight Report by band number or name:*

- ***Band 1** - Advanced/Critical Illness*
- ***Band 2** - Multiple Chronic Illnesses*
- ***Band 3** - At Risk for serious illness*
- ***Band 4** - Stable*
- ***Band 5** - Healthy*

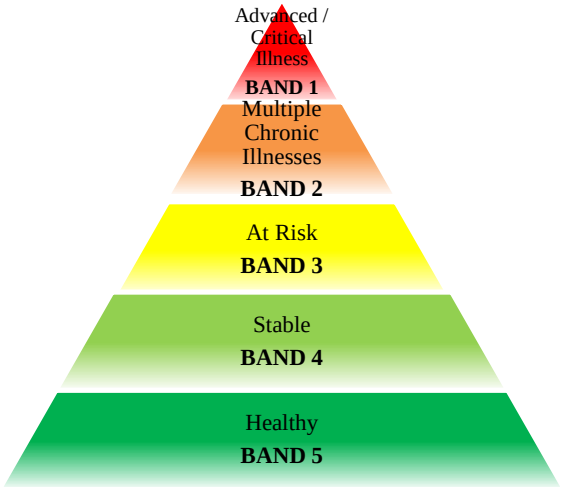
*This information not only reveals the illness characteristics of a Panel's whole Member population, it also shows where costs are concentrated and/or distributed. Among other things, it is used to identify Members that may benefit from care plans or enhanced monitoring.*

*Members are assigned to an illness band using a diagnostic and risk assessment grouping methodology widely considered the industry standard. This methodology assigns an Illness Burden Score to each Member based on the trailing 12 months of claims data inclusive of diagnosis codes from inpatient, outpatient, and professional services. While the methodology does not consider cost in making an Illness Band assignment, the results place "like" illness burdens together in a reasonably reliable way - thus causing Members to be grouped in ways that correlate well with their actual medical costs. See Appendix - Method for Calculating Illness Burden Scores of Members for more on this methodology (DxCG).*

# II. Profile of Members in Panel (Cont.)

*PCMH SearchLight Report for Panel ABC*

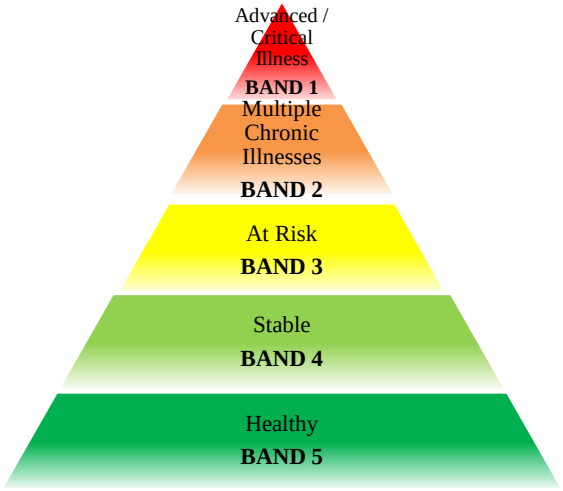
## *CareFirst - Overall PCMH Proaram*




| | % of Members | % of Cost | Average IB Score |
|---|---|---|---|
| **Illness Burden (5.00 and Above) Extremely heavy health care users with significant advanced / critical illness.** | **3.1%** | **31.3%** | **11.09** |
| **Illness Burden (2.00 - 4.99) Heavy users of health care system, mostly for more than one chronic disease.** | **11.1%** | **29.0%** | **2.96** |
| **Illness Burden (1.00 - 1.99) Fairly heavy users of health care system who are at risk of becoming more ill.** | **16.1%** | **18.5%** | **1.43** |
| **Illness Burden (0.25 - 0.99) Generally healthy, with light use of health care services.** | **38.9%** | **17.3%** | **0.55** |
| **Illness Burden (0 - 0.24) Generally healthy, often not using health system.** | **30.8%** | **3.8%** | **0.12** |

*The figure below shows the distribution of Members and cost for the specific Panel that is the subject of this report showing the distribution of all attributed Members, by illness band. Cost is based over the trailing 12 months of claims data after allowing 3 months of run out of claims payments.*

## *Panel Specific Profile*




| | % of Members | % of Cost | Average IB Score |
|---|---|---|---|
| **Illness Burden (5.00 and Above) Extremely heavy health care users with significant advanced / critical illness.** | **5.1%** | **49.0%** | **10.39** |
| **Illness Burden (2.00 - 4.99) Heavy users of health care system, mostly for more than one chronic disease.** | **17.3%** | **27.9%** | **2.98** |
| **Illness Burden (1.00 - 1.99) Fairly heavy users of health care system who are at risk of becoming more ill.** | **23.8%** | **14.2%** | **1.43** |
| **Illness Burden (0.25 - 0.99) Generally healthy, with light use of health care services.** | **36.3%** | **7.9%** | **0.59** |
| **Illness Burden (0 - 0.24) Generally healthy, often not using health system.** | **17.5%** | **1.1%** | **0.12** |

# II. Profile of Members in Panel

**PCMH SearchLight Report for Panel ABC**

## A. Attributed Members

*This chart shows the number of CareFirst Members attributed to the Panel each month, including adds and deletes of attributed Members. Deletes may be due to disenrollment from CareFirst or attribution to another Panel.*

| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Deletes** | | 74 | 80 | 67 | 61 | 63 | 75 | 120 | 64 | 62 | 54 | 119 |
| **Adds** | | 69 | 75 | 58 | 53 | 123 | 66 | 62 | 72 | 58 | 59 | 45 |
| **Total Attributed** | **2,486** | **2,481** | **2,475** | **2,466** | **2,458** | **2,518** | **2,509** | **2,451** | **2,459** | **2,455** | **2,461** | **2,387** |

## B. Average Member Age by Illness Band vs. Peers

*This chart shows the average age of Members as of the most recent month's data by illness band, as well as a comparison with other Panels in the program. The illness burden assignment of Members is based on the band ranges shown in the introduction to this section.*

| Illness Band | Average Age | | | |
|---|---|---|---|---|
| | Panel | Panel Type Peers (192) | Provider Type Peers (277) | PCMH All (423) |
| **Advanced/Critical Illness** | 57 | 54 | 56 | 53 |
| **Multiple Chronic Illnesses** | 51 | 50 | 51 | 49 |
| **At Risk** | 50 | 46 | 48 | 46 |
| **Stable** | 46 | 35 | 43 | 35 |
| **Healthy** | 38 | 24 | 35 | 24 |
| **Overall Average** | **47** | **39** | **45** | **39** |

## C. Number of Members by Illness Band

*This chart displays the number of Members in each illness band and offers some insight into the extent of Member illness or health for the Panel as a whole.*

| Illness Band | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Advanced/Critical Illness** | 138 | 134 | 127 | 122 | 124 | 129 | 129 | 124 | 120 | 124 | 126 | 121 |
| **Multiple Chronic Illnesses** | 435 | 436 | 432 | 434 | 441 | 466 | 460 | 440 | 433 | 424 | 422 | 413 |
| **At Risk** | 558 | 563 | 570 | 579 | 571 | 583 | 585 | 580 | 596 | 589 | 591 | 569 |
| **Stable** | 921 | 916 | 919 | 918 | 916 | 933 | 935 | 903 | 905 | 907 | 906 | 867 |
| **Healthy** | 435 | 432 | 427 | 414 | 407 | 408 | 401 | 404 | 406 | 412 | 417 | 418 |
| **Total** | **2,486** | **2,481** | **2,476** | **2,467** | **2,459** | **2,519** | **2,509** | **2,452** | **2,459** | **2,456** | **2,461** | **2,387** |

## D. Percentage of Members by Illness Band

*This chart shows the percentage of the Panel's Member population in each illness band.*

| Illness Band | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Advanced/Critical Illness** | 5.6% | 5.4% | 5.1% | 4.9% | 5.0% | 5.1% | 5.1% | 5.1% | 4.9% | 5.0% | 5.1% | 5.1% |
| **Multiple Chronic Illnesses** | 17.5% | 17.6% | 17.4% | 17.6% | 17.9% | 18.5% | 18.3% | 18.0% | 17.6% | 17.3% | 17.1% | 17.3% |
| **At Risk** | 22.4% | 22.7% | 23.0% | 23.5% | 23.2% | 23.2% | 23.3% | 23.6% | 24.2% | 24.0% | 24.0% | 23.8% |
| **Stable** | 37.0% | 36.9% | 37.1% | 37.2% | 37.3% | 37.0% | 37.3% | 36.8% | 36.8% | 36.9% | 36.8% | 36.3% |
| **Healthy** | 17.5% | 17.4% | 17.3% | 16.8% | 16.5% | 16.2% | 16.0% | 16.5% | 16.5% | 16.8% | 16.9% | 17.5% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

# II. Profile of Members in Panel

**PCMH SearchLight Report for Panel ABC**

## E. Member Gender by Illness Band

*This chart shows the number and percentage of Members as of the most recent month's data that fall into each illness band by gender.*

| Illness Band | Male | | Female | | Gender Split | |
|---|---|---|---|---|---|---|
| | Members | % | Members | % | Male | Female |
| Advanced/Critical Illness | 54 | 5.7% | 67 | 4.6% | 50.3% | 49.7% |
| Multiple Chronic Illnesses | 185 | 14.0% | 228 | 20.0% | 36.3% | 63.7% |
| At Risk | 255 | 21.7% | 314 | 25.6% | 40.8% | 59.2% |
| Stable | 389 | 36.3% | 478 | 36.3% | 44.9% | 55.1% |
| Healthy | 187 | 22.4% | 230 | 13.5% | 57.3% | 42.7% |
| **Total** | **1,070** | **100.0%** | **1,317** | **100.0%** | **44.8%** | **55.2%** |

## F. Member Movement Across Illness Bands

*This chart shows Panel Membership/Member composition over time (within the current year) from the start of the year to the latest month. It displays the movement across bands as well as additions and losses to the overall Panel population.*

| Illness Band | Jan-16 | Change in Enrollment | | Change in Band | | Dec-16 |
|---|---|---|---|---|---|---|
| | Members | Left Panel | New To Panel | - | + | Members |
| Advanced/Critical Illness | 138 | 35 | 18 | 171 | 171 | 121 |
| Multiple Chronic Illnesses | 435 | 85 | 64 | 579 | 574 | 413 |
| At Risk | 558 | 108 | 97 | 808 | 874 | 569 |
| Stable | 921 | 203 | 194 | 1025 | 891 | 867 |
| Healthy | 435 | 163 | 122 | 466 | 539 | 418 |
| **Total** | **2,486** | **594** | **495** | | | **2,387** |

## G. Change YTD in Average Member Illness Burden Scores

*This chart shows changes in average illness band score within bands from the start of the current year to the most recent available month.*

| Illness Band | Jan-16 | | Dec-16 | | % Change |
|---|---|---|---|---|---|
| | % Members | Average IB Score | % Members | Average IB Score | |
| Advanced/Critical Illness | 5.6% | 11.58 | 5.1% | 10.39 | -10.3% |
| Multiple Chronic Illnesses | 17.5% | 2.93 | 17.3% | 2.98 | 1.6% |
| At Risk | 22.4% | 1.44 | 23.8% | 1.43 | -1.0% |
| Stable | 37.0% | 0.60 | 36.3% | 0.59 | -0.7% |
| Healthy | 17.5% | 0.11 | 17.5% | 0.12 | 3.7% |
| **Overall Average** | **100%** | **1.72** | **100%** | **1.62** | **-6.0%** |

# II. Profile of Members in Panel

**PCMH SearchLight Report for Panel ABC**

## H. Members by Illness Band vs. Peers

*This chart compares the Panel's illness distribution as of the most recent month's data with peer groups for benchmarking purposes.*

| Illness Band | Panel | | Panel Type Peers (192) | Provider Type Peers (277) | PCMH All (423) |
|---|---|---|---|---|---|
| | Members | % | % | % | % |
| Advanced/Critical Illness | 121 | 5.1% | 3.3% | 3.9% | 3.1% |
| Multiple Chronic Illnesses | 413 | 17.3% | 11.3% | 13.9% | 11.0% |
| At Risk | 569 | 23.8% | 16.6% | 19.6% | 16.2% |
| Stable | 867 | 36.3% | 38.4% | 38.9% | 39.0% |
| Healthy | 418 | 17.5% | 30.5% | 23.8% | 30.8% |
| **Total** | **2,387** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |

## I. Average Member Illness Burden Scores vs. Peers

*This chart compares the Panel's average illness burden score within each band as of the most recent month's data to that of various peer groups.*

| Illness Band | Panel | Panel Type Peers (192) | Provider Type Peers (277) | PCMH All (423) |
|---|---|---|---|---|
| Advanced/Critical Illness | 10.03 | 11.15 | 10.85 | 11.06 |
| Multiple Chronic Illnesses | 2.88 | 2.96 | 2.96 | 2.95 |
| At Risk | 1.38 | 1.43 | 1.43 | 1.43 |
| Stable | 0.57 | 0.55 | 0.57 | 0.55 |
| Healthy | 0.11 | 0.12 | 0.12 | 0.12 |
| **Average** | **1.62** | **1.18** | **1.36** | **1.15** |

## J. Member Illness Band Distribution by Provider

*This chart displays Member attribution by provider within the Panel as of the most recent month's data. This allows Primary Care Providers (PCPs) in the Panel to view a profile of their individual Member populations. The percentages under the Illness bands show the distribution of Members across bands for each provider (i.e., each row adds to 100%), while the % of Panel Total columns on the right show the distribution of Members and debits across providers within the Panel.*

| Provider | Advanced/ Critical Illness | | Multiple Chronic Illnesses | | At Risk | | Stable | | Healthy | | Provider Total Members | % of Panel Total Members | Average IB Score | Provider Total Debits | % of Panel Total Debits |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Donald Daisy | 34 | 4.9% | 97 | 14.0% | 147 | 21.2% | 263 | 38.0% | 152 | 21.9% | 231 | 9.7% | 1.52 | $1,349,930 | 11.1% |
| Bob Blue | 37 | 5.7% | 128 | 19.7% | 147 | 22.7% | 223 | 34.4% | 114 | 17.6% | 216 | 9.1% | 1.74 | $1,512,373 | 12.5% |
| Ray Purple | 28 | 5.4% | 74 | 14.2% | 106 | 20.3% | 215 | 41.3% | 98 | 18.8% | 174 | 7.3% | 1.76 | $1,295,762 | 10.7% |
| Robin Red | 28 | 5.4% | 80 | 15.4% | 122 | 23.5% | 199 | 38.3% | 91 | 17.5% | 173 | 7.3% | 1.74 | $1,201,235 | 9.9% |
| Gary Green | 34 | 6.8% | 111 | 22.1% | 106 | 21.1% | 167 | 33.3% | 84 | 16.7% | 167 | 7.0% | 1.81 | $999,935 | 8.3% |
| Irene Indigo | 16 | 3.5% | 83 | 18.3% | 109 | 24.1% | 181 | 40.0% | 64 | 14.1% | 151 | 6.3% | 1.47 | $957,376 | 7.9% |
| Fletch Orange | 22 | 5.6% | 70 | 17.8% | 92 | 23.4% | 152 | 38.6% | 58 | 14.7% | 131 | 5.5% | 1.78 | $993,762 | 8.2% |
| Ronald Brown | 25 | 7.4% | 73 | 21.6% | 85 | 25.1% | 118 | 34.9% | 37 | 10.9% | 113 | 4.7% | 2.06 | $900,824 | 7.4% |
| Samuel Yellow | 27 | 8.2% | 77 | 23.5% | 74 | 22.6% | 127 | 38.7% | 23 | 7.0% | 109 | 4.6% | 1.98 | $919,176 | 7.6% |
| Theodore Lavender | 26 | 9.6% | 70 | 25.9% | 52 | 19.3% | 76 | 28.1% | 46 | 17.0% | 90 | 3.8% | 2.66 | $772,437 | 6.4% |
| | | | | | | | | | | | | | | | |
| Attributed to Panel* | 10 | 10.1% | 17 | 17.2% | 34 | 34.3% | 29 | 29.3% | 9 | 9.1% | 99 | 4.1% | 2.00 | $530,647 | 4.4% |
| **Total** | **121** | **5.1%** | **413** | **17.3%** | **569** | **23.8%** | **867** | **36.3%** | **418** | **17.5%** | **2,387** | **100.0%** | **1.62** | **$12,112,291** | **100.0%** |

*No specific Primary Care Provider identified due to lack of specific rendering provider ID on claims.

# II. Profile of Members in Panel

**PCMH SearchLight Report for Panel ABC**

## K. Member Geographic Distribution by Zip Code

*This chart shows the top 10 zip codes having the largest geographic distribution of attributed Members as of the most recent month's data. The geographic distribution is based on attributed Members' home address zip code.*

| City | State* | Zip | Members | % |
|---|---|---|---|---|
| GLEN BURNIE | MD | 21061 | 156 | 6.5% |
| PASADENA | MD | 21122 | 139 | 5.8% |
| GLEN BURNIE | MD | 21060 | 92 | 3.9% |
| CROFTON | MD | 21114 | 65 | 2.7% |
| BALTIMORE | MD | 21234 | 54 | 2.3% |
| SEVERN | MD | 21144 | 53 | 2.2% |
| BALTIMORE | MD | 21206 | 41 | 1.7% |
| ELKRIDGE | MD | 21075 | 41 | 1.7% |
| PARKVILLE | MD | 21234 | 40 | 1.7% |
| MILLERSVILLE | MD | 21108 | 40 | 1.7% |
| Other in State | MD | | 1,630 | 68.3% |
| Out of State | | | 36 | 1.5% |
| **Total** | | | **2,387** | **100.0%** |

*The state shown indicates the state with the largest distribution of attributed Members

# II. Profile of Members in Panel

**PCMH SearchLight Report for Panel ABC**

## L. Profile of Band 1 - Advanced/Critical Illness - Three Key Categories

*This chart displays a further breakdown of Members in the advanced/critical band (Band 1) into three sub-bands shown, based upon their illness burden scores as of the most recent month's data. Gross Debit PMPM $ is for the trailing 12 months.*

| Sub-Band | Dec-16 | | Average Illness Burden Score | Gross Debit PMPM $ |
|---|---|---|---|---|
| | Members | % | | |
| Catastrophic / End Stage | 6 | 5.0% | 37.39 | $15,352.82 |
| Acute - Return to Chronic | 30 | 25.1% | 15.07 | $5,027.11 |
| Acute with Likely Recovery | 84 | 69.9% | 6.83 | $1,921.15 |
| **Total** | **121** | **100.0%** | **10.42** | **$3,369.80** |

Catastrophic / End Stage - Illness burden scores 25.00 and above

Acute - Return to Chronic - Illness burden scores ranging between 10.00 - 24.99

Acute with Likely Recovery - Illness burden scores ranging between 5.00 and 9.99

Note: The average Illness burden score for the CareFirst non-Medicare primary population is 1.00

## M. Profile of Band 2 - Multiple Chronic Illnesses - Two Key Categories

*This chart separates Members in band 2 into two sub-bands based on the extent of their illnesses, providing an indication of those Members who may be more likely to move into more advanced stages of illness as of the most recent month's data. Gross Debit PMPM $ is for the trailing 12 months.*

| Sub-Band | Dec-16 | | Average Illness Burden Score | Gross Debit PMPM $ |
|---|---|---|---|---|
| | Members | % | | |
| Upper - More Extensive Illness | 96 | 23.3% | 4.12 | $1,211.71 |
| Lower - Less Extensive Illness | 316 | 76.7% | 2.63 | $735.69 |
| **Total** | **413** | **100.0%** | **2.98** | **$846.81** |

Upper - More Extensive Illness - Members at or above the midpoint for the illness band range (3.50)

Lower - Less Extensive Illness - Members below the midpoint for the illness band range (3.50)

Note: The average Illness burden score for the CareFirst non-Medicare primary population is 1.00

## N. Profile of Band 3 - At Risk - Two Key Categories

*This chart separates Members in band 3 into two sub-bands based on the extent of their illnesses, as an assist in finding Members who could benefit from enhanced monitoring as of the most recent month's data. Gross Debit PMPM $ is for the trailing 12 months.*

| Sub-Band | Dec-16 | | Average Illness Burden Score | Gross Debit PMPM $ |
|---|---|---|---|---|
| | Members | % | | |
| Upper - Elevated Risk | 227 | 39.8% | 1.73 | $415.12 |
| Lower - Moderate Risk | 342 | 60.2% | 1.22 | $286.36 |
| **Total** | **569** | **100.0%** | **1.43** | **$337.65** |

Upper - Elevated Risk - Members at or above the midpoint for the illness band range (1.50)

Lower - Moderate Risk - Members below the midpoint for the illness band range (1.50)

Note: The average Illness burden score for the CareFirst non-Medicare primary population is 1.00

# III. Profile of Episodes of Care

**PCMH SearchLight Report for Panel ABC**

*This section of the SearchLight Report gathers every Member's claim information from multiple providers of treatment in all settings and then groups this information into similar, clinically relevant episodes. A medical episode is composed of all related but independent services used to treat a Member's condition or illness within a predetermined time period. This allows for the identification and grouping of services together that otherwise might appear unrelated, particularly when they are for services rendered by different providers in different settings at different points in time.*

*Thus, episodes of care are defined as a series of sequential health services that are related to the treatment of a given illness or in response to a Member request for healthcare. These series of related events, as seen in claims data, each have a beginning date and an end date which define the episode boundaries.*

*To identify episodes, claims information from all inpatient, outpatient, professional, and pharmacy providers for all services received by a Member are included in episodes of care. In total, episodes can be established for well over 95% of all medical claims paid for by CareFirst on behalf of Panel Members. The methodology used to calculate and display episode data is explained further in Appendix - Method for Determining Episodes of Care.*

*This SearchLight Report uses nearly 200 distinct Episode Summary Groups. Further detailed breakdowns are available, but are not used since they can make overall pattern recognition difficult. The hierarchy of episodes is as follows:*

- ***Episode Summary Group** - Summarizes condition-related Episode Groups. An example would be 'Diabetes'.*
- ***Episode Group** - Provides more granular condition-related information. An example would be 'Diabetes Mellitus Type 1 Maintenance'.*
- ***Episode Subgroup** - This is the most granular level of an episode. It includes disease staging and co-morbidities. An example would be 'Diabetes Mellitus type 1 with renal failure'.*
- ***Disease Stage** - Severity of an episode is shown on a 4 point scale. The above Episode Subgroup example (Diabetes Mellitus type 1 with renal failure) could have a disease stage of 3.01. The higher the score on the 4 point scale, the more severe the illness, with "4" typically being end stage.*

*The greater the granularity of an Episode Group, the more difficult it is to review the pattern of illnesses and conditions across a whole population. Episode Summary Groups combine condition related episode groups, thus allowing the PCP an overview of the Members within their Panel with "like" conditions. Disease staging within episodes enables an understanding of disease progression. Each episode is assigned a disease stage that enhances basic cost comparisons with condition and severity-mix adjustment.*

*This SearchLight Report uses the concept of "Dominant" Episodes. These are identified for Members based on the Episode Summary Group responsible for the largest spending over the trailing 12 month period for a particular Member. Through analysis of dominant episodes, a Panel can gain a view of the contrasting landscape of Members' conditions, whether acute or chronic, thereby providing information helpful in enabling more focus on where effective care management is most important. It also enables greater Primary Care Provider attention on certain Members with higher risk and/or greater likelihood of disease progression and future high costs.*

# III. Profile of Episodes of Care

**PCMH SearchLight Report for Panel ABC**

## A. Dominant Episodes of Care - All Bands - Based on Gross Debit Dollars

*This chart displays the top 50% of all gross debits charged to the Panel by dominant episode summary group. This includes debits for Members attributed to the Panel for the trailing 12 month period, including the number of Members who have these episodes. Gross debits are shown at CareFirst "allowed" payment levels with no application of Individual Stop Loss limits on very high cost Members. Additionally, this chart shows the dominant episode gross debits broken out by institutional claims, professional claims, and standard drug claims (Rx).*

*The ranking below shows the dominant episodes related to illnesses among Panel Members and excludes Preventative and Administrative Health episodes, even though these encounters are often one of the highest volume episode categories.*

| # | Dominant Episode | Members | % of Total Members | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $** | Total Members Gross Debit $* | % of Total Gross Debit $ |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Cancer - Breast | 59 | 0.9% | $2,284,871 | $1,512,589 | $648,526 | $123,756 | $3,051,226 | 7.5% |
| 2 | Diabetes | 353 | 5.5% | $1,456,094 | $608,960 | $281,672 | $565,462 | $2,699,711 | 6.7% |
| 3 | Osteoarthritis | 239 | 3.7% | $1,428,559 | $888,669 | $509,574 | $30,316 | $2,412,368 | 5.9% |
| 4 | Coronary Artery Disease | 83 | 1.3% | $1,041,428 | $835,789 | $162,330 | $43,309 | $1,643,436 | 4.1% |
| 5 | Hypertension, Essential | 474 | 7.4% | $787,759 | $418,605 | $272,379 | $96,775 | $1,608,049 | 4.0% |
| 6 | Cerebrovascular Disease | 39 | 0.6% | $787,585 | $677,102 | $107,533 | $2,950 | $1,411,865 | 3.5% |
| 7 | Pregnancy w Cesarean Section | 32 | 0.5% | $689,599 | $500,796 | $188,627 | $176 | $795,932 | 2.0% |
| 8 | Overweight and Obesity | 90 | 1.4% | $590,528 | $434,143 | $155,848 | $537 | $858,557 | 2.1% |
| 9 | Pregnancy w Vaginal Delivery | 49 | 0.8% | $571,253 | $406,257 | $164,208 | $788 | $658,157 | 1.6% |
| 10 | Renal Function Failure | 20 | 0.3% | $515,314 | $466,580 | $37,225 | $11,509 | $921,327 | 2.3% |
| 11 | Mental Hlth - Substance Abuse | 37 | 0.6% | $487,153 | $430,311 | $55,699 | $1,143 | $691,726 | 1.7% |
| 12 | Spinal/Back Disorders, Excl. Low | 87 | 1.4% | $479,883 | $330,421 | $133,689 | $15,773 | $663,155 | 1.6% |
| 13 | Tumors - Gynecological, Benign | 53 | 0.8% | $451,251 | $333,169 | $117,874 | $208 | $627,001 | 1.5% |
| 14 | Infec/Inflam - Skin/Subcu Tiss | 141 | 2.2% | $432,894 | $349,340 | $54,030 | $29,524 | $640,203 | 1.6% |
| 15 | Rheumatoid Arthritis | 19 | 0.3% | $402,210 | $0 | $261,976 | $140,234 | $460,443 | 1.1% |
| 16 | Vascular Disorders, Arterial | 23 | 0.4% | $400,055 | $279,353 | $119,229 | $1,473 | $910,193 | 2.2% |
| 17 | Crohns Disease | 17 | 0.3% | $393,052 | $194,374 | $35,671 | $163,007 | $471,595 | 1.2% |
| **Subtotal** | | **1,815** | **28.3%** | **$13,199,487** | **$8,666,459** | **$3,306,090** | **$1,226,939** | **$20,524,943** | **50.6%** |

*Gross Debit $ shows only debits associated with the dominant episode. Total Members Gross Debit $ reflect all paid claims before the application of the Individual Stop Loss limit of $85,000.

** Rx Gross Debit $ represents only pharmacy claims for those Members with a CareFirst pharmacy benefit. As a result, the dollar figure may be lower than the Member's actual pharmacy expense.

# III. Profile of Episodes of Care

**PCMH SearchLight Report for Panel ABC**

## B. Dominant Episodes of Care - All Bands - Based on Gross Debits expressed as PMPM

*This chart displays the top dominant episode summary group gross debits per Member per month (PMPM). Gross debits are all claim costs for Members at CareFirst "allowed" payment levels with no application of Individual Stop Loss limits on very high cost Members over the trailing 12 months. Additionally, this chart shows the dominant episode gross debits broken out by institutional claims, professional claims, and standard drug claims (Rx).*
*The ranking below shows the dominant episodes related to illnesses among Panel Members and excludes Preventative and Administrative Health episodes, even though these encounters are often one of the highest volume episode categories. The volume and cost for Preventive and Administrative Health Episodes are shown separately in the successive view.*

| # | Dominant Episode | Members | % of Total Members | Gross Debit $* | Gross Debit PMPM | Institutional Gross Debit PMPM | Professional Gross Debit PMPM | Rx Gross Debit PMPM** |
|---|---|---|---|---|---|---|---|---|
| 1 | Cancer - Leukemia | 4 | 0.9% | $2,284,871 | $3,273.45 | $2,167.03 | $929.12 | $177.30 |
| 2 | Cancer - Lung | 3 | 0.1% | $1,456,094 | $354.80 | $148.38 | $68.63 | $137.78 |
| 3 | Alpha 1-Antitrypsin Deficiency | 1 | 0.0% | $1,428,559 | $509.11 | $316.70 | $181.60 | $10.80 |
| 4 | Cond Rel to Implant/Grft - CNS | 1 | 0.0% | $1,041,428 | $1,061.60 | $851.98 | $165.47 | $44.15 |
| 5 | HIV Infection | 2 | 0.1% | $787,759 | $142.37 | $75.66 | $49.23 | $17.49 |
| 6 | Multiple Sclerosis | 7 | 0.6% | $787,585 | $1,704.73 | $1,465.59 | $232.75 | $6.39 |
| 7 | Renal Function Failure | 11 | 0.6% | $689,599 | $1,795.83 | $1,304.16 | $491.22 | $0.46 |
| 8 | Hepatitis, Viral | 1 | 0.1% | $590,528 | $553.97 | $407.26 | $146.20 | $0.50 |
| 9 | Cancer - Colon | 3 | 0.8% | $571,253 | $1,018.28 | $724.17 | $292.71 | $1.40 |
| **Subtotal** | | **33** | **3.2%** | **$9,637,676** | **$10,414.14** | **$7,460.93** | **$2,556.93** | **$396.27** |

*Gross Debit $ shows only debits associated with the dominant episode. Total Members Gross Debit $ reflect all paid claims before the application of the Individual Stop Loss limit of $85,000.

** Rx Gross Debit $ represents only pharmacy claims for those Members with a CareFirst pharmacy benefit. As a result, the dollar figure may be lower than the Member's actual pharmacy expense.

## C. Dominant Episodes of Care - Preventive/Administrative Health Encounters

*Preventative and Administrative Health episodes typically account for a substantial percentage of all debits, but are spread over many Members. Preventive services generally include recommended immunizations and screenings (such as colonoscopies and mammograms), as well as those identified by "history of" diagnoses (such as family history of colon cancer, risk of a fall, and amputation). Administrative services may include those related to historical injury (such as prosthetic supplies and physical/occupational therapy).*

*The distribution of Members with Preventive/Administrative Health Encounters as their dominant episode is displayed by Illness Band below over the trailing 12 months. Of all Panel Members, 15.6% have Dominant Episodes of Preventive/Administrative Health Encounters, while the total debits associated with these Members account for 4.3% of the Panel's total gross debits.*

| Illness Band | Members | % of Total Members | Total Member Debit $ | Total Member PMPM | Preventive/Admin Encounters | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Debit $ | Debit PMPM | Average Cost per Service | Services per Member |
| Advanced/Critical Illness | 8 | 0.1% | $102,705 | $1,069.84 | $38,985 | $965.27 | $333 | 14.6 |
| Multiple Chronic Illnesses | 64 | 1.0% | $249,396 | $329.89 | $82,502 | $302.19 | $108 | 11.9 |
| At Risk | 178 | 2.8% | $539,203 | $257.38 | $184,869 | $238.01 | $117 | 8.9 |
| Stable | 500 | 7.8% | $568,484 | $97.76 | $225,511 | $115.74 | $66 | 6.9 |
| Healthy | 252 | 3.9% | $101,135 | $34.75 | $57,141 | $59.64 | $43 | 5.3 |
| **Total** | **1,002** | **15.6%** | **$1,560,924** | **$133.73** | **$589,008** | **$50.46** | **$81** | **7.2** |

# III. Profile of Episodes of Care

**PCMH SearchLight Report for Panel ABC**

## D. Dominant Episodes of Care for Band 1 - Advanced/Critical Illness

*This chart displays the most expensive dominant episodes for Members in Band 1. It shows gross debits in the trailing 12 months for Members with a primary dominant episode, as well as gross debits for other episodes related to the dominant episode. Click on any underlined field below to see additional information.*

| # | Dominant Episode | Members | % of Total Members in Band 1 | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $* | Total Member Gross Debit $ | % of Total Gross Debit $ in Band 1 |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Cancer - Breast | 25 | 6.4% | $1,794,795 | $1,326,593 | $445,111 | $23,091 | $2,454,261 | 12.0% |
| 2 | Coronary Artery Disease | 31 | 7.9% | $845,348 | $725,920 | $110,731 | $8,697 | $1,305,861 | 6.4% |
| 3 | Cerebrovascular Disease | 18 | 4.6% | $671,533 | $591,553 | $79,975 | $6 | $1,234,613 | 6.0% |
| 4 | Diabetes | 22 | 5.6% | $654,422 | $520,848 | $48,239 | $85,334 | $1,183,234 | 5.8% |
| 5 | Osteoarthritis | 30 | 7.6% | $676,947 | $522,810 | $153,521 | $616 | $1,081,137 | 5.3% |
| 6 | Renal Function Failure | 14 | 3.6% | $504,630 | $461,487 | $32,838 | $10,305 | $899,546 | 4.4% |
| 7 | Vascular Disorders, Arterial | 9 | 2.3% | $338,570 | $249,916 | $88,179 | $476 | $812,392 | 4.0% |
| 8 | Hypertension, Essential | 13 | 3.3% | $321,630 | $268,305 | $49,092 | $4,233 | $671,814 | 3.3% |
| 9 | Rheumatic Fever/Valvular Dis | 6 | 1.5% | $245,049 | $210,006 | $34,945 | $98 | $614,014 | 3.0% |
| 10 | Condition Rel to Tx - Med/Surg | 7 | 1.8% | $281,620 | $237,026 | $44,225 | $368 | $468,774 | 2.3% |
| **Subtotal** | | **175** | **44.5%** | **$6,334,544** | **$5,114,464** | **$1,086,856** | **$133,224** | **$10,725,646** | **52.4%** |

* Dominant Episode Gross Debit $ shows only debits associated with the dominant episode.

## D. Detail of Dominant Episodes of Care for Band 1

Sample Drill Through

**Dominant Episode: Coronary Artery Disease**

*This chart displays other episodes Members have in conjunction with the dominant episode over the trailing 12 months. This provides additional details on the cost of comorbid episodes. Click on any underlined field below to see additional information.*

| # | Dominant Comorbid Episode | Members | % of Total Members | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $* | Total Member Gross Debit $ |
|---|---|---|---|---|---|---|---|---|
| 1 | Hypertension, Essential | 25 | 3.6% | $29,016 | $9,533 | $10,561 | $8,922 | $1,046,636 |
| 2 | Cerebrovascular Disease | 12 | 1.7% | $41,882 | $33,750 | $6,673 | $1,459 | $800,666 |
| 3 | Diabetes | 25 | 3.6% | $25,022 | $1,928 | $9,879 | $13,214 | $751,702 |
| 4 | Cardiac Arrhythmias | 17 | 2.5% | $32,388 | $24,048 | $8,340 | $0 | $687,981 |
| 5 | Congestive Heart Failure | 7 | 1.0% | $20,440 | $13,700 | $5,503 | $1,237 | $621,271 |
| 6 | Osteoarthritis | 11 | 1.6% | $11,482 | $6,483 | $3,890 | $1,110 | $359,311 |
| 7 | Vascular Disorders, Arterial | 7 | 1.0% | $11,064 | $5,457 | $4,613 | $994 | $294,945 |
| 8 | Renal Function Failure | 7 | 1.0% | $30,659 | $22,833 | $7,510 | $316 | $254,827 |
| 9 | Prostatic Disorders | 4 | 0.6% | $12,548 | $9,313 | $3,234 | $0 | $108,580 |
| 10 | Chronic Obstruc Pulm Dis(COPD) | 4 | 0.6% | $12,582 | $11,321 | $1,262 | $0 | $47,827 |

* Dominant Comorbid Episode Gross Debit $ shows only debits associated with the dominant comorbid episode.

## D. Detail of Dominant Episodes of Care for Band 1

Sample Drill Through

**Dominant Episode: Coronary Artery Disease**
**Dominant Comorbid Episode: Cardiac Arrhythmias**

*This chart provides Member level information for dominant and related comorbid episodes over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Total Member Gross Debit $ in Band 1 |
|---|---|---|---|---|
| 1 | John White | 11/23/1964 | Bonnie Beige | $101,732 |
| 2 | Sam Green | 12/07/1963 | Irene Indigo | $96,524 |
| | | | | |
| 17 | JaGross Black | 3/3/1961 | Robin Red | $9,295 |

# III. Profile of Episodes of Care

**PCMH SearchLight Report for Panel ABC**

## E. Dominant Episodes of Care for Band 2 - Multiple Chronic Illnesses

*This chart displays the most expensive dominant episodes for Members in Band 2. It shows gross debits in the trailing 12 months for Members with a primary dominant episode, as well as gross debits for other episodes related to the dominant episode. Click on any underlined field below to see additional information.*

| # | Dominant Episode | Members | % of Total Members in Band 2 | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $* | Total Member Gross Debit $ | % of Total Gross Debit $ in Band 2 |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Osteoarthritis | 88 | 7.5% | $537,027 | $309,705 | $219,795 | $7,527 | $915,597 | 6.7% |
| 2 | Diabetes | 80 | 6.8% | $339,681 | $40,579 | $89,288 | $209,813 | $762,564 | 5.6% |
| 3 | Pregnancy w Cesarean Section | 28 | 2.4% | $547,572 | $387,353 | $160,043 | $176 | $626,692 | 4.6% |
| 4 | Pregnancy w Vaginal Delivery | 31 | 2.6% | $444,891 | $321,015 | $123,535 | $341 | $503,118 | 3.7% |
| 5 | Overweight and Obesity | 30 | 2.5% | $368,238 | $287,471 | $80,767 | $0 | $488,677 | 3.6% |
| 6 | Hypertension, Essential | 68 | 5.8% | $168,723 | $97,108 | $54,254 | $17,361 | $399,983 | 2.9% |
| 7 | Cancer - Breast | 20 | 1.7% | $283,863 | $128,027 | $153,201 | $2,635 | $376,765 | 2.8% |
| 8 | Mental Hlth - Substance Abuse | 16 | 1.4% | $235,240 | $206,621 | $28,492 | $127 | $356,335 | 2.6% |
| 9 | Dysfunctional Uterine Bleeding | 16 | 1.4% | $194,324 | $125,347 | $65,162 | $3,815 | $296,211 | 2.2% |
| 10 | Tumors - Gynecological, Benign | 18 | 1.5% | $190,349 | $135,840 | $54,471 | $37 | $292,265 | 2.1% |
| | **Subtotal** | **395** | **33.5%** | **$3,309,908** | **$2,039,067** | **$1,029,008** | **$241,833** | **$5,018,206** | **36.6%** |

* Dominant Episode Gross Debit $ shows only debits associated with the dominant episode.

## E. Detail of Dominant Episodes of Care for Band 2

Sample Drill Through

**Dominant Episode: Osteoarthritis**

*This chart displays other episodes Members have in conjunction with the dominant episode over the trailing 12 months. This provides additional details on the cost of comorbid episodes. Click on any underlined field below to see additional information.*

| # | Dominant Comorbid Episode | Members | % of Total Members | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $* | Total Member Gross Debit $ |
|---|---|---|---|---|---|---|---|---|
| 1 | Hypertension, Essential | 61 | 5.0% | $24,289 | $4,773 | $15,700 | $3,816 | $1,064,028 |
| 2 | Prevent/Admin Hlth Encounters | 56 | 4.5% | $18,555 | $1,873 | $11,974 | $4,708 | $768,596 |
| 3 | Diabetes | 22 | 1.8% | $10,639 | $915 | $8,858 | $866 | $311,659 |
| 4 | Arthropathies/Joint Disord NEC | 13 | 1.1% | $10,215 | $2,308 | $7,219 | $687 | $221,420 |
| 5 | Spinal/Back Disorders, NEC | 20 | 1.6% | $14,115 | $3,799 | $9,132 | $1,184 | $209,582 |
| 6 | Headache, Migraine/Muscle Tens | 10 | 0.8% | $7,069 | $1,874 | $3,763 | $1,432 | $187,239 |
| 7 | Hernia/Reflux Esophagitis | 16 | 1.3% | $7,107 | $2,750 | $3,603 | $755 | $187,062 |
| 8 | Vascular Disorders, Arterial | 7 | 0.6% | $39,496 | $31,678 | $5,615 | $2,203 | $125,503 |
| 9 | Injury - Knee | 5 | 0.4% | $20,418 | $12,513 | $7,904 | $2 | $91,761 |
| 10 | Neurological Disorders, NEC | 9 | 0.7% | $7,191 | $2,251 | $4,037 | $903 | $48,800 |

* Dominant Comorbid Episode Gross Debit $ shows only debits associated with the dominant comorbid episode.

## E. Detail of Dominant Episodes of Care for Band 2

Sample Drill Through

**Dominant Episode: Osteoarthritis**
**Dominant Comorbid Episode: Diabetes**

*This chart provides Member level information for dominant and related comorbid episodes over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Total Member Gross Debit $ in Band 2 |
|---|---|---|---|---|
| 1 | Shelly White | 11/23/1964 | Peter Black | $24,758 |
| 2 | Evan Gray | 12/07/1963 | Donald Daisy | $15,623 |
| | | | | |
| 22 | Susan Brown | 3/3/1961 | Ray Purple | $2,998 |

# III. Profile of Episodes of Care

**PCMH SearchLight Report for Panel ABC**

## F. Dominant Episodes of Care for Band 3 - At Risk

*This chart displays the most expensive dominant episodes for Members in Band 3. It shows gross debits in the trailing 12 months for Members with a primary dominant episode, as well as gross debits for other episodes related to the dominant episode. Click on any underlined field below to see additional information.*

| # | Dominant Episode | Members | % of Total Members in Band 3 | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $* | Total Member Gross Debit $ | % of Total Gross Debit $ in Band 3 |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Diabetes | 102 | 7.1% | $266,975 | $32,040 | $94,165 | $140,771 | $442,955 | 6.0% |
| 2 | Osteoarthritis | 74 | 5.2% | $170,892 | $45,033 | $105,522 | $20,336 | $338,347 | 4.6% |
| 3 | Hypertension, Essential | 109 | 7.6% | $145,730 | $42,643 | $78,898 | $24,190 | $274,536 | 3.7% |
| 4 | Hepatitis, Viral | 4 | 0.3% | $13,406 | $1,509 | $7,265 | $4,632 | $264,594 | 3.6% |
| 5 | Tumors - Gynecological, Benign | 23 | 1.6% | $189,353 | $141,603 | $47,675 | $75 | $242,203 | 3.3% |
| 6 | Crohns Disease | 7 | 0.5% | $211,295 | $86,087 | $16,475 | $108,733 | $226,058 | 3.1% |
| 7 | Cancer - Breast | 10 | 0.7% | $193,016 | $50,350 | $45,964 | $96,702 | $204,759 | 2.8% |
| 8 | Rheumatoid Arthritis | 10 | 0.7% | $184,488 | $0 | $127,823 | $56,664 | $199,123 | 2.7% |
| 9 | Infec/Inflam - Skin/Subcu Tiss | 25 | 1.7% | $127,044 | $107,696 | $9,950 | $9,399 | $177,104 | 2.4% |
| 10 | Arthropathies/Joint Disord NEC | 43 | 3.0% | $83,801 | $26,604 | $30,630 | $26,567 | $160,113 | 2.2% |
| | **Subtotal** | **463** | **29.9%** | **$2,224,194** | **$1,029,321** | **$947,523** | **$247,350** | **$3,505,992** | **41.9%** |

* Dominant Episode Gross Debit $ shows only debits associated with the dominant episode.

## F. Detail of Dominant Episodes of Care for Band 3

**Dominant Episode: Osteoarthritis**

Sample Drill Through

*This chart displays other episodes Members have in conjunction with the dominant episode over the trailing 12 months. This provides additional details on the cost of comorbid episodes. Click on any underlined field below to see additional information.*

| # | Dominant Comorbid Episode | Members | % of Total Members | Gross Debit $* | Institutional Gross Debit $* | Professional Gross Debit $* | Rx Gross Debit $* | Total Member Gross Debit $ |
|---|---|---|---|---|---|---|---|---|
| 1 | Prevent/Admin Hlth Encounters | 64 | 4.0% | $18,971 | $3,682 | $11,844 | $3,445 | $480,185 |
| 2 | Hypertension, Essential | 57 | 3.5% | $11,242 | $0 | $8,848 | $2,394 | $345,433 |
| 3 | Spinal/Back Disorders, Excl. Low | 14 | 0.9% | $11,733 | $810 | $10,923 | $0 | $183,914 |
| 4 | Spinal/Back Disorders, NEC | 13 | 0.8% | $12,502 | $3,198 | $9,304 | $0 | $156,355 |
| 5 | Arthropathies/Joint Disord NEC | 14 | 0.9% | $6,095 | $169 | $5,453 | $473 | $120,148 |
| 6 | Diabetes | 24 | 1.5% | $9,780 | $260 | $7,498 | $2,022 | $99,656 |
| 7 | Eye Disorders, NEC | 8 | 0.5% | $9,177 | $6,211 | $2,823 | $142 | $85,061 |
| 8 | Gastritis/Gastroenteritis | 8 | 0.5% | $7,216 | $1,783 | $4,717 | $715 | $48,405 |
| 9 | Gastroint Disord, NEC | 10 | 0.6% | $6,074 | $2,286 | $3,780 | $8 | $46,457 |
| 10 | Hallux Deformities | 2 | 0.1% | $7,087 | $4,412 | $2,676 | $0 | $39,671 |

* Dominant Comorbid Episode Gross Debit $ shows only debits associated with the dominant comorbid episode.

## F. Detail of Dominant Episodes of Care for Band 3

**Dominant Episode: Osteoarthritis**

**Dominant Comorbid Episode: Diabetes**

Sample Drill Through

*This chart provides Member level information for dominant and related comorbid episodes over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Total Member Gross Debit $ in Band 3 |
|---|---|---|---|---|
| 1 | Laura Black | 11/23/1964 | Samuel Yellow | $17,529 |
| 2 | Harry Rose | 12/07/1963 | Ace Emerald | $7,632 |
| | | | | |
| 24 | Cynthia Blue | 3/3/1961 | Ronald Brown | $1,159 |

# IV. Key Use Patterns

## PCMH SearchLight Report for Panel ABC

*This section of the SearchLight Report displays admission, readmission, ER visit, and prescription drug patterns for Members in the Panel. These patterns are essential to see and understand in any attempt to control health care costs and achieve better outcomes for the Members involved. Readmissions are defined as the occurrence of a Member admission to a hospital within 30 days of a prior hospitalization discharge date. Hospital based services are not only the most expensive of all services, but are indicators of serious illness in many cases. For these reasons, they are separately reported and displayed to focus attention on Members who have had these services.*

*The extent and use of prescription drugs is also a key indicator of Member illness status. Drug spending now approximates inpatient hospital spending as a percentage of overall medical costs. Drug treatment is the most common form of therapeutic intervention in medicine and is most often taken at home where compliance/adherence to protocols is often most difficult to monitor. It is not uncommon to see Members who are taking a dozen or more prescription drugs prescribed by different physicians at different times, often without the knowledge of the Primary Care Physician (or Nurse Practictioner). Hence, gaining a comprehensive view of the medications a Member is taking is critical to avoiding progression in disease and avoiding breakdowns causing ER visits and/or admissions/readmissions.*

*Prescription drug data presented in the following section is grouped into three categories:*

- ***Mail/Retail Pharmacy Drugs*** *- include drugs that are paid under a Member's separate pharmacy benefit. These are generally prescriptions for brand and/or generic drugs that Members obtain from their local pharmacy or by mail order through a Pharmacy Benefit Manager (PBM). For reporting purposes, specialty drugs are excluded from all Mail/Retail Pharmacy Drug calculations and are reported separately.*
- ***Medical Drugs*** *- include drugs that are paid under a Member's medical benefit and are filed as part of a medical claim. Medical drugs typically include drugs such as vaccinations and birth control drugs/devices, as well as chemotherapy drugs. For reporting purposes, specialty drugs are excluded from all Medical Drug calculations and are reported separately.*
- ***Specialty Drugs*** *- include drugs that generally require special storage and/or handling and close monitoring of the Member's drug therapy. Specialty drugs are typically injected or infused. These can be paid under either the pharmacy or medical benefit.*

*Hospital data is broken down into three categories: High, Mid, and Low Cost hospitals as measured by Inpatient Cost per Admission, Emergency Room Visit Cost and Cost per Outpatient Visit.*

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## A. Admissions and Readmissions and Gross Debits by Hospital

### Admissions and Readmissions by Hospital

*This chart shows the top ten most frequently used hospitals for Members attributed to the Panel for the trailing 12 months. It includes the number of admissions, readmissions, and associated percentages by hospital. The hospital Cost Tier (High, High Mid, Low Mid, Low), a measure of total hospital based cost, is shown for each hospital used in the CareFirst service area. Note that a single Member may have multiple admissions or readmissions displayed. Readmissions and associated rates include all Member admissions for any reason within 30, 60 or 90 days of a previous discharge. Readmissions are cumulative, so the 60 and 90 day figures will include counts from preceding columns.*

Filter By: All Providers

| Hospital | Cost Tier | Total Admissions | | 30 Day Readmissions | | 60 Day Readmissions | | 90 Day Readmissions | |
|---|---|---|---|---|---|---|---|---|---|
| | | Count | % | Count | % of Admissions | Count | % of Admissions | Count | % of Admissions |
| Yellow County General | High | 10 | 5.5% | 1 | 9.2% | 2 | 18.7% | 2 | 23.5% |
| Gold Medical Ctr | High | 9 | 5.4% | 2 | 25.9% | 3 | 33.5% | 4 | 38.5% |
| Cornflower-Blue Medical Ctr | High | 8 | 4.8% | 2 | 26.2% | 3 | 32.0% | 3 | 34.9% |
| Beige Memorial | High Mid | 16 | 9.2% | 2 | 12.3% | 3 | 18.1% | 3 | 21.0% |
| Green Medical Ctr | High Mid | 5 | 2.9% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Red General Hospital | Low Mid | 7 | 4.0% | 0 | 6.3% | 1 | 12.9% | 1 | 16.2% |
| Lavender Hospital Ctr | Low Mid | 5 | 2.8% | 0 | 4.6% | 1 | 14.0% | 1 | 14.1% |
| Brown Hospital Cntr | Low | 31 | 17.5% | 4 | 11.5% | 5 | 16.2% | 5 | 17.8% |
| Blue Hospital | Low | 28 | 15.8% | 3 | 12.0% | 5 | 16.2% | 6 | 20.4% |
| Purple Hospital | Low | 6 | 3.2% | 0 | 8.0% | 0 | 8.1% | 0 | 8.2% |
| Other High Hospitals | High | 6 | 3.3% | 0 | 7.6% | 0 | 7.8% | 1 | 15.7% |
| Other High Mid Hospitals | High Mid | 8 | 4.7% | 3 | 32.4% | 3 | 35.7% | 3 | 38.7% |
| Other Low Mid Hospitals | Low Mid | 14 | 8.1% | 1 | 9.3% | 2 | 11.1% | 2 | 11.1% |
| Other Low Hospitals | Low | 5 | 2.6% | 0 | 4.8% | 0 | 4.9% | 0 | 4.9% |
| Other NA Hospitals | NA | 18 | 10.2% | 8 | 42.1% | 9 | 49.2% | 10 | 53.3% |
| **Total** | | **176** | **100.0%** | **28** | **15.8%** | **36** | **20.6%** | **41** | **23.4%** |

| Cost Tier | Total Admissions | | Total Outpatient | | Combined IP/OP | |
|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % |
| **High** | 33 | 19.0% | 473 | 16.7% | 507 | 16.9% |
| **High Mid** | 30 | 16.8% | 380 | 13.4% | 410 | 13.6% |
| **Low Mid** | 26 | 14.9% | 471 | 16.7% | 497 | 16.5% |
| **Low** | 69 | 39.1% | 795 | 28.1% | 865 | 28.8% |
| **NA** | 18 | 10.2% | 711 | 25.1% | 727 | 24.2% |
| **Total** | **176** | **100.0%** | **2,830** | **100.0%** | **3,006** | **100.0%** |
| **Total Low + Low Mid** | **95** | **60.1%** | **1,266** | **59.7%** | **1,362** | **59.8%** |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## A. Admissions and Readmissions and Gross Debits by Hospital (Cont.)

### Admission and Readmission Gross Debits by Hospital

*This chart shows the top ten most frequently used hospitals for Members attributed to the Panel for the trailing 12 months. It includes the gross debits of admissions and readmissions by hospital. The hospital Cost Tier (High, High Mid, Low Mid, Low), a measure of total hospital based cost, is shown for each hospital used in the CareFirst service area. Note that a single Member may have multiple admissions or readmissions displayed. Readmissions and associated rates include all Member admissions for any reason within 30, 60 or 90 days of a previous discharge. Readmissions are cumulative, so the 60 and 90 day figures will include counts from preceding columns.*

| Hospital | Cost Tier | Total Admissions | | 30 Day Readmissions | | 60 Day Readmissions | | 90 Day Readmissions | |
|---|---|---|---|---|---|---|---|---|---|
| | | Gross Debit $ | Gross Debit $ per Admission | Gross Debit $ | Gross Debit $ per Readmission | Gross Debit $ | Gross Debit $ per Readmission | Gross Debit $ | Gross Debit $ per Readmission |
| Yellow County General | High | $155,927 | $16,079.99 | $5,979 | $6,725.81 | $34,732 | $19,175.18 | $41,745 | $18,326.90 |
| Gold Medical Ctr | High | $274,609 | $29,045 | $48,174 | $19,708 | $64,607 | $20,382 | $80,722 | $22,149 |
| Cornflower-Blue Medical Ctr | High | $332,032 | $39,132 | $82,459 | $37,106 | $101,996 | $37,540 | $105,272 | $35,552 |
| Beige Memorial | High Mid | $377,111 | $23,218 | $91,231 | $45,616 | $109,478 | $37,194 | $116,031 | $33,960 |
| Green Medical Ctr | High Mid | $157,859 | $31,008 | $0 | $0 | $0 | $0 | $0 | $0 |
| Red General Hospital | Low Mid | $122,074 | $17,364 | $8,105 | $18,235 | $13,183 | $14,556 | $16,231 | $14,252 |
| Lavender Hospital Ctr | Low Mid | $84,800 | $17,490 | $2,714 | $12,213 | $4,520 | $6,655 | $4,626 | $6,769 |
| Brown Hospital Cntr | Low | $471,766 | $15,323 | $49,401 | $13,894 | $73,531 | $14,762 | $87,438 | $15,995 |
| Blue Hospital | Low | $309,355 | $11,096 | $32,695 | $9,809 | $46,568 | $10,284 | $58,432 | $10,261 |
| Purple Hospital | Low | $65,499 | $11,747 | $499 | $1,123 | $562 | $1,241 | $575 | $1,262 |
| Other High Hospitals | High | $156,565 | $26,910 | $9,390 | $21,127 | $10,573 | $23,348 | $28,577 | $31,365 |
| Other High Mid Hospitals | High Mid | $152,591 | $18,513 | $35,704 | $13,389 | $44,646 | $15,168 | $47,942 | $15,034 |
| Other Low Mid Hospitals | Low Mid | $190,837 | $13,342 | $6,931 | $5,198 | $8,964 | $5,656 | $9,172 | $5,753 |
| Other Low Hospitals | Low | $42,418 | $9,209 | $736 | $3,313 | $829 | $3,661 | $848 | $3,724 |
| Other NA Hospitals | NA | $193,251 | $10,772 | $46,482 | $6,152 | $61,236 | $6,935 | $68,867 | $7,199 |
| **Total** | | **$3,086,693** | **$17,538** | **$420,500** | **$15,138** | **$575,425** | **$15,884** | **$666,477** | **$16,166** |

# IV. Key Use Patterns

PCMH SearchLight Report for Panel ABC

## B. ER and Outpatient Visits and Gross Debits by Hospital

### ER and Outpatient Visits by Hospital

*This chart shows the top ten most frequently used hospitals for Members attributed to the Panel for the trailing 12 months. It includes the number of observation stays, Ambulatory ER visits (not followed by inpatient or observation stays), and other outpatient hospital visits and associated percentages by hospital. The hospital Cost Tier (High, High Mid, Low Mid, Low), a measure of total hospital based cost, is shown for each hospital used in the CareFirst service area. Note that a single Member may have multiple visits displayed.*

Filter By: All Providers

| Hospital | Cost Tier | Total Outpatient | | Observation Stays | | | | ER Visits | | | | Outpatient Visits | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | w/Surgery | | w/o Surgery | | w/Surgery | | w/o Surgery | | w/Surgery | | w/o Surgery | |
| | | Gross Debit $ | Gross Debit $ per Visit | Gross Debit $ | Gross Debit $ per Visit | Gross Debit $ | Gross Debit $ per Visit | Gross Debit $ | Gross Debit $ per Visit | Gross Debit $ | Gross Debit $ per Visit | Gross Debit $ | Gross Debit $ per Visit | Gross Debit $ | Gross Debit $ per Visit |
| Yellow County General | High | 192 | 6.6% | 1 | 0.3% | 1 | 0.7% | 0 | 0.0% | 5 | 2.7% | 68 | 35.3% | 113 | 59.1% |
| Gold Medical Ctr | High | 109 | 3.7% | 2 | 1.7% | 4 | 3.6% | 2 | 1.8% | 34 | 31.4% | 20 | 18.0% | 47 | 43.5% |
| Cornflower-Blue Medical Ctr | High | 100 | 3.5% | 0 | 0.0% | 1 | 0.8% | 0 | 0.2% | 9 | 9.1% | 12 | 12.4% | 73 | 73.1% |
| Beige Memorial | High Mid | 164 | 5.7% | 5 | 2.9% | 7 | 4.6% | 3 | 2.1% | 34 | 20.9% | 60 | 36.5% | 56 | 34.4% |
| Green Medical Ctr | High Mid | 87 | 3.0% | 1 | 1.2% | 2 | 2.4% | 0 | 0.6% | 11 | 12.5% | 11 | 12.8% | 58 | 66.9% |
| Red General Hospital | Low Mid | 205 | 7.1% | 1 | 0.3% | 2 | 0.9% | 0 | 0.0% | 13 | 6.2% | 59 | 28.8% | 126 | 61.5% |
| Lavender Hospital Ctr | Low Mid | 465 | 16.0% | 2 | 0.5% | 23 | 4.9% | 6 | 1.3% | 135 | 29.0% | 43 | 9.3% | 248 | 53.3% |
| Brown Hospital Cntr | Low | 237 | 8.2% | 2 | 1.0% | 5 | 2.2% | 2 | 0.8% | 55 | 23.3% | 57 | 24.0% | 114 | 48.3% |
| Blue Hospital | Low | 111 | 3.8% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 103 | 92.4% |
| Purple Hospital | Low | 74 | 2.5% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 68 | 92.4% |
| Other High Hospitals | High | 84 | 2.9% | 1 | 1.3% | 3 | 3.1% | 0 | 0.0% | 11 | 13.1% | 19 | 22.2% | 49 | 58.3% |
| Other High Mid Hospitals | High Mid | 139 | 4.8% | 2 | 1.3% | 3 | 2.4% | 0 | 0.4% | 36 | 26.2% | 38 | 27.4% | 59 | 42.8% |
| Other Low Mid Hospitals | Low Mid | 278 | 9.6% | 3 | 1.1% | 8 | 2.9% | 15 | 5.4% | 86 | 31.0% | 30 | 10.9% | 132 | 47.6% |
| Other Low Hospitals | Low | 114 | 3.9% | 1 | 1.2% | 2 | 1.6% | 4 | 3.2% | 32 | 28.3% | 32 | 28.5% | 43 | 38.2% |
| Other NA Hospitals | NA | 543 | 18.7% | 10 | 1.8% | 28 | 5.2% | 0 | 0.0% | 3 | 0.5% | 38 | 7.0% | 432 | 79.5% |
| **Total** | | **2,902** | **100.0%** | **31** | **1.1%** | **90** | **3.1%** | **33** | **1.1%** | **465** | **16.0%** | **487** | **16.8%** | **1,724** | **59.4%** |

| Cost Tier | Total Admissions | | Total Outpatient | | Combined IP/OP | |
|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % |
| **High** | 33 | 19.0% | 473 | 16.7% | 507 | 16.9% |
| **High Mid** | 30 | 16.8% | 380 | 13.4% | 410 | 13.6% |
| **Low Mid** | 26 | 14.9% | 471 | 16.7% | 497 | 16.5% |
| **Low** | 69 | 39.1% | 795 | 28.1% | 865 | 28.8% |
| **NA** | 18 | 10.2% | 711 | 25.1% | 727 | 24.2% |
| **Total** | **176** | **100.0%** | **2,830** | **100.0%** | **3,006** | **100.0%** |
| **Total Low + Low Mid** | **95** | **60.1%** | **1,266** | **59.7%** | **1,362** | **59.8%** |

## IV. Key Use Patterns



### B. ER and Outpatient Visits and Gross Debits by Hospital

### ER and Outpatient Gross Debits by Hospital

*This chart shows the top ten most frequently used hospitals for Members attributed to the Panel for the trailing 12 months. It includes the gross debits of observation stays, Ambulatory ER visits (not followed by inpatient or observation stays), and other outpatient hospital visits by hospital. The hospital Cost Tier (High, High Mid, Low Mid, Low), a measure of total hospital based cost, is shown for each hospital used in the CareFirst service area. Note that a single Member may have multiple visits displayed.*

| Hospital | Cost Tier | Total Outpatient | | Observation Stays | | | | ER Visits | | | | Outpatient Visits | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | w/Surgery | | w/o Surgery | | w/Surgery | | w/o Surgery | | w/Surgery | | w/o Surgery | |
| | | Gross Debit | Gross Debit $ per Visit | Gross Debit | Gross Debit $ per Visit | Gross Debit | Gross Debit $ per Visit | Gross Debit | Gross Debit $ per Visit | Gross Debit | Gross Debit $ per Visit | Gross Debit | Gross Debit $ per Visit | Gross Debit | Gross Debit $ per Visit |
| Yellow County General | High | $447,087 | $2,334 | $4,049 | $7,592 | $4,922 | $3,809 | $0 | $0 | $7,522 | $1,470 | $202,948 | $3,003 | $218,540 | $1,930 |
| Gold Medical Ctr | High | $183,128 | $1,686 | $6,199 | $3,321 | $18,031 | $4,652 | $1,798 | $917 | $20,602 | $604 | $114,381 | $5,837 | $27,019 | $571 |
| Cornflower-Blue Medical Ctr | High | $205,563 | $2,046 | $0 | $0 | $3,430 | $4,424 | $4,413 | $18,004 | $13,291 | $1,461 | $49,441 | $3,957 | $126,789 | $1,726 |
| Beige Memorial | High Mid | $237,961 | $1,449 | $19,659 | $4,096 | $23,405 | $3,123 | $2,525 | $736 | $23,349 | $679 | $152,408 | $2,543 | $26,237 | $464 |
| Green Medical Ctr | High Mid | $96,023 | $1,109 | $3,096 | $2,902 | $7,116 | $3,442 | $319 | $651 | $13,104 | $1,213 | $33,304 | $3,007 | $38,569 | $666 |
| Red General Hospital | Low Mid | $235,147 | $1,145 | $3,411 | $6,396 | $8,505 | $4,702 | $0 | $0 | $10,115 | $790 | $160,148 | $2,711 | $56,119 | $444 |
| Lavender Hospital Ctr | Low Mid | $562,781 | $1,210 | $5,175 | $2,156 | $93,818 | $4,079 | $4,326 | $706 | $92,438 | $686 | $193,761 | $4,459 | $172,475 | $696 |
| Brown Hospital Cntr | Low | $288,730 | $1,220 | $2,065 | $860 | $17,362 | $3,359 | $2,091 | $1,066 | $39,641 | $719 | $185,054 | $3,258 | $48,770 | $427 |
| Blue Hospital | Low | $67,084 | $603 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $61,741 | $601 |
| Purple Hospital | Low | $21,747 | $294 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $20,015 | $293 |
| Other High Hospitals | High | $188,907 | $2,236 | $7,608 | $7,133 | $12,258 | $4,744 | $0 | $0 | $11,906 | $1,074 | $88,545 | $4,724 | $68,661 | $1,395 |
| Other High Mid Hospitals | High Mid | $261,390 | $1,883 | $4,352 | $2,331 | $9,686 | $2,883 | $454 | $926 | $30,562 | $840 | $166,649 | $4,379 | $54,693 | $921 |
| Other Low Mid Hospitals | Low Mid | $319,130 | $1,148 | $14,078 | $4,799 | $29,675 | $3,704 | $12,293 | $822 | $50,827 | $590 | $122,640 | $4,036 | $92,487 | $699 |
| Other Low Hospitals | Low | $132,496 | $1,166 | $5,809 | $4,356 | $10,190 | $5,633 | $3,429 | $933 | $21,718 | $676 | $74,037 | $2,287 | $21,056 | $485 |
| Other No Tier Hospitals | NA | $232,966 | $429 | $4,088 | $414 | $9,744 | $343 | $0 | $0 | $1,035 | $404 | $55,973 | $1,482 | $152,180 | $352 |
| **Total** | | **$3,480,141** | **$1,199** | **$79,590** | **$2,595** | **$248,143** | **$2,767** | **$31,649** | **$949** | **$336,113** | **$723** | **$1,599,290** | **$3,282** | **$1,185,355** | **$687** |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## C. Hospital Admissions & Readmissions by Month

*This chart shows the number of hospital admissions and readmissions of Members by month and illness band for the trailing 12 months.*

| Illness Band | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advanced/Critical Illness | 8 | 7 | 5 | 10 | 7 | 9 | 10 | 9 | 11 | 9 | 8 | 4 | 98 |
| Multiple Chronic Illnesses | 4 | 4 | 4 | 4 | 5 | 9 | 4 | 5 | 7 | 4 | 7 | 4 | 61 |
| At Risk | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 3 | 1 | 2 | 1 | 1 | 16 |
| Stable | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Healthy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **12** | **12** | **10** | **15** | **13** | **19** | **17** | **17** | **19** | **15** | **16** | **10** | **176** |

## D. Hospital Admissions & Readmissions Gross Debits by Month

*This chart shows gross debits incurred for hospital admission and readmissions of Members by month and illness band for the trailing 12 months.*

| Illness Band | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advanced/Critical Illness | $175,711 | $105,906 | $136,210 | $206,484 | $157,163 | $183,667 | $210,365 | $191,078 | $255,792 | $176,735 | $138,611 | $58,512 | $1,996,235 |
| Multiple Chronic Illnesses | $55,265 | $95,621 | $55,741 | $51,593 | $90,026 | $111,042 | $39,546 | $73,602 | $99,870 | $64,996 | $134,763 | $43,842 | $915,905 |
| At Risk | $8,491 | $12,704 | $10,542 | $17,548 | $6,782 | $17,057 | $24,187 | $20,954 | $6,820 | $14,265 | $7,487 | $24,402 | $171,240 |
| Stable | $0 | $0 | $0 | $2,171 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $1,142 | $3,313 |
| Healthy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total** | **$239,467** | **$214,231** | **$202,493** | **$277,797** | **$253,971** | **$311,765** | **$274,097** | **$285,635** | **$362,482** | **$255,997** | **$280,861** | **$127,897** | **$3,086,693** |

## E. ER Visits by Month

*This chart shows the number of ER visits of Members by month and illness band for the trailing 12 months.*

| Illness Band | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advanced/Critical Illness | 6 | 9 | 6 | 7 | 9 | 5 | 6 | 8 | 10 | 10 | 10 | 7 | 93 |
| Multiple Chronic Illnesses | 20 | 16 | 14 | 20 | 20 | 20 | 20 | 15 | 16 | 12 | 14 | 11 | 196 |
| At Risk | 10 | 13 | 10 | 7 | 13 | 16 | 10 | 11 | 11 | 10 | 12 | 7 | 130 |
| Stable | 6 | 7 | 4 | 7 | 7 | 7 | 9 | 6 | 6 | 5 | 5 | 4 | 72 |
| Healthy | 1 | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 8 |
| **Total** | **42** | **45** | **36** | **41** | **49** | **49** | **45** | **40** | **43** | **36** | **42** | **30** | **498** |

## F. ER Visits Gross Debits by Month

*This chart shows gross debits incurred for ER visits of Members by month and illness band for the trailing 12 months.*

| Illness Band | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advanced/Critical Illness | $4,224 | $7,309 | $5,793 | $5,101 | $7,433 | $4,988 | $3,862 | $8,687 | $7,362 | $8,706 | $8,683 | $5,035 | $77,182 |
| Multiple Chronic Illnesses | $12,352 | $12,287 | $11,101 | $13,693 | $15,721 | $18,268 | $16,458 | $11,101 | $14,232 | $8,810 | $10,870 | $7,892 | $152,786 |
| At Risk | $6,584 | $9,124 | $6,882 | $4,085 | $9,770 | $9,265 | $6,749 | $7,052 | $11,030 | $8,937 | $7,908 | $4,810 | $92,197 |
| Stable | $3,181 | $4,632 | $1,843 | $3,859 | $3,679 | $5,022 | $4,743 | $3,774 | $2,887 | $2,935 | $2,801 | $3,040 | $42,397 |
| Healthy | $220 | $43 | $702 | $135 | $498 | $308 | $157 | #VALUE! | $235 | $122 | $286 | $495 | $3,201 |
| **Total** | **$26,561** | **$33,396** | **$26,321** | **$26,873** | **$37,101** | **$37,851** | **$31,969** | **$30,614** | **$35,746** | **$29,510** | **$30,548** | **$21,273** | **$367,762** |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## G. Hospital Admissions & Readmissions by Provider

*This chart shows hospital admissions and readmissions and associated debits by provider over the trailing 12 months. Admissions are also broken out into two types: Planned (direct admissions) and Unplanned (immediately preceded by an Emergency Room Visit).*

| Provider | Members with Admission | Admissions | | | | | Admission Debits | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total Count | Planned Count | Unplanned Count | Planned % | Unplanned % | Total $ | Planned $ | Unplanned $ | Average $ | Average Planned $ | Average Unplanned $ |
| Bob Blue | 28 | 51 | 24 | 27 | 47.1% | 52.9% | $1,050,838 | $587,255 | $463,582 | $2,060,466 | $2,446,896 | $1,716,972 |
| Ray Purple | 22 | 76 | 29 | 47 | 38.2% | 61.8% | $1,203,758 | $469,390 | $734,368 | $1,583,892 | $1,618,587 | $1,562,485 |
| Robin Red | 21 | 44 | 19 | 25 | 43.2% | 56.8% | $746,639 | $389,781 | $356,857 | $1,696,906 | $2,051,481 | $1,427,429 |
| Gary Green | 19 | 52 | 27 | 25 | 51.9% | 48.1% | $1,155,054 | $656,420 | $498,634 | $2,221,258 | $2,431,185 | $1,994,537 |
| Irene Indigo | 15 | 33 | 17 | 16 | 51.5% | 48.5% | $424,958 | $231,791 | $193,167 | $1,287,752 | $1,363,479 | $1,207,292 |
| Fletch Orange | 14 | 34 | 18 | 16 | 52.9% | 47.1% | $781,812 | $369,481 | $412,331 | $2,299,447 | $2,052,673 | $2,577,068 |
| Ronald Brown | 13 | 24 | 16 | 8 | 66.7% | 33.3% | $428,198 | $319,902 | $108,295 | $1,784,158 | $1,999,389 | $1,353,694 |
| Bonnie Beige | 12 | 26 | 15 | 11 | 57.7% | 42.3% | $494,499 | $342,504 | $151,995 | $1,901,920 | $2,283,362 | $1,381,773 |
| S. Cornflower-Blue | 12 | 29 | 14 | 15 | 48.3% | 51.7% | $451,266 | $273,871 | $177,395 | $1,556,090 | $1,956,221 | $1,182,633 |
| Peter Black | 10 | 27 | 14 | 13 | 51.9% | 48.1% | $586,812 | $322,859 | $263,953 | $2,173,377 | $2,306,138 | $2,030,404 |
| | | | | | | | | | | | | |
| Attributed to Panel* | 4 | 5 | 5 | 0 | 100.0% | 0.0% | $112,668 | $112,668 | $0 | $4,707,900 | $4,707,900 | $0 |
| **Total** | **166** | **176** | **72** | **104** | **40.9%** | **59.1%** | **$3,086,693** | **$1,660,010** | **$1,426,683** | **$4,276,318** | **$2,214,303** | **$445,296** |

*No specific Primary Care Provider identified due to lack of specific rendering provider ID on claims.

## H. Members with Admissions & Readmissions - All Bands

*This chart shows hospital admissions and readmissions for Members by illness band over the trailing 12 months. This chart also shows counts for unique Members rather than counts for each admission event. Click on any underlined field below to see additional information.*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 121 | 40 | 33.4% | 14 | 11.9% | 6 | 5.0% | 61 | 50.3% |
| | 413 | 51 | 12.3% | 3 | 0.8% | 1 | 0.2% | 55 | 13.3% |
| | 569 | 13 | 2.3% | 0 | 0.0% | 0 | 0.1% | 14 | 2.4% |
| | 867 | 1 | 0.1% | 0 | 0.0% | 0 | 0.0% | 1 | 0.1% |
| | 418 | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| **Total** | **2,387** | **105** | **4.4%** | **18** | **0.7%** | **7** | **0.3%** | **130** | **5.4%** |

## H. Detail of Members with Admissions & Readmissions

**3+ Admissions**
**Illness Band: Advanced Critical**

Sample Drill Through

*This chart displays detailed admission information at the Member level. Care Management Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), Expert Consult Program (ECP), and Health Assessment over the trailing 12 months. The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| Member Name | DOB | Provider | Admission Date | Episode | Hospital Name | Admissions | Gross Debit $ Per Admission | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|
| Anthony Lavender | 11/23/1964 | Bob Blue | 10/29/2015 | Osteoarthritis | Yellow County General | 1 | $31,941 | CCM (C), CCC (A), HTC |
| Gary White | 12/07/1963 | Ray Purple | 11/4/2015 | Condition Rel to Tx - Med/Surg | Gold Medical Center | 1 | $19,965 | CCM (C), CCC (A), HTC |
| Penelope Peach | 09/18/1935 | Robin Red | 3/12/2015 | Infec/Inflam - Skin/Subcu Tiss | Beige Memorial | 1 | $3,708 | CCM (C), CCC (R), HTC |
| Black White | 03/03/1961 | Gary Green | 3/18/2015 | Infec/Inflam - Skin/Subcu Tiss | Red General Hospital | 1 | $5,390 | CCM (C), CCC (R), HTC |
| | | | | | | | | |
| Eddie Fusie | 10/12/1931 | Fletch Orange | 4/10/2015 | Pneumonia, Bacterial | Lavender Hospital Center | 1 | $7,332 | CCC (C) |
| Sally Yellow | 08/09/1999 | Ronald Brown | 6/5/2015 | Pneumonia, Bacterial | Blue Hospital | 1 | $12,406 | CCC (C) |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## I. Members with ER Visits - All Bands

*This chart shows unique Members with multiple ER visits by illness band over the trailing 12 months. Click on any underlined field below to see additional information.*

| Illness Band | Total Members | 1-2 Visits | | 3-5 Visits | | 6+ Visits | | All ER Visits | |
|---|---|---|---|---|---|---|---|---|---|
| | | Members | % of Band | Members | % of Band | Members | % of Band | Members | % of Band |
| Advanced/Critical Illness | 393 | 149 | 37.9% | 22 | 5.6% | 5 | 1.3% | 176 | 44.8% |
| Multiple Chronic Illnesses | 1,178 | 350 | 29.7% | 28 | 2.4% | 7 | 0.6% | 385 | 32.7% |
| At Risk | 1,432 | 257 | 17.9% | 13 | 0.9% | 1 | 0.1% | 271 | 18.9% |
| Stable | 2,348 | 189 | 8.0% | 5 | 0.2% | 1 | 0.0% | 195 | 8.3% |
| Healthy | 1,056 | 23 | 2.2% | 0 | 0.0% | 0 | 0.0% | 23 | 2.2% |
| **Total** | **6,407** | **968** | **15.1%** | **68** | **1.1%** | **14** | **0.2%** | **968** | **15.1%** |

## I. Detail of Members with ER Visits

**ER Visits: 1-2 Visits**

**Illness Band: Advanced Critical**

Sample Drill Through

*This chart displays detailed ER visit information at the Member level. Care Management Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), Expert Consult Program (ECP), and Health Assessment over the trailing 12 months. The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| Member Name | DOB | Provider | Service Date | Diagnosis | Hospital Name | ER Visits | ER Visit Debit $ | Care Coordination Program Status* |
|---|---|---|---|---|---|---|---|---|
| Eddie Fusie | 11/23/1964 | Bob Blue | 7/5/2015 | Other Pulmonary Embolism And Infarction | Good Samaritan Hospital | 1 | $837 | CCM (A) |
| Anthony Lavender | 12/07/1963 | Ray Purple | 6/18/2015 | Constipation , Unspecified | University Of Maryland Medical | 1 | $786 | CCM (R), HTC |
| Gary White | 09/18/1935 | Robin Red | 5/22/2015 | Other Pulmonary Embolism And Infarction | Johns Hopkins Hospital | 1 | $1,692 | CCM (A), HTC |
| Penelope Peach | 03/03/1961 | Gary Green | 5/19/2015 | Venous Embolism And Thrombosis Of Deep Vessels | Good Samaritan Hospital | 1 | $629 | |
| | | | | | | | | |
| Black White | 05/09/1992 | Ronald Brown | 5/10/2015 | Deep Vein Thrombosis Nos Dvt Nos | Good Samaritan Hospital | 1 | $831 | CCM (A), HTC |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## J. Top 10 Procedures in Both ASC and Outpatient Hospital Settings

*The chart below shows the Panel's top 10 procedures - based on total Outpatient use routinely performed in both the Ambulatory Surgery Center (ASC) and Outpatient Hospital settings - along with frequency and average costs for the trailing 12 months. Data is sorted by Outpatient Hospital use.*

| Procedure | Total # | Outpatient Hospital | | | ASC | | | |
|---|---|---|---|---|---|---|---|---|
| | | # | Panel % | PCMH Average Cost per Procedure | # | Panel % | PCMH Average Cost per Procedure | PCMH % |
| 45380 Colonoscopy and Biopsy | 121 | 36 | 29.8% | $2,864 | 85 | 70.2% | $1,514 | 78.7% |
| 45378 Diagnostic Colonoscopy | 153 | 33 | 21.6% | $2,061 | 120 | 78.4% | $1,174 | 76.1% |
| 20610 Drain/Inject joint/Bursa | 26 | 24 | 92.3% | NA | 2 | 7.7% | NA | 21.8% |
| 58558 Hysteroscopy Biopsy | 27 | 24 | 88.9% | $4,047 | 3 | 11.1% | $1,513 | 23.4% |
| 43239 Upper Gi Endoscopy Biopsy | 112 | 23 | 20.5% | $2,758 | 89 | 79.5% | $1,337 | 77.9% |
| 62311 Inject Spine Lumbar/Sacral | 34 | 10 | 29.4% | $1,166 | 24 | 70.6% | $665 | 73.9% |
| 29881 Knee Arthroscopy/Surgery | 11 | 9 | 81.8% | $4,790 | 2 | 18.2% | $2,785 | 56.7% |
| 29827 Arthroscop Rotator Cuff Repr | 12 | 8 | 66.7% | $10,829 | 4 | 33.3% | $6,817 | 46.6% |
| 63030 Low Back Disk Surgery | 7 | 7 | 100.0% | $8,969 | 0 | 0.0% | $6,469 | 25.0% |
| 29848 Wrist Edoscopy/Surgery | 11 | 5 | 45.5% | $3,526 | 6 | 54.5% | $2,625 | 75.5% |
| Other | 485 | 232 | 47.8% | NA | 253 | 52.2% | NA | 49.7% |
| **Total** | **999** | **411** | **41.1%** | | **588** | **58.9%** | | **61.7%** |

## Top 10 Procedures in Both ASC and Outpatient Hospital Settings by Provider

*The chart below shows the Panel's top 10 procedures - based on total Outpatient use routinely performed in both the Ambulatory Surgery Center (ASC) and Outpatient Hospital settings by Provider - along with frequency and percent for the trailing 12 months. Data is sorted by ASC Provider %.*

| Provider | Total # | Outpatient Hospital | | ASC | |
|---|---|---|---|---|---|
| | | # | Provider % | # | Provider % |
| Donald Daisy | 90 | 28 | 31.1% | 62 | 68.9% |
| Bob Blue | 92 | 33 | 35.9% | 59 | 64.1% |
| Irene Indigo | 75 | 28 | 37.3% | 47 | 62.7% |
| Fletch Orange | 61 | 14 | 23.0% | 47 | 77.0% |
| Ronald Brown | 85 | 39 | 45.9% | 46 | 54.1% |
| Theodore Lavender | 62 | 18 | 29.0% | 44 | 71.0% |
| Ace Emerald | 68 | 26 | 38.2% | 42 | 61.8% |
| | | | | | |
| Attributed To Panel | 22 | 9 | 40.9% | 13 | 59.1% |
| **Total** | **999** | **411** | **41.1%** | **588** | **58.9%** |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## K. Use of Urgent Care Backup (UCB) - Weekend/Weekday Visits by Illness Band

*The charts below show the percent of visits taking place in an Emergency Room (ER), Urgent Care Center, Convenience Care, or Primary Care Provider (PCP) Office setting for weekends and weekdays by illness band over the trailing 12 months.*

Filter By: All Providers

### ER vs. Urgent Care Center, Convenience Care, and Office Settings - Weekend Visits

| Illness Band | Total Visits | ER | | | Urgent Care | | | Convenience Care | | | PCP Office | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Average Debit $ | Panel % | PCMH % | Average Debit $ | Panel % | PCMH % | Average Debit $ | Panel % | PCMH % | Average Debit $ | Panel % | PCMH % |
| Advanced/Critical Illness | 217 | $1,495 | 77.0% | 16.2% | $120 | 8.8% | 3.9% | $76 | 1.8% | 1.9% | $144 | 12.4% | 3.6% |
| Multiple Chronic Illnesses | 335 | $1,033 | 54.3% | 26.1% | $120 | 17.3% | 13.8% | $63 | 1.8% | 11.4% | $152 | 26.6% | 10.4% |
| At Risk | 257 | $1,054 | 37.0% | 21.8% | $133 | 28.4% | 18.7% | $57 | 6.6% | 16.8% | $138 | 28.0% | 15.0% |
| Stable | 277 | $865 | 27.1% | 30.0% | $130 | 43.7% | 44.3% | $54 | 6.5% | 43.6% | $126 | 22.7% | 46.5% |
| Healthy | 69 | $648 | 7.2% | 6.0% | $123 | 50.7% | 19.3% | $67 | 18.8% | 26.3% | $127 | 23.2% | 24.6% |
| **Total** | **1,155** | **$1,156** | **45.4%** | **34.4%** | **$127** | **26.5%** | **25.5%** | **$60** | **5.0%** | **6.8%** | **$140** | **23.1%** | **33.3%** |

### ER vs. Urgent Care Center, Convenience Care, and Office Settings - Weekday Visits

| Illness Band | Total Visits | ER | | | Urgent Care | | | Convenience Care | | | PCP Office | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Average Debit $ | Panel % | PCMH % | Average Debit $ | Panel % | PCMH % | Average Debit $ | Panel % | PCMH % | Average Debit $ | Panel % | PCMH % |
| Advanced/Critical Illness | 2,118 | $1,491 | 18.2% | 18.7% | $128 | 1.7% | 3.8% | $72 | 0.4% | 2.7% | $152 | 79.7% | 5.7% |
| Multiple Chronic Illnesses | 4,592 | $1,225 | 10.6% | 28.0% | $126 | 3.5% | 14.5% | $65 | 0.9% | 12.5% | $142 | 85.0% | 15.7% |
| At Risk | 4,218 | $1,173 | 6.4% | 21.6% | $123 | 5.5% | 19.5% | $60 | 1.0% | 17.1% | $132 | 87.1% | 19.8% |
| Stable | 4,762 | $932 | 3.6% | 27.0% | $129 | 5.1% | 43.8% | $58 | 1.1% | 43.3% | $126 | 90.2% | 42.1% |
| Healthy | 679 | $859 | 3.1% | 4.8% | $118 | 14.1% | 18.4% | $59 | 3.5% | 24.4% | $115 | 79.2% | 16.7% |
| **Total** | **16,369** | **$1,248** | **8.2%** | **6.2%** | **$125** | **4.7%** | **4.4%** | **$61** | **1.0%** | **1.3%** | **$135** | **86.1%** | **88.1%** |

## L. Use of Urgent Care Backup (UCB) - Weekend/Weekday Visits by Provider

*The chart below shows the percent of visits taking place in an Emergency Room (ER), Urgent Care Center, Convenience Care, or Primary Care Provider (PCP) Office setting by provider over the trailing 12 months.*

### ER vs. Urgent Care Center, Convenience Care, and Office Settings - Weekend Visits

| Provider | Total Visits | ER | | | Urgent Care | | | Convenience Care | | | PCP Office | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Average Debit $ | PCP % | PCMH % | Average Debit $ | PCP % | PCMH % | Average Debit $ | PCP % | PCMH % | Average Debit $ | PCP % | PCMH % |
| Peter Black | 178 | $1,064 | 25.3% | 34.4% | $133 | 14.6% | 25.5% | $52 | 3.9% | 6.8% | $174 | 56.2% | 33.3% |
| Fer Brick-Red | 140 | $1,729 | 22.9% | 34.4% | $115 | 20.0% | 25.5% | $79 | 5.7% | 6.8% | $157 | 51.4% | 33.3% |
| | | | | | | | | | | | | | |
| Sarah Cobalt | 6 | $2,948 | 50.0% | 34.4% | $138 | 50.0% | 25.5% | $0 | 0.0% | 6.8% | $0 | 0.0% | 33.3% |
| Donald Daisy | 5 | $679 | 80.0% | 34.4% | $0 | 0.0% | 25.5% | $51 | 20.0% | 6.8% | $0 | 0.0% | 33.3% |
| **Total** | **1,155** | **$1,156** | **45.4%** | **34.4%** | **$127** | **26.5%** | **25.5%** | **$60** | **5.0%** | **6.8%** | **$140** | **23.1%** | **33.3%** |

### ER vs. Urgent Care Center, Convenience Care, and Office Settings - Weekday Visits

| Provider | Total Visits | ER | | | Urgent Care | | | Convenience Care | | | PCP Office | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Average Debit $ | PCP % | PCMH % | Average Debit $ | PCP % | PCMH % | Average Debit $ | PCP % | PCMH % | Average Debit $ | PCP % | PCMH % |
| Tom Turquoise | 1,807 | $1,169 | 7.0% | 6.2% | $118 | 6.5% | 4.4% | $55 | 1.2% | 1.3% | $109 | 85.2% | 88.1% |
| Fer Brick-Red | 1,632 | $1,388 | 5.9% | 6.2% | $118 | 2.9% | 4.4% | $59 | 0.9% | 1.3% | $158 | 90.3% | 88.1% |
| | | | | | | | | | | | | | |
| Sarah Cobalt | 62 | $764 | 4.8% | 6.2% | $108 | 8.1% | 4.4% | $0 | 0.0% | 1.3% | $137 | 87.1% | 88.1% |
| Attributed to Panel | 30 | $912 | 60.0% | 6.2% | $134 | 13.3% | 4.4% | $24 | 3.3% | 1.3% | $131 | 23.3% | 88.1% |
| **Total** | **16,369** | **$1,248** | **8.2%** | **6.2%** | **$125** | **4.7%** | **4.4%** | **$61** | **1.0%** | **1.3%** | **$135** | **86.1%** | **88.1%** |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## M. Debits for Prescription Drugs by Source and Type

*This chart shows all pharmacy debits for the Panel to the extent that they are made available to CareFirst by the various Pharmacy Benefit Managers (PBMs) that serve CareFirst Members. The totals provided are for the trailing 12 month period for Members attributed to the Panel.*

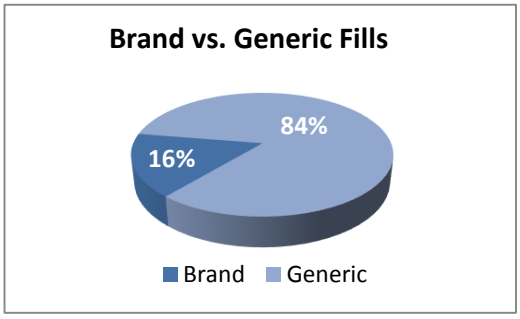
### Total Drug Spend

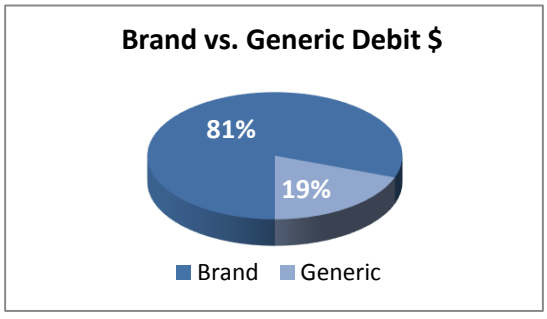
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 393 | 143 | 36.4% | $1,173,271 | $1,741 | $504,040 | $1,039,483 | $2,718,536 |
| | 1,178 | 500 | 42.4% | $1,931,165 | $4,168 | $160,826 | $605,727 | $2,701,886 |
| | 1,432 | 633 | 44.2% | $1,545,654 | $6,022 | $151,010 | $302,692 | $2,005,379 |
| | 2,348 | 1,138 | 48.5% | $817,244 | $528 | $64,312 | $21,570 | $903,655 |
| | 1,056 | 667 | 63.2% | $132,936 | $0 | $36,579 | $1,652 | $171,167 |
| **Total** | **6,407** | **3,081** | **48.1%** | **$5,600,271** | **$12,460** | **$916,767** | **$1,971,125** | **$8,500,623** |

## N. Generic Dispensing Rate for Mail/Retail Pharmacy Drugs

*This chart shows the brand and generic dollar spend and fill rates by illness band over the trailing 12 months. The fill counts and debits include only the drugs that are classified as generic or brand and do not include drugs such as diabetic supplies or bulk chemicals used for compounds.*

| Illness Band | Mail/Retail Pharmacy # of Fills | Mail/Retail Pharmacy Debit $ | Total Brand | | | | Total Generic | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | # of Fills | % of Total Fills | Debit $ | % of Total Debit $ | # of Fills | % of Total Fills | Debit $ | % of Total Debit $ |
| Advanced/Critical Illness | 5,581 | $1,173,270 | 970 | 17.4% | $996,028 | 84.9% | 4,611 | 80.9% | $177,242 | 15.1% |
| Multiple Chronic Illnesses | 12,899 | $1,931,165 | 2,439 | 18.9% | $1,588,744 | 82.3% | 10,460 | 81.1% | $342,421 | 17.7% |
| At Risk | 11,126 | $1,545,655 | 1,689 | 15.2% | $1,236,149 | 80.0% | 9,437 | 84.9% | $309,506 | 20.0% |
| Stable | 10,928 | $817,245 | 1,636 | 15.0% | $600,205 | 73.4% | 9,292 | 85.2% | $217,040 | 26.6% |
| Healthy | 1,905 | $132,936 | 254 | 13.3% | $90,275 | 67.9% | 1,651 | 85.1% | $42,661 | 32.1% |
| **Total** | **42,439** | **$5,600,271** | **6,988** | **16.5%** | **$4,511,401** | **80.6%** | **35,451** | **83.5%** | **$1,088,870** | **19.4%** |




## O. Generic Dispensing Rate - Max Potential Savings

*This chart shows the number of fills for brand drugs with a generic substitute available and the maximum potential savings that could be achieved if all such fills were converted to generic over the trailing 12 months. The data includes all prescriptions for the Panel's Members regardless of the prescriber (providers both in and out of the Panel). The potential savings is an aggregation of the difference between the brand and typical generic cost for each of these fills.*

| Illness Band | Brand # of Fills | # of Brand Fills With Generic Equivalent | % of Brand Fills With Generic Equivalent | Max Potential Generic Cost Savings |
|---|---|---|---|---|
| Advanced/Critical Illness | 970 | 29 | 3.0% | $675 |
| Multiple Chronic Illnesses | 2,439 | 97 | 4.0% | $2,906 |
| At Risk | 1,689 | 65 | 3.8% | $1,676 |
| Stable | 1,636 | 114 | 7.0% | $3,696 |
| Healthy | 254 | 40 | 15.7% | $1,169 |
| **Total** | **6,988** | **345** | **4.9%** | **$10,121** |

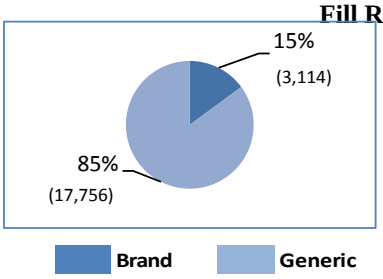
# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## P. Generic Fill Rates for Mail/Retail Pharmacy Drugs - Provider Detail

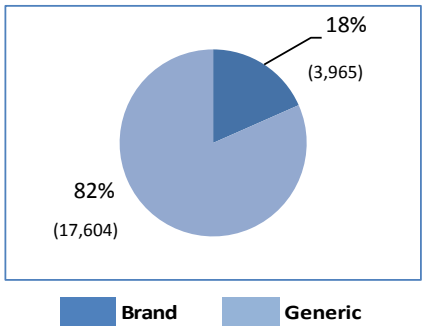
*These views show brand and generic fill rates over the trailing 12 months for drugs that were either filled by mail order or a retail pharmacy. The charts to the left are overall for the Panel and the tables to the right show the top 10 prescribing providers, sorted to show the providers with the highest brand fill rates in descending order. The top views show the in-Panel providers, while the bottom views show specialists and other providers out of Panel caring for Panel Members. Only drugs classified as generic or brand are included. Drugs such as diabetic supplies or bulk chemicals used for compounds are excluded.*

### Fill Rates for In-Panel Prescribing Providers




| | | # of Fills |
|---|---|---|
| Bob Blue | 15% | 2,752 |
| Ronald Brown | 13% | 2,152 |
| Fletcher Orange | 11% | 1,887 |
| Bonnie Beige | 14% | 1,537 |
| Sarah Colbalt | 22% | 1,517 |
| Ace Emerald | 14% | 1,495 |
| Samuel Yellow | 14% | 1,480 |
| Gary Green | 21% | 1,381 |
| Peter Black | 19% | 1,298 |
| Michael Mauve | 13% | 876 |

### Fill Rates for Specialists and Other Non-Panel Prescribing Providers caring for Panel Members

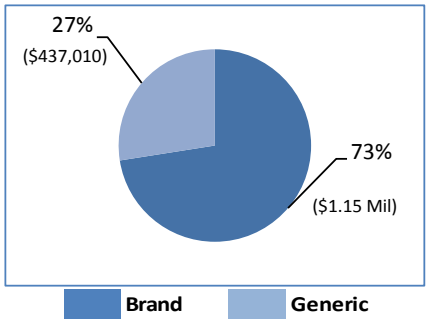



| | | # of Fills |
|---|---|---|
| Dennis Maroon | 20% | 884 |
| Sarah Rainbow | 13% | 678 |
| Amy Redding | 22% | 229 |
| Nora Violet | 22% | 202 |
| Arthur Brown | 17% | 187 |
| Kimberly Yellow | 28% | 146 |
| Rafael Pinkman | 12% | 146 |
| Eden Sunshine-Glow | 5 | 141 |
| Angela Green | 13% | 135 |
| Jeffrey Blacksmith | 20% | 121 |

## Q. Generic Cost Ratios for Mail/Retail Pharmacy Drugs - Provider Detail

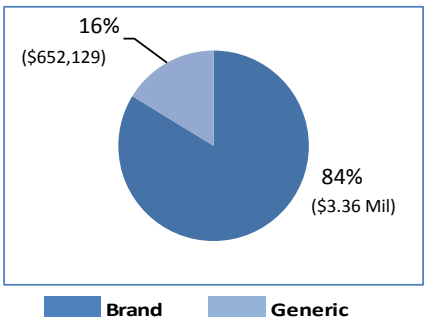
*These views show percent of cost spent on brand vs. generic drugs over the trailing 12 months for drugs that were either filled by mail order or a retail pharmacy. The charts to the left are overall for the Panel and the tables to the right show the top 10 prescribing providers, sorted to show the providers with the highest brand cost ratios in descending order. The top views show in-Panel providers, while the bottom views show specialists and other providers out of Panel caring for Panel Members. Only drugs classified as generic or brand are included. Drugs such as diabetic supplies or bulk chemicals used for compounds are excluded.*

### Cost Ratios for In-Panel Prescribing Providers




| | | # of Fills |
|---|---|---|
| Bob Blue | 74% | 2,752 |
| Fletcher Orange | 71% | 1,887 |
| Ronald Brown | 84% | 2,152 |
| Bonnie Beige | 80% | 1,537 |
| Sarah Colbalt | 69% | 1,517 |
| Ace Emerald | 73% | 1,495 |
| Peter Black | 70% | 1,298 |
| Gary Green | 75% | 1,381 |
| Samuel Yellow | 69% | 1,480 |
| Michael Mauve | 75% | 876 |

### Cost Ratios for Specialists and Other Non-Panel Prescribing Providers caring for Panel Members




| | | | # of Fills |
|---|---|---|---|
| Ayse Bluekoglu | 100% | 0% | 707 |
| Michael Rose | 99% | 1% | 542 |
| Natarajan Orange-Patel | 100% | 0% | 183 |
| Mark Goldenrod | 97% | 3% | 162 |
| Reezwana Crimson | 100% | 0% | 150 |
| Alana Honeydew | 100% | 0% | 117 |
| Sangjin Ivory | 100% | 0% | 117 |
| Harshad Lavendar | 100% | 0% | 113 |
| Dennis Champange | 68% | 32% | 108 |
| William Orchid | 96% | 4% | 97 |

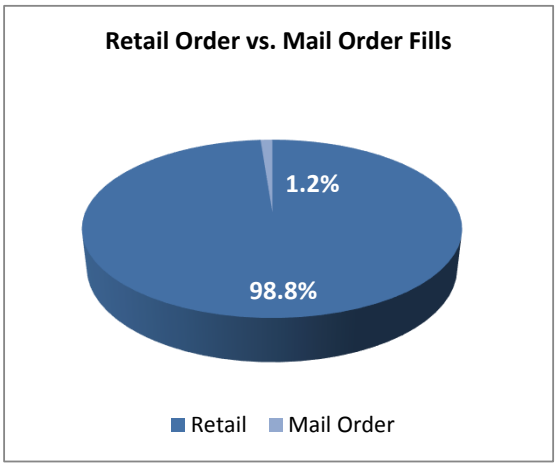
# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

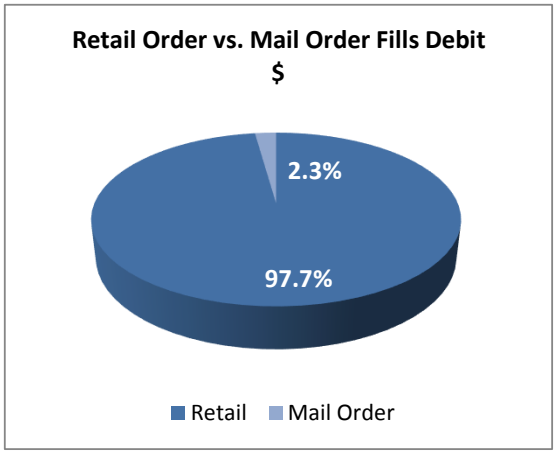
## R. Mail Order Dispensing Rate for Mail/Retail Pharmacy Drugs

*This view shows the retail and mail order cost and fill rates by illness band over the trailing 12 months. Overall rates are charted beneath, as well as a detailed view of Panel providers and all other providers with the highest Mail Order rates.*

| Illness Band | Mail/Retail Pharmacy # of Fills | Mail/Retail Pharmacy Debit $ | Total Retail | | | | Total Mail Order | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | # of Fills | % of Total Fills | Debit $ | % of Total Debit $ | # of Fills | % of Total Fills | Debit $ | % of Total Debit $ |
| Advanced/Critical Illness | 5,581 | $1,173,271 | 5,474 | 98.1% | $1,147,497 | 97.8% | 107 | 1.9% | $25,774 | 2.2% |
| Multiple Chronic Illnesses | 12,899 | $1,931,165 | 12,743 | 98.8% | $1,904,940 | 98.6% | 156 | 1.2% | $26,225 | 1.4% |
| At Risk | 11,126 | $1,545,654 | 10,942 | 98.3% | $1,527,342 | 98.8% | 184 | 1.7% | $18,312 | 1.2% |
| Stable | 10,928 | $817,244 | 10,672 | 97.7% | $784,748 | 96.0% | 256 | 2.3% | $32,496 | 4.0% |
| Healthy | 1,905 | $132,936 | 1,884 | 98.9% | $129,412 | 97.3% | 21 | 1.1% | $3,525 | 2.7% |
| **Total** | **42,439** | **$5,600,271** | **41,715** | **98.3%** | **$5,493,939** | **98.1%** | **724** | **1.7%** | **$106,332** | **1.9%** |




| | | | |
|---|---|---|---|
| Ronald Brown | 2,650 | 111 | 4.2% |
| Fletcher Orange | 1,979 | 77 | 3.9% |
| Bob Blue | 1,963 | 14 | 0.7% |
| Bonnie Beige | 1,779 | 26 | 1.5% |
| Ace Emerald | 1,480 | 35 | 2.4% |
| Samuel Yellow | 1,455 | 43 | 3.0% |
| Peter Black | 1,385 | 60 | 4.3% |
| Gary Green | 1,382 | 58 | 4.2% |
| Tom Turquoise | 1,292 | 6 | 0.5% |
| Michael Mauve | 1,290 | 130 | 10.1% |




| Specialists and Other Out of Panel Providers | Mail/Retail # of Fills | Mail Order # of Fills | Mail Order Fill Rate |
|---|---|---|---|
| Jay Seaweed | 579 | 4 | 0.7% |
| Joy'El Moss | 208 | 7 | 3.4% |
| Barbara Scarlet | 170 | 3 | 1.8% |
| Natalie Nickel | 109 | 2 | 1.8% |
| Bruce Opal | 91 | 1 | 1.1% |
| Mary Chestnut | 83 | 9 | 10.8% |
| Mehtap Periwinkle | 68 | 1 | 1.5% |
| Sanaz Plum | 52 | 3 | 5.8% |
| Louis Pine | 52 | 2 | 3.8% |
| Lisa Quartz-Silver | 50 | 2 | 4.0% |

## S. Mail Order Dispensing Rate - Calculated Potential Savings

*This chart shows the retail dispensing rate (regardless of brand or generic status) over the trailing 12 months, with an estimated potential for cost savings if mail order rates were increased by 5% or to maximum potential. Mail Order rates are available at a lower cost due to lower ingredient costs and reduced dispensing fees.*

| | # of Retail Fills | Retail Debit $ | Current Mail Order Fill Rate | Current Cost Savings | Mail Order Fill Rate If Increased by 5% | Potential Cost Savings For Every 5% Increase | Maximum Potential Cost Savings |
|---|---|---|---|---|---|---|---|
| **Total** | 41,715 | $5,493,939 | 1.7% | $0 | 6.7% | $194,575 | $3,827,485 |

## IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

### T. Costliest Brand Drugs

*This chart lists the Panel's costliest brand prescription drugs used by Members in the Panel, ranked by cost for the trailing 12 months. It also shows the formulary tier of the drug and if a generic equivalent or alternative is available. The formulary tier of the drug (as determined by CareFirst) is an indicator of the estimated out-of-pocket cost level to the Member (through copayments/coinsurance). Members pay the lowest copay for generic drugs (Tier 1), a higher copay for brand name drugs on CareFirst's preferred drug or formulary list (Tier 2), and the highest copay for brand name drugs not on the formulary list (Tier 3). Click on any underlined field below to see additional information.*

| Drug Name | Formulary Tier | Generic Equivalent Available* | Generic Alternative Available* | Therapeutic Class | Members | Debit $ | Average Debit $ |
|---|---|---|---|---|---|---|---|
| HARVONI | 2 | No | No | Other | 8 | $733,330 | $91,666.22 |
| HUMIRA | 2 | No | Yes | Analgesic, Anti-inflammatory or Antipyretic | 6 | $183,387 | $30,564.48 |
| ENBREL | 2 | No | Yes | Analgesic, Anti-inflammatory or Antipyretic | 5 | $183,155 | $36,630.94 |
| SOVALDI | 2 | No | No | Anti-Infective Agents | 1 | $141,964 | $141,963.75 |
| COPAXONE | 2 | No | No | Multiple Sclerosis Agents | 2 | $120,523 | $60,261.28 |
| CRESTOR | 2 | No | Yes | Cardiovascular Therapy Agents | 76 | $113,962 | $1,499.49 |
| JANUVIA | 2 | No | Yes | Endocrine | 36 | $90,214 | $2,505.94 |
| LEVEMIR FLEXTOUCH | 2 | No | No | Endocrine | 27 | $87,990 | $3,258.90 |
| GLEEVEC | 2 | No | No | Antineoplastics | 1 | $68,169 | $68,169.45 |
| REBIF REBIDOSE | 3 | No | No | Multiple Sclerosis Agents | 1 | $67,506 | $67,506.09 |
| **Total** | | | | | **163** | **$1,790,199** | **$10,983** |

*Generic Equivalent drugs contain active ingredients that are identical in chemical composition to the brand drug. Generic Alternative drugs are in the same therapeutic class as the brand drug but are not identical in chemical composition. For example, certain statins (cholesterol-lowering medicines) are better for a Member depending on the individual circumstances such as LDL level of the Member and history of heart disease or heart attacks. The brand drug Lipitor (Atorvastatin) has no generic equivalent and is used in the instance of highly elevated LDL and heart attack history. Generic alternative statin drugs include: Lovastatin or Pravastatin (if LDL levels need to be lowered by less than 30 percent) and simvastatin (LDL reduction of 30 percent or more is needed and/or presence of heart disease, diabetes, or heart attack is known or acute coronary syndrome is known and the Member's LDL level is not highly elevated).

Sample Drill Through

### T. Detail of Costliest Brand Drugs

**Therapeutic Class: Cardiovascular Therapy Agents**

**Drug Name: CRESTOR**

**Generic Equivalent (GE): No**

**Generic Alternative (GA): Atorvastatin**

*This chart displays savings information at the aggregate level over the trailing 12 months, grouped by Panel providers and by specialists and other prescribers caring for Panel Members. A list of generic equivalents and generic therapeutic alternatives for the brand drug listed are made available. The potential savings reflect savings that could be achieved if all fills for the selected brand drug were switched to either their generic equivalent or alternative. Potential savings is obtained by replacing the brand per unit cost with the average per unit cost for generic equivalents/alternatives.*

| Prescriber | # of Fills | Members | Debit $ | Average Debit $ Per Member | Potential Savings (switch to GE) | Potential Savings (switch to GA) |
|---|---|---|---|---|---|---|
| Providers in Panel | 75 | 50 | $85,556 | $1,711 | None | $1,413 |
| Specialists and Other Providers | 33 | 26 | $28,406 | $1,093 | None | $818 |

Sample Drill Through

### T. Detail of Members with Costliest Brand Drugs

**Therapeutic Class: Cardiovascular Therapy Agents**

**Prescriber: Specialists and Other Providers**

**Generic Equivalent (GE): No**

**Drug Name: Crestor**

**Generic Alternative (GA): Atorvastatin**

*This chart displays detailed drug information at the Member level, with the PCMH Provider, Prescribing Provider, and the debits associated with the selected Brand Drug over the trailing 12 months. A list of generic equivalents and generic therapeutic alternatives for the brand drug listed are made available. Debit dollars are associated with the Brand Drug selected. The potential savings reflect savings that could be achieved if all fills for the selected brand drug were switched to either their generic equivalent or alternative. Potential savings is obtained by replacing the brand per unit cost with the average per unit cost for generic equivalents/alternatives. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| | Member Name | DOB | Prescribing Provider | PCMH Provider | Rx Debit $ | Potential Savings (switch to GE) | Potential Savings (switch to GA) |
|---|---|---|---|---|---|---|---|
| 1 | Edna Black | 5/9/1962 | Bob Blue | Peter Black | $1,555 | None | $96 |
| 2 | Ray Plum | 3/3/1969 | Peter Black | Tom Turquoise | $1,270 | None | $74 |
| 3 | John Blue | 7/11/1979 | Ace Emerald | Bonnie Beige | $1,237 | None | $74 |
| | | | | | | | |
| 26 | Rita Yellow | 9/18/1988 | Irene Indigo | Margaret Orange | $1,110 | None | $64 |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## U. Members with Multiple Drugs

*This chart identifies multiple drug usage for Panel Members with available pharmacy benefit information. The chart lists Members assigned to each illness band and the number of different drugs (counted by drug name) these Members are taking. The totals provided are for the trailing 12 month period for Members attributed to the Panel. All Drug Sources and Types are included. Click on any underlined field below to see additional information.*

| Illness Band | Total Members | Members with Pharmacy Benefit | | 3 - 6 Drugs | | 7 - 11 Drugs | | 12+ Drugs | |
|---|---|---|---|---|---|---|---|---|---|
| | | # | % of Band | Members | % of Rx Members | Members | % of Rx Members | Members | % of Rx Members |
| Advanced/Critical Illness | 393 | 143 | 36.4% | 24 | 16.8% | 33 | 23.1% | 84 | 58.7% |
| Multiple Chronic Illnesses | 1,178 | 500 | 42.4% | 139 | 27.8% | 158 | 31.6% | 163 | 32.6% |
| At Risk | 1,432 | 633 | 44.2% | 227 | 35.9% | 218 | 34.4% | 85 | 13.4% |
| Stable | 2,348 | 1,138 | 48.5% | 501 | 44.0% | 168 | 14.8% | 42 | 3.7% |
| Healthy | 1,056 | 667 | 63.2% | 135 | 20.2% | 14 | 2.1% | 2 | 0.3% |
| **Total** | **6,407** | **3,081** | **48.1%** | **1,026** | **33.3%** | **591** | **19.2%** | **376** | **12.2%** |

## U. Detail of Members with Multiple Drugs

**Multiple Drugs: 12+ Drugs**

**Illness Band: Advanced Critical Illness**

Sample Drill Through

*This chart shows Member details for those Members in the selected multiple drug range over the trailing 12 months. Click on any underlined field below to see additional information.*

| # | Member Name | DOB | Illness Band | Provider | Dominant Episode | # of Drugs | Debit $ |
|---|---|---|---|---|---|---|---|
| 1 | Edna Black | 11/1/1999 | Band 1 | Bob Blue | Chrons Disease | 22 | $31,351 |
| 2 | Kathleen Green | 12/11/1986 | Band 1 | Tom Turquoise | Multiple Sclerosis | 14 | $39,220 |
| | | | | | | | |
| 79 | Barbara Brown | 4/18/1960 | Band 1 | Gary Green | Mental Hlth - Neuroses, NEC | 14 | $632 |
| 80 | Carolyn Amber | 8/10/1959 | Band 1 | Bonnie Beige | Coronary Artery Disease | 12 | $513 |
| 84 | Juan Blue | 5/9/1962 | Band 1 | Margaret Orange | Choleysitis/Cholelithiasis | 15 | $174 |

## U. Detail of Members with Multiple Drugs

**Member: Edna Black**

**Dominant Episode: Chrons Disease**

Sample Drill Through

*This chart shows increased Member specific detail on drugs taken by Members, along with their therapeutic class, frequency of fills, and the total cost relating to each drug over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name above.*

| # | Drug Name | Therapeutic Class | # of Fills | Debit $ | Maintenance |
|---|---|---|---|---|---|
| 1 | CIMZIA | Hepatitis Agents | 9 | $29,606 | Yes |
| 2 | ESOMEPRA MAG | Hepatitis Agents | 6 | $1,133 | Yes |
| 3 | HYDROCORTISONE | Hematopoietic Agents - Hematopoietic Growth Factors | 1 | $132 | No |
| 4 | PREPOPIK | Hepatitis Agents | 1 | $125 | No |
| 5 | ESCITALOPRAM OXALATE | Other | 11 | $82 | Yes |
| 6 | GABAPENTIN | Injectable Antidiabetic Agents | 13 | $57 | Yes |
| 7 | ESCITALOPRAM | Medical Supplies & DME | 2 | $21 | Yes |
| 8 | CYCLOBENZAPRINE | Analgesic Narcotic Agonists and Cominations | 12 | $18 | No |
| | | | | | |
| 22 | CIPROFLOXACIN HCL | Beta Blockers Non-Cardiac Selective, All | 1 | $2 | No |
| | **Total** | | | **$31,351** | |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## V. Members with Multiple Maintenance Drugs

*This chart identifies multiple maintenance drug usage for Panel Members with available pharmacy benefit information. The chart lists Members assigned to each Illness band and the number of different maintenance drugs (counted by drug name) these Members are taking. The totals provided are for the trailing 12 month period for Members attributed to the Panel. Click on any underlined field below to see additional information.*

| Illness Band | Total Members | Members with Pharmacy Benefit | | 3 - 6 Drugs | | 7 - 11 Drugs | | 12+ Drugs | |
|---|---|---|---|---|---|---|---|---|---|
| | | # | % of Band | Members | % of Rx Members | Members | % of Rx Members | Members | % of Rx Members |
| Advanced/Critical Illness | 393 | 143 | 36.4% | 37 | 25.9% | 56 | 39.2% | 23 | 16.1% |
| Multiple Chronic Illnesses | 1,178 | 500 | 42.4% | 196 | 39.2% | 103 | 20.6% | 26 | 5.2% |
| At Risk | 1,432 | 633 | 44.2% | 227 | 35.9% | 77 | 12.2% | 6 | 0.9% |
| Stable | 2,348 | 1,138 | 48.5% | 318 | 27.9% | 33 | 2.9% | 1 | 0.1% |
| Healthy | 1,056 | 667 | 63.2% | 24 | 3.6% | 1 | 0.1% | 0 | 0.0% |
| **Total** | **6,407** | **3,081** | **48.1%** | **802** | **26.0%** | **270** | **8.8%** | **56** | **1.8%** |

## V. Detail of Members with Maintenance Drugs

**Maintenance Drugs: 12+ Drugs**

**Illness Band: Advanced Critical Illness**

Sample Drill Through

*This chart shows Member details for those Members in the selected multiple drug range over the trailing 12 months. Click on any underlined field below to see additional information.*

| # | Member Name | DOB | Illness Band | Provider | Dominant Episode | # of Drugs | Debit $ |
|---|---|---|---|---|---|---|---|
| 1 | Elizabeth Orange | 11/1/1999 | Band 1 | Gary Green | Diabetes | 15 | $9,048 |
| 2 | Kimberly Mauve | 12/11/1986 | Band 1 | Bonnie Beige | Spinal/Back Disorders, Lower Back | 15 | $6,611 |
| 3 | Linda Tan | 4/18/1960 | Band 1 | Michael Mauve | Cerebrovascular Disease | 12 | $6,024 |
| | | | | | | | |
| 22 | George Yellow | 8/10/1959 | Band 1 | Sarah Cobalt | Injury - Head/Spinal Cord | 12 | $1,884 |
| 23 | Georgia Pink | 5/9/1962 | Band 1 | Ace Emerald | Hypertension, Essential | 13 | $1,281 |

## V. Detail of Members with Maintenance Drugs

**Member: Elizabeth Orange**

**Dominant Episode: Diabetes**

Sample Drill Through

*This chart shows Member specific information for all maintenance drugs taken by each Member over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name above.*

| # | Drug Name | Therapeutic Class | # of Fills | Debit $ |
|---|---|---|---|---|
| 1 | DIVALPROEX SODIUM ER | Anticonvulsant - Carboxylic Acid Derivatives | 3 | $3,009 |
| 2 | RANEXA | Antianginal and Anti-ischemic Agents | 4 | $2,912 |
| 3 | XARELTO | Factor Xa Inhibitors | 2 | $1,589 |
| 4 | CYMBALTA | Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors | 5 | $1,134 |
| 5 | TAMOXIFEN CITRATE | Antineoplastic - Selective Estrogen Receptor Mudulators | 3 | $106 |
| 6 | ATROVASTATIN CALCIUM | Antihyperlipidemix - HMG CoA Reductase Inhibitors | 4 | $76 |
| 7 | KLOR-CON M20 | Minerals & Electrolytes - Potassium & Combinations | 2 | $63 |
| 8 | OMEPRAZOLE | GI Acid Secretion Reducing Agents - Antisecretory Agents | 3 | $55 |
| | | | | |
| 14 | AMLODIPINE BESYLATE | Calcium Channel Blockers | 3 | $7 |
| 15 | FUROSEMIDE | Diuretic - Loop and Combinations | 2 | $5 |
| | **Total** | | | **$9,048** |

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## W. Costliest Specialty Drugs

*This chart lists the highest cost specialty drugs used by Members in the Panel ranked by largest gross debits for the trailing 12 months. Specifically, it shows the number of Members using high cost specialty drugs and the average cost attributed to each individual Member per month. Click on any underlined field below to see additional information.*

| Drug Name | Specialty Category | Members | Maintenance Drug* | Debit $ | Average Debit $ |
|---|---|---|---|---|---|
| REMICADE | Rheumatoid Arthritis | 12 | Yes | $456,853 | $38,071 |
| NEULASTA | Neutropenia | 15 | No | $345,127 | $23,008 |
| HERCEPTIN | Cancer | 6 | Yes | $261,388 | $43,565 |
| GAMMAGARD LIQUID | Intravenous Immunoglobulin Deficiency | 1 | Yes | $128,123 | $128,123 |
| XOLAIR | Asthma | 3 | Yes | $67,259 | $22,420 |
| OCTAGAM | Intravenous Immunoglobulin Deficiency | 1 | Yes | $61,868 | $61,868 |
| RITUXIMAB | Cancer, Rheumatoid Arthritis | 2 | Yes | $40,216 | $20,108 |
| ALOXI | Cancer - Antiemetic | 17 | No | $27,460 | $1,615 |
| GAMUNEX | Intravenous Immunoglobulin Deficiency | 1 | Yes | $25,108 | $25,108 |
| BOTOX | Muscle Spasms | 8 | No | $24,085 | $3,011 |
| **Total** | | **66** | | **$1,437,487** | **$366,896** |

*A Maintenance Drug indication of "Yes/No" indicates that the drug referenced can be used as either a maintenance drug or used independently of the targeted condition the drug is used to treat.

Sample Drill Through

## W. Detail of Members with Costliest Specialty Drugs

**Drug Name: ALOXI** **Specialty Category: Cancer - Antiemetic**

*This chart displays detailed drug information at the Member level, including Member Name, Illness Burden Score, PCP, and Dominant Episode over the trailing 12 months. Care coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorder (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). For Members engaged with CMR, the date of the last consult is included. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Care Coordination Program/Status* | Last CMR Consult |
|---|---|---|---|---|---|---|---|
| 1 | Mark Silver | 5/9/1962 | 8.58 | Ray Purple | Cancer - Breast | | 3/1/2015 |
| 2 | Dalia Red | 12/11/1986 | 10.89 | Samuel Yellow | Cancer - Colon | CCC (C) | 4/14/2015 |
| 3 | Gary Fuchsia | 6/16/1999 | 9.89 | Gary Green | Cancer - Breast | CCM (R), HTC | 3/1/2015 |
| | | | | | | | |
| 17 | Catherine Red | 4/18/1960 | 22.34 | Fer Brick-Red | Cancer - Lung | CCM (C), HTC | 12/1/2014 |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# IV. Key Use Patterns

**PCMH SearchLight Report for Panel ABC**

## X. Most Prescribed Brand Drugs

*This chart lists the most prescribed brand drugs used by Members in the Panel ranked by largest number of fills for the trailing 12 months. It also shows the number of Members using the brand drug, the average cost per fill, and if a generic alternative is available.*

Click on any underlined field below to see additional information.

| Drug Name | Therapeutic Class | # of Fills | Members | Maintenance Drug* | Debit $ | Average Debit $ Per Fill | Generic Alternative Available* |
|---|---|---|---|---|---|---|---|
| ALPHAGAN P | Rheumatoid Arthritis | 239 | 57 | Yes | $31,339 | $550 | Yes |
| ABILIFY | Neutropenia | 218 | 38 | Yes | $137,933 | $3,630 | No |
| ADDERALL XR | Intravenous Immunoglobulin Deficiency | 111 | 37 | Yes | $17,435 | $471 | No |
| INNOPRAN XL | Cancer, Rheumatoid Arthritis | 33 | 11 | Yes | $11,020 | $1,002 | Yes |
| BARACLUDE | Macular Degeneration | 27 | 9 | Yes | $37,423 | $4,158 | No |
| AVALIDE | Asthma | 15 | 5 | Yes | $1,533 | $307 | No |
| ALPHAGAN P | Cancer | 12 | 4 | Yes | $1,036 | $259 | No |
| ADIPEX-P | Osteoporosis | 2 | 2 | No | $735 | $368 | No |
| PROCRIT | Multiple Sclerosis | 2 | 2 | No | $7,196 | $3,598 | No |
| ARTHROTEC 50 | Cancer - Antiemetic | 1 | 1 | Yes | $97 | $97 | No |
| **Total** | | **660** | **134** | | **$245,749** | **$1,834** | |

*A Maintenance Drug indication of "Yes/No" indicates that the drug referenced can be used as either a maintenance drug or used independently of the targeted condition the drug is used to treat.

* Generic Alternative drugs are in the same therapeutic class as the brand drug but are not identical in chemical compostition.


## X. Detail of Most Prescribed Brand Drugs

**Drug Name: ABILIFY**

*This chart shows the largest number of fills by provider for Members attrtibuted to the Panel over the trailing 12 months.*

| # | PCP Name | # of Fills | Members |
|---|---|---|---|
| 1 | Fer Brick-Red | 121 | 12 |
| 2 | Gary Green | 96 | 5 |
| 3 | Michael Mauve | 53 | 2 |
| | | | |
| 10 | Ray Purple | 10 | 1 |
| **Total** | | **218** | **38** |

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

*This section of the SearchLight Report presents views of the top Members who have the highest costs, highest utilization, or show other patterns of progressive disease or instability that places them at High Risk. These Members typically experience unplanned hospital events related to chronic conditions, multiple gaps in care, repeat admissions and emergency room visits, or are on a large number of prescriptions. An intense focus on these sensitive Member populations is a vital component in a Panel's approach toward managing future quality and cost outcomes.*

*This section is organized into categories of "top 10" Member lists - all with the intent of drawing the attention of the Panel and its PCPs to focus on those Members most in need of their attention. In each category, drill downs to the individual Member level are provided. The extent and nature of actions taken to date with these Members is also shown.*

*Progressive "top 10" lists are shown in each category. For example, a second "top 10" (11-20) and third "top 10" (21-30) list is shown in each category to provide a continuous picture of High Cost/High Use/High Risk Members. These tiered lists extend to the top 50 Members in each category.*

*"Top 10" Members are identified in the 10 different categories below:*

1. ***Overall PMPM $*** *- Members with an overall PMPM at least 5 times greater than that of the Panel's average.*
2. ***Pharmacy PMPM $*** *- Members with a pharmacy PMPM at least 5 times greater than that of the Panel's average.*
3. ***Drug Volatility Score (DVS)*** *- Members with a DVS greater than 7, indicating the use of medications that are recognized as having severe side effects or extreme sensitivity to variations in dosage.*
4. ***Specialty Drug PMPM $*** *- Members with a specialty drug PMPM at least 5 times greater than that of the Panel's average.*
5. ***High Rx Utilization*** *- Members with 12 or more different drugs utilized.*
6. ***Hospital Use*** *- Members with 4+ hospital admissions, 2+ readmissions (within a 30-day time span), hospital lengths of stay exceeding 30 days, or 3+ ER visits.*
7. ***Multiple Comorbidities*** *- Members with 4 or more chronic conditions.*
8. ***Gaps in Care*** *- Members with the highest rates of non-compliance with recommended chronic care or population health screenings and treatments or without a recent PCP visit dependent on Member age.*
9. ***Disease Instability*** *- Members with rapid progression in disease stage or those at unstable disease stages associated with a chronic condition.*
10. ***Health Assessments*** *- Members with the lowest Health Assessment Wellness Scores and the highest number of potential risk factors as identified from completed Health Assessments, indicating high potential for disease progression or breakdown.*

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## A. Core Target Members Most Likely in Need of Care Coordination

*The Core Target Population includes Members who have been identified through specific criteria that indicate a severity of 'sickness' associated with the highest use of health care resources. Providing the Core Target Member list ensures that all of these members are reviewed for care coordination needs. This report is not restricted to 50 members but contains all Core Target members as of the current month.*

*There are 5 Core Target Categories including:*

1. *Predictive High Cost Flag and Lace Score- includes members that were assigned a HTC level 1 admission category and flagged as potentially high cost by a nurse and/or members assigned a LACE score between 11 and 19 in the trailing 12 months.*
2. *Readmission Utilization - includes members with hospital readmissions for any reason within 30 days of a previous discharge in the last twelve months.*
3. *Consistent High Cost Spend - includes members with 6 or more months of $5,000 medical spend in the last twelve months.*
4. *Band 1: Acute - Return to Chronic - includes members with an Illness Burden Score between 10 - 24.99 as of the current month.*
5. *Multiple High Risk Indicators - includes members with a combination of indicators of high costs, high utilization, or other patterns of progressive disease or instability in the last twelve months. These indicators include Overall PMPM $, Hospital Use, Multiple Comorbidities, Specialty Rx PMPM $, Advanced Chronic Kidney Disease (CKD) and Drug Volatility Score (DVS).*

*The chart below displays all Members identified as Core Target along with an indicator showing their most recent TCCI Care Coordination Program status and if they had an Assessment Outcome (AO) completed. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). It is sorted to show Members by IB Score and Medical PMPM $. In addition, the chart also includes Medical PMPM $, Pharmacy PMPM $, number of Hospital Admissions (# Admits), Readmissions (# Readmits) and Emergency Room visits (# ER) in the trailing 12 months, Chronic Kidney Disease stage (CKD), Drug Volatility Score (DVS) and Metabolic Index Score (MIS) as of the current month and High Cost Notification and LACE score (HCN/LACE). Additional information can be found in the PCMH Program Description and Guidelines.*

*Members can be displayed in groups of 10. Options to filter on Members attributed to an individual provider is also provided. Names of Members without active CCM or CCC care plans or a completed AO are highlighted. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

**Filter By:** All Members (Members 1-10, Members 11-20, Members 21-30, Members 31-40, Members 41-50, Members 51-60) — All Providers (Beige, Bonnie; Black, Peter; Blue, Bob; Green, Gary; Indigo, Irene)

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Medical PMPM $ | Pharmacy PMPM $ | # Admits | # Readmits | # ER | CKD | DVS | HCN/ LACE | MIS | Care Coordination Program/Status* | Assessment Outcome (AO) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Mark Silver | 08/16/1955 | 24.01 | Ray Purple | Cancer - Colon | $12,117 | $2,314 | 2 | 1 | 1 | 2 | 8 | Yes / 6 | 9 | | |
| 2 | Paul Blue | 03/14/1961 | 22.97 | Theodore Lavender | Coronary Artery Disease | $5,926 | $1,685 | 1 | 0 | 0 | 0 | 1 | No / 3 | 4 | HTC, CCM (A) | 10/19/2016 |
| 3 | Gary Fuchsia | 01/18/1968 | 20.88 | Gary Green | Fracture/Disloc - Upper Extrem | $10,001 | $74 | 1 | 0 | 1 | 1 | 2 | Yes / 3 | 1 | | |
| 4 | Michael Fuschia | 05/05/1967 | 15.74 | Bonnie Beige | Coronary Artery Disease | $2,376 | $941 | 0 | 0 | 2 | 0 | 1 | No / 1 | 1 | HTC, CCM (R) | 11/20/2016 |
| 5 | Rita Orange | 02/08/2002 | 11.23 | Bob Blue | Cancer - Colon | $2,526 | $2,314 | 1 | 1 | 1 | 0 | 10 | No / 4 | 5 | RxP (C) | 08/16/2016 |
| 6 | William Orange | 10/18/1946 | 9.97 | Irene Indigo | Hypertension, Essential | $1,770 | $451 | 0 | 0 | 0 | 3 | 1 | No / 5 | 3 | HTC, CCC (A) | 08/16/2016 |
| 7 | Debora Eggplant | 09/19/1979 | 9.23 | Fletch Orange | Cerebrovascular Disease | $976 | $841 | 0 | 0 | 0 | 0 | 2 | No / 2 | 4 | | 08/16/2016 |
| 8 | Dalia Red | 10/29/1952 | 6.21 | Samuel Yellow | Condition Rel to Tx - Med/Surg | $9,829 | $147 | 0 | 0 | 1 | 0 | 3 | No / 13 | 2 | CMR | |
| 9 | Stephen Silver | 02/08/2002 | 4.65 | Fletch Orange | Gynecological Disord, NEC | $1,455 | $64 | 0 | 0 | 2 | 0 | 1 | No / 1 | 1 | | 12/13/2016 |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## B. High Cost/High Risk Members with Multiple Indicators

*The chart below displays the list of Members identified as high cost/high use/high risk along with their most recent TCCI Care Coordination Program status. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D).*

*The chart is sorted to show Members with the most checked categories at the top. Check marks indicate potential High Cost/High Risk based on the following categories within the trailing 12 months:*

1. ***Overall PMPM $*** *- Members with an overall PMPM at least 5 times greater than that of the Panel's average.*
2. ***Pharmacy PMPM $*** *- Members with a pharmacy PMPM at least 5 times greater than that of the Panel's average.*
3. ***Drug Volatility Score*** *(DVS) - Members with a DVS greater than 7, indicating the use of medications that are recognized as having severe side effects or extreme sensitivity to variations in dosage.*
4. ***Specialty Drug PMPM $*** *- Members with a specialty drug PMPM at least 5 times greater than that of the Panel's average.*
5. ***High Rx Utilization*** *- Members with 12 or more different drugs utilized.*
6. ***Hospital Use*** *- Members with 4+ hospital admissions, 2+ readmissions (within a 30-day time span), hospital lengths of stay exceeding 30 days, or 3+ ER visits.*
7. ***Multiple Comorbidities*** *- Members with 4 or more chronic conditions.*
8. ***Gaps in Care*** *- Members with the highest rates of non-compliance with recommended at-risk or preventive health screenings and treatments or without a recent PCP visit dependent on Member age.*
9. ***Disease Instability*** *- Members with rapid progression in disease stage or those at unstable disease stages associated with a chronic condition.*
10. ***Health Assessments*** *- Members with a Very Poor, Poor, or Fair Wellness Band and/or with 2 or more indicated potential risks based on Member responses to specific lifestyle and biometric questions on completed Health Assessments.*

*This view is a summarization of the Top 10 to 50 lists that follow. By default, the view shows the top 50 Members identified based on the total number of High Cost/High Risk categories in which they fall. These are checked below. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Overall PMPM $ | Pharmacy PMPM $ | Drug Volatility Score | Specialty Drug PMPM $ | High Rx Utilization | Hospital Use | Multiple Comorbidities | Gaps in Care | Disease Instability | Health Assess | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Mark Silver | 02/07/61 | 22.97 | Ray Purple | Headache, Migraine/Muscle Tens | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | HTC |
| 2 | Gary Fuchsia | 08/16/52 | 35.01 | Gary Green | Renal Function Failure | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | CCM (R), CCC (A), HTC |
| 3 | Michael Fuschia | 09/01/44 | 16.53 | Bonnie Beige | Diabetes | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | | CCM (R), HTC |
| 4 | Roberta Green | 08/08/79 | 22.92 | Peter Black | Functional Digest Disord, NEC | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | CCM (C), HTC |
| 5 | Dalia Red | 06/12/82 | 20.88 | Samuel Yellow | Osteoarthritis | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | | ✓ | EMP, CMR |
| 6 | William Orange | 02/02/68 | 15.74 | Irene Indigo | Mental Hlth - Bipolar Disorder | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ | | | CCC (R) |
| 7 | Debora Eggplant | 05/09/62 | 11.23 | Fletch Orange | Cerebrovascular Disease | ✓ | | ✓ | | ✓ | ✓ | | ✓ | | | CCM (R), HTC |
| 8 | Charles Canary | 04/18/60 | 14.54 | Fletch Orange | Osteoarthritis | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | HTC, HBS |
| 9 | Paul Blue | 09/18/61 | 26.65 | Theodore Lavender | Renal Function Failure | ✓ | | | ✓ | | ✓ | ✓ | ✓ | | ✓ | CCM (R), HTC, CBP |
| 10 | Rita Orange | 11/05/59 | 4.65 | Bob Blue | Cerebrovascular Disease | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | | CCM (C), HTC, RXP (A) |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## C. Overall PMPM $

*The chart below displays a list of Members with an overall PMPM at least 5 times greater than that of the Panel's average costs over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Member Rx Debit % will show zero for Members without Pharmacy data available. Names of Members without active CCM or CCC care plans are highlighted. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Overall Debit $ | Overall PMPM $ | Average PMPM $ for Band | Member Institutional Debit % | Member Professional Debit % | Member Rx Debit % | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Mark Silver | 02/07/61 | 22.97 | Ray Purple | Fracture/Disloc - Hip/Fem Head | $517,301 | $43,108 | $3,451.58 | 85.7% | 14.2% | 0.1% | CCM (C), HTC |
| 2 | Dalia Red | 08/16/52 | 20.88 | Samuel Yellow | Cancer - Gastroint Ex Colon | $321,846 | $26,821 | $3,451.58 | 83.8% | 16.2% | 0.0% | CCC (A), HTC |
| 3 | Gary Fuchsia | 09/01/44 | 35.01 | Gary Green | Cerebrovascular Disease | $246,975 | $20,581 | $3,451.58 | 90.4% | 9.4% | 0.2% | CCM (R), HTC, EMP |
| 4 | Brittany Electric | 08/08/79 | 4.27 | Ace Emerald | Infections - Body Sites, NEC | $237,701 | $19,808 | $3,543.72 | 87.7% | 12.3% | 0.0% | CCM (C), CCC (A), HTC |
| 5 | Catherine Red | 06/12/82 | 11.05 | Fer Brick-Red | Renal Function Failure | $170,150 | $18,906 | $3,451.58 | 92.7% | 7.3% | 0.0% | CCM (C), HTC |
| 6 | Kathleen Eggplant | 02/02/68 | 11.49 | Ronald Brown | Cardiac Arrhythmias | $225,375 | $18,781 | $2,444.23 | 90.2% | 6.5% | 3.3% | CCC (A), HTC, BSD (A) |
| 7 | Kimberly Electric | 05/09/62 | 25.01 | Shastine Gold | Tumors - Central Nervous Sys | $223,417 | $18,618 | $3,543.72 | 85.3% | 13.7% | 1.0% | CCM (A), HTC, HBS |
| 8 | Charles Canary | 04/18/60 | 14.54 | Fletch Orange | Skin Burns | $220,363 | $18,364 | $3,543.72 | 91.1% | 8.6% | 0.3% | CCM (C), CCC (R), HTC |
| 9 | Paul Blue | 11/05/59 | 26.65 | Theodore Lavender | Cerebrovascular Disease | $199,947 | $16,662 | $3,543.72 | 87.3% | 12.7% | 0.0% | CCC (C), HTC |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## D. Pharmacy PMPM $

*The chart below displays a list of Members with an overall PMPM at least 5 times greater than that of Panel's average costs over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program(EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Member Rx Debit % will show zero for Members without Pharmacy data available. Names of Members without active CCM or CCC care plans are highlighted. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Overall Debit $ | Pharmacy Debit $ | Pharmacy Debit % vs. Overall | Pharmacy PMPM $ | Dominant Drug | Therapeutic Class | Dominant Drug $ | Care Coordination Program/Status* | Last CMR Consult |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Raymond Fuchsia | 02/07/61 | 4.29 | Bob Blue | $79,230 | $75,000 | 94.7% | $6,249.97 | GLEEVEC | Antineoplastics | $71,714 | HBS | 3/1/2015 |
| 2 | Diana Electric | 08/16/52 | 4.31 | Ace Emerald | $64,650 | $61,313 | 94.8% | $5,109.39 | GILENYA | Multiple Sclerosis Agents | $57,803 | | 4/14/2015 |
| 3 | Hans Brick | 09/01/44 | 1.97 | Sarah Cobalt | $81,188 | $54,887 | 67.6% | $4,989.71 | VICTRELIS | Anti-Infective Agents | $30,471 | RXP (C) | 1/13/2015 |
| 4 | Kathleen Orange | 08/08/79 | 4.11 | Gary Green | $29,701 | $29,701 | 100.0% | $4,950.23 | FLUTICASONE PROPIONATE | Chemicals-Pharmaceutical Adjuvants | $20,941 | | 7/5/2014 |
| 5 | Brenda Blue | 06/12/82 | 3.20 | Tom Turquoise | $61,801 | $57,187 | 92.5% | $4,765.62 | REBIF REBIDOSE | Multiple Sclerosis Agents | $56,740 | CCC (A) | 12/12/2014 |
| 6 | Edna Fuchsia | 02/02/68 | 3.81 | Samuel Yellow | $59,907 | $54,906 | 91.7% | $4,575.46 | PREZISTA | Anti-Infective Agents | $14,968 | | 11/19/2014 |
| 7 | Wendy Red | 05/09/62 | 4.41 | Peter Black | $52,301 | $48,703 | 93.1% | $4,058.60 | FLUTICASONE PROPIONATE | Chemicals-Pharmaceutical Adjuvants | $41,119 | CBP | 12/1/2014 |
| 8 | Margaret Canary | 04/18/60 | 1.50 | Robin Red | $48,590 | $46,447 | 95.6% | $3,870.56 | COPAXONE | Multiple Sclerosis Agents | $42,808 | | 2/23/2015 |
| 9 | Michelle Silver | 09/18/61 | 2.77 | Bonnie Beige | $43,717 | $42,575 | 97.4% | $3,547.95 | ZENPEP | Gastrointestinal Therapy Agents | $16,969 | | 12/1/2014 |
| 10 | Patricia Red | 11/05/59 | 3.27 | Fletch Orange | $107,699 | $40,412 | 37.5% | $3,367.65 | KETAMINE HYDROCHLORIDE | Chemicals-Pharmaceutical Adjuvants | $17,045 | CCM (R), HTC | 5/9/2015 |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## E. Drug Volatility Score

*The chart below displays a list of Members with a DVS greater than 7 over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). For Members engaged with CMR, the date of the last consult is included. By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. See Appendix K - Drug Volatility Score Methodology for more details. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Total Debit $ | Total Pharmacy Debit $ | Total Pharmacy Debit % | DVS | # of Drugs | # of Fills | Care Coordination Program/Status* | Last CMR Consult |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Chester Red | 02/07/61 | 2.44 | Irene Indigo | Fracture/Disloc - Hip/Fem Head | $517,301 | $281 | 0% | 9 | 8 | 12 | CCM (C), HTC | 3/1/15 |
| 2 | Virginia Orange | 08/16/52 | 1.12 | Gary Green | Cerebrovascular Disease | $246,975 | $373 | 0% | 9 | 15 | 52 | HTC, HBS | 4/14/15 |
| 3 | Stephanie Red | 09/01/44 | 0.81 | Peter Black | Diabetes | $41,355 | $4,866 | 12% | 9 | 14 | 23 | RXP (A) | 1/13/15 |
| 4 | Ruth Blue | 08/08/79 | 38.02 | Sarah Cobalt | Gastroint Disord, NEC | $22,777 | $4,205 | 18% | 9 | 15 | 79 | CCC (C), HTC | 7/5/14 |
| 5 | Terri Canary | 06/12/82 | 2.61 | Donald Daisy | Cancer - Breast | $21,668 | $256 | 1% | 9 | 10 | 29 | CCM (A), CBP | 12/12/14 |
| 6 | Robert Red | 02/02/68 | 11.70 | Ronald Brown | Cancer - Breast | $126,635 | $444 | 0% | 9 | 11 | 19 | CCM (C), HTC | 11/19/14 |
| 7 | Joyce Red | 05/09/62 | 4.29 | Robin Red | Cerebrovascular Disease | $16,634 | $1,625 | 10% | 9 | 16 | 18 | | 12/1/14 |
| 8 | Carole Fuchsia | 04/18/60 | 25.29 | Ace Emerald | Cancer - Colon | $29,369 | $2,257 | 8% | 9 | 18 | 50 | CCC (A) | 2/23/15 |
| 9 | Theresa Canary | 09/18/61 | 12.56 | Michael Mauve | Cerebrovascular Disease | $14,429 | $6,151 | 43% | 9 | 13 | 51 | CCM (R), HTC | 12/1/14 |
| 10 | Marion Eggplant | 11/05/59 | 6.24 | Samuel Yellow | Signs/Symptoms/Oth Cond, NEC | $27,480 | $21,408 | 78% | 9 | 12 | 41 | HTC, HBS, EMP | 4/7/15 |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## F. Specialty Drug PMPM $

*The chart below displays a list of Members flagged as having the highest specialty drug costs per Member per month (PMPM) over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). For Members engaged with CMR, the date of the last consult is included. By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Drug | Specialty Category | Total Debit $ | Specialty Drug Debit $ | % of Total Debit $ | Specialty PMPM $ | Care Coordination Program/Status* | Last CMR Consult |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Diana Electric | 02/07/61 | 3.59 | Ace Emerald | ABRAXANE | Cancer | $173,699 | $75,569 | 43.5% | $6,297.42 | CCM (C), HTC | 03/01/2015 |
| 2 | Brenda Blue | 08/16/52 | 0.99 | Tom Turquoise | ELOXATIN | Cancer | $140,570 | $54,903 | 39.1% | $6,100.32 | CCM (R), HTC | 04/14/2015 |
| 3 | Hans Black | 09/01/44 | 3.40 | Sarah Cobalt | REMICADE | Rheumatoid Arthritis | $44,599 | $37,399 | 83.9% | $3,116.57 | RXP (A) | 01/13/2015 |
| 4 | Kathleen Orange | 08/08/79 | 2.32 | Gary Green | REMICADE | Rheumatoid Arthritis | $45,232 | $35,827 | 79.2% | $3,256.96 | | 07/05/2014 |
| 5 | Wendy Red | 06/12/82 | 4.46 | Peter Black | ADRIAMYCIN | Cancer | $126,635 | $35,685 | 28.2% | $2,973.75 | CCM (C), HTC | 12/12/2014 |
| 6 | Margaret Canary | 02/02/68 | 1.76 | Robin Red | REMICADE | Rheumatoid Arthritis | $59,230 | $34,401 | 58.1% | $2,866.75 | CCM (A), EMP | 11/19/2014 |
| 7 | Edna Fuchsia | 05/09/62 | 2.08 | Samuel Yellow | REMICADE | Rheumatoid Arthritis | $34,373 | $30,057 | 87.4% | $3,757.16 | | 12/01/2014 |
| 8 | Nikki Orange | 04/18/60 | 1.57 | Ronald Brown | AVASTIN | Cancer | $223,417 | $29,774 | 13.3% | $2,481.16 | CCM (A), CCC (A), HTC | 02/23/2015 |
| 9 | Patricia Red | 09/18/61 | 0.93 | Fletch Orange | RITUXIMAB | Cancer, Rheumatoid | $33,363 | $27,970 | 83.8% | $2,330.82 | | 12/01/2014 |
| 10 | Patricia Blush | 11/05/59 | 1.85 | Ray Purple | HERCEPTIN | Cancer | $29,036 | $26,285 | 90.5% | $4,380.80 | | 04/07/2015 |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## G. High Rx Utilization

*The chart below displays a list of Members with 12 or more different drugs utilized over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). For Members engaged with CMR, the date of the last consult is included. By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. Click on any underlined field below to see additional information.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Total Rx Debit $ | # of Drugs | # of Maint. Drugs | Rx PMPM $ | Total # Prescribing Providers | Care Coordination Program/Status* | Last CMR Consult |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Debora Eggplant | 02/07/61 | 11.23 | Fletch Orange | Headache, Migraine/Muscle Tens | $2,234 | 37 | 14 | $186.14 | 77 | HTC, EMP, BSD | |
| 2 | Richard Orange | 08/16/52 | 10.74 | Ray Purple | Diabetes | $13,554 | 36 | 15 | $1,129.48 | 43 | CCC (A), HBS | |
| 3 | Marilyn Eggplant | 09/01/44 | 6.51 | Gary Green | Spinal/Back Disorders, Lower Back | $21,152 | 35 | 25 | $1,762.66 | 45 | | |
| 4 | Glenda Fuchsia | 08/08/79 | 3.00 | Irene Indigo | Renal Function Failure | $12,611 | 34 | 24 | $1,050.93 | 40 | CCM (R), CCC (A), HTC | |
| 5 | Janice Orange | 06/12/82 | 4.50 | Fer Brick-Red | Diabetes | $15,795 | 33 | 19 | $1,316.28 | 47 | | |
| 6 | Ruth Blue | 02/02/68 | 38.02 | Sarah Cobalt | Asthma | $11,227 | 30 | 18 | $935.62 | 49 | CCC (R) | |
| 7 | Donna Orange | 05/09/62 | 4.01 | Shastine Gold | Osteoarthritis | $5,231 | 29 | 11 | $435.92 | 37 | CCM (R), HTC, EMP | |
| 8 | Robert Red | 04/18/60 | 2.62 | Ronald Brown | Infec/Inflam - Skin/Subcu Tiss | $15,479 | 29 | 13 | $1,289.90 | 50 | CCM (C), CCC (R), HTC | |
| 9 | Kimberly Fuchsia | 09/18/61 | 1.23 | Bonnie Beige | Fracture/Disloc - Ankle/Foot | $4,144 | 28 | 12 | $345.36 | 34 | | |
| 10 | Doreen Orange | 11/05/59 | 5.41 | Bob Blue | Vascular Disorders, Venous | $2,213 | 28 | 10 | $184.46 | 47 | CMR, CBP | |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## G. Detail of High Rx Utilization

Sample Drill Through

**Member Name: Debora Eggplant**

**Number of Drugs: 37** **Age: 53**

*This chart shows a detailed list of drugs filled by the Member over the trailing 12 months. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above.*

| Drug Name | Therapeutic Class | Maintenance | Last Date Filled | # of Fills (Last Fill) | Days Supplied (Last | Prescribing Provider | Practice Name | # of Fills | Rx Debit $ |
|---|---|---|---|---|---|---|---|---|---|
| TRAZODONE HCL | Central Nervous System Agents | Y | 05/27/15 | 1 | 30 | John Blue | Doctors and Associates | 3 | $6 |
| LISINOPRIL | Cardiovascular Therapy Agents | Y | 03/24/15 | 1 | 30 | Mark Grey | Doctors and Associates | 5 | $14 |
| PHENAZOPYRIDINE HCL | Genitourinary Therapy | N | 11/09/14 | 1 | 3 | Mark Grey | Doctors and Associates | 1 | $3 |
| TRAMADOL HCL | Analgesic, Anti-inflammatory or Antipyretic | N | 04/07/15 | 1 | 30 | Smith Red | Medical Providers Practice | 2 | $15 |
| | | | | | | | | | |
| ORACEA | Dermatological | N | 11/11/14 | 1 | 30 | Mark Grey | Doctors and Associates | 1 | $435 |
| METOCLOPRAMIDE HCL | Gastrointestinal Therapy Agents | N | 5/18/2014 | 1 | 4 | Mary Magenta | Medical Providers Practice | 1 | $3 |

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## H. Hospital Use

*The chart below displays a list of Members with the highest number of hospital admissions or ER visits: Members with 4+ admissions, 2+ readmissions (within a 30-day time span), 3+ ER visits, or lengths of stay exceeding 30 days over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. Click on any underlined field below to see additional information.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | # of Admits | # of Readmits | # of ER Visits | Total Admits/ Visits | Max Length of Stay | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Kimberly Electric | 02/07/61 | 25.01 | Bonnie Beige | Functional Digest Disord, NEC | 3 | 2 | 48 | 53 | 5 | CCM (C), HTC, HBS, CBP |
| 2 | Patricia Electric | 08/16/52 | 32.12 | Shastine Gold | Infec/Inflam - Skin/Subcu Tiss | 0 | 0 | 21 | 21 | 0 | CMR |
| 3 | Marjorie Cornflower-Blue | 09/01/44 | 43.47 | Ray Purple | Mental Hlth - Substance Abuse | 3 | 3 | 10 | 16 | 6 | HTC |
| 4 | Daniel Electric | 08/08/79 | 26.14 | Robin Red | Mental Hlth - Substance Abuse | 3 | 0 | 10 | 13 | 22 | CCM (R), HTC |
| 5 | Angelia Electric | 06/12/82 | 21.13 | Bob Blue | Renal Function Failure | 5 | 2 | 5 | 12 | 6 | CCM (R), CCC (A), HTC |
| 6 | Mark Silver | 02/02/68 | 22.97 | Ronald Brown | Cancer - Gastroint Ex Colon | 4 | 0 | 7 | 11 | 8 | CCC (A), HBS, EMP |
| 7 | James Electric | 05/09/62 | 20.99 | Irene Indigo | Tumors - Central Nervous Sys | 4 | 1 | 6 | 11 | 12 | CCM (A), HTC |
| 8 | Gary Fuchsia | 04/18/60 | 35.01 | Gary Green | Renal Function Failure | 5 | 1 | 5 | 11 | 23 | CCC (C) |
| 9 | Carville Electric | 09/18/61 | 23.10 | Sarah Cobalt | Myasthenia Gravis | 1 | 0 | 9 | 10 | 1 | CCC (R), HTC |
| 10 | Neil Red | 11/05/59 | 30.16 | Samuel Yellow | Cancer - Renal/Urinary | 3 | 0 | 7 | 10 | 6 | CCM (R), HTC |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## H. Detail of Hospital Use

**Member Name: Neil Red**

**Number of Admissions/Visits: 10** **Age: 56**

Sample Drill Through

*This chart shows detailed hospital/ER Encounters for identified Members over the trailing 12 months. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above.*

| Type of Hospital Service | Service Begin Date | Length of Stay | Hospital Service $ | Primary Procedure | Primary Diagnosis |
|---|---|---|---|---|---|
| Admission | 10/17/15 | 6 | $24,577 | PARTIAL NEPHRECTOMY | MALIGNANT NEOPLASM OF KIDNEY, EXCEPT PELVIS |
| Admission | 03/31/15 | 2 | $20,362 | TOTAL KNEE REPLACEMENT | OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG |
| ER Visit | 09/02/15 | 0 | $619 | Unknown Proc | OBSTRUCTIVE CHRONIC BRONCHITIS WITH ACUTE EXACERBATION |
| Admission | 09/02/15 | 4 | $8,590 | ROUTINE CHEST X-RAY, SO DESCRIBED | OBSTRUCTIVE CHRONIC BRONCHITIS WITH ACUTE EXACERBATION |
| ER Visit | 08/21/15 | 0 | $622 | ER E&M HI SEVER IMMED SIGNIF THREAT | UNSPECIFIED CHEST PAIN |
| ER Visit | 09/14/15 | 0 | $467 | ER VISIT E&M HI SEVER URGENT EVAL | ABDOMINAL PAIN UNSPECIFIED SITE |
| ER Visit | 11/14/14 | 0 | $234 | ER DEPT VISIT E&M MODERATE SEVERITY | ABDOMINAL PAIN OTHER SPECIFIED SITE |
| ER Visit | 04/21/15 | 0 | $432 | ER VISIT E&M HI SEVER URGENT EVAL | EFFUSION OF LOWER LEG JOINT |
| ER Visit | 09/21/15 | 0 | $622 | ER E&M HI SEVER IMMED SIGNIF THREAT | LUMBAGO |
| ER Visit | 10/03/15 | 0 | $467 | ER VISIT E&M HI SEVER URGENT EVAL | CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED |
| **Total** | | **12** | **$56,992** | | |

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## I. Multiple Comorbidities

*The chart below displays a list of Members with 4 or more comorbidities over the trailing 12 months. Comorbidities include chronic conditions or acute conditions with advanced disease staging of 2 or higher. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. Click on any underlined field below to see additional information.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | # of Comorbidities | Total Debit $ | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|
| 1 | Hallam Sepia | 02/07/61 | 25.43 | Ray Purple | Hepatitis, Viral | 10 | $39,033 | HTC, HBS |
| 2 | Marjorie Cornflower-Blue | 08/16/52 | 43.47 | Bonnie Beige | Immunodeficiency Disorders | 9 | $15,894 | CCC (A) |
| 3 | Patricia Electric | 09/01/44 | 32.12 | Gary Green | Renal Function Failure | 9 | $62,962 | CCC (A), HTC |
| 4 | Angelina Orange | 08/08/79 | 33.53 | Peter Black | Diabetes | 8 | $9,632 | EMP |
| 5 | Ruth Blue | 06/12/82 | 38.02 | Sara Cobalt | Cancer - Prostate | 8 | $7,946 | CCM (A), CBP |
| 6 | Mary Red | 02/02/68 | 26.57 | Bob Blue | Cancer - Lymphoma | 8 | $8,708 | |
| 7 | Carl Canary | 05/09/62 | 23.74 | Shastine Gold | Osteoarthritis | 8 | $47,613 | HTC |
| 8 | Charles Red | 04/18/60 | 8.84 | Irene Indigo | Mental Hlth - Bipolar Disorder | 8 | $5,205 | BSD |
| 9 | Ann Electric | 09/18/61 | 35.79 | Fletch Orange | Diabetes | 8 | $20,930 | CCC (C) |
| 10 | Frances Fuchsia | 11/05/59 | 24.04 | Robin Red | Asthma | 8 | $32,270 | HTC (A), EMP |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## I. Detail of Multiple Comorbidities

Sample Drill Through

**Member Name: Charles Red**

**Number of Comorbidities: 8** **Age: 62**

*This chart shows the detail for Members with multiple comorbidities over the trailing 12 months. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above.*

| Last Claim Date Related to Chronic Disease | Chronic Disease | Current Disease Stage | Episode $ |
|---|---|---|---|
| 06/05/15 | Asthma | Asymptomatic bronchial asthma | $2,600 |
| 06/05/15 | Immunodeficiency Disorders | Other immunodeficient disorders | $1,767 |
| 01/07/15 | Chronic Obstruc Pulm Dis (COPD) | Chronic bronchitis | $288 |
| 04/17/15 | Hypertension, Essential | Hypertension, minimal | $204 |
| 04/03/15 | Cancer - Skin | Bowens disease, actinic/arsenic keratosis, squamous cell CIS, leukoplakia | $174 |
| 01/06/15 | Osteoarthritis | Osteoarthritis of the lumbar spine | $157 |
| 04/17/15 | Thyroid Disorders | Symptomatic hypothyroidism | $11 |
| 11/12/16 | Lipid Abnormalities | Hyperlipid, hypercholesterol, lipid deficiencies, other lipid disorders. | $4 |

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## J. Gaps in Care

*The chart below displays a list of Members with identified gaps in care for the trailing 12 months. The information is sorted by Total Gaps, then number of At Risk Gaps, then Preventive Health Gaps. Gaps in Care are categorized into three types of care gaps: at risk care gaps, preventive health gaps, and PCP visit gaps. Criteria for at risk measures, preventive health measures, and PCP visit gaps vary for each measure by person, age, and illness condition. More information on at risk measures and preventive health measures can be found in the Quality Scorecard. Members age 45 and older and 21 and younger are considered to have a PCP visit gap if they have not had a visit in 1 year. Members ages 22-44 are included if they have not had a visit in 2 years. Members with any chronic condition regardless of age may require more frequent PCP Visits. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Click on any underlined number to see Member specific information.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | # of At Risk Gaps | # of Preventive Health Gaps | PCP Visit Gaps | Total Gaps | Last PCP Visit | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Mark Silver | 02/07/61 | 22.97 | Ray Purple | 5 | 1 | 1 | 7 | 03/05/12 | HTC, CCM (A) |
| 4 | Roberta Green | 08/08/93 | 22.92 | Peter Black | 4 | 3 | 1 | 8 | 03/04/13 | CBP |
| 2 | Michael Fuchsia | 08/16/52 | 16.53 | Bonnie Beige | 4 | 1 | 1 | 6 | 04/13/13 | EMP |
| 3 | Gary Fuchsia | 09/01/44 | 35.01 | Gary Green | 4 | 1 | 1 | 6 | 05/04/13 | HTC, CCM (R) |
| 6 | Rita Orange | 02/02/90 | 4.65 | Bob Blue | 3 | 2 | 1 | 6 | 05/09/10 | |
| 5 | Ogden Fuchsia | 06/12/94 | 9.11 | Sara Cobalt | 3 | 2 | 1 | 6 | 05/06/12 | CCM, HBS |
| 8 | Louis Electric | 04/18/60 | 3.44 | Irene Indigo | 2 | 1 | 1 | 4 | 09/04/10 | CCC (C) |
| 9 | Thomas Canary | 09/08/94 | 2.77 | Fletch Orange | 2 | 1 | 1 | 4 | 03/05/12 | CCC(A) |
| 7 | Harry Eggplant | 05/09/62 | 4.21 | Ronald Brown | 2 | 0 | 0 | 2 | 07/05/13 | |
| 10 | Kimberley Electric | 11/05/59 | 38.02 | Shastine Gold | 1 | 2 | 1 | 4 | 08/03/11 | |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

Sample Drill Through

## J. Member Detail of Care Gaps

**Member Name: Mark Silver**

**Number of Care Gaps: 7** **Age: 55 Years**

*This chart shows the detail of care gap measures that the Member has not completed within the measurement year. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above.*

| Care Gap | Type of Gap |
|---|---|
| Persistent Beta Blocker Treatment After a Heart Attack | At Risk |
| Medication Management for People with Asthma | At Risk |
| Diabetes - Eye Exam | At Risk |
| Diabetes - Hemoglobin A1C Testing | At Risk |
| Diabetes - Medical Attention for Nephropathy | At Risk |
| Colorectal Cancer Screening | Preventive Health |
| Needs Recent PCP Visit | PCP Visit |

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## K. Disease Instability

*The chart below displays a list of Members with unstable chronic conditions, as indicated by frequent flare ups, or disease stage progression over the trailing 12 months. Chronic flare ups occur when a condition is not well controlled, often resulting in high cost events such as emergency room visits and/or hospital admissions. Chronic Condition Flare Ups and Disease Progression are identified by the medical episode grouper. For additional information see Appendix Method for Determining Episodes of Care. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Names of Members without active CCM or CCC care plans are highlighted. Click on any underlined field below to see additional information.*

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | # of Chronic Condition Flare Ups | Disease Stage Progression | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|
| 1 | Thomas Maroon | 02/07/61 | 1.49 | Bonnie Beige | Asthma | 5 | No | |
| 2 | Norman Electric | 08/16/52 | 1.25 | Ray Purple | Asthma | 4 | No | |
| 3 | Margaret Orange | 09/01/44 | 7.25 | Fletch Orange | Cerebrovascular Disease | 3 | No | CCM (R), HTC, ECP |
| 4 | Paula Orange | 08/08/79 | 5.68 | Sarah Colbalt | Infections - Respiratory, NEC | 3 | No | |
| 5 | Charles Orange | 06/12/82 | 1.50 | Donald Daisy | Cerebrovascular Disease | 4 | No | HTC |
| 6 | William Orange | 02/02/68 | 0.86 | Irene Indigo | Coronary Artery Disease | 3 | Yes | |
| 7 | Diana Red | 05/09/62 | 46.40 | Shastine Gold | Renal Function Failure | 2 | No | CCC (C) |
| 8 | Judith Electric | 04/18/60 | 42.07 | Ace Emerald | Coronary Artery Disease | 2 | No | CCC (C), HTC, HBS |
| 9 | Lillian Canary | 09/18/61 | 33.31 | Theodore Lavender | Diabetes | 2 | Yes | CCM (R), HTC |
| 10 | Laurie Green | 11/05/59 | 28.11 | S. Cornflower-Blue | Cerebrovascular Disease | 2 | No | CCM (C), HTC, CMR |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## K. Detail of Disease Instability

Sample Drill Through

**Member Name: Charles Orange**
**Chronic Condition Flare Ups: 4** **Age: 57**

*This chart shows the detailed chronic condition flare up profile of the Member over the trailing 12 months. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above.*

| Start Date of Episode | End Date of Episode | Condition | Flare Up Description |
|---|---|---|---|
| 8/3/2015 | 08/03/15 | Cerebrovascular Dis with Stroke | Intracranial hemorrhage/infarct/nonpyogenic venous sinus thrombus; Moyamoya |
| 8/3/2015 | 08/03/15 | Cerebrovascular Dis with TIA | Transient ischemic attack or occlusion or stenosis of precerebral arteries |
| 1/19/2015 | 01/19/15 | Cerebrovascular Dis with Stroke | Intracranial hemorrhage/infarct/nonpyogenic venous sinus thrombus; Moyamoya |
| 10/6/2015 | 11/11/15 | Cerebrovascular Dis with TIA | Transient ischemic attack or occlusion or stenosis of precerebral arteries |

## K. Detail of Disease Instability

**Member Name: William Orange**
**Disease Stage Progression: Yes** **Age: 64**

*This chart shows the detailed disease stage progression of the Member over the trailing 12 months. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above.*

| Disease Stage in State of Progression | Date | Stage | Description |
|---|---|---|---|
| Coronary Artery Disease | 02/17/15 | 1.01 | CAD/asymptomatic chronic ischemic heart disease or old MI |
| Coronary Artery Disease | 08/12/15 | 2.03 | Angina w/ hypertrophy/akinesia/dyskinesia/S3 or S4 gallop |

# V. Top 10 to 50 Lists of High Cost/High Risk/Highly Unstable Members

**PCMH SearchLight Report for Panel ABC**

## L. Members with Adverse / High Risk Health Assessment Results

*The chart below displays a list of Members with a completed Health Assessment with adverse screening results indicating a high risk for a decline in health for the trailing 12 months. These assessments are based on biometric screening results such as blood pressure and cholesterol results, and Member responses to specific lifestyle questions such as smoking status and level of physical activity. Members on this chart have a Risk Category of Full Expression or High Risk and/or 2 or more adverse metrics on biometric screenings. Well Being Scores are classified into one of three Risk Categories that are based on a 100 point scale. Full Expression Members have the full expression of one or more diseases and therefore are assigned to either a more intensive TCCI Program or telephonic Disease Management Coaching. High Risk Members are at elevated risk for preventable disease and targeted for telephonic or online Lifestyle Health Coaching. Low Risk Members are generally healthy or exhibit low risk and are not automatically referred for coaching, but have online and telephonic Health Coaching available to them if they seek it. A Full Expression or High Risk Category can be an early predictor of potential advancement in Illness Band if current unhealthy lifestyle behaviors are left unchecked. Please note that relatively few Members complete a Well Being Assessment. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorders (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). By default the clip shows the top 50 Members. Members can be displayed in groups of 10 (up to 50). Options to filter on Members attributed to an individual provider and to filter by All Members or just those who are Care Plan Eligible are provided as well. Click on any underlined field below to see additional information.*

Click on any underlined field below to see additional information.

**Filter By:** Members 1-10 | All Providers | Care Plan Eligible

| # | Member Name | DOB | IB Score | Provider | Dominant Episode | Risk Category | Biometric Screenings | | Care Coordination Program/Status* |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | # of Metrics | # with Adverse Metrics | |
| 1 | Debora Eggplant | 02/07/61 | 11.23 | Fletch Orange | Gynecological Disord, NEC | Full Expression | 5 | 4 | CMR (R) |
| 2 | Richard Orange | 08/16/52 | 10.74 | Ray Purple | Spinal/Back Disorders, NEC | Full Expression | 5 | 4 | CCC (A), HBS |
| 3 | Marilyn Eggplant | 09/01/44 | 6.51 | Gary Green | Cancer - Breast | Full Expression | 5 | 4 | CCM (A), RxP (A) |
| 4 | Glenda Fuchsia | 08/08/79 | 3.00 | Irene Indigo | Diabetes | High Risk | 5 | 3 | CCC (A) |
| 5 | Janice Orange | 06/12/82 | 4.50 | Fer Brick-Red | Gastritis/Gastroenteritis | Full Expression | 5 | 3 | CMR (C) |
| 6 | Ruth Blue | 02/02/68 | 38.02 | Sarah Cobalt | Injury - Head/Spinal Cord | Full Expression | 5 | 3 | CCC (A), EMP |
| 7 | Donna Orange | 05/09/62 | 4.01 | Shastine Gold | Diabetes | Full Expression | 5 | 3 | CMR (C) |
| 8 | Robert Red | 04/18/60 | 2.62 | Ronald Brown | Coronary Artery Disease | High Risk | 5 | 3 | CCM (A), RxP (A) |
| 9 | Kimberly Fuchsia | 09/18/61 | 1.23 | Bonnie Beige | Diabetes | High Risk | 5 | 3 | CCC (R) |
| 10 | Doreen Orange | 11/05/59 | 5.41 | Bob Blue | Mental Hlth - Substance Abuse | Full Expression | 5 | 3 | BSD |

*Additional information on Member care coordination activities can be viewed through the care plan links on the Member roster.

## L. Detail of Health Assessment Results

Sample Drill Through

**Member Name: Debora Eggplant**

**Number of Adverse Metrics: 4** **Age: 53**

*This chart shows the detailed Health Assessment risk factor flag profile of the Member over the trailing 12 months. The Member Health Record (MHR) for the Member can be accessed by clicking on the Member's name above*

| Date of Health Assessment | Biometric Screening with Adverse Results * | Biometric Screening Results |
|---|---|---|
| 12/22/2014 | BMI | 40 |
| | Blood Pressure | 210/105 |
| | Total Cholesterol | 425 mg/dL |
| | LDL-C | 205 LDL |

*Expected Ranges:

[1] BMI normal range: between 18.5 and 24.9
[2] Blood Pressure normal range: < 140/<90 for age group of 18 - 59 or < 150/<90 for ages 60+
[3] Fasting Blood Glucose normal range: < 100 mg/dl
[4] Total Cholesterol normal range: < 200 mg/dl
[5] LDL Cholesterol normal range: < 100 mg/dl
[6] HDL Cholesterol normal range: >= 60 mg/dl
[7] Triglycerides normal range: < 150 mg/dl

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

*This section shows the degree to which Members in the Panel are receiving various care coordination services that are suited to the nature and extent of their illness, condition or risk status. All fifteen distinct TCCI Programs are aimed at helping PCPs and Panels find, manage, and care for Members at high risk or at stages in their illnesses where coordination is critical to avoiding breakdown. A brief summary of each TCCI Program is listed below for quick reference. See the Program Description and Guidelines for more complete information on each element.*

***Continuous Tracking of TCCI Programs***

*All Programs used in support of a specific Member or all Members in a particular Panel are tracked and shown in the PCMH SearchLight Report. Included in this tracking is a pre and post view of the Member's claims experience in order to assess the degree to which the Program Element(s) is working to improve care to the Member and reduce breakdowns that may involve expensive hospital based services.*

*It should be noted that care coordination fees in the form of Debits are charged to each Panel's Patient Care Account for TCCI care coordination programs However, these programs are only relevant for the small percentage of high-cost Members who need the services provided in the TCCI Program portfolio. The reduction in care costs resulting from these programs far outweighs any Debits. See Appendix - Method For Charging TCCI Care Coordination Fees As Debits to Member Care Accounts for a more complete understanding of how these fees are included as Debits in the Patient Care Accounts of Panels for TCCI Programs.*

***Health Promotion, Wellness and Disease Management Program (WDM)*** *consists of lifestyle and Disease Management coaching by licensed professional coaches who are experts in motivating people toward healthier lifestyles and reducing risk if they are headed towards or already have certain common chronic diseases. Also included in this program is a Health Assessment - with and without biometric screening - that reveals one's overall health and wellbeing as well as the changes in this over time - not only for each individual, but for an employer group as a whole. A broad array of supporting program elements on fitness, smoking cessation and other health promotion activities is available as is a rich online set of resources and information to Members that support their wellness and Disease Management efforts.*

***Hospital Transition of Care Program (HTC)*** *monitors admissions of CareFirst Members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC program assesses Member need upon admission and during a hospital stay with a focus on post discharge needs. It begins the Care Plan process for Members who will be placed in the CCM or CCC program. The HTC process also categorizes Members based on the level of their severity of need and the nature of their illness or condition so that they can be placed in the best possible "track" for follow-up care coordination services and flags cases that will likely result in high cost to ensure they receive the attention they need.*

***Complex Case Management Program (CCM)*** *offers Care Plans for Members with advanced or critical illnesses. These Members are typically being cared for by specialists/super specialists. CareFirst Specialty Case Managers provide care coordination services in concert with the various specialists involved. Case management services most often follow a hospitalization. The Hospital Transition of Care Program is typically the entry point for Members into Case Management which begins prior to discharge. All Specialty Case Managers are registered nurses with substantial experience in their respective specialties.*

***Chronic Care Coordination Program (CCC)*** *offers Care Plans to targeted Members that are developed under the direction of the PCP. This program provides coordination of care for Members with multiple chronic illnesses. While Care Plans often result from a case management episode, they can result from a review of the trailing 12 months of healthcare use by an attributed member who is identified as likely to benefit from a Care Plan. Care coordination for these Members is carried out through the Local Care Coordinator (LCC) who is assigned to each provider/practice within a Panel. The LCC, who is a Registered Nurse, assists the PCP in coordinating all elements of the Member's healthcare and ensures all action steps in the plan are followed up and carried out.*

***Behavioral Health and Substance Use Disorders (BSD)*** *includes a range of services that deal with the behavioral health needs of Members (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program Category are substance abuse services as well as psycho-social services.*

***Home Based Services Program (HBS)*** *serves Members in CCM or CCC who often need considerable support at home, sometimes on a prolonged basis. These services can include home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following an assessment of the home situation by an RN Home Care Coordinator (HCC) and become part of the overall plan of care maintained by the LCC or Case Manager responsible for the Member. Home based services are often critical to avoiding the cycle of breakdown (admission, readmission) that commonly occurs with Members who have multiple chronic diseases. Only Members specifically referred to the Home Based Care Coordination Program by a Case Manager or an LCC are eligible for full assessment and integrated home-based services pursuant to a Care Plan. A select list of home care agencies are used in the provision of home care services.*

***Enhanced Monitoring Program (EMP)*** *focuses on those Members at high risk for disease progression to more advanced or serious illness. The Enhanced Monitoring Program uses prescription drug and other data to identify members in each Panel that have patterns of illness that suggest incipient high risk for progression or have chronic conditions already that need active monitoring to ensure member stability. EMP services are provided at home or in the work setting using mobile and digital capabilities that send a stream of data to a central monitoring station staffed by highly qualified nurses. Special alerts are sent to PCPs as necessary.*

***Comprehensive Medication Review Program (CMR)*** *is offered to Members where there are indications of high potential for drug interaction, overdosing, side effects, etc. Each CMR review is performed by a specially trained pharmacist who consults with a Member's physician prescribers. Certain criteria such as high drug use, high cost and high likelihood of drug-induced instability is used to flag Members for a CMR. The objective is to assure a Member's drug profile is optimal and to resolve any issues with it in order to assure an enhanced therapeutic result as well as improve overall Member compliance.*

***Community Based Program (CBP)*** *is a compendium of local Programs that have been reviewed and selected in advance by CareFirst to be made available to Members with identified needs who could benefit from such Programs. These selected programs are created in collaboration with specifically contracted Providers on an ongoing basis and typically reflect improvements in organization of care within existing benefits that are linked to other TCCI elements to enable Care Coordination and reporting. Examples include, but are not limited to, programs to better manage diabetes and congestive heart failure, as well as improved processes for supporting Members in need of skilled nursing facility care or palliative care/hospice care.*

***Pharmacy Coordination Program (RxP)*** *is a program available for Members with pharmacy benefits as part of their coverage plan. This includes management of retail and wholesale pharmacy benefits, including formulary management as well as specialty pharmacy benefits for certain disease states (such as hepatitis C, rheumatoid arthritis, and multiple sclerosis) that require high-cost pharmaceuticals that must be administered according to rigorous treatment plans. The RxP program consists of five key elements including obtaining the best possible ingredient cost pricing for generic and brand drugs, optimum formulary design and administration, specialty pharmacy preauthorization and case management, analysis of drug therapy problems and identification of Members taking drugs for behavioral health purposes.*

***Expert Consult Program (ECP)*** *allows network physicians or CareFirst to seek an outside expert opinion from leading, recognized medical experts when this is needed for highly complex cases. Through this Program, CareFirst has access to the top physicians in the nation in every specialty and sub-specialty category, organized by disease state. Cases referred to this program from CCM and CCC after CareFirst Medical Director review are complex, expensive and have the characteristic that diagnosis and treatment have not been complete, accurate or effective up to the point of referral. Recommendations are made in each case by the expert reviewers that are almost always followed by treating providers resulting in lower overall cost due to fewer Member breakdowns or inappropriate treatments.*

***Urgent Care and Convenience Access Program (UCA)*** *offers organized back up for PCPs to support Members with urgent care needs that might otherwise go to a hospital based emergency department or outpatient facility. Generally the costs are one-third of what they would otherwise have been.*

***Centers of Distinction Program (CDP)*** *identifies providers that offer specialized categories of care – such as transplants and certain surgeries - that are accessed by targeted referrals to centers throughout the country that have been pre-screened and certified by the Blue Cross Blue Shield Association as being the best in their designated categories.*

***Preauthorization Programs (PRE)*** *obtains a review of certain proposed services to Members that are usually infrequent but that are high cost and where evidence of medical need must be established before approval for payment is given. Examples include high cost specialty drugs and certain durable medical equipment.*

***Telemedicine Program (TMP)*** *offers the integration of voice, data and image to create a "Video Visit" to a provider for a Member. Through "Video Visit", the Program also enables a specialty consult for a Member or PCP in certain cases where this is more responsive than an in person visit. TMP also applies in cases where an off hours visit to a Member's PCP is not readily available.*

***Dental-Medical Health Program (DMH)*** *recognizes dental care is an important part of overall health. This Program Element is designed to enable and encourage appropriate dental care as determined by the Member's treating dentist and to integrate the Member's dental health into their overall health profile.*

***Comprehensive Medication Review Program (CMR)*** *is offered to Members where there are indications of high potential for drug interaction, overdosing, side effects, etc. The review is performed by a local pharmacist who consults with prescribers. High Rx use, high cost and high DVS Members are flagged for a comprehensive Rx review by a local pharmacist or specialty pharmacist to assure a Member's drug profile is optimal and to resolve any issues with it. In addition, other cases are identified from data mining for review to reduce problems resulting from dosage or drug interactions, etc.*

***Community Based Program (CBP)*** *is a compendium of local programs that have been reviewed and selected in advance by CareFirst to be made available to Members with identified needs who could benefit from such programs. The Service Request Hub connects members to specific community based services such as diabetes, congestive heart failure and palliative care/hospice programs.*

***Pharmacy Coordination Program (RxP)*** *is available for Members with pharmacy benefits as part of their coverage plan. This includes management of retail and wholesale pharmacy benefits, including formulary management as well as specialty pharmacy benefits for certain disease states (such as hepatitis C, rheumatoid arthritis, and multiple sclerosis) that require high-cost pharmaceuticals that must be administered according to rigorous treatment plans. The Specialty Pharmacy Coordination Program not only delivers cost savings, but also optimizes Member treatment outcomes through a compliance program that includes refill reminders and side effect management. Management of drugs associated with transplants is included in this category.*

***Expert Consult Program (ECP)*** *allows network providers, Members or CareFirst to seek an outside expert opinion from leading, recognized experts when needed for highly complex treatment plans. Through this program, CareFirst has access to the top physicians in each specialty and sub-specialty category, organized by disease state.*

***Urgent Care and Convenience Access Program (UCA)*** *offers, where available, organized back up to panels as an off hours support for members with urgent care needs that might otherwise go to a hospital based emergency department or outpatient facility. Generally the costs are one-third of what they otherwise would have been.*

# VI. Use of TCCI Programs (Cont.)

**PCMH SearchLight Report for Panel ABC**

***Centers of Distinction Program (CDP)*** *includes highly specialized, high cost categories of care that are accessed by targeted referrals to centers throughout the country that have been prescreened and certified by the BlueCross BlueShield Association as being the best in their designated categories.*

***Preauthorization Programs (PRE)*** *obtains a review of certain proposed services to Members that are usually infrequent but that are high cost and where evidence of medical need must be established before approval for payment is given. Examples include high cost specialty drugs and certain durable medical equipment.*

***Telemedicine Program (TMP)*** *offers the integration of voice, data and image to create a virtual visit to a provider for a Member. The program also enables a specialty consult for a Member or PCP in certain cases where this is more responsive than an in-person visit. TMP also applies in cases where an off hours visit to a Member's PCP is not readily available.*

***Dental-Medical Health Program (DMH)*** *recognizes dental care is an important part of overall health. This Program Element is designed to enable and encourage appropriate dental care as determined by the Member's treating dentist and to integrate the Member's dental health into their overall health profile.*

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## A. Illness Band and TCCI Program Intersection

*This chart shows Members who have been in a TCCI Program with an active or closed status over the trailing 12 months.*

| Illness Band | HTC | CCM | CCC | BSD | HBS | EMP | CMR | CBP | RxP |
|---|---|---|---|---|---|---|---|---|---|
| **Advanced/Critical Illness** | 138 | 85 | 57 | 7 | 27 | 6 | 3 | 10 | 0 |
| **Multiple Chronic Illnesses** | 43 | 25 | 24 | 8 | 5 | 4 | 4 | 1 | 3 |
| **At Risk** | 17 | 5 | 12 | 6 | 1 | 4 | 0 | 1 | 0 |
| **Stable** | 2 | 4 | 5 | 0 | 0 | 3 | 0 | 0 | 0 |
| **Healthy** | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **201** | **120** | **98** | **21** | **33** | **17** | **7** | **12** | **3** |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## B. Member Wellness - Risk Category vs. Illness Band

*This chart compares Member Wellness Risk Categories with claims-based Illness Bands over the trailing 12 months. Well Being Scores are classified into one of three Risk Categories. Full Expression Members have the full expression of one or more diseases and therefore are assigned to either a more intensive TCCI Program or telephonic Disease Management Coaching. High Risk Members are at elevated risk for preventable disease and targeted for telephonic or online Lifestyle Health Coaching. Low Risk Members are generally healthy or exhibit low risk and are automatically referred for coaching, but have online and telephonic Health Coaching available to them if they seek it. A Full Expression or High Risk Category can be an early predictor of potential advancement on Illness Band of current unhealthy lifestyle behaviors are left unchecked. Please note that relatively few Members complete a Well Being Assessment.*

Click on any underlined field below to see additional information.

| Risk Category | Illness Band | | | | | |
|---|---|---|---|---|---|---|
| | Advanced/ Critical Illness | Multiple Chronic Illnesses | At Risk | Stable | Healthy | Total |
| **Full Expression** | 3 | 7 | 12 | 11 | 0 | 33 |
| **High Risk** | 12 | 13 | 29 | 22 | 14 | 90 |
| **Low Risk** | 4 | 7 | 52 | 70 | 32 | 165 |
| **Total Members w/ Well Being Score** | **19** | **27** | **93** | **103** | **46** | **288** |
| **All Panel Members** | 393 | 1,178 | 1,432 | 2,348 | 1,056 | 6,407 |
| **% of Members w/ Well Being Score** | 4.8% | 2.3% | 6.5% | 4.4% | 4.4% | 4.5% |

Sample Drill Through

## B. Detail of Member Wellness - Risk Category vs. Illness Band

**Risk Category: Full Expression**

**Illness Band: Multiple Chronic Illnesses**

*This drill down shows information at the Member level, comparing the overall Well Being score to the Illness Burden Score for each Member for the bands selected. The data shows the Member name, date of birth, attributed PCP, and total gross and PMPM debits, and dominant episode (if evident) over the trailing 12 months. This data is included in the MHR. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Well Being Score | Illness Burden Score | Total Debit $ | $ PMPM | Dominant Episode |
|---|---|---|---|---|---|---|---|---|
| 1 | Chester Red | 12/7/63 | Irene Indigo | 50 | 2.13 | $3,795 | $316.23 | Male Genital Disorders, NEC |
| 2 | Virginia Orange | 11/23/64 | Gary Green | 42 | 3.81 | $16,005 | $1,333.76 | Hepatobiliary Disorder, NEC |
| 3 | Stephanie Red | 1/22/56 | Peter Black | 74 | 3.87 | $7,747 | $645.55 | Gastroint Disord, NEC |
| | | | | | | | | |
| 7 | Marion Eggplant | 4/24/71 | Samuel Yellow | 58 | 4.25 | $9,562 | $796.83 | Prevent/Admin Hlth Encounters |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## C. Member Wellness - Movement Across Risk Categories

*This chart shows Member movement amoung Risk Categories from the prior year to current year. Well Being Scores are classified into one of three Risk Categories. Full Expression Members have the full expression of one or more diseases and therefore are assigned to either a more intensive TCCI Program or telephonic Disease Management Coaching. High Risk Members are at elevated risk for preventable disease and targeted for telephonic or online Lifestyle Health Coaching. Low Risk Members are generally healthy or exhibit low risk and are not automatically referred for coaching, but have online and telephonic Health Coaching available to them if they seek it. A Full Expression or High Risk Category can be an early predictor of potential advancement in Illness Band if current unhealthy lifestyle behaviors are left unchecked. Please note that relatively few Members complete a Well Being Assessment.*

Click on any underlined field below to see additional information.

| Prior Year (2015) | Current Year (2016) | | | | |
|---|---|---|---|---|---|
| | Full Expression | High Risk | Low Risk | Not Done | Total |
| **Full Expression** | 0 | 22 | 7 | 24 | 53 |
| **High Risk** | 13 | 0 | 57 | 65 | 135 |
| **Low Risk** | 5 | 5 | 0 | 157 | 167 |
| **Not Available** | 15 | 63 | 98 | 5,876 | 6,052 |
| **Total** | **33** | **90** | **162** | **6,122** | **6,407** |

Sample Drill Through

## C. Detail of Member Wellness - Movement Across Risk Categories

**Prior Year Risk Category: Not Available**

**Current Year Risk Category: Full Expression**

*This drill down shows information at the Member level, comparing the prior year and current year Well Being score, Illness Burden Score, Total Debit Dollars and PMPM debits for each listed Member from the current year. The data also shows the Member name, date of birth, and attributed PCP. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Prior Well Being Score | Current Well Being Score | Prior Illness Burden Score | Current Illness Burden Score | Prior Total Debit $ | Current Total Debit $ | Prior $ PMPM | Current $ PMPM |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Bianca Blue | 06/09/1963 | Irene Indigo | | 42 | 4.57 | 3.81 | $16,188 | $16,005 | $1,349 | $1,334 |
| 2 | Johnny Green | 11/23/1964 | Gary Green | | 50 | 1.96 | 2.13 | $3,598 | $3,795 | $300 | $316 |
| 3 | Mathew Mauve | 01/12/1956 | Peter Black | | 52 | 0.00 | 0.99 | $0 | $3,048 | $0 | $339 |
| | | | | | | | | | | | |
| 14 | Gerry Grass-Green | 08/04/1951 | Robin Red | | 74 | 1.98 | 1.41 | $2,681 | $21,420 | $223 | $1,785 |
| 15 | Mary Eggplant | 05/24/1971 | Samuel Yellow | | 74 | 1.31 | 3.87 | $1,331 | $7,747 | $111 | $646 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## D. Member Wellness - by Risk Category and TCCI Program

*This chart compares Member Wellness Risk Categories with claims-based Illness Bands over the trailing 12 months. Well Being Scores are classified into one of three Risk Categories. Full Expression Members have the full expression of one or more diseases and therefore are assigned to either a more intensive TCCI Program or telephonic Disease Management Coaching. High Risk Members are at elevated risk for preventable disease and targeted for telephonic or online Lifestyle Health Coaching. Low Risk Members are generally healthy or exhibit low risk and are automatically referred for coaching, but have online and telephonic Health Coaching available to them if they seek it. A Full Expression or High Risk Category can be an early predictor of potential advancement on Illness Band of current unhealthy lifestyle behaviors are left unchecked. Please note that relatively few Members complete a Well Being Assessment.*

Click on any underlined field below to see additional information.

| Risk Category | Members | Well Being Score | HTC | CCM | CCC | RxP | Other TCCI Programs | Total in TCCI Programs |
|---|---|---|---|---|---|---|---|---|
| **Full Expression** | 33 | 37.2 | 25 | 13 | 22 | 0 | 34 | 94 |
| **High Risk** | 90 | 73.1 | 14 | 18 | 11 | 1 | 23 | 67 |
| **Low Risk** | 165 | 58.2 | 8 | 2 | 0 | 0 | 12 | 22 |
| **Not Available** | 6,119 | NA | 154 | 87 | 65 | 2 | 540 | 848 |
| **Total** | **6,407** | **NA** | **201** | **120** | **98** | **3** | **609** | **1,031** |

Sample Drill Through

## D. Detail of Member Wellness - by Risk Category and TCCI Program

**Risk Category: Full Expression**

**TCCI Program: CCM**

*This drill down shows information at the Member level, including Member name, date of birth, Well Being score, care coordination programs, PCP, and total debit $ over the trailing 12 months. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorder (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Well Being Score | Care Coordination Program/Status | Total Debit $ |
|---|---|---|---|---|---|---|
| 1 | Chester Red | 12/7/63 | Irene Indigo | 68 | CCM (A) | $60,206 |
| 2 | Virginia Orange | 11/23/64 | Gary Green | 62 | HTC, CCM (A) | $27,721 |
| 3 | Stephanie Red | 1/22/56 | Peter Black | 60 | HTC, CCM (C) | $6,658 |
| | | | | | | |
| 13 | Marion Eggplant | 4/24/71 | Samuel Yellow | 42 | BSD (A), CCM (C) | $13,972 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## E. Member Wellness - Members by Health Condition Track

*This chart displays Members by Health Condition Track, compared to the Panel population, and their Risk Categories as identified from their Health Assessments as well as the subsequent actions relating to these Members. Debits PMPM is for the trailing 12 months. Click on any underlined number to see Member specific information.*

| Health Condition Track | Members | % of Panel Members | Risk Category | | Well Being Score | Average Illness Burden Score | Debits PMPM |
|---|---|---|---|---|---|---|---|
| | | | Full Expression | High Risk | | | |
| Behavioral Health | 3 | 3.4% | 1 | 0 | 45 | 8.50 | $766.00 |
| Cancer | 5 | 5.6% | 1 | 1 | 60 | 10.89 | $2,472.87 |
| Cardiovascular Disease | 8 | 9.0% | 3 | 2 | 7 | 3.01 | $962.13 |
| COPD | 5 | 5.6% | 1 | 1 | 90 | 3.05 | $1,951.65 |
| Diabetes | 8 | 9.0% | 2 | 4 | 44 | 5.22 | $3,703.00 |
| Hypertension | 21 | 23.6% | 3 | 5 | 75 | 8.12 | $129.95 |
| Kidney Disease | 4 | 4.5% | 1 | 0 | 21 | 15.20 | $551.57 |
| Metabolic Cluster | 1 | 1.1% | 0 | 0 | 99 | 18.90 | $989.06 |
| Musculoskeletal Cluster | 6 | 6.7% | 3 | 1 | 87 | 14.80 | $184.78 |
| Obesity | 28 | 31.5% | 6 | 2 | 54 | 8.80 | $5,034.63 |
| **Total** | **89** | **100.0%** | **21** | **21** | **NA** | **9.65** | **$16,745.64** |

Sample Drill Through

## E. Detail of Member Wellness - Members by Health Condition Track

**Health Condition Track: Diabetes**

*This drill down shows information at the Member level, including Member name, date of birth, Well Being Score, Illness Burden Score and Program Referred to over the trailing 12 months and is sorted by Well Being Score. Care Coordination Programs include Hospital Transition of Care (HTC), Complex Case Management (CCM), Chronic Care Coordination (CCC), Behavioral Health and Substance Use Disorder (BSD), Home Based Services (HBS), Enhanced Monitoring Program (EMP), Comprehensive Medication Review (CMR), Community Based Programs (CBP), Pharmacy Coordination Program (RxP), and Expert Consult Program (ECP). The Member's status in these programs is indicated as follows: Active (A), Closed (C), Member Refused (R), or PCP Declined (D). The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Risk Category | Well Being Score | Illness Burden Score | # of Health Risk Factors | Care Coordination Program/Status |
|---|---|---|---|---|---|---|---|---|
| 1 | Virginia Orange | 11/23/1964 | Gary Green | High Risk | 69 | 3.34 | 5 | CCM (A) |
| 2 | Christina Brown | 11/29/1984 | Sarah Cobalt | Full Expression | 37 | 0.21 | 4 | CCC (A) |
| | | | | | | | | |
| 8 | Emily Red | 12/7/1963 | Sarah Cobalt | Full Expression | 26 | 0.54 | 3 | CCM (A) |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## F. Profile of Members in Hospital Transition of Care (HTC) - Admissions and Costs

*This chart shows Member admissions by Illness Band and HTC assigned admission Category, with PMPM debit dollars for each over the trailing 12 months. Category 1 Members are more acutely ill and are often targeted for TCCI Program services. Category 2 Members are less acutely ill or have admissions for more routine care and usually need little if any care coordination services. Category 3 admissions are not triaged by HTC due to 1-day, evening or weekend admissions that are too brief to allow an assessment.*

| Illness Band | Total Admits | HTC Category 1 Admits | % Category 1 Admits | Category 1 PMPM | HTC Category 2 Admits | % Category 2 Admits | Category 2 PMPM | HTC Category 3 Admits | % Category 3 Admits | Category 3 PMPM |
|---|---|---|---|---|---|---|---|---|---|---|
| Advanced/Critical Illness | 239 | 197 | 82.4% | $8,307.40 | 35 | 14.6% | $3,219.40 | 1 | 0.4% | $801.83 |
| Multiple Chronic Illnesses | 148 | 79 | 53.4% | $1,687.50 | 59 | 39.9% | $2,269.47 | 0 | 0.0% | $0.00 |
| At Risk | 35 | 16 | 45.7% | $1,539.72 | 13 | 37.1% | $1,531.32 | 0 | 0.0% | $0.00 |
| Stable | 11 | 7 | 63.6% | $9,253.77 | 3 | 27.3% | $115.06 | 0 | 0.0% | $0.00 |
| Healthy | 9 | 7 | 77.8% | $7,033.34 | 1 | 11.1% | $120.56 | 0 | 0.0% | $0.00 |
| **Total** | **442** | **306** | **69.2%** | **$6,107.53** | **111** | **25.1%** | **$2,430.02** | **1** | **0.2%** | **$801.83** |

## G. Profile of Members in Hospital Transition of Care (HTC) - Follow Up Care for High Risk Admissions

*This chart shows a more detailed breakdown of Members identified through the HTC program for Category 1 and their subsequent transitions to other programs, if any, including Complex Case Management (CCM), Chronic Care Coordination (CCC), or alternative engagement at home through Self Management for the trailing 12 months. Click on an underlined number to see Member specific information.*

| Breakdown of Admission Category 1 | Members | Follow Up Care Coordination | | | | High Cost Cases |
|---|---|---|---|---|---|---|
| | | CCM | CCC | Refused CCM or CCC | Not Referred to CCM or CCC* | |
| 1A - Advanced Illness/Palliative | 15 | 7 | 3 | 2 | 4 | 0 |
| 1B - Catastrophic Events | 139 | 83 | 8 | 18 | 24 | 0 |
| 1C - Multi-Morbid Chronic Conditions | 38 | 17 | 1 | 13 | 28 | 0 |
| 1D - NICU Babies | 0 | 0 | 0 | 0 | 0 | 0 |
| 1E - Special Needs Pediatrics | 1 | 0 | 0 | 0 | 1 | 0 |
| 1F - Complex Infections/Immunological Conditions | 8 | 5 | 1 | 1 | 3 | 0 |
| 1G - Transplant | 0 | 0 | 0 | 0 | 0 | 0 |
| 1H - End Stage Renal Disease | 0 | 0 | 0 | 0 | 0 | 0 |
| 1I - Other | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **201** | **112** | **13** | **34** | **60** | **0** |

*Self Management, Palliative Care, Death, Alternative Institution.

Sample Drill Through

## G. Detail of Members in Hospital Transition of Care (HTC) - Follow Up Care for High Risk Admissions

**Category: 1C - Multi-Morbid Chronic Conditions**

**Follow Up Care Coordination: CCM**

*This drill down shows HTC program activity at the Member level showing Member name, date of birth, dominant episode, provider, discharge date, program referral, current program status, total gross debits, and debits PMPM for the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | High Cost Case | Dominant Episode | Discharge Date | Total Debit $ | Debits PMPM | Care Coordination Program Status |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Paul Purple | 09/09/60 | Samuel Yellow | Y | Osteoarthritis | 7/29/15 | $76,003 | $6,333.60 | CCM (C), CCC (R), HTC |
| 2 | Cynthia Mauve | 04/09/49 | Fletch Orange | N | Crohns Disease | 9/30/15 | $67,404 | $5,616.97 | CCM (A), HTC |
| 3 | Mike Orange | 11/05/66 | Irene Indigo | N | Overweight and Obesity | 11/14/15 | $61,816 | $5,151.31 | CCM(C), HTC |
| | | | | | | | | | |
| 17 | Katie Black | 05/14/56 | Peter Black | N | Overweight and Obesity | 2/21/15 | $40,630 | $3,385.82 | CCM (C), HTC, CMR, BSD (A) |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## H. Profile of Members in Complex Case Management (CCM)

*This chart shows total Panel Members by band who have been identified for engagement in CCM, their current average illness burden scores, referral source (HTC or Other for active and closed Care Plans), and current program status: active, closed or Member refused over the trailing 12 months. Click on any underlined number to see Member specific information.*

| Illness Band | Identified CCM Members | Average IB Score | Source | | Active | Closed | Member Refused |
|---|---|---|---|---|---|---|---|
| | | | HTC | Other | | | |
| Advanced/Critical Illness | 130 | 18.57 | 113 | 17 | 13 | 72 | 45 |
| Multiple Chronic Illnesses | 42 | 3.34 | 39 | 3 | 2 | 23 | 17 |
| At Risk | 8 | 1.77 | 6 | 2 | 1 | 4 | 3 |
| Stable | 4 | 0.71 | 2 | 2 | 0 | 4 | 0 |
| Healthy | 1 | 0.06 | 0 | 1 | 1 | 0 | 0 |
| **Total** | **185** | **4.89** | **160** | **25** | **17** | **103** | **65** |

Sample Drill Through

## H. Detail of Members in Complex Case Management (CCM)

**Illness Band: Advanced/Critical Illness**

**Status: Active**

*This drill down shows CCM Member level information, including Member name, date of birth provider, dominant episode, active dates, closed dates, and program participation duration over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Dominant Episode | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|
| 1 | Nick Brown | 09/05/56 | Gary Green | Male Genital Disorders, NEC | 6/13/15 | | 201 |
| 2 | Ray Purple | 10/14/53 | Donald Daisey | Tumors - Central Nervous Sys | 8/29/15 | | 124 |
| | | | | | | | |
| 13 | Fey Rose | 12/14/57 | Peter Black | Coronary Artery Disease | 9/29/15 | | 93 |

## I. Members in Complex Case Management (CCM) - Key Measures / Outcomes

*This chart shows Panel Members who are or have been in CCM and key statistics on a pre and post active basis that show the use and cost patterns applicable to each Member. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Program Status | Active Date | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active | | Post Active | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Admits | ER | Admits | ER |
| 1 | Paul Purple | 12/05/69 | Sarah Cobalt | Closed | 8/5/15 | 86.69 | 78.34 | $6,464.74 | $0.00 | 2 | 2 | 0 | 0 |
| 2 | Mike Orange | 10/31/50 | Ray Purple | Closed | 7/27/15 | 12.05 | 28.03 | $8,378.31 | $1,375.20 | 3 | 2 | 0 | 0 |
| 3 | Cindy Blue | 09/10/45 | Gary Green | Closed | 6/13/15 | 3.30 | 18.70 | $39,953.35 | $23,306.69 | 3 | 1 | 2 | 0 |
| | | | | | | | | | | | | | |
| 185 | Bonnie Pink | 10/18/51 | Ace Emerald | Active | 12/2/15 | 1.73 | 1.73 | $1,387.71 | $0.00 | 1 | 1 | 0 | 0 |

## J. CCM Members Engaged in Other TCCI Programs

*This chart shows Panel Members who are or have been in CCM and have also been engaged in an additional TCCI Program (BSD, HBS, EMP, CMR, CBP or RxP). Key statistics on a pre and post active basis are also included to show the use and cost patterns applicable to each Program. Members are broken out into "vintage" groups based on the activation date of the program. Pre and post figures are only shown after three months of run out and thus are not displayed for the most recent three months.*

| TCCI Program and Activation Date | # Members | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits & ER | Post-Active Admits & ER |
|---|---|---|---|---|---|---|---|
| **BSD Total** | 17 | 10.03 | 10.52 | $2,390.94 | $2,347.25 | 15 | 4 |
| 0 to <3 Months | 2 | 5.84 | 5.77 | $2,125.34 | $461.27 | 2 | 0 |
| 3 to <6 Months | 1 | 7.65 | 8.97 | $2,754.14 | $7,977.30 | 2 | 2 |
| 6 to <9 Months | 3 | 18.67 | 20.81 | $4,836.48 | $1,174.53 | 19 | 6 |
| 9 to <12 Months | 2 | 3.72 | 3.25 | $781.75 | $744.59 | 2 | 2 |
| 12+ Months | 1 | 14.25 | 13.78 | $1,456.97 | $1,378.54 | 2 | 2 |
| **HBS Total** | 24 | 22.85 | 24.67 | $4,827.74 | $9,966.20 | 18 | 2 |
| 0 to <3 Months | 10 | 35.11 | 37.78 | $10,507.34 | $2,377.88 | 4 | 0 |
| 3 to <6 Months | 2 | 19.99 | 24.61 | $906.08 | $703.82 | 3 | 0 |
| 6 to <9 Months | 4 | 19.03 | 23.68 | $7,552.16 | $870.51 | 6 | 1 |
| 9 to <12 Months | 3 | 33.10 | 19.80 | $3,751.44 | $20,632.95 | 2 | 0 |
| 12+ Months | 5 | 7.04 | 17.50 | $1,421.67 | $25,245.86 | 3 | 1 |
| **EMP Total** | 21 | 1.36 | 1.24 | $741.34 | $521.67 | 22 | 16 |
| 0 to <3 Months | 4 | 0.05 | 0.40 | $272.03 | $611.42 | 3 | 1 |
| 3 to <6 Months | 2 | 1.13 | 0.81 | $353.48 | $1,105.55 | 2 | 0 |
| 6 to <9 Months | 6 | 1.14 | 1.14 | $1,060.80 | $0.00 | 4 | 1 |
| 9 to <12 Months | 4 | 1.79 | 1.16 | $1,074.53 | $783.60 | 4 | 9 |
| 12+ Months | 5 | 2.69 | 2.69 | $945.88 | $107.80 | 9 | 5 |
| **CMR Total** | 32 | 13.12 | 8.98 | $3,372.47 | $1,844.23 | 28 | 13 |
| 0 to <3 Months | 5 | 36.63 | 19.80 | $11,039.17 | $4,093.22 | 11 | 5 |
| 3 to <6 Months | 8 | 7.48 | 9.73 | $2,098.00 | $797.56 | 6 | 3 |
| 6 to <9 Months | 7 | 11.52 | 7.05 | $2,768.37 | $3,319.09 | 4 | 4 |
| 9 to <12 Months | 9 | 5.02 | 4.21 | $473.95 | $661.28 | 5 | 1 |
| 12+ Months | 3 | 4.93 | 4.10 | $482.87 | $350.00 | 2 | 0 |
| **CBP Total** | 26 | 2.27 | 1.41 | $393.23 | $1,090.17 | 1 | 3 |
| 0 to <3 Months | 7 | 0.43 | 0.43 | $22.08 | $350.00 | 0 | 0 |
| 3 to <6 Months | 1 | 1.24 | 0.86 | $1,130.71 | $1,849.89 | 0 | 1 |
| 6 to <9 Months | 8 | 5.54 | 1.45 | $213.87 | $1,623.90 | 1 | 0 |
| 9 to <12 Months | 9 | 1.68 | 1.57 | $51.61 | $1,021.00 | 0 | 2 |
| 12+ Months | 1 | 2.47 | 2.74 | $547.88 | $606.05 | 0 | 0 |
| **RxP Total** | 10 | 9.88 | 11.18 | $2,843.87 | $3,200.03 | 25 | 27 |
| 0 to <3 Months | 0 | 0.00 | 0.00 | $0.00 | $0.00 | 0 | 0 |
| 3 to <6 Months | 2 | 12.63 | 22.87 | $777.69 | $7,144.10 | 1 | 3 |
| 6 to <9 Months | 3 | 28.19 | 21.83 | $11,242.50 | $5,165.10 | 7 | 4 |
| 9 to <12 Months | 4 | 8.53 | 10.81 | $1,927.13 | $3,079.53 | 4 | 9 |
| 12+ Months | 1 | 0.05 | 0.40 | $272.03 | $611.42 | 9 | 5 |

**PCMH SearchLight Report for Panel ABC**

## K. Profile of Members in Chronic Care Coordination (CCC)

*This chart shows the total Panel Members by band, who have been identified for engagement in CCC, their current average illness burden scores, and current program status: active, closed or Member refused over the trailing 12 months as of May, 2017. "Potential" Members are those with Illness Burden Scores of 6.0 or higher or who have been identified by an LCC or CCM. The Top 50 SearchLight reports present views of the 50 Members who have the highest costs, highest utilization, or show other patterns of progressive disease or instability that places them at greatest risk within a Panel's membership. High IBS identifies members from a Panel who have the PCMH benefit and are eligible to participate in care coordination.*

Click on any underlined field below to see additional information.

| Illness Band | Potential CCC Members | Average IB Score | Source | | | | | | Active | Closed | Member Refused | PCP Declined |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Top 50 List | High IBS | PCP | CCM | HTC | Other | | | | |
| Advanced/Critical Illness | 277 | 37.86 | 39 | 13 | 2 | 0 | 5 | 1 | 44 | 13 | 3 | 1 |
| Multiple Chronic Illnesses | 130 | 9.95 | 17 | 0 | 6 | 0 | 5 | 0 | 20 | 4 | 4 | 5 |
| At Risk | 46 | 4.88 | 6 | 1 | 0 | 0 | 5 | 0 | 10 | 2 | 0 | 5 |
| Stable | 9 | 2.53 | 0 | 0 | 1 | 0 | 4 | 0 | 4 | 1 | 0 | 0 |
| Healthy | 1 | 0.08 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **209** | **7.83** | **21** | **14** | **8** | **4** | **2** | **1** | **23** | **13** | **5** | **11** |

Sample Drill Through

## K. Detail of Members in Chronic Care Coordination (CCC)

**Illness Band: Multiple Chronic Illnesses**
**Status: Active**

*This drill down shows CCC Member level information, including Member name, date of birth, provider, dominant episode, active dates, closed dates, and program participation duration over the trailing 12 months. This report is sorted by descending duration days, and then active date in order of oldest to newest. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Dominant Episode | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|
| 1 | John White | 10/29/56 | Bonnie Beige | Cancer - Cervical | 5/11/15 | | 541 |
| 2 | Cindy Blue | 07/14/57 | Bob Blue | Anthropathies/Joint Disord NEC | 5/29/15 | | 523 |
| 3 | Gandolf Grey | 05/30/60 | Theodore Lavender | Cancer - Prostate | 6/12/15 | | 220 |
| 4 | Lee Purple | 09/09/61 | Ace Emerald | Gout | 2/28/15 | | 306 |
| | | | | | | | |
| 20 | Bonnie Pink | 05/28/42 | Tom Turquoise | Renal Function Failure | 8/18/15 | | 135 |

## L. Members in Chronic Care Coordination (CCC) - Key Measures / Outcomes

Filter By: All Providers

### Summary by Status

*This chart shows the reduction in admits and ER visits for Care Plan members. Pre-Active includes admits and ER visits 12 months prior to the active date of CCC and Post-Active includes admits and ER visits 12 months after the active date of CCC. Admits and ER visits for pre and post active periods for less than 12 months are annualized to facilitate comparisons.*

| Status | Total Members | Total Admits & ER | Total Member Months | Admits & ER per Month |
|---|---|---|---|---|
| Pre-Active | 98 | 213 | 1,147 | 2.19 |
| Post-Active | 98 | 109 | 602 | 1.47 |
| Post-Active vs. Pre-Active % Reduction | | | | 32.88% |

### Summary by Member

*This chart shows Panel Members who are or have been in CCC and key statistics on a pre and post active basis that show the use and cost patterns applicable to each Member over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Program Status | Active Date | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits & ER | Post-Active Admits & ER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Shelly White | 11/18/47 | Irene Indigo | Active | 4/6/15 | 100.87 | 78.34 | $82,301.83 | $9,351.74 | 15 | 1 |
| 2 | Evan Gray | 10/29/56 | Bob Blue | Closed | 12/16/14 | 11.33 | 54.40 | $8,269.97 | $10,224.99 | 3 | 2 |
| 3 | Harry Black | 06/09/51 | Ronald Brown | Active | 5/11/15 | 13.26 | 13.33 | $2,004.40 | $385.77 | 0 | 0 |
| | | | | | | | | | | | |
| 98 | John Blue | 05/30/60 | Gary Green | Active | 12/10/15 | 0.77 | 0.77 | $49.15 | $0.00 | 0 | 0 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## M. CCC Members Engaged in Other TCCI Programs

*This chart shows Panel Members who are or have been in CCC and have also been engaged in an additional TCCI Program (BSD, HBS, EMP, CMR, CBP, or RxP). Key statistics on a pre and post active basis are also included to show the use and cost patterns applicable to each Program. Members are broken out into "vintage" groups based on the activation date of the program. Pre and post figures are only shown after three months of run out and thus are not displayed for the most recent three months.*

| TCCI Program and Activation Date | # Members | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits& ER | Post-Active Admits & ER |
|---|---|---|---|---|---|---|---|
| **BSD Total** | 30 | 11.13 | 10.78 | $878.70 | $780.43 | 18 | 7 |
| 0 to <3 Months | 17 | 19.79 | 18.02 | $514.58 | $481.21 | 4 | 0 |
| 3 to <6 Months | 4 | 17.02 | 16.56 | $642.89 | $537.84 | 3 | 0 |
| 6 to <9 Months | 6 | 10.03 | 9.02 | $801.45 | $712.46 | 5 | 1 |
| 9 to <12 Months | 2 | 3.70 | 3.71 | $776.89 | $742.14 | 3 | 3 |
| 12+ Months | 1 | 5.10 | 5.00 | $1,571.56 | $1,389.87 | 3 | 3 |
| **HBS Total** | 30 | 1.96 | 2.00 | $4,815.41 | $9,785.15 | 20 | 5 |
| 0 to <3 Months | 3 | 1.02 | 0.98 | $10,404.51 | $2,751.56 | 5 | 0 |
| 3 to <6 Months | 5 | 2.32 | 2.35 | $942.15 | $801.41 | 3 | 1 |
| 6 to <9 Months | 4 | 0.90 | 0.94 | $7,612.04 | $951.41 | 5 | 2 |
| 9 to <12 Months | 6 | 3.10 | 3.20 | $3,814.01 | $21,014.14 | 3 | 0 |
| 12+ Months | 12 | 2.46 | 3.00 | $1,423.54 | $24,145.87 | 4 | 2 |
| **EMP Total** | 27 | 3.08 | 3.10 | $844.20 | $831.53 | 22 | 21 |
| 0 to <3 Months | 6 | 6.20 | 7.00 | $281.41 | $711.45 | 3 | 2 |
| 3 to <6 Months | 3 | 3.20 | 3.21 | $341.45 | $1,102.54 | 2 | 1 |
| 6 to <9 Months | 8 | 1.14 | 1.14 | $1,044.58 | $21.41 | 4 | 2 |
| 9 to <12 Months | 4 | 2.10 | 2.11 | $1,401.41 | $831.51 | 4 | 10 |
| 12+ Months | 6 | 2.75 | 2.76 | $951.15 | $104.85 | 9 | 6 |
| **CMR Total** | 33 | 4.01 | 4.02 | $3,549.48 | $6,306.56 | 37 | 19 |
| 0 to <3 Months | 7 | 7.26 | 7.24 | $11,082.56 | $15,002.87 | 12 | 9 |
| 3 to <6 Months | 11 | 4.20 | 4.00 | $2,106.05 | $7,945.41 | 7 | 2 |
| 6 to <9 Months | 6 | 1.26 | 1.26 | $2,598.88 | $3,219.54 | 6 | 5 |
| 9 to <12 Months | 7 | 5.05 | 5.03 | $473.95 | $661.28 | 9 | 2 |
| 12+ Months | 2 | 2.30 | 2.34 | $481.41 | $694.84 | 3 | 1 |
| **CBP Total** | 35 | 1.65 | 1.99 | $406.08 | $1,059.71 | 3 | 6 |
| 0 to <3 Months | 9 | 0.31 | 0.38 | $25.57 | $250.45 | 0 | 0 |
| 3 to <6 Months | 1 | 1.24 | 0.86 | $1,154.56 | $1,794.54 | 1 | 2 |
| 6 to <9 Months | 9 | 3.57 | 4.24 | $212.90 | $1,731.85 | 2 | 0 |
| 9 to <12 Months | 12 | 1.81 | 1.58 | $49.41 | $1,015.15 | 0 | 3 |
| 12+ Months | 4 | 1.34 | 2.89 | $548.15 | $506.54 | 0 | 1 |
| **RxP Total** | 24 | 3.35 | 4.05 | $8,928.58 | $22,726.42 | 30 | 33 |
| 0 to <3 Months | 1 | 5.90 | 6.00 | $26,549.51 | $97,215.51 | 5 | 7 |
| 3 to <6 Months | 4 | 4.23 | 4.65 | $981.56 | $8,145.45 | 2 | 5 |
| 6 to <9 Months | 6 | 3.12 | 3.20 | $12,621.50 | $5,041.14 | 9 | 5 |
| 9 to <12 Months | 8 | 1.03 | 1.00 | $1,841.51 | $2,584.54 | 3 | 10 |
| 12+ Months | 5 | 2.48 | 5.00 | $281.41 | $645.45 | 11 | 6 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## N. Profile of Members in Behavioral Health and Substance Use Disorder Program (BSD)

*This chart shows total Panel Members by band who have been engaged in BSD, their current average illness burden scores, and referral source (CCM, CCC or Other) over the trailing 12 months.*

Click on any underlined number to see Member specific information.

| Illness Band | BSD Members | Average IB Score | Source | | | Active | Closed | Average Duration |
|---|---|---|---|---|---|---|---|---|
| | | | CCM | CCC | Other | | | |
| Advanced/Critical Illness | 42 | 15.55 | 5 | 7 | 33 | 2 | 5 | 108 |
| Multiple Chronic Illnesses | 71 | 3.04 | 3 | 6 | 62 | 5 | 3 | 116 |
| At Risk | 45 | 1.48 | 0 | 1 | 44 | 1 | 5 | 117 |
| Stable | 27 | 0.70 | 0 | 1 | 26 | 0 | 0 | 0 |
| Healthy | 6 | 0.10 | 0 | 0 | 6 | 0 | 0 | 0 |
| **Total** | **191** | **4.17** | **8** | **15** | **171** | **8** | **13** | **68** |

Sample Drill Through

## N. Detail of Members in Behavioral Health and Substance Use Disorder Program (BSD)

**Illness Band: Multiple Chronic Illnesses**

**Status: Active**

*This drill down shows BSD Member level information, including Member name, date of birth, Illness Burden Score, referral source (CCM, CCC, or Other), dominant episode, active dates, closed dates, and program participation duration over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | IB Score | Source (CCM, CCC, Other) | Dominant Episode | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | John White | 10/29/56 | Bonnie Beige | 2.78 | CCM | Overweight and Obesity | 4/24/2015 | | 251 |
| 2 | Cindy Blue | 07/14/57 | Bob Blue | 3.11 | CCM | Ulcers, Peptic | 8/7/2015 | | 146 |
| 3 | Gandolf Grey | 05/30/60 | Theodore Lavender | 3.94 | CCC | Osteoarthritis | 12/2/2015 | | 29 |
| | | | | | | | | | |
| 5 | Lee Purple | 09/09/61 | Ace Emerald | 3.45 | Other | Asthma | 12/23/2015 | | 8 |

## O. Members in Behavioral Health and Substance Substance Use Disorder Program (BSD) - Key Measures / Outcomes

*This chart shows Panel Members who are or have been in BSD and key statistics on a pre and post active basis that show the use and cost patterns applicable to each Member for the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Program Status | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits & ER | Post-Active Admits & ER |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Shelly White | 11/18/47 | Irene Indigo | Active | 100.87 | 78.34 | $82,301.83 | $9,351.74 | 15 | 1 |
| 2 | Evan Gray | 10/29/56 | Bob Blue | Closed | 11.33 | 54.40 | $8,269.97 | $10,224.99 | 3 | 2 |
| 3 | Harry Black | 06/09/51 | Ronald Brown | Active | 13.26 | 13.33 | $2,004.40 | $385.77 | 0 | 0 |
| | | | | | | | | | | |
| 98 | John Blue | 05/30/60 | Gary Green | Active | 0.77 | 0.77 | $49.15 | $0.00 | 0 | 0 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## P. Profile of Members in Home Based Services (HBS)

*This chart shows total Panel Members by band who have been engaged in HBS, their current average illness burden scores, and referral source (CCM, CCC or Other) over the trailing 12 months. Click on any underlined number to see Member specific information.*

| Illness Band | HBS Members | Average IB Score | Source | | | Active | Closed | Average Duration |
|---|---|---|---|---|---|---|---|---|
| | | | CCM | CCC | Other | | | |
| Advanced/Critical Illness | 35 | 19.97 | 21 | 16 | 0 | 9 | 18 | 53 |
| Multiple Chronic Illnesses | 6 | 2.56 | 3 | 3 | 0 | 2 | 3 | 25 |
| At Risk | 2 | 1.13 | 1 | 1 | 0 | 1 | 0 | 44 |
| Stable | 0 | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 |
| Healthy | 0 | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **43** | **7.88** | **25** | **20** | **0** | **12** | **21** | **41** |

Sample Drill Through

## P. Detail of Members in Home Based Services (HBS)

**Illness Band: Advanced/Critical Illness**

**Status: Active**

*This drill down shows HBS Member level information, including Member name, date of birth, provider, dominant episode, active dates, closed dates, and program participation duration over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | IB Score | Source (CCM, CCC, Other) | Dominant Episode | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Lee Purple | 10/17/71 | Ace Emerald | 14.22 | CCC | Crohns Disease | 7/1/15 | | 183 |
| 2 | Gandolf Grey | 08/29/65 | Theodore Lavender | 9.78 | CCC | Functional Digest Disord, NEC | 7/5/15 | | 179 |
| 3 | Cindy Blue | 10/06/69 | Sarah Cobalt | 11.42 | CCM | Cerebrovascular Disease | 8/2/15 | | 151 |
| | | | | | | | | | |
| 9 | John White | 10/05/59 | Bonnie Beige | 8.87 | CCM | Cardiac Arrhythmias | 9/8/15 | | 114 |

## Q. Members in Home Based Services (HBS) - Key Measures / Outcomes

*This chart shows Panel Members who are or have been in HBS and key statistics on a pre and post active basis that show the use and cost patterns applicable to each Member. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Program Status | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits & ER | Post-Active Admits & ER |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Peter Brown | 10/22/69 | Theodore Lavender | Closed | 21.47 | 61.41 | $8,650.79 | $14,853.85 | 3 | 10 |
| 2 | Gus Grapefruit | 04/05/56 | Bob Blue | Closed | 18.00 | 32.84 | $6,908.75 | $2,738.23 | 2 | 1 |
| 3 | Gandolf Grey | 09/12/72 | Bonnie Beige | Closed | 15.86 | 28.00 | $7,507.37 | $228.98 | 5 | 0 |
| 4 | Chris Eggplant | 07/25/48 | Ace Emerald | Closed | 15.22 | 15.22 | $4,365.13 | $0.00 | 2 | 0 |
| | | | | | | | | | | |
| 33 | Bonnie Pink | 11/10/48 | Tom Turquoise | Active | 1.85 | 1.76 | $254.43 | $692.39 | 0 | 0 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## R. Profile of Members in Enhanced Monitoring Program (EMP)

*This chart shows total Panel Members by band who have been engaged in EMP their current average illness burden scores, referral source (CCM, CCC or Other), active, closed, and average duration over the trailing 12 months as of May, 2017. A Member could be referred to a TCCI program from more than one source. Click on any underlined number to see Member specific information.*

| Illness Band | EMP Members | Average IB Score | Source | | | Active | Closed | Average Duration |
|---|---|---|---|---|---|---|---|---|
| | | | CCM | CCC | Other | | | |
| Advanced/Critical Illness | 12 | 12.15 | 0 | 10 | 2 | 3 | 3 | 41 |
| Multiple Chronic Illnesses | 16 | 3.78 | 0 | 9 | 7 | 2 | 2 | 17 |
| At Risk | 8 | 1.61 | 0 | 6 | 2 | 2 | 2 | 71 |
| Stable | 4 | 0.45 | 0 | 3 | 1 | 0 | 3 | 50 |
| Healthy | 0 | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **40** | **4.50** | **0** | **28** | **12** | **7** | **10** | **45** |

Sample Drill Through

## R. Detail of Members in Enhanced Monitoring Program (EMP)

**Illness Band: Advanced/Critical Illness**

**Status: Active**

*This drill down shows EMP Member level information, including Member name, date of birth, provider, Illness Burden Score, referral source (CCM, CCC, or Other), dominant episode, active dates, closed dates, and program participation duration over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | IB Score | Source (CCM, CCC, Other) | Dominant Episode | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | John Black | 08/23/55 | Bonnie Beige | 14.92 | CCC | Coronary Artery Disease | 4/8/15 | | 267 |
| 2 | Cindy Blue | 07/16/54 | Bob Blue | 7.19 | CCC | Condition Rel to Tx - Med/Surg | 12/24/15 | | 68 |
| 3 | Purple Panther | 09/09/61 | Ace Emerald | 6.97 | CCM | Neurological Disorders, NEC | 7/6/15 | | 178 |

## S. Members in Enhanced Monitoring Program (EMP) - Key Measures / Outcomes

*This chart shows Panel Members who are or have been in EMP and key statistics on a pre and post active basis that show the use and cost patterns applicable to each Member. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Program Status | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits/ER | Post-Active Admits/ER |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | John Black | 08/23/55 | Bonnie Beige | Active | 19.87 | 14.92 | $12,186.68 | $3,374.12 | 5 | 5 |
| 2 | Cindy Bue | 07/16/54 | Bob Blue | Active | 7.19 | 7.19 | $627.73 | $0.00 | 2 | 0 |
| 3 | Gandolf Grey | 05/30/60 | Theodore Lavender | Closed | 6.06 | 5.89 | $1,606.68 | $176.49 | 0 | 0 |
| 4 | Lee Purple | 09/09/61 | Ace Emerald | Closed | 6.69 | 4.61 | $1,459.06 | $561.86 | 1 | 0 |
| | | | | | | | | | | |
| 17 | Purple Panther | 09/09/61 | Ace Emerald | Active | 6.11 | 6.97 | $2,246.32 | $1,786.40 | 3 | 0 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## T. Profile of Members in Comprehensive Medication Review (CMR)

*This chart shows the total Panel Members with a pharmacy benefit who were referred for CMR services and the number completing a review over the trailing 12 months. Members are identified for CMR through referral by a Local Care Coordinator (LCC) or Complex Case Manager (CCM), as well as an automatic iCentric "trigger" that calls for a review. Click on any underlined number to see Member specific information.*

| Illness Band | Referred CMR Members | Average IB Score | Completed CMR | Member Refused |
|---|---|---|---|---|
| Advanced/Critical Illness | 5 | 13.57 | 3 | 2 |
| Multiple Chronic Illnesses | 8 | 2.98 | 4 | 4 |
| At Risk | 1 | 1.84 | 0 | 1 |
| Stable | 1 | 0.44 | 0 | 1 |
| Healthy | 0 | 0.00 | 0 | 0 |
| **Total** | **15** | **6.27** | **7** | **8** |

Sample Drill Through

## T. Detail of Members in Comprehensive Medication Review (CMR)

**Illness Band: Multiple Chronic Illnesses**

**Status: Completed**

*This drill down shows CMR Member level information, including Member name, date of birth, provider, top 50 list, referral date, completed date, $ savings, and script changes (adds and deletes) as a result of the CMR over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Top 50 List | Referral Date | Completed Date | $ Savings | Scripts | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Adds | Deletes |
| 1 | Katherine Gold | 07/01/61 | Fletcher Orange | High # Rx | 8/24/15 | 9/2/15 | Yes | 2 | 1 |
| 2 | Dale Denim | 05/20/65 | Robin Red | High Rx $, High DVS, High # Rx | 7/15/15 | 8/3/15 | Yes | 2 | 3 |
| 3 | Purple Panther | 09/09/61 | Ace Emerald | High DVS | 2/22/15 | 4/5/15 | No | 1 | 8 |
| 4 | Mary Maroon | 10/15/69 | Sarah Cobalt | High Rx $, High DVS, High # Rx | 11/18/15 | 11/25/15 | Yes | 2 | 0 |

## U. Members in Comprehensive Medication Review (CMR) - Key Measures / Outcomes

*This chart shows Panel Members who are or have been in CMR and key statistics on a pre and post active basis that show the pharmacy use and cost patterns applicable to each Member over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Program Status | Completed Date | Pre-Active # Drugs | Post-Active # Drugs | Pre-DVS (At Active) | Post-DVS (Current) | Pre-Active Rx PMPM | Post-Active Rx PMPM |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Katherine Gold | 02/04/69 | Fletcher Orange | Closed | 9/2/15 | 7 | 7 | 1 | 2 | $1,097.00 | $602.96 |
| 2 | Dale Denim | 05/08/74 | Robin Red | Closed | 8/3/15 | 14 | 15 | 0 | 0 | $974.63 | $1,004.34 |
| 3 | Purple Panther | 08/02/54 | Ace Emerald | Closed | 4/5/15 | 9 | 11 | 0 | 0 | $12,130.10 | $3,466.78 |
| | | | | | | | | | | | |
| 7 | Bonnie Pink | 09/01/60 | Ace Emerald | Closed | 10/7/15 | 5 | 7 | 0 | 0 | $4,400.97 | $0.00 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## V. Profile of Members in Community Based Programs (CBP)

*This chart shows total Panel Members by band who have been engaged in CBP their current average illness burden scores, referral source (CCM, CCC or Other), active, closed, and average duration over the trailing 12 months. A Member could be referred to a TCCI program from more than one source and may be engaged in more than one CBP program.*
*Click on any underlined number to see Member specific information.*

| Illness Band | CBP Members | Average IB Score | Source | | | Active | Closed | Average Duration |
|---|---|---|---|---|---|---|---|---|
| | | | CCM | CCC | Other | | | |
| Advanced/Critical Illness | 10 | 34.33 | 2 | 0 | 8 | 0 | 10 | 48 |
| Multiple Chronic Illnesses | 1 | 1.52 | 0 | 0 | 1 | 1 | 0 | 20 |
| At Risk | 1 | 0.48 | 0 | 0 | 1 | 1 | 0 | 0 |
| Stable | 0 | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 |
| Healthy | 0 | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **12** | **12.11** | **2** | **0** | **10** | **2** | **10** | **34** |

Sample Drill Through

## V. Detail of Profile of Members in Community Based Programs (CBP)

**Illness Band: Advanced/Critical Illness**
**Status: Closed**

*This drill down shows Member level information, including Member name, date of birth, provider, dominant episode, referral source (CCM or CCC), CBP program, active dates, closed dates, and program participation duration over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | IB Score | Source (CCM, CCC, Other) | Dominant Episode | CBP Program | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | John White | 2/21/63 | Bonnie Beige | 15.06 | Other | Infections -Eye | Skilled Nursing Facility Program | 4/13/15 | 8/10/15 | 119 |
| 2 | Cindy Blue | 3/12/66 | Bob Blue | 8.41 | Other | Diabetes | Skilled Nursing Facility Program | 6/8/15 | 7/6/15 | 28 |
| 3 | Gary Lime | 11/8/52 | Peter Black | 9.87 | Other | Spinal/Back Disord, Ex Low | Skilled Nursing Facility Program | 12/22/15 | 12/31/15 | 9 |
| 4 | Lora Lemon | 6/17/56 | Tom Turqoise | 15.12 | CCC | Infec/Inflam - Skin/Subcu Tiss | Skilled Nursing Facility Program | 7/19/15 | 8/5/15 | 17 |
| | | | | | | | | | | |
| 10 | Rita Rose | 10/22/69 | Irene Indigo | 61.41 | CCM | Cancer - Breast | Hospice and Palliative Care Program | 9/26/15 | 10/3/15 | 7 |

## W. Members in Community Based Programs (CBP) - Key Measures / Outcomes

*This chart shows Panel Members who are or have been in CBP and key statistics on a pre and post active basis that show the use and cost patterns applicable to each Member. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | CBP Program | Program Status | Pre-IB Score (At Active) | Post-IB Score (Current) | Pre-Active PMPM | Post-Active PMPM | Pre-Active Admits & ER | Post-Active Admits & ER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | John White | 10/29/56 | Bonnie Beige | Cardiac Rehabilitation Program | Active | 15.85 | 27.98 | $3,266.72 | $2,443.28 | 9 | 9 |
| 2 | Cindy Blue | 07/14/57 | Bob Blue | Hospice and Palliative Care Program | Closed | 43.86 | 25.09 | $3,073.74 | $2,991.36 | 6 | 5 |
| 3 | Gandolf Grey | 05/30/60 | Theodore Lavender | Holy Cross Hospital CHF Program | Closed | 22.47 | 22.48 | $1,157.39 | $739.09 | 7 | 7 |
| 4 | Lee Purple | 09/09/61 | Ace Emerald | Diabetic Education | Active | 13.33 | 13.58 | $2,385.33 | $1,842.25 | 8 | 6 |
| | | | | | | | | | | | |
| 17 | Bonnie Pink | 05/28/42 | Tom Turquoise | Skilled Nursing Facility | Closed | 5.55 | 20.38 | $836.10 | $614.08 | 5 | 4 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## X. Profile of Members in Pharmacy Coordination Program (RxP)

*This chart shows total Panel Members by band who have been referred to the RxP Program, their current average illness burden scores, and current program status: active, closed or Member refused over the trailing 12 months. The RxP program applies only to Members taking specialty drugs. Click on any underlined number to see Member specific information.*

| Illness Band | Referred RxP Members | Average IB Score | Active | Closed | Member Refused |
|---|---|---|---|---|---|
| Advanced/Critical Illness | 3 | 5.49 | 0 | 0 | 3 |
| Multiple Chronic Illnesses | 4 | 5.54 | 2 | 1 | 0 |
| At Risk | 1 | 1.22 | 0 | 0 | 1 |
| Stable | 0 | 0.55 | 0 | 0 | 0 |
| Healthy | 0 | 0.00 | 0 | 0 | 0 |
| **Total** | **8** | **4.98** | **2** | **1** | **4** |

## X. Detail of Members in Pharmacy Coordination Program (RxP)

**Illness Band: Advanced/Critical Illness**
**Status: Active**

Sample Drill Through

*This drill down shows RxP Member level information, including Member name, date of birth, provider, specialty category, dominant episode, active dates, closed dates, and program participation duration over the trailing 12 months. The RxP program applies only to Members taking specialty drugs. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Specialty Pharmacy Category | Dominant Episode | Active Date | Closed Date | Duration (Days) |
|---|---|---|---|---|---|---|---|---|
| 1 | Magnolia Mauve | 5/22/79 | Bonnie Beige | Multiple Sclerosis | Multiple Sclerosis | 3/4/15 | | 302 |
| 2 | Walter White | 5/30/60 | Robin Red | Multiple Sclerosis with Sepsis | Multiple Sclerosis with Sepsis | 5/9/15 | | 236 |

## Y. Profile of Members by Specialty Pharmacy Category

*This chart identifies referred, active, and closed RxP Members by Specialty Pharmacy Category (conditions treated) and debits PMPM over the trailing 12 months for active and closed Members. The RxP program applies only to Members taking specialty drugs. Click on any underlined number to see Member specific information.*

| Specialty Pharmacy Category | Referred RxP Members | Active | Closed | Active & Closed PMPM |
|---|---|---|---|---|
| Hemophilia | 0 | 0 | 0 | $0.00 |
| Hepatitis C | 0 | 0 | 3 | $6,574.69 |
| Multiple Sclerosis | 2 | 1 | 5 | $6,725.96 |

## Y. Detail of Profile of Members by Specialty Pharmacy Category

**Pharmacy Coordination Category: Multiple Sclerosis**
**Status: Active**

Sample Drill Through

*This drill down shows RxP Member level information, including Member name, date of birth, provider, specialty category, dominant episode, active dates, closed dates, program participation duration, and PMPM over the trailing 12 months. The RxP program applies only to Members taking specialty drugs. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Specialty Pharmacy Category | Dominant Episode | Active Date | Closed Date | Duration (Days) | PMPM Rx $ | PMPM Total $ |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Paul Purple | 05/22/79 | Sarah Cobalt | Multiple Sclerosis | Multiple Sclerosis | 03/04/15 | | 302 | $7,604.89 | $8,588.83 |
| 2 | Cindy Blue | 06/09/74 | Gary Green | Multiple Sclerosis | Multiple Sclerosis | 01/02/15 | | 363 | $3,922.52 | $4,014.80 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## Z. Profile of Members Using Expert Consult Program (ECP)

*This chart shows ECP Member level information, including Member name, date of birth, provider, Illness Burden Score, dominant episode, referred and report dates, gross debits, and debits PMPM over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | IB Score | Dominant Episode | Referred Date | Summary Delivered Date | Expert Report Date | Total Debit $ | Pre-Active PMPM | Post-Active PMPM |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Thomas Maroon | 5/20/1965 | Bonnie Beige | 4.34 | Lipid Abnormalities | 7/25/15 | 9/12/15 | 9/23/15 | $13,151 | $1,121.31 | $239.10 |
| 2 | Norman Electric | 8/5/1961 | Ray Purple | 8.97 | Glomerulonephritis, Acute | 7/29/15 | 9/19/15 | 9/22/15 | $18,535 | $1,527.26 | $344.43 |
| 3 | Margaret Orange | 6/7/1952 | Fletch Orange | 3.71 | Hernia/Reflux Esophagit | 1/28/15 | | | $12,859 | $0.00 | $0.00 |
| | | | | | | | | | | | |
| 5 | Lillian Canary | 8/29/1965 | Theodore Lavender | 9.78 | Functional Digest Disord, NEC | 7/27/15 | | 9/28/15 | $106,503 | $8,892.27 | $3,998.08 |

## AA. Profile of Members Using Centers of Distinction Program (CDP)

*This chart shows Members receiving treatments covered by the Centers of Distinction Program (CDP). It includes Member name, date of birth, provider, illness burden score, dominant procedural episode, center of distinction name, service date, total gross debits, and debits PMPM over the trailing 12 months. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | IB Score | Dominant Procedural Episode | Center of Distinction | Service Date | Total Debit $ | Debits PMPM |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Paul Purple | 09/09/60 | Samuel Yellow | 23.69 | Infec/Inflam - Skin Tissue | | 5/28/15 | $125,644 | $10,470.40 |
| 2 | Cynthia Mauve | 04/09/49 | Fletch Orange | 10.33 | Cardiac Arrhythmias | | 12/5/15 | $79,360 | $6,613.38 |
| 3 | Mike Orange | 11/05/66 | Irene Indigo | 4.40 | Pnemonia, Bacterial | | 2/28/15 | $65,915 | $5,492.99 |
| 4 | Katie Black | 05/14/56 | Peter Black | 16.87 | Infections - Urinary Tract | | 2/4/15 | $9,721 | $810.11 |

## AB. Profile of Members in Dental Medical Health (DMH)

*This chart shows the total of Panel Members by band, who have been identified for DMH, and the number of months since their last dental visit. The DMH program applies only to Members with dental benefit information.*

Click on any underlined field below to see additional information.

| Illness Band | Total Members | % with Dental Benefit | Last Dental Visit | | | |
|---|---|---|---|---|---|---|
| | | | <= 6 Months | 7 - 12 Months | 13 - 24 Months | 25 + Months |
| Advanced/Critical Illness | 393 | 25.2% | 36 | 15 | 5 | 10 |
| Multiple Chronic Illnesses | 1,178 | 25.4% | 147 | 40 | 29 | 43 |
| At Risk | 1,432 | 28.4% | 89 | 29 | 24 | 40 |
| Stable | 2,348 | 26.7% | 141 | 33 | 24 | 35 |
| Healthy | 1,056 | 26.0% | 231 | 72 | 38 | 76 |
| **Total** | **6,407** | **24.2%** | **644** | **602** | **291** | **53** |

Sample Drill Through

## AB.Detail of Members in Dental Medical Health (DMH)

**Illness Band: Healthy**

**Last Dental Visit: 25+ Months**

*This drill down shows DMH Member level information, including Member name, date of birth, provider, and last dental visit date. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below.*

| # | Member Name | DOB | Provider | Last Dental Visit |
|---|---|---|---|---|
| 1 | John Snow | 08/14/1970 | Bonnie Beige | 04/25/2009 |
| 2 | Peter Beacon | 03/20/1959 | Bob Blue | 05/05/2009 |
| 3 | Lucy Lime | 05/30/1960 | Theodore Lavendar | 01/12/2010 |
| 4 | Carrie Cobalt | 03/14/1965 | Flecher Orange | 04/29/2010 |
| | | | | |
| 76 | Tony Tiger | 02/13/1980 | Irene Indigo | 09/04/2014 |

# VI. Use of TCCI Programs

**PCMH SearchLight Report for Panel ABC**

## AC. Summary of Care Coordination Costs for Members in TCCI Programs

*This chart shows the number of Members engaged in Total Care and Cost Improvement (TCCI) Programs and the associated Care Coordination costs for each of these programs posted as debits to the Patient Care Account of the Panel, along with debits PMPM (up to 12 months) before and after starting each program for the trailing 12 months.*

| TCCI Program | Members | Pre Active Care Costs PMPM | Post Active Care Costs PMPM | Debits for Coordination Services | |
|---|---|---|---|---|---|
| | | | | $ | % of Total Debits |
| Hospital Transition of Care (HTC) | 201 | $11,358.08 | $4,541.72 | $0 | 0.0% |
| Complex Case Management (CCM) | 120 | $11,570.08 | $50,832.25 | $0 | 0.0% |
| Chronic Care Coordination (CCC) | 98 | $6,403.91 | $6,177.48 | $308,280 | 16.4% |
| Behavioral Health and Substance Use Disorder (BSD) | 21 | $6,317.60 | $8,582.63 | $18,100.00 | 1.0% |
| Home Based Services (HBS) | 33 | $18,115.87 | $24,405.73 | $3,627 | 0.2% |
| Enhanced Monitoring Program (EMP) | 17 | $18,946.57 | $13,043.65 | $6,086 | 0.3% |
| Comprehensive Medication Review (CMR) | 7 | $6,527.47 | $16,593.28 | $1,505 | 0.1% |
| Community Based Programs (CBP) | 12 | $39,521.68 | $21,072.82 | $0 | 0.0% |
| Pharmacy Coordination Program (RxP) | 3 | $0.00 | $2,352.09 | $0 | 0.0% |
| Expert Consult Program (ECP) | 4 | $25,868.84 | $16,846.48 | $20,000 | 1.1% |
| **Total** | **516** | | | **$357,598** | **19.0%** |

# VII. Key Referral Patterns

**PCMH SearchLight Report for Panel ABC**

*Primary care services rendered directly by PCPs account for approximately 6 percent of all health care spending for CareFirst Members. The balance results from services and decisions by specialists, hospitals and other ancillary providers. The PCP, however, often starts the process by making a referral to a specialist. The cumulative impact of these "when to refer" and "where to refer" decisions by PCPs greatly influences both cost and quality. Often PCPs lack valuable cost information to make informed decisions when referring to specialty providers.*

*Before the advent of the PCMH Program, PCPs had no economic interest in the downstream cost implications of their referral decisions. In the PCMH Program, they do. Information in this section is intended to help PCPs in making referral choices by providing cost information regarding referrals to specialists. Costs are shown by episode inclusive of the cost of all services encompassed in each episode, not just provider fees.*

*Specialists are reviewed by CareFirst on an episode basis and given an overall cost rating annually in one of four quartiles based on their cost efficiency: Low, Low Mid, High Mid or High. This rating is calculated for procedure based specialties (typically surgeons, orthopedists, neurologists, etc.) using a complex algorithm that calculates the cost of each episode surrounding a particular procedure or cluster of procedures. These are called Procedure Episode Groups (PEGs). They are inclusive of all relevant costs in the episode, not just specialists' fee levels. For medical episodes, a similar process is followed using Medical Episode Groups (MEGs). These two methodologies are explained fully in Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals of the PCMH Program Guidelines. In general:*

- *A "**Low**" rating is given to those specialists whose actual total episode costs are significantly lower than the average costs for the same episodes performed by the same category of specialists in the entire CareFirst Network.*
- *A "**Low Mid**" rating is given to those specialists whose actual total episode costs are slightly better than average costs for the same episodes performed by the same category of specialists in the entire CareFirst Network.*
- *A "**High Mid**" rating is given to those specialists whose actual total episode costs are slightly worse than average costs for the same episodes performed by the same category of specialists in the entire CareFirst Network.*
- *A "**High**" rating is given to those specialists with actual total episode costs significantly higher than the average costs for the same episodes performed by the same category of specialists in the entire CareFirst Network.*

*As noted, all costs are included in determining these rankings. In other words, the costs of the services that make up an episode - the specialist's fees, the hospital's costs where the specialist admits, and all the other components of cost that are integral to an episode are taken into consideration.*

*In addition to the Low/Low Mid/ HighMid/High ratings of specialists, ratings are also available at the episode, specialty provider group, and hospital level.*

*It must be stressed, that the picture that emerges from the data on cost per episode does not reflect on the quality or outcome of services. Indeed, CareFirst and other payers have found that correlations between cost and quality are weak. That is, high cost episodes do not equate to "high quality" and low cost episodes do not equate to "low quality." It is up to the PCP to make judgments about quality. The data in this section is intended only to inform PCPs in the Panel about the cost implications of their referral decisions.*

*Further, it should be noted that the costs in any and all episodes vary greatly across a broad range, with variation within any episode from high to low cost of 100 to 200 percent (and occasionally higher).*

*See Appendix - Method for Calculating High, Medium, and Low Cost Specialists And Hospitals for more information on the methodology supporting these ratings.*

# VII. Key Referral Patterns

**PCMH SearchLight Report for Panel ABC**

## A. Profile of Medical Specialist Referrals

*This chart shows Members with medical episodes involving specialists over the trailing 12 months. Episodes are grouped into 3 types: those with an unplanned admission through the ER; those with one or more admissions not through the ER; and those referrals not resulting in an admission. A Member with different episode types will be included in multiple rows but will only be counted once in the grand total of distinct Members. The count of referrals to specialists (one per episode) is grouped into Low, Low Mid, High Midand High cost categories. Some specialists are not ranked by CareFirst due to insufficient data at the time of ranking, which includes newer providers or providers changing identifiers. See Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals for more on this methodology.*

Filter By: All Providers

| Episode Type | Distinct Members | Episodes | % of Episodes | Gross Debit $ | Debit $ per Episode | Specialist Referrals | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked | % Low | % Low Mid | % High Mid | % High | % Not Ranked | % Cost Efficient |
| With an Unplanned Admission | 139 | 166 | 1.3% | $5,310,148 | $31,989 | 453 | 179 | 180 | 25 | 32 | 37 | 39.5% | 39.7% | 5.5% | 7.1% | 8.2% | 86.3% |
| With a Planned Admission | 195 | 204 | 1.7% | $6,558,103 | $32,148 | 441 | 170 | 175 | 36 | 34 | 26 | 38.5% | 39.7% | 8.2% | 7.7% | 5.9% | 83.1% |
| Without an Admission | 4,014 | 11,933 | 97.0% | $15,141,120 | $1,269 | 11,891 | 3,876 | 5,228 | 1,225 | 642 | 920 | 32.6% | 44.0% | 10.3% | 5.4% | 7.7% | 83.0% |
| **Total** | **4,348** | **12,303** | **100.0%** | **$27,009,371** | **$2,195** | **12,785** | **4,225** | **5,583** | **1,286** | **708** | **983** | **33.0%** | **43.7%** | **10.1%** | **5.5%** | **7.7%** | **83.1%** |
| **% of Total Panel** | **67.9%** | | | **73.8%** | | | | | | | | | | | | | |

## B. Profile of Medical Specialist Referrals by Provider

*This chart shows Members with medical episodes involving specialists by Provider over the trailing 12 months. Episodes are grouped into 3 types: those with an unplanned admission through the ER; those with one or more admissions not through the ER; and those referrals not resulting in an admission. A Member with different episode types will be included in multiple rows but will only be counted once in the grand total of distinct Members. The count of referrals to specialists (one per episode) is grouped into Low, Low Mid, High Mid,and High cost categories. Some specialists are not ranked by CareFirst due to insufficient data at the time of ranking, which includes newer providers or providers changing identifiers. See Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals for more on this methodology.*

| Provider | Distinct Members | Episodes | % of Episodes | Gross Debit $ | Debit $ per Episode | Specialist Referrals | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked | % Low | % Low Mid | % High Mid | % High | % Not Ranked | % Cost Efficient |
| Irene Indigo | 240 | 895 | 7.3% | $1,414,264 | $1,580 | 3,167 | 1,358 | 1,258 | 240 | 263 | 48 | 42.9% | 39.7% | 7.6% | 8.3% | 1.5% | 83.9% |
| Bonnie Beige | 174 | 562 | 4.6% | $725,339 | $1,291 | 3,042 | 1,279 | 1,267 | 230 | 227 | 39 | 42.0% | 41.7% | 7.6% | 7.5% | 1.3% | 84.8% |
| Donald Daisy | 94 | 272 | 2.2% | $501,523 | $1,844 | 3,132 | 1,267 | 1,301 | 301 | 226 | 37 | 40.5% | 41.5% | 9.6% | 7.2% | 1.2% | 83.0% |
| Ace Emerald | 54 | 161 | 1.3% | $585,009 | $3,634 | 3,355 | 1,551 | 1,169 | 311 | 307 | 17 | 46.2% | 34.8% | 9.3% | 9.2% | 0.5% | 81.5% |
| | | | | | | | | | | | | | | | | | |
| Fletch Orange | 31 | 89 | 0.7% | $118,955 | $1,337 | 89 | 25 | 10 | 14 | 19 | 21 | 28.1% | 11.2% | 15.7% | 21.3% | 23.6% | 51.5% |
| **Total** | **4,066** | **12,303** | **100.0%** | **$27,009,371** | **$2,195** | **12,785** | **5,480** | **5,005** | **1,096** | **1,042** | **162** | **42.9%** | **35.0%** | **19.6%** | **8.2%** | **1.3%** | **83.1%** |

## C. Profile of Medical Specialist Referrals by Specialty

*This chart shows Members with medical episodes involving specialists over the trailing 12 months, grouped by provider specialty. A selection box allows the chart to be filtered for 4 episode types: those with an unplanned admission through the ER; those with one or more admissions not through the ER; those without an admission, and all episode types. The count of referrals to specialists (one per episode) is grouped into Low, Low Mid, High Mid,and High cost categories. Expected debit $ per episode is determined by looking at the case-mix of the Panel's episodes in comparison to average costs for like episodes for all CareFirst episodes involving specialists. Some specialists are not ranked by CareFirst due to insufficient data at the time of ranking, which includes newer providers or providers changing identifiers. See Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals for more on this methodology.*

Filter By: All Episode Types (With an Unplanned Admission / With a Planned Admission / Without an Admission) | All Providers

Click on any underlined field below to see additional information.

| Specialty | Members | Episodes | Gross Debit $ | Actual Debit $ per Episode | Expected Debit $ per Episode | Specialists | Solo Specialists | | | | | | Group Specialists | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked |
| Dermatology | 322 | 389 | $205,385 | $132 | $141 | 198 | 57 | 7 | 18 | 22 | 8 | 2 | 130 | 14 | 35 | 35 | 43 | 3 |
| Ob-Gynecology | 400 | 476 | $372,931 | $360 | $389 | 277 | 20 | 7 | 5 | 5 | 2 | 1 | 98 | 26 | 23 | 24 | 21 | 4 |
| Ophthalmology | 389 | 455 | $201,754 | $209 | $226 | 352 | 82 | 9 | 21 | 24 | 19 | 9 | 148 | 43 | 41 | 42 | 14 | 8 |
| Gastroenterology | 300 | 489 | $360,139 | $440 | $466 | 162 | 13 | 7 | 2 | 2 | 2 | 0 | 130 | 41 | 16 | 27 | 36 | 10 |
| Cardiovascular Disease | 344 | 541 | $159,005 | $181 | $193 | 163 | 75 | 20 | 12 | 22 | 18 | 3 | 85 | 12 | 20 | 13 | 25 | 15 |
| Psychiatry | 167 | 205 | $74,254 | $362 | $363 | 94 | 1 | 0 | | 0 | 0 | 1 | 31 | 2 | 2 | 5 | 1 | 21 |
| | | | | | | | | | | | | | | | | | | |
| Other | 96 | 113 | $41,368 | $366 | $378 | 69 | 5 | 0 | 1 | 1 | 0 | 3 | 64 | 4 | 12 | 14 | 9 | 25 |
| **Total** | **2,041** | **2,844** | **$3,437,180** | **$1,209** | **$582** | **1,182** | **191** | **52** | **46** | **40** | **29** | **24** | **1,004** | **202** | **241** | **245** | **172** | **144** |

## C. Detail for Profile of Medical Specialist Referrals by Specialty

**Provider: All Providers**
**Specialty: Dermatology**
**Solo or Group Practice: Group**
**Cost Ranking: High**

*This drill down shows the specialist names, cost ranking, the specialists group, and the number of episodes managed in the trailing 12 months as of November, 2016.*

| # | Specialist | Cost Ranking | Group | # of Episodes |
|---|---|---|---|---|
| 1 | Shastine Aqua | HIGH | Provider Associates | 12 |
| 2 | John Blue | HIGH | Endocrinology Assoc of VA | 11 |
| 3 | James Yellow | HIGH | Provider Associates | 9 |
| 4 | Mohamad Aquamarine | HIGH | NA | 6 |
| | | | | |
| 43 | Pavanjit S Lavender | HIGH | Lavender and White | 5 |

# VII. Key Referral Patterns

**PCMH SearchLight Report for Panel ABC**

## D. Profile of Procedural Specialist Referrals

*This chart shows Members with procedural episodes involving specialists over the trailing 12 months. Episodes are grouped into 3 types: those with an unplanned admission through the ER; those with one or more admissions not through the ER; and those referrals not resulting in an admission. A Member with different episode types will be included in multiple rows but will only be counted once in the grand total of distinct Members. The count of referrals to specialists (one per episode) is grouped into Low, Low Mid, High Mid,and High cost categories. Some specialists are not ranked by CareFirst due to insufficient data at the time of ranking, which includes newer providers or providers changing identifiers. See Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals for more on this methodology.*

Filter By: All Providers

| Episode Type | Distinct Members | Episodes | % of Episodes | Gross Debit $ | Debit $ per Episode | Specialist Referrals | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked | % Low | % Low Mid | % High Mid | % High | % Not Ranked | % Cost Efficient |
| With an Unplanned Admission | 39 | 40 | 3.7% | $1,375,102 | $34,378 | 69 | 25 | 21 | 6 | 8 | 9 | 36.2% | 30.4% | 8.7% | 11.6% | 13.0% | 76.7% |
| With a Planned Admission | 124 | 133 | 12.4% | $3,507,160 | $26,370 | 233 | 133 | 52 | 23 | 16 | 9 | 57.1% | 22.3% | 9.9% | 6.9% | 3.9% | 82.6% |
| Without an Admission | 771 | 897 | 83.8% | $5,036,678 | $5,615 | 768 | 263 | 341 | 64 | 58 | 42 | 34.2% | 44.4% | 8.3% | 7.6% | 5.5% | 83.2% |
| **Total** | **934** | **1,070** | **100.0%** | **$9,918,940** | **$9,270** | **1,070** | **421** | **414** | **93** | **82** | **60** | **39.3%** | **38.7%** | **8.7%** | **7.7%** | **5.6%** | **82.7%** |
| **% of Total Panel** | **14.6%** | | | **97.8%** | | | | | | | | | | | | | |

## E. Profile of Procedural Specialist Referrals by Provider

*This chart shows Members with procedural episodes involving specialists over the trailing 12 months. Episodes are grouped into 3 types: those with an unplanned admission through the ER; those with one or more admissions not through the ER; and those referrals not resulting in an admission. A Member with different episode types will be included in multiple rows but will only be counted once in the grand total of distinct Members. The count of referrals to specialists (one per episode) is grouped into Low, Low Mid, High Mid, and High cost categories. Some specialists are not ranked by CareFirst due to insufficient data at the time of ranking, which includes newer providers or providers changing identifiers. See Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals for more on this methodology.*

| Provider | Distinct Members | Episodes | % of Episodes | Gross Debit $ | Debit $ per Episode | Specialist Referrals | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked | % Low | % Low Mid | % High Mid | % High | % Not Ranked | % Cost Efficient |
| Bob Blue | 26 | 33 | 23.4% | $87,519 | $2,652 | 33 | 4 | 8 | 8 | 9 | 4 | 12.1% | 24.2% | 48.5% | 27.3% | 12.1% | 41.4% |
| Samuel Yellow | 22 | 23 | 16.2% | $104,742 | $4,554 | 23 | 7 | 8 | 3 | 1 | 4 | 30.4% | 34.8% | 13.0% | 4.3% | 17.4% | 78.9% |
| Sarah Cobalt | 12 | 14 | 9.9% | $54,500 | $3,893 | 14 | 1 | 2 | 7 | 2 | 2 | 7.1% | 14.3% | 50.0% | 14.3% | 14.3% | 25.0% |
| | | | | | | | | | | | | | | | | | |
| Theodore Lavendar | 2 | 2 | 1.4% | $9,756 | $4,876 | 2 | 1 | 1 | 1 | 0 | 0 | 50.0% | 50.0% | 50.0% | 0.0% | 0.0% | 66.7% |
| **Total** | **934** | **1,070** | **100.0%** | **$9,918,940** | **$9,270** | **1,070** | **459** | **428** | **77** | **106** | **83** | **42.9%** | **40.0%** | **20.7%** | **18.5%** | **7.8%** | **82.7%** |

## F. Profile of Procedural Specialist Referrals by Specialty

*This chart shows Members with procedural episodes involving specialists over the trailing 12 months, grouped by provider specialty. A selection box allows the chart to be filtered for 4 episode types: those with an unplanned admission through the ER; those with one or more admissions not through the ER; those without an admission, and all episode types. The count of referrals to specialists (one per episode) is grouped into Low, Low Mid, High Mid, and High cost categories. Expected debit $ per episode is determined by looking at the case-mix of the Panel's episodes in comparison to average costs for like episodes for all CareFirst episodes involving specialists. Some specialists are not ranked by CareFirst due to insufficient data at the time of ranking, which includes newer providers or providers changing identifiers. See Appendix - Method for Calculating High, Medium, and Low Cost Specialists and Hospitals for more on this methodology.*

Filter By: All Episode Types (With an Unplanned Admission / With a Planned Admission / Without an Admission) | All Providers

Click on any underlined field below to see additional information.

| Specialty | Members | Episodes | Gross Debit $ | Actual Debit $ per Episode | Expected Debit $ per Episode | Specialists | Solo Specialists | | | | | | Group Specialists | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked | # Total | # Low | # Low Mid | # High Mid | # High | # Not Ranked |
| Cardiovascular Disease | 54 | 63 | $1,418,695 | $22,519 | $21,940 | 46 | 0 | 0 | 0 | 0 | 0 | 0 | 46 | 7 | 12 | 15 | 2 | 10 |
| Colon And Rectal Surgery | 37 | 37 | $177,814 | $4,806 | $4,964 | 9 | 1 | 1 | 0 | 0 | 0 | 0 | 8 | 0 | 2 | 4 | 2 | 0 |
| Gastroenterology | 359 | 361 | $866,633 | $2,401 | $2,269 | 108 | 12 | 7 | 1 | 3 | 0 | 1 | 98 | 23 | 20 | 27 | 18 | 10 |
| Gynecologic Oncology | 5 | 5 | $101,257 | $20,251 | $22,457 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 2 | 0 | 2 |
| Hematology & Oncology | 1 | 1 | $22,712 | $22,712 | $18,711 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Neurosurgery | 23 | 23 | $800,739 | $34,815 | $30,428 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 7 | 2 | 3 | 3 | 2 |
| | | | | | | | | | | | | | | | | | | |
| Urology | 47 | 55 | $441,546 | $8,028 | $8,352 | 30 | 0 | 0 | 0 | 0 | 0 | 0 | 30 | 5 | 9 | 9 | 4 | 3 |
| **Total** | **979** | **1,070** | **9,918,940** | **$9,270** | **$9,442** | **535** | **57** | **19** | **1** | **25** | **8** | **3** | **481** | **88** | **123** | **80** | **99** | **46** |

## F. Detail for Profile of Procedural Specialist Referrals by Specialty

**Provider: All Providers**

**Specialty: Cardiovascular Disease**

**Solo or Group Practice: Group**

**Cost Ranking: High**

*This drill down shows the specialist names, cost ranking, the specialists group, and the number of episodes managed in the trailing 12 months as of November, 2016.*

| # | Specialist | Cost Ranking | Group | # of Episodes |
|---|---|---|---|---|
| 1 | Hatem Agate | HIGH | Provider Associates | 71 |
| 2 | Pavanjit S Lavender | HIGH | Endocrinology Assoc of VA | 28 |

# VII. Key Referral Patterns

**PCMH SearchLight Report for Panel ABC**

## G. Profile of Top Specialists by Specialty

*This chart shows the top 5 specialists within each cost category for medical episodes over the trailing 12 months. It includes Member and episode counts by specialist, along with the percent of total episodes managed by the specialist and the number and percentage of Panel providers referring to the specialist. A selection box allows the chart to be filtered for a specific provider specialty.*

**Specialty:** Dermatology

Click on any underlined field below to see additional information.

| Cost Category | Provider | Members | Episodes | % of Episodes | Panel Providers | % Panel Providers |
|---|---|---|---|---|---|---|
| LOW | Green, Ann | 62 | 104 | 4.0% | 11 | 91.7% |
| LOW | Orange, John | 46 | 76 | 2.9% | 11 | 91.7% |
| LOW | Lime, Joseph | 37 | 62 | 2.4% | 10 | 83.3% |
| LOW | Greenly, Walter | 29 | 61 | 2.3% | 11 | 91.7% |
| LOW | Brown, Jay | 34 | 57 | 2.2% | 11 | 91.7% |
| Total | | 208 | 360 | 13.7% | | |
| LOW MID | Scarlett, Yasmine | 59 | 98 | 3.7% | 11 | 100.0% |
| LOW MID | Keystone, Matthew | 50 | 84 | 3.2% | 11 | 100.0% |
| LOW MID | Navy, Samuel | 46 | 76 | 2.9% | 11 | 100.0% |
| LOW MID | Jeep, Mark | 43 | 71 | 2.7% | 11 | 100.0% |
| LOW MID | Yellow-Green, Thomas | 29 | 49 | 1.9% | 10 | 90.9% |
| Total | | 227 | 378 | 14.4% | | |
| HIGH MID | Golden, Debra | 62 | 76 | 2.9% | 11 | 91.7% |
| HIGH MID | Sandy, Sean | 37 | 61 | 2.3% | 11 | 91.7% |
| HIGH MID | Blue, Jeff | 34 | 98 | 3.7% | 11 | 91.7% |
| HIGH MID | Jerald, Michael | 50 | 76 | 2.9% | 11 | 91.7% |
| HIGH MID | Red, Alvin | 43 | 84 | 3.2% | 10 | 83.3% |
| Total | | 227 | 395 | 15.1% | | |
| HIGH | Blackstone, Sara | 315 | 525 | 20.0% | 11 | 91.7% |
| HIGH | Pumpkin, Roberta L | 10 | 17 | 0.6% | 10 | 83.3% |
| HIGH | Lemon, David | 4 | 7 | 0.3% | 6 | 50.0% |
| HIGH | Henna, Ali | 2 | 5 | 0.2% | 5 | 41.7% |
| HIGH | Maroon, Mary | 4 | 5 | 0.2% | 5 | 41.7% |
| Total | | 335 | 559 | 21.3% | | |
| All Providers | | 1,571 | 2,619 | 100.0% | 12 | |

## G. Detail for Profile of Top Specialists by Specialty

**Specialty: Dermatology**

**Specialist: Henna, Ali**

**Cost Ranking: High**

*This drill down shows the specific Panel providers who have attributed members receiving services from the selected specialist. Information includes the Panel provider name, the count of unique attributed Members who have seen the specialist, and the number of associated episodes.*

| # | PCP Name | Members | Episodes |
|---|---|---|---|
| 1 | Donald Daisy | 1 | 3 |
| 2 | Irene Indigo | 1 | 2 |
| **Total** | | 2 | 5 |

# VII. Key Referral Patterns

**PCMH SearchLight Report for Panel ABC**

## H. Medical Specialist Referrals - Savings Impact of Shifting Referral Patterns

*The chart below illustrates the potential debit savings if episodes were shifted from High to Mid or Low cost tier providers. The top section shows actual panel experience over the trailing 12 months, comparing episode counts and actual and expected debits for High vs. Mid/Low specialist episodes. Expected debits are determined based on the average Peer Group costs for the Panel's specific mix of episodes in each cost tier. The bottom section shows the potential impact of shifting 1% of all High tier episodes to Mid/Low tier specialists. The savings calculation assumes that 1% of the High tier actual debits are replaced with 1% of the expected debits for the same episodes, adjusted by the ratio of actual to expected for Mid/Low tier episodes.*

| Current Metrics by High vs. Mid/Low Cost Tier | High | Mid/Low |
|---|---|---|
| Total Episodes | 288,909 | 1,492,342 |
| Total Episode Debits | $542,650,089 | $1,632,303,153 |
| Total Expected Debits | $397,738,232 | $1,777,896,442 |
| % Actual vs. Expected | 136.4% | 91.8% |
| Actual Debits per Episode | $1,878 | $1,094 |
| Expected Debits per Episode | $1,377 | $1,191 |

| If 1% of episodes shifted from High to Mid/Low | |
|---|---|
| High cost reduction (1% of actual) | $5,426,501 |
| Expected costs (1% of expected) | $3,977,382 |
| % of Expected for Mid/Low | 91.8% |
| New Mid/Low Cost (91.8% of expected) | $3,651,671 |
| Potential cost savings for every 1% shift | $1,774,829 |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

*The PCMH Program takes the point of view that high quality and cost effective results go hand in hand and are not at odds with one another. Indeed, one cannot achieve moderation in health care cost growth without improving quality.*

*While quality is hard to define and measure, there is growing consensus among health professionals, consumers, employers, health plans, and a number of third party entities around a core set of quality measures. These encompass both process and outcome metrics.*

*The multi-stakeholder independent organization, National Quality Forum (NQF), has been the gold standard for evaluation and endorsement of these measures. In recent years, the NQF has expanded its measures to include additional quality measures that encompass the entire continuum of care across all settings.*

*The National Committee for Quality Assurance (NCQA) has continued to refine the HEDIS (Healthcare Effectiveness Data and Information Set) measurement system, which has been widely applied to health plans for the past 20 years, and is seen as a highly credible set of measures throughout the medical profession. HEDIS measures are updated annually to reflect best medical practice consistent with scientific advancement. The technical specifications are transparent, and can be applied not only to a health plan, but to a practice participating in such a Program as the CareFirst PCMH Program. NCQA has also developed an objective process for certifying physician practices as Patient-Centered Medical Homes.*

*In addition, the American Medical Association (AMA) convened the Physician Consortium for Performance Improvement (PCPI) to lead efforts in developing, testing and implementing evidence-based performance measures that reflect the best practices of medicine. The PCPI is a national, physician-led initiative dedicated to improving Member health and safety.*

*To supplement the data on clinical quality measures, the PCMH Program undertakes continuous surveys to measure Member satisfaction (once per calendar quarter) for Members in Care Plans. A high level of Member participation in these surveys is achieved (over 80 percent, typically) to assure an accurate and complete view of the Member experience.*

*Taken as a whole, the measures used have provided a basis during the 2011-2015 period (Performance Years #1-5) to ascertain the relative quality of care being provided to Members in each Panel by comparing quality performance across Panels in a standard way. Considerable variation, indeed, has existed across Panels and Panel types. But, overall scores have slowly risen and PCPs seem to increasingly focus on Quality Scorecard improvement.*

*In **2016, (Performance Year #6),** the PCMH Program began to use the core clinical quality measures developed by CMS. This is in the belief that the consistency of these measures will result in greater behavior change, understanding and compliance among medical panels.*

*In addition to measures of clinical quality, the PCMH Program has, from the start, placed a substantial (and increasing) emphasis on the degree of PCP/NP Engagement with the Program, especially with the Care Plan process and the use of supporting Programs available through TCCI. While Measures of Engagement carried a 35 percent weight in 2015, this increased to a 50 percent weight in 2016 with far greater emphasis on referral management and measures of practice transformation.*

*Thus, beginning in **Performance Year #6 (2016),** the Quality Score for each Panel consists of two equally weighted parts: A Clinical Score and an Engagement Score. Each is worth 50 points. The Clinical Score uses the CMS core clinical measures while the Engagement Score uses a set of measures in 3 categories, each of which carries a relative weight as shown below:*

| ***Engagement Score Category*** | ***Possible Points*** |
|---|---|
| • *Engagement and Knowledge of PCMH* | *12.5* |
| • *PCP Engagement with Care Plans* | *15.0* |
| • *Practice Transformation* | *22.5* |

*Panels must score at least 35 out of 50 Engagement points and attain an average of five Care Plans per PCP/NP with at least 90 percent of all PCPs and NPs in the Panel contributing to this average. Both Chronic Care Coordination and Behavioral Health Care Plans will count towards the minimum. Failure to meet these minimums disqualifies a Panel from receiving an OIA in 2016, even when cost savings are achieved.*

*The Clinical Score is divided into an Adult and Pediatric measure set and weighting. Separate Clinical Scores allow for measures and weighting that better highlight the quality measures for these populations. The Clinical Score uses 4 categories, each of which carries a relative weight as shown below:*

.

| ***Clincial Score Category*** | ***Adult & Mixed Possible Points*** | ***Pediatric Possible Points*** |
|---|---|---|
| • *Member Safety/Care Coordination* | 12.5 | 40.0 |
| • *At Risk Population* | 12.5 | *(first 3 categories* |
| • *Preventive Care* | 12.5 | *are combined)* |
| • *Member/Caregiver Expererience* | 12.5 | 10.0 |

# VIII. Overall Quality Score (Cont.)

**PCMH SearchLight Report for Panel ABC**

*In order to have been eligible for an OIA for **Performance Year #5 (2015),** Panels must have scored score at least 22 Engagement points on the Quality Score Card and attained an average of three Care Plans per PCP/NP with at least 80 percent of all PCPs and NPs in the Panel contributing to this average. Failure to meet these minimums disqualified a Panel from receiving an OIA in 2015, even when cost savings are achieved.*

*In order to have been eligible for an OIA in **Performance Year #4 (2014),** Panels must have had a score of at least 20 out of the 35 possible engagement points on the Quality Score Card and at a minimum, have an average of two Care Plans per PCP/NP with at least 60 percent of all PCPs and NPs in the Panel contributing to this average. For Panels that scored at least 18 out of the 20 possible points, a waiver of the 20 point maximum was considered in certain circumstances when strong progress had been shown by a Panel.*

*Starting with **Performance Year #3 (2013)** all Panels are rated on a 100 point scale.*

*For **Performance Year #2 (2012),** Panels with an average of more than one chronic care plan activated per PCP in the Panel during the Performance Year received an Engagement Score on a 100 point scale, while those with less than this number of care plans were rated using the same approach as in 2011.*

*For **Performance Year #1 (2011),** the Degree of Engagement was not counted since the Program was just getting underway and the volume of care plans undertaken was too small to determine a reliable score for this category. So, the quality score earned by a Panel was based on points attained in all other categories and the calculation was based on 70 possible points.*

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## H. Overall Panel Composite Quality Score

*The chart below shows the Panel's Composite Quality Score for Performance Year #6 together with comparisons relative to Provider Type Peers and All of PCMH. The Overall Quality Score is the sum of the Panel's points from two components: Engagement ScoreCard and Clinical ScoreCard, each worth up to 50 Possible Points. More detailed versions of the ScoreCards can be viewed in Overall Engagement ScoreCard (Section VIII. I.) or the Overall Clinical ScoreCard (Section VIII. J.) reports.*

| Overall Quality Score | Possible Points | Panel Points | Provider Type Peers Average Points | Best in Peer Group Points | PCMH All Average Points |
|---|---|---|---|---|---|
| Engagement ScoreCard Total | 50.00 | 34.82 | 30.04 | 48.24 | 29.22 |
| Clinical ScoreCard Total | 50.00 | 32.60 | 30.97 | 38.87 | 30.76 |
| **Overall Quality Score** | **100.00** | **67.42** | **61.02** | **83.36** | **59.73** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## I. Engagement Quality Score

### Overall Panel Engagement Quality Score vs. Provider Peers

*The chart below shows the Panel's Engagement ScoreCard during Performance Year #6 together with comparisons relative to Provider Type Peers and All of PCMH. For each measure, the Panel Rate shows the percentage of goal achievement met by dividing the Panel Points by the Possible Points.*

| Engagement Score Measure Components | Possible Points | Panel Points | Panel Rate | Provider Type Peers Average Rate | Best in Peer Group Rate | PCMH All Average Rate |
|---|---|---|---|---|---|---|
| Engagement with and Knowledge of PCMH Program | 12.5 | 10.14 | 81.0% | 65.1% | 99.2% | 66.1% |
| PCP Engagement with Care Plans | 15.0 | 12.69 | 84.4% | 47.8% | 97.2% | 39.5% |
| Practice Transformation | 22.5 | 18.27 | 81.1% | 65.4% | 96.8% | 66.7% |
| **Overall Engagement Score Rating** | **50.0** | **41.10** | **82.1%** | **60.0%** | **96.4%** | **58.4%** |

# VIII. Overall Quality Score

PCMH SearchLight Report for Panel ABC

## I. Engagement Quality Score

### Panel Engagement Scores

*The chart below shows the Panel's cumulative Engagement ScoreCard points during Performance Year #6 together with the average Points for Provider Type Peers. Points are assigned for each question by averaging the scores for each PCP in the Panel.*

| | Engagement Measure | Possible Points | Panel Points | Provider Peer Type Average Points |
|---|---|---|---|---|
| **Engagement with and Knowledge of PCMH Program** | | **12.50** | **10.14** | **8.15** |
| 1. | Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end. | 2.50 | 2.29 | 1.91 |
| 2. | PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. | 2.50 | 1.99 | 1.61 |
| 3. | PCP attends and actively/constructively participates in PCMH Panel meetings. | 2.50 | 2.03 | 1.59 |
| 4. | PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel. | 2.50 | 1.97 | 1.55 |
| 5. | PCP uses the categories in HealthCheck to take action that leads to better cost and quality outcomes. | 2.50 | 1.87 | 1.50 |
| **PCP Engagement with Care Plans** | | **15.00** | **12.69** | **7.20** |
| 1. | PCP actively and constructively reviews top 50 and other target lists on a timely basis to identify appropriate Care Plan eligible Members. | 2.50 | 2.17 | 1.21 |
| 2. | PCP actively seeks to work with the LCC to schedule patients appropriate for Care Plans. | 2.50 | 2.13 | 1.18 |
| 3. | PCP clearly and effectively explains to Care Plan eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and targeted "State of Being" for Care Plan Members. | 2.50 | 2.08 | 1.17 |
| 4. | PCP is responsive to requests of LCC when consultation about a patient is needed and works actively on Care Plan compliance with Members. | 2.50 | 2.16 | 1.23 |
| 5. | PCP takes due care to review a patient's medication list and cooperates with the LCC and pharmacist as part of CMRs. | 2.50 | 1.97 | 1.17 |
| 6. | PCP ensures LCC has access to needed clinical information to identify that a Member is appropriate for a Care Plan and collaborates with the LCC to complete the Care Plan on a timely basis. | 2.50 | 2.19 | 1.24 |
| **Practice Transformation** | | **22.50** | **18.27** | **14.74** |
| 1. | PCP identifies and refers to cost-efficient specialists in the top 10 specialty categories. | 10.00 | 7.71 | 6.16 |
| 2. | PCP has an effective plan for after-hours care, including active use of telemedicine and nurse hotline capabilities to enhance Member access and avoid unnecessary emergency room visits or breakdowns. | 5.00 | 4.02 | 3.22 |
| 3. | PCP actively refers Members to TCCI Program elements through LCCs assigned to Panel. | 5.00 | 4.35 | 3.53 |
| 4. | PCP actively collaborates with hospitalists on patients prior to and after admission. | 2.50 | 2.19 | 1.83 |
| **Overall Engagement Score Rating** | | **50.00** | **41.10** | **30.09** |

## VIII. Overall Quality Score

PCMH SearchLight Report for Panel ABC

### I. Engagement Quality Score

### Panel Engagement Rates

*The chart below shows the Engagement Quality ScoreCard performance rates during Performance Year #6 on a quarterly basis. The average Rate for Provider Type Peers are shown for comparison. The Performance Rate is the percentage actual achievement divided by the maximum possible Score. For each quarter, the Rate is specific to that quarter. The Cumulative Year Panel Rate includes all Year to Date Scores.*
*'NA' indicates that the data is Not Available, because quarterly measures aren't available until the end of the quarter.*
*'Not Scored' indicates that Panel did not receive any Scores for the individual measure during the measurement period.*

| | Engagement Measure | Q1 Rate | Q2 Rate | Q3 Rate | Q4 Rate | Cumulative Year Panel Rate | Provider Peer Type Average Rate |
|---|---|---|---|---|---|---|---|
| **Engagement with and Knowledge of PCMH Program** | | | | | | **81.0%** | **65.1%** |
| 1. | Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end. | 91.5% | 89.3% | 93.3% | 93.0% | 91.7% | 76.2% |
| 2. | PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. | 92.0% | 73.3% | 63.3% | 94.2% | 79.4% | 64.3% |
| 3. | PCP attends and actively/constructively participates in PCMH Panel meetings. | 98.0% | 73.3% | 63.3% | 91.1% | 81.0% | 63.5% |
| 4. | PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel. | 96.0% | 70.0% | 63.3% | 95.5% | 78.6% | 62.1% |
| 5. | PCP uses the categories in HealthCheck to take action that leads to better cost and quality outcomes. | 84.0% | 70.0% | 62.0% | 90.9% | 74.8% | 60.0% |
| **PCP Engagement with Care Plans** | | | | | | **84.4%** | **47.8%** |
| 1. | PCP actively and constructively reviews top 50 and other target lists on a timely basis to identify appropriate Care Plan eligible Members. | 88.2% | 86.3% | 89.1% | 82.2% | 86.8% | 48.4% |
| 2. | PCP actively seeks to work with the LCC to schedule patients appropriate for Care Plans. | 87.4% | 84.0% | 87.3% | 79.4% | 85.0% | 47.3% |
| 3. | PCP clearly and effectively explains to Care Plan eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and targeted "State of Being" for Care Plan Members. | 85.0% | 83.1% | 84.6% | 77.9% | 83.1% | 46.7% |
| 4. | PCP is responsive to requests of LCC when consultation about a patient is needed and works actively on Care Plan compliance with Members. | 89.0% | 85.8% | 87.9% | 81.7% | 86.5% | 49.0% |
| 5. | PCP takes due care to review a patient's medication list and cooperates with the LCC and pharmacist as part of CMRs. | 80.5% | 77.3% | 81.4% | 74.1% | 78.7% | 46.8% |
| 6. | PCP ensures LCC has access to needed clinical information to identify that a Member is appropriate for a Care Plan and collaborates with the LCC to complete the Care Plan on a timely basis. | 89.8% | 86.1% | 89.6% | 83.5% | 87.6% | 49.6% |
| **Practice Transformation** | | | | | | **81.1%** | **65.4%** |
| 1. | PCP identifies and refers to cost-efficient specialists in the top 10 specialty categories. | 90.0% | 70.0% | 63.3% | 87.1% | 77.1% | 61.6% |
| 2. | PCP has an effective plan for after-hours care, including active use of telemedicine and nurse hotline capabilities to enhance Member access and avoid unnecessary emergency room visits or breakdowns. | 88.8% | 80.0% | 58.8% | 84.8% | 80.3% | 64.4% |
| 3. | PCP actively refers Members to TCCI Program elements through LCCs assigned to Panel. | 83.9% | 87.6% | 89.1% | 87.8% | 87.0% | 70.6% |
| 4. | PCP actively collaborates with hospitalists on patients prior to and after admission. | 84.4% | 86.4% | 88.9% | 92.5% | 87.6% | 73.1% |
| **Overall Engagement Score Rating** | | | | | | **82.1%** | **60.0%** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## I. Engagement Quality Score

### Engagement Category Ratings and Care Plan Participation by PCP

*In order to be eligible to receive an Outcome Incentive Award (OIA), a panel is required to meet certain engagement goals as specified in the PCMH Program Description and Guidelines. As part of the engagement goal, each PCP is scored on a series of Engagement Measures across three Engagement Categories. The scores for each Engagement Measure and Category are shown at the panel-level in the Panel Engagement Rates report found in this section (VIII. I Engagement Quality Score). The chart below shows the individual PCP performance rates for these same Engagement Categories. Panel Rate and Panel Points are also displayed for comparison as found in the panel-level reports in this section.*

*The rates displayed in the PCP Results table below represent each PCP's average YTD performance rate out of 100 on individual Engagement Measures. PCPs are sorted in descending order on Overall Engagement Score Rating. The column '# of Care Plans' displays the total number of Care Plans for each PCP that were active at any time within the Performance Year. The column 'Month Joined PCMH' is the month the PCP joined the PCMH program. The TOP 25% performers are highlighted in green, the MIDDLE 50% in yellow and the BOTTOM 25% in red.*

| # | PCP / NP Name | Engagement with and Knowledge of PCMH Program | PCP Engagement with Care Plans | Practice Transformation | Overall Engagement Score Rating | # of Care Plans | Month Joined PCMH |
|---|---|---|---|---|---|---|---|
| 1 | FLETCH ORANGE | 83.7% | 94.2% | 85.7% | 87.7% | 14 | Jan 2011 |
| 2 | PETER BLACK | 83.1% | 91.9% | 84.1% | 86.2% | 9 | Feb 2011 |
| 3 | MICHAEL MAUVE | 84.0% | 87.8% | 84.3% | 85.3% | 10 | Dec 2011 |
| 4 | RONALD BROWN | 83.5% | 81.3% | 81.7% | 82.0% | 14 | Mar 2011 |
| | | | | | | | |
| 10 | BONNIE BEIGE | 82.0% | 60.0% | 80.7% | 74.8% | 4 | Mar 2014 |
| **Panel Rates** | | 81.0% | 84.4% | 81.1% | 82.1% | | |
| **Panel Points** | | 10.14 | 12.69 | 18.27 | 41.10 | | |

*The chart below demonstrates the Panel's Overall Performance towards fulfilling the Care Plan Engagement goal. When calculating the Panel Results towards the Care Plan Engagement goal, engagement for a new PCP or NP is not measured for the first 3 months of enrollment in PCMH to allow time for the PCP or NP to become established and to meet Members of the Care Coordination Team as well as to schedule Care Plan appointments. If a PCP is within the first 3 months of enrollment at the end of the year, the PCP will not be included when calculating the Panel's Care Plan Engagement Results. If the PCP joins PCMH on or after July 1st, but prior to the last 3 months of the year, the PCP's Care Plan Engagement goal will be prorated at 50% of the Care Plan goal for the performance year.*

| | Goal Average # of Care Plans per PCP | Panel Results Average # of Care Plans per PCP | Goal % of PCPs with Care Plans | Panel Results % of PCPs with Care Plans |
|---|---|---|---|---|
| **Care Plan Engagement** | **5.00** | **12.20** | **100.0%** | **100.0%** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Overall Panel Clinical Score vs. Provider Peers

*The chart below shows the Panel's Clinical ScoreCard for Performance Year #6 together with comparisons relative to Provider Type Peers and All of PCMH. For each measure, the Panel Rate shows the percentage of goal achievement met by dividing the Panel Points by the Possible Points.*

| Clinical Score Measures | Possible Points | Panel Points | Panel Rate | Provider Type Peers Average | Best in Peer Group |
|---|---|---|---|---|---|
| Care Coordination/Patient Safety | 12.50 | 8.02 | 64.1% | 79.4% | 100.0% |
| At-Risk Population | 12.50 | 8.23 | 65.8% | 60.8% | 78.4% |
| Preventive Health | 12.50 | 8.71 | 69.6% | 64.9% | 79.9% |
| Patient and Caregiver Experience of Care | 12.50 | 7.46 | 59.7% | 53.0% | 73.7% |
| **Overall Clinical Score Rating** | **50.00** | **32.42** | **64.8%** | **64.5%** | **77.0%** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Panel Clinical Scores

*The chart below shows the Panel's Clinical performance on all Clinical Measures during Performance Year #6 together with the average Points for Provider Type Peers. Actual Points achieved by the Panel within each category are shown against the Possible Points in each Category.*
*The greyed out measures will not be included in the scores for this performance year but will be in subsequent years.*

| | | Clinical Measure | Possible Points | Cumulative Year Panel Points | Provider Peer Type Average Points |
|---|---|---|---|---|---|
| **Care Coordination/Patient Safety** | | | **12.50** | **8.02** | **9.76** |
| Appropriate Use of Services | 1. | All-Cause Readmissions | | | |
| | 2. | Use of Imaging Studies for Low Back Pain | | | |
| | 3. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | | | |
| | | Medication Reconciliation Post-Discharge | | | |
| **At-Risk Population** | | | **12.50** | **8.23** | **6.95** |
| Chronic Care | 1. | Persistent Beta Blocker Treatment After a Heart Attack | | | |
| | 2. | Medication Management for People with Asthma | | | |
| | 3. | Diabetes Composite | | | |
| | | Controlling High Blood Pressure | | | |
| | | Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic | | | |
| | | Depression Composite | | | |
| **Preventive Health** | | | **12.50** | **8.71** | **7.83** |
| Population Health | 1. | Breast Cancer Screening | | | |
| | 2. | Colorectal Cancer Screening | | | |
| | 3. | Cervical Cancer Screening | | | |
| | | Body Mass Index Screening | | | |
| | | Tobacco Use: Screening and Cessation Intervention | | | |
| **Patient and Caregiver Experience of Care** | | | **12.50** | **7.46** | **8.33** |
| Member Survey | 1. | Quarter 1 Panel Points | 2.50 | 1.77 | 1.47 |
| | 2. | Quarter 2 Panel Points | 2.50 | 0.72 | 1.49 |
| | 3. | Quarter 3 Panel Points | 2.50 | 1.57 | 1.56 |
| | 4. | Quarter 4 Panel Points | 2.50 | 1.53 | 1.87 |
| CAHPS Clinical Group Survey: Region Level | 1. | Getting Timely Care, Appointments, and Information | 2.50 | 1.94 | 1.94 |
| | 2. | How Well Your Providers Communicate | | | |
| | 3. | Patients' Rating of Provider | | | |
| | 4. | Access to Specialists | | | |
| | 5. | Health Promotion and Education | | | |
| | 6. | Shared Decision Making | | | |
| | 7. | Health Status/Functional Status | | | |
| | 8. | Stewardship of Patient Resources | | | |
| **Overall Clinical Score Rating** | | | **50.00** | **32.42** | **32.87** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Panel Clinical Rates

*The chart below shows the Panel's Clinical ScoreCard Performance Rates on all Clinical Measures during Performance Year #6 together with the average Performance Rate for Provider Type Peers. The Performance Rate is the percentage of members who met the goal for each measure. Sub-measure Rates used to determine Composite Rates are indented and shown here.*
*Claims-based rates for Care Coordination/Patient Safety, At-Risk Population and Preventive Health components reflect the cumulative rate up to and including that quarter. The Cumulative Year Rate for these categories will always match the rate as of the current quarter through December of the Performance Year.*
*Survey-based rates for Patient and Caregiver Experience of Care are only available at the end of each measurement period. Member Survey reflect end of quarter results while CAHPS is measured annually.*
*The greyed out measures will not be included in the scores for this performance year but will be in subsequent years.*
*'NA' indicates that the data is Not Available because the measure is only available at the end of the measurement period.*
*'NR' indicates the measure was Not Rated because the Panel did not meet the minimum threshold for the measure.*

| | | Clinical Measure | Performance Rates | | | | Cumulative Year Panel Rate | Provider Peer Type Average Rate |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| **Care Coordination / Patient Safety** | | | | | | | **64.1%** | **78.1%** |
| Appropriate Use of Services | 1. | All-Cause Readmissions | 91.6% | 89.9% | 90.2% | 88.8% | 89.1% | 92.2% |
| | 2. | Use of Imaging Studies for Low Back Pain | NR | NR | 60.1% | 70.5% | 71.1% | 76.4% |
| | 3. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | NR | NR | NR | 24.4% | 24.5% | 24.9% |
| | | Medication Reconciliation Post-Discharge | NR | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| **At-Risk Population** | | | | | | | **65.8%** | **55.6%** |
| Chronic Care | 1. | Persistent Beta Blocker Treatment After a Heart Attack | NR | NR | NR | NR | NR | NR |
| | 2. | Medication Management for People with Asthma | NR | NR | NR | NR | NR | 56.1% |
| | 3. | Diabetes Composite | 28.2% | 49.5% | 59.1% | 63.8% | 63.8% | 63.4% |
| | | Diabetes: Eye Exam | 11.9% | 22.8% | 30.1% | 33.4% | 33.7% | 36.3% |
| | | Diabetes: Hemoglobin A1c Testing | 34.4% | 63.8% | 74.5% | 79.5% | 79.6% | 80.0% |
| | | Diabetes: Medical Attention for Nephropathy | 38.3% | 61.8% | 72.8% | 78.4% | 78.0% | 74.0% |
| | | Diabetes: Foot Exam | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% |
| | | Diabetes: Hemoglobin A1c Poor Control (>9) | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% |
| | | Controlling High Blood Pressure | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| | | Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic | 0.0% | 0.3% | 0.5% | 0.4% | 0.4% | 0.1% |
| | | Depression Composite | NA | NA | NA | NA | NA | NA |
| | | Depression Remission | NA | NA | NA | NA | NA | NA |
| | | Depression Response | NA | NA | NA | NA | NA | NA |
| **Preventive Health** | | | | | | | **69.6%** | **62.6%** |
| Population Health | 1. | Breast Cancer Screening | 70.0% | 71.3% | 75.3% | 78.6% | 78.2% | 74.9% |
| | 2. | Colorectal Cancer Screening | 37.0% | 37.0% | 61.1% | 63.4% | 63.1% | 60.4% |
| | 3. | Cervical Cancer Screening | 63.5% | 64.0% | 66.8% | 67.7% | 67.4% | 65.0% |
| | | Body Mass Index Screening | 5.6% | 6.5% | 7.5% | 9.0% | 9.1% | 9.8% |
| | | Tobacco Use: Screening and Cessation Intervention | 0.5% | 0.5% | 0.7% | 0.7% | 0.7% | 1.1% |
| **Patient and Caregiver Experience of Care** | | | | | | | **59.7%** | **50.6%** |
| Member Survey | | Quarterly Panel Rate | 70.6% | 71.8% | 62.8% | 61.1% | 59.9% | 49.4% |
| CAHPS Clinical Group Survey: Region Level | 1. | Getting Timely Care, Appointments, and Information | 59.4% | | | | 59.0% | 55.6% |
| | 2. | How Well Your Providers Communicate | | | | | | |
| | 3. | Patients' Rating of Provider | | | | | | |
| | 4. | Access to Specialists | | | | | | |
| | 5. | Health Promotion and Education | | | | | | |
| | 6. | Shared Decision Making | | | | | | |
| | 7. | Health Status/Functional Status | | | | | | |
| | 8. | Stewardship of Patient Resources | | | | | | |
| **Overall Clinical Score Rating** | | | | | | | **64.8%** | **61.9%** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Clinical Category Rating by PCP

*The chart below shows all Category Scores by PCP for Performance Year #6 together with the relative Performance within the Panel and the Overall Panel results. Points at the PCP level are averaged to create the points for the Panel. The rates displayed represent each PCP's average YTD performance rate out of 100 on individual Care Coordination/Patient Safety measures. PCPs are sorted in descending order based on Overall Clinical Score Rating.*
*The TOP 25% performers are highlighted in green, the MIDDLE 50% in yellow and the BOTTOM 25% in red.*

| # | PCP / NP Name | Care Coordination/Patient Safey | At-Risk Population | Preventive Health | Patient and Caregiver Experience of Care | Overall Clinical Score Rating |
|---|---|---|---|---|---|---|
| 1 | FLETCH ORANGE | 80.0% | 82.0% | 70.6% | 39.1% | 78.0% |
| 2 | RAY PURPLE | 74.4% | 58.3% | 68.1% | 56.0% | 64.2% |
| 3 | PETER BLACK | 64.2% | 72.0% | 72.4% | 33.6% | 60.5% |
| 4 | GARY GREEN | 83.5% | 75.0% | 86.2% | 26.3% | 73.0% |
| | | | | | | |
| 10 | ROBIN RED | 75.0% | 57.6% | 74.2% | 0.0% | 49.8% |
| **Panel Rates *** | | 64.1% | 65.8% | 69.6% | 59.7% | 64.8% |
| **Panel Points** | | 8.02 | 8.23 | 8.71 | 7.46 | 32.42 |

* Panel Rates may not be directly calculated from PCP rates as Panel Rates exclude those measures that did not meet the minimum threshold; whereas, PCP rates are averaged across all measures irrespective of any thresholds

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Detail for the Appropriate Use of Services Measures

*The chart below details the success rate by measure for the Panel for Appropriate Use of Services Measures. A drill-through report is available by clicking on the hyperlinked number of Did Not Meet Goal which will reveal a corresponding member detail table. This report is filterable by Panel PCP with default selection to all Providers.*
*The greyed out measures are not scored for the Performance Year.*

**Filter By:** All Providers

| # | Measure | Eligible Encounters | Met Goal | Did Not Meet Goal | Success Rate |
|---|---|---|---|---|---|
| 1 | All-Cause Readmissions | 90 | 80 | 10 | 88.9% |
| 2 | Use of Imaging Studies for Low Back Pain | 25 | 18 | 7 | 70.6% |
| 3 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | 29 | 8 | 21 | 27.6% |
| | Medication Reconciliation Post-Discharge | 104 | 0 | 104 | 0.0% |

### Detail for the Appropriate Use of Services Measures

Sample Drill Through

**PCP: All Providers** **Year: 2016**

**Measure: Use of Imaging Studies for Low Back Pain**

**Did Not Meet Goal**

*The chart below shows the PCP's Member List and details for the measure listed above at the time of the qualifying event. The Member Health Record (MHR) for each member can be accessed by clicking on the Member's name below. If a measure is attestable, then PCPs may choose to attest to a Member's measure result by clicking the 'Attest' hyperlink which will bring the user to the Attestation report.*

| # | Member Name | DOB | IB Score | Provider | Qualifying Event Date | Service Date | Servicing Provider | Attestation Status |
|---|---|---|---|---|---|---|---|---|
| 1 | Silver, Mark | 09/01/1944 | 8.47 | Melvin Ruby | 12/8/2015 | 1/13/2016 | Holy Cross Hospital | Attest |
| 2 | Fuchsia, Gary | 08/16/1952 | 1.12 | Cora White | 1/22/2016 | 2/17/2016 | Johns Hopkins Hospital | Attest |
| | | | | | | | | |
| 7 | Green, Roberta | 12/08/1979 | 0.52 | Chester Black | 1/30/2016 | 2/29/2016 | Johns Hopkins Hospital | Attest |

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# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Detail for the Chronic Care Measures

*The chart below details the success rate by measure for the Panel for Chronic Care Measures. A drill-through report is available by clicking on the hyperlinked number of Did Not Meet Goal which will reveal a corresponding member detail table. This report is filterable by Panel PCP with default selection to all Providers.*
*The greyed out measures are not scored for the Performance Year.*

**Filter By:** All Providers

| # | Measure | Eligible Encounters | Met Goal | Did Not Meet Goal | Success Rate |
|---|---|---|---|---|---|
| 1 | Persistent Beta Blocker Treatment After a Heart Attack | 1 | 1 | 0 | 100.0% |
| 2 | Medication Management for People with Asthma | 5 | 2 | 3 | 33.2% |
| 3 | Diabetes Composite | | | | |
| | Diabetes: Eye Exam | 253 | 87 | 166 | 34.4% |
| | Diabetes: Hemoglobin A1c Testing | 253 | 188 | 65 | 74.3% |
| | Diabetes: Medical Attention for Nephropathy | 253 | 195 | 58 | 77.2% |
| | Diabetes: Foot Exam | 253 | 0 | 253 | 0.0% |
| | Diabetes: Hemoglobin A1c Poor Control (>9) | 253 | 0 | 253 | 0.0% |
| | Controlling High Blood Pressure | 547 | 0 | 547 | 0.0% |
| | Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic | 132 | 1 | 131 | 0.5% |
| | Depression Composite | | | | |
| | Depression Remission at 12 Months | 0 | 0 | 0 | 0.0% |
| | Depression Response at 12 Months | 0 | 0 | 0 | 0.0% |

### Detail for the Chronic Care Measures

Sample Drill Through

**PCP: All Providers** **Year: 2016**

**Measure: Diabetes: Eye Exam**

**Did Not Meet Goal**

*The chart below shows the PCP's Member List and details for the measure listed above at the time of the qualifying event. The Member Health Record (MHR) for each member can be accessed by clicking on the Member's name below. If a measure is attestable, then PCPs may choose to attest to a Member's measure result by clicking the 'Attest' hyperlink which will bring the user to the Attestation report.*

| # | Member Name | DOB | IB Score | Provider | Qualifying Event Date | Attestation Status |
|---|---|---|---|---|---|---|
| 1 | Fuchsia, Mike | 06/15/1984 | 1.77 | Bonnie Beige | | Attest |
| 2 | Orange, William | 02/02/1978 | 2.40 | Michael Mauve | | Attest |
| | | | | | | |
| 50 | Canary, Charles | 05/09/1962 | 13.47 | Fletch Orange | | Attest |

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# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Detail for the Population Health Measures

*The chart below details the success rate by measure for the Panel for Population Health Measures. A drill-through report is available by clicking on the hyperlinked number of Did Not Meet Goal which will reveal a corresponding member detail table. This report is filterable by Panel PCP with default selection to all Providers.*
*The greyed out measures are not scored for the Performance Year.*

**Filter By:** All Providers

| # | Measure | Eligible Encounters | Met Goal | Did Not Meet Goal | Success Rate |
|---|---|---|---|---|---|
| 1 | Breast Cancer Screening | 367 | 289 | 78 | 78.7% |
| 2 | Colorectal Cancer Screening | 798 | 502 | 296 | 62.9% |
| 3 | Cervical Cancer Screening | 514 | 348 | 166 | 67.7% |
| | Body Mass Index Screening | 1,492 | 136 | 1,356 | 9.1% |
| | Tobacco Use: Screening and Cessation Intervention | 1,815 | 14 | 1,801 | 0.8% |

### Detail for the Population Health Measures

Sample Drill Through

**PCP: All Providers** **Year: 2016**

**Measure: Body Mass Index Screening**

**Did Not Meet Goal**

*The chart below shows the PCP's Member List and details for the measure listed above. The Member Health Record (MHR) for each member can be accessed by clicking on the Member's name below. If a measure is attestable, then PCPs may choose to attest to a Member's measure result by clicking the 'Attest' hyperlink which will bring the user to the Attestation report.*

| # | Member Name | DOB | IB Score | Provider | Attestation Status |
|---|---|---|---|---|---|
| 1 | Electric, Marjorie | 02/21/1994 | 0.21 | Fletch Orange | N/A |
| 2 | Eggplant, Deb | 04/18/1980 | 0.36 | Fletch Orange | N/A |
| | | | | | |
| 50 | Orange, Rita | 11/05/1959 | 4.74 | Violet Smith | N/A |

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# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## J. Clinical Quality Score

### Detail for the Member Survey

*The Question Detail chart below shows the quarterly Member Satisfaction Scores for each Member Survey Question. Member Satisfaction Scores are based on a five-point Likert scale and reflect the member's perception of the value of their Care Plan. The Respondent's Average Score is the average across all Member Survey Question scores for that quarter where each question carries equal weight. Only members with an active Care Plan who respond to the survey are included when calculating the Respondent's Average Score. This reflects the opinion of those Members who responded to the Survey.*
*Members with an active Care Plan who did not respond to the survey (Non-Responders) are scored as a zero and included in determining the Panel Score. The Overall Panel Score in the Results chart below is an average of the Member Survey Question scores including a zero score for each Non-Responder. The Overall Panel Rate is the Panel's degree of achievement against the 5 maximum score available. as reflected in the Overall Panel Score. Quarterly Panel Points are determined by multiplying the Overall Panel Rate by the 2.5 Possible Points for the quarter. The Total Possible Points for the year is 10 which is the sum of the possible Points for each quarter.*

| | Member Satisfaction Scores - Question Detail | | | |
|---|---|---|---|---|
| **Member Survey Questions** | **Quarter 1** | **Quarter 2** | **Quarter 3** | **Quarter 4** |
| 1. You understand the Care Coordination Plan, including the actions you are supposed to take. | 4.42 | 4.37 | 4.62 | 4.48 |
| 2. Your Care Coordination nurse and Care Coordination team are helpful in coordinating your care. | 4.52 | 4.60 | 4.55 | 4.73 |
| 3. Your doctor or nurse practitioner spends enough time with you. | 4.60 | 4.64 | 4.66 | 4.52 |
| 4. After starting your Care Coordination Plan, you have had access to information that you need to understand and manage your health better. | 4.47 | 4.47 | 4.61 | 4.44 |
| 5. Finally, overall, health is more stable and better managed as a result of the Care Coordination Plan. | 4.23 | 4.32 | 4.43 | 4.56 |
| **Respondent's Average Score** | 4.44 | 4.48 | 4.58 | 4.54 |

| | Member Satisfaction Score - Results | | | |
|---|---|---|---|---|
| **Total # of Possible Surveys** | **31** | **23** | **26** | **22** |
| **# Non-Responders** | **5** | **5** | **5** | **1** |
| **Member Survey Response Rate** | **87.1%** | **78.3%** | **83.3%** | **94.8%** |
| **Respondent's Average Score** | **4.44** | **4.48** | **4.58** | **4.54** |
| **Overall Panel Score** | **3.87** | **3.50** | **3.81** | **4.31** |
| **Overall Panel Rate** | **77.4%** | **69.9%** | **76.1%** | **86.1%** |
| **Possible Points** | **2.50** | **2.50** | **2.50** | **2.50** |
| **Quarterly Panel Points** | **1.93** | **1.75** | **1.90** | **2.15** |

# VIII. Overall Quality Score

**PCMH SearchLight Report for Panel ABC**

## K. Members Qualifying for Clinical Component Measures

*The chart below displays all Members for whom at least one measure is applicable within the three Clinical Quality ScoreCard components: Appropriate Use of Services, Chronic Care, and Population Health. Applicable Clinical Measures is the count of all measures for which a member qualifies. Total Gaps in Care is the count of all measures for which a member failed to meet the goal. Gaps in Care measure counts are also broken out into each component.*
*The chart is sorted to show Members with the most Total Gaps in Care at the top. The Member Name is used to sort Members with the same number of gaps.*
*This chart can be filtered by PCP and Measure. When selecting by Measure, a list of Members who qualify for that measure will be shown in the chart. The Member Health Record (MHR) for each Member can be accessed by clicking on the Member's name below. Specific measure information for each member is available by clicking on any of the underlined numbers within the report.*

**Filter by:** All Providers | All Measures

| # | Member Name | DOB | Provider | Applicable Clinical Measures | Total Gaps in Care | Gaps in Appropriate Use | Gaps in Chronic Care | Gaps in Population Health |
|---|---|---|---|---|---|---|---|---|
| 1 | Fuchsia, Gary | 08/16/1952 | Cora White | 12 | 9 | 4 | 3 | 1 |
| 2 | Canary, Charles | 05/09/1962 | Fletch Orange | 14 | 8 | 1 | 3 | 2 |
| 3 | Silver, Mark | 09/01/1944 | Melvin Ruby | 8 | 6 | 3 | 1 | 2 |
| | | | | | | | | |
| 50 | Orange, Rita | 11/05/1959 | Violet Smith | 7 | 5 | 2 | 0 | 3 |

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Sample Drill Through

### Member Summary

**Member Name: Mark Silver** **DOB: 09/01/1944** **Age: 72** **Gender: M**
**Total Gaps in Care**

*The Quality ScoreCard Gap Measures are a set of HEDIS-like measures that detect compliance with clinical guidelines. If the patient is in compliance then the measure status shows Met Goal. If the patient was not in compliance then the measure status shows Did Not Meet Goal.*

| # | Measure | Measure Compliance |
|---|---|---|
| 1 | All-Cause Readmissions | Did Not Meet Goal |
| 2 | Use of Imaging Studies for Low Back Pain | Did Not Meet Goal |
| 3 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | Did Not Meet Goal |
| 4 | Medication Management for People with Asthma | Did Not Meet Goal |
| 5 | Controlling High Blood Pressure | Met Goal |
| 6 | Colorectal Cancer Screening | Did Not Meet Goal |
| 7 | Body Mass Index Screening | Met Goal |
| 8 | Tobacco Use: Screening and Cessation Intervention | Did Not Meet Goal |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

*This section of the SearchLight Report shows the status of the Patient Care Account (PCA) for the Panel that is the subject of this report. This section presents views of 2011, 2012, 2013, 2014, and 2015 results (Performance Years #1 - #5). It also shows monthly updates of the PCA reflecting Panel performance in Performance Year #6 (2016).*

*The Patient-Centered Medical Home Program Guidelines describe how a PCA is established for each Medical Care Panel in the Program (see Part III Program Element #4: Establishing Global Expected Care Costs For Each Panel).*

*A box score is presented showing the Outcome Incentive Award (if any) that the Panel was entitled to for Performance Years #1 - #5. Accompanying the box score is the step by step methodology used to calculate the award in accordance with the PCMH Program Guidelines. It should be noted that each lettered step in the methodology that is underscored has additional drill down data views showing the underlying calculations used.*

*Also of note, the quality score for the Panel is calculated reflecting the various measures of quality as outlined in the Program Guidelines (see Part III Program Element #8: Measuring Quality of Care – The Single Most Essential Ingredient). Because 2011 was the first performance year of the Program, one category of performance measurement – the degree of engagement – was not calculated because of the lack of sufficient data for many Panels. All other measures were included. The remaining 70 possible points were reset to a 100 point scale in determining degree of quality achievement for this first Performance Year (2011).*

*In Performance Year #2 and #3, the Engagement category was counted for Panels that have an average of at least one Chronic Care Coordination (CCC) plan for each PCP in the Panel.*

*In Performance Year #4 (2014), Panels had to achieve at least 20 out of 35 possible points in the Engagement Category and have at least two or more Care Plans activated per PCP, on average, within the Panel with at least 60 percent of the PCPs in the Panel contributing to this average.*

*In 2015, (Performance Year #5), Panels must score at least 22 points in the Engagement Cateogry of the Quality Score Card and attain an average of three Care Plans per PCP with at least 80 percent of all PCPs in the Panel contributing to these areas.*

*In 2016 (Performance Year #6), Panels must score 35 out of 50 Engagement points and attain an average of five Care Plans per PCP with at least 90 percent of all PCPs in the Panel contributing to this average. This standard is subject to the number of CPE Members that are in the Panel's population of attributed Members and assumes a 90% Member consent rate is acheived. For Panels that do not have sufficient number of CPE Members to complete this requirement, there is a pediatric and adult alternative described in Part III, Design Element #8 - Measuring Quality of Care - The Single Most Essential Ingredient.*

*The explanation for how the annual settlement and calculation of the OIA is made is provided under Part IIII Program Element #9: Reward for Strong Performance - Calculating Outcome Incentive Awards (OIA) in the Program Guidelines.*

*The results of each current performance year are updated monthly. Credits appear monthly as each month's enrollment is updated. However, debits do not appear for any month until there has been three months of claims run out. This protects against the display of incomplete information that could lead to erroneous judgments and results. Quality of care data is shown monthly as it occurs. Hence, the PCA is meant to be viewed as a running scorecard of Panel performance. Note that all figures for the current performance year are subject to change and are not final until the settlement of the Patient Care Account is completed by June 1 after the end of the Performance Year.*

*The HealthCheck Summary at the front of this SearchLight Report is meant to give insight into emerging results in the current Performance Year and show where actionable steps could be taken to improve results during the course of each Performance Year in order to maximize the potential OIA of the Panel.*

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

## A. Outcome Incentive Award Performance Year #6 (2016)

*This chart summarizes the key elements of the Panel's Outcome Incentive Award (OIA) during the Performance Year #6 (2016). This Outcome Incentive Award is calculated in accordance with the PCMH Program Guidelines. Outcome Incentive Awards are subject to a maximum yearly award of 100%. Any Outcome Incentive Award that is in excess of 100% is limited to 100% and any award below 100% is fully recognized. This is meant to deal with data anomalies or volatility in a Panel's population that always contains some degree of randomness and volatility. If a Panel "wins" two or more years consecutively, the application of a persistency award as called for in the Guidelines is applied either to the actual award or to the 100% maximum.*

** Includes an additional Outcome Incentive Award for having 2 or 3 years of persistent wins.*

**Report Period: 2016**

| Outcome Incentive Award Metric | Result |
|---|---|
| Viable Panel | Yes |
| 2016 Total Credit $ | $12,654,571 |
| 2016 Net Debit $ | $11,274,857 |
| Savings Percentage | 11.4% |
| Overall Quality Score | 77.00 |
| Engagement Score (35 out of 60 needed) | 44.60 |
| Incidence of Care Plans (5 / PCP, 90% PCPs contributing) | 12.5 /100% |
| Portion of Performance Year | 100% |
| Panel Size (Members) Category | >= 3,000 |
| OIA Percentage Point Award | 57 |
| Consecutive "Win" Years | 3 |
| Final OIA Percentage Point Award* | 69 |

*This chart summarizes the key elements of the Panel's Outcome Incentive Award (OIA) during the Performance Year #5 (2015). This Outcome Incentive Award is calculated in accordance with the PCMH Program Guidelines. Outcome Incentive Awards are subject to a maximum yearly award of 100%. Any Outcome Incentive Award that is in excess of 100% is limited to 100% and any award below 100% is fully recognized. This is meant to deal with data anomalies or volatility in a Panel's population that always contains some degree of randomness and volatility. If a Panel "wins" two or more years consecutively, the application of a persistency award as called for in the Guidelines is applied either to the actual award or to the 100% maximum.*

** Includes an additional Outcome Incentive Award for having 2 or 3 years of persistent wins.*

**Report Period: 2015**

| Outcome Incentive Award Metric | Result |
|---|---|
| Viable Panel | Yes |
| 2015 Total Credit $ | $15,688,798 |
| 2015 Net Debit $ | $14,302,769 |
| Savings Percentage | 8.7% |
| Overall Quality Score | 67.26 |
| Engagement Score (22 out of 35 needed) | 25.63 |
| Incidence of Care Plans (2 / PCP, 60% PCPs contributing) | 10.3 / 95% |
| Portion of Performance Year | 100% |
| Panel Size (Members) Category | >= 3,000 |
| OIA Percentage Point Award | 44 |
| Consecutive "Win" Years | 2 |
| Final OIA Percentage Point Award* | 53 |

**Report Period: 2014**

| Outcome Incentive Award Metric | Result |
|---|---|
| 2014 Total Credit $ | $15,689,133 |
| 2014 Net Debit $ | $15,326,311 |
| Savings Percentage | 11.5% |
| Overall Quality Score | 73.40 |
| Engagement Score (20 out of 35 needed) | 17.00 |
| Incidence of Care Plans (2 / PCP, 60% PCPs contributing) | 3.1 / 75% |
| Portion of Performance Year | 100% |
| Panel Size (Members) Category | >= 3,000 |
| OIA Percentage Point Award | 66 |
| Consecutive "Win" Years | 3 |
| Final OIA Percentage Point Award* | 89 |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

## A. Outcome Incentive Award Performance Year

*This chart summarizes the key elements of the Panel's Outcome Incentive Award (OIA) for Performance Year #3 (2013).*

**Report Period: 2013**

| Outcome Incentive Award Metric | Result |
|---|---|
| Savings Percentage | 5.3% |
| Quality Score | 65.7 |
| Portion of Performance Year | 100% |
| Panel Size (Members) Category | >= 3,000 |
| OIA Percentage Point Award | 77 |
| Maximum Award | 100 |
| Consecutive "Win" Years | 3 |
| Qualifying Persistency | Yes |
| OIA Adjustment from Prior Years | 2 |
| **Final OIA Percentage Point Fee Increase** | **90** |

*This chart summarizes the key elements of the Panel's Outcome Incentive Award (OIA) during the Performance Year #2 (2012).*

**Report Period: 2012**

| Outcome Incentive Award Metric | Result |
|---|---|
| Savings Percentage | 3.9% |
| Quality Score | 68.6 |
| Portion of Performance Year | 100% |
| Panel Size (Members) Category | > 3,000 |
| OIA Percentage Point Award | 22 |
| Maximum Award | 100 |
| Consecutive "Win" Years | 2 |
| Qualifying Persistency | Yes |
| Final OIA Percentage Point Fee Increase | 25 |
| Overall Quartile Performance Ranking (3 yrs) | NA |

## A. Outcome Incentive Award Performance Year #1 (2011)

*This chart summarizes the key elements of the Panel's Outcome Incentive Award (OIA) for performance year #1 (2011).*

**Report Period: 2011**

| Outcome Incentive Award Metric | Result |
|---|---|
| Savings Percentage | 4.2% |
| Quality Score | 30.5 |
| Portion of Performance Year | 100% |
| Panel Size (Members) Category | >3,000 |
| OIA Percentage Point Award | 17 |
| Overall Quartile Performance Ranking (3 yrs) | NA |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

## B. Summary of Performance Year #6 (2016)

*This section shows the steps used in calculating each Panel's Outcome Incentive Award (OIA) including net debits, Member months, and all other data essential to the calculation. Pharmacy costs are listed separately since the number of Members with pharmacy benefits can vary from year to year. The step by step process presented below follows the requirements of the PCMH Program Guidelines. Underlined section headers show where further detail is available via a drill down report.*

| Calculation of Performance Year #5 Credits (2016) | | Medical | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|---|
| a. | Base Net Debit $ | $11,862,555 | $1,772,415 | | **$13,634,970** | **(a)** |
| b. | Base Member Months | 32,669 | 15,177 | | | |
| c. | Base Net PMPM Debit $ (a ÷ b) | $363.11 | $116.78 | | | |
| d. | Base to Current Overall Medical Trend (OMT) | 30.8% | 44.4% | | | |
| e. | 2016 PMPM Credit $ (c + (c x d)) | $477.98 | $166.28 | | | |
| f. | Base Average Illness Burden Score | 1.68 | 1.50 | | | |
| g. | 2016 Average Illness Burden Score | 1.67 | 1.37 | | | |
| h. | 2016 Average Illness Burden Adjustment (g ÷ f) | 99.7% | 91.7% | | | |
| i. | 2016 Illness Burden Adjusted PMPM Credit $ (e x h) | $476.64 | $152.42 | $514.37 | | |
| j. | 2016 Member Months | 29,621 | 14,014 | | | |
| k. | 2016 Total Credit $ (i x j) | $14,529,291 | $2,303,191 | | **$16,832,482** | **(k)** |

| Performance Year #5 Debits (2016) | | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|
| l. | 2016 Gross Debit $ | $16,364,016 | | | |
| m. | 2016 Individual Stop Loss $ Reduction | $1,167,793 | | | |
| n. | 2016 Net Debit $ (l - m) | $15,196,224 | | **$15,196,224** | **(n)** |
| o. | 2016 Member Months | 29,621 | | | |
| p. | 201 Net PMPM Debit $ (n ÷ o) | $514.37 | $514.37 | | |

| Performance Year #5 Financial Results (2016) | | | |
|---|---|---|---|
| q. | $ Difference (k - n) | **$1,636,258** | **(q)** |
| r. | % Difference (q ÷ k) | **9.7%** | **(r)** |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

## B. Summary of Performance Year #5 (2015)

*This section shows the steps used in calculating each Panel's Outcome Incentive Award (OIA) including net debits, Member months, and all other data essential to the calculation. Pharmacy costs are listed separately since the number of Members with pharmacy benefits can vary from year to year. The step by step process presented below follows the requirements of the PCMH Program Guidelines. Underlined section headers show where further detail is available via a drill down report.*

| Calculation of Performance Year #5 Credits (2015) | | Medical | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|---|
| a. | Base Net Debit $ | $37,543,344 | $5,560,721 | | **$43,104,065** | **(a)** |
| b. | Base Member Months | 128,570 | 60,938 | | | |
| c. | Base Net PMPM Debit $ (a ÷ b) | $292.01 | $91.25 | | | |
| d. | Base to Current Overall Medical Trend (OMT) | 20.8% | 20.8% | | | |
| e. | 2015 PMPM Credit $ (c + (c x d)) | $352.74 | $110.23 | | | |
| f. | Base Average Illness Burden Score | 1.57 | 1.31 | | | |
| g. | 2015 Average Illness Burden Score | 1.81 | 1.41 | | | |
| h. | 2015 Average Illness Burden Adjustment (g ÷ f) | 115.3% | 107.1% | | | |
| i. | 2015 Illness Burden Adjusted PMPM Credit $ (e x h) | $406.67 | $118.07 | $350.92 | | |
| j. | 2015 Member Months | 72,400 | 48,259 | | | |
| k. | 2015 Total Credit $ (i x j) | $29,442,707 | $5,697,763 | | **$35,140,470** | **(k)** |

| Performance Year #5 Debits (2015) | | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|
| l. | 2015 Gross Debit $ | $34,069,344 | | | |
| m. | 2015 Individual Stop Loss $ Reduction | $806,726 | | | |
| n. | 2015 Net Debit $ (l - m) | $33,262,618 | | **$1,877,852** | **(n)** |
| o. | 2015 Member Months | 72,400 | | | |
| p. | 2015 Net PMPM Debit $ (n ÷ o) | $459.43 | $459.43 | | |

| Performance Year #5 Financial Results (2015) | | | |
|---|---|---|---|
| q. | $ Difference (k - n) | **$1,877,852** | **(q)** |
| r. | % Difference (q ÷ k) | **5.3%** | **(r)** |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

## B. Outcome Incentive Awards - Summary of Performance Year #4 (2014)

*This section shows the steps used in calculating each Panel's Outcome Incentive Award (OIA) including net debits, Member months, and all other data essential to the calculation. Pharmacy costs are listed separately since the number of Members with pharmacy benefits can vary from year to year. The step by step process presented below follows the requirements of the PCMH Program Guidelines. Underlined section headers show where further detail is available via a drill down report.*

| Calculation of Performance Year #4 Credits (2014) | | Medical | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|---|
| a. | Base Net Debit $ | $37,543,344 | $5,560,721 | | **$43,104,065** | **(a)** |
| b. | Base Member Months | 128,570 | 60,938 | | | |
| c. | Base Net PMPM Debit $ (a ÷ b) | $292.01 | $91.25 | | | |
| d. | Base to Current Overall Medical Trend (OMT) | 20.8% | 20.8% | | | |
| e. | 2014 PMPM Credit $ (c + (c x d)) | $352.74 | $110.23 | | | |
| f. | Base Average Illness Burden Score | 1.57 | 1.31 | | | |
| g. | 2014 Average Illness Burden Score | 1.81 | 1.41 | | | |
| h. | 2014 Average Illness Burden Adjustment (g ÷ f) | 115.3% | 107.1% | | | |
| i. | 2014 Illness Burden Adjusted PMPM Credit $ (e x h) | $406.67 | $118.07 | $350.92 | | |
| j. | 2014 Member Months | 72,400 | 48,259 | | | |
| k. | 2014 Total Credit $ (i x j) | $29,442,707 | $5,697,763 | | **$35,140,470** | **(k)** |

| Performance Year #4 Debits (2014) | | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|
| l. | 2014 Gross Debit $ | $34,069,344 | | | |
| m. | 2014 Individual Stop Loss $ Reduction | $806,726 | | | |
| n. | 2014 Net Debit $ (l - m) | $33,262,618 | | **$1,877,852** | **(n)** |
| o. | 2014 Member Months | 72,400 | | | |
| p. | 2014 Net PMPM Debit $ (n ÷ o) | $459.43 | $459.43 | | |

| Performance Year #4 Financial Results (2014) | | | |
|---|---|---|---|
| q. | $ Difference (k - n) | **$1,877,852** | **(q)** |
| r. | % Difference (q ÷ k) | **5.3%** | **(r)** |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

## B. Outcome Incentive Awards - Summary of Performance Year #3 (2013)

*This section shows the steps used in calculating each Panel's Outcome Incentive Award (OIA) including net debits, Member months, and all other data essential to the calculation. Pharmacy costs are listed separately since the number of Members with pharmacy benefits can vary from year to year. The step by step process presented below follows the requirements of the PCMH Program Guidelines. Underlined section headers show where further detail is available via a drill down report.*

| Calculation of Performance Year #3 Credits (2013) | | Medical | Pharmacy | PMPM | $ Total | |
|---|---|---|---|---|---|---|
| a. | Base Net Debit $ | $37,543,344 | $5,560,721 | | **$43,104,065** | **(a)** |
| b. | Base Member Months | 128,570 | 60,938 | | | |
| c. | Base Net PMPM Debit $ (a ÷ b) | $292.01 | $91.25 | | | |
| d. | Base to Current Overall Medical Trend (OMT) | 20.8% | 20.8% | | | |
| e. | 2013 PMPM Credit $ (c + (c x d)) | $352.74 | $110.23 | | | |
| f. | Base Average Illness Burden Score | 1.57 | 1.31 | | | |
| g. | 2013 Average Illness Burden Score | 1.81 | 1.41 | | | |
| h. | 2013 Average Illness Burden Adjustment (g ÷ f) | 115.3% | 107.1% | | | |
| i. | 2013 Illness Burden Adjusted PMPM Credit $ (e x h) | $406.67 | $118.07 | $350.92 | | |
| j. | 2013 Member Months | 72,400 | 48,259 | | | |
| k. | 2013 Total Credit $ (i x j) | $29,442,707 | $5,697,763 | | **$35,140,470** | **(k)** |

| Performance Year #3 Debits (2013) | | | PMPM | $ Total | |
|---|---|---|---|---|---|
| l. | 2013 Gross Debit $ | $34,069,344 | | | |
| m. | 2013 Individual Stop Loss $ Reduction | $806,726 | | | |
| n. | 2013 Net Debit $ (l - m) | $33,262,618 | | **$1,877,852** | **(n)** |
| o. | 2013 Member Months | 72,400 | | | |
| p. | 2013 Net PMPM Debit $ (n ÷ o) | $459.43 | $459.43 | | |

| Performance Year #3 Financial Results (2013) | | | |
|---|---|---|---|
| q. | $ Difference (k - n) | **$1,877,852** | **(q)** |
| r. | % Difference (q ÷ k) | **5.3%** | **(r)** |

*This chart summarizes the key elements of the Panel's Outcome Incentive Award (OIA) for Performance Year #3 (2013). This Outcome Incentive Award is calculated in accordance with the PCMH Program Guidelines. Outcome Incentive Awards are subject to a maximum yearly award of 100%. Any Outcome Incentive Award that is in excess of 100% is limited to 100% and any award below 100% is fully recognized. This is meant to deal with data anomalies or volatility in a Panel's population that always contains some degree of randomness and volatility. If a Panel "wins" two or more years consecutively, the application of a persistency award as called for in the Guidelines is applied either to the actual award or to the 100% maximum.*

| Performance Year #3 Outcome Incentive Award (2013) | | |
|---|---|---|
| s. | Savings Percentage (from r) | 5.3% |
| t. | Quality Score | 65.7 |
| u. | Portion of Performance Year | 100% |
| v. | Panel Size (Members) Category | >= 3,000 |
| w. | OIA Percentage Point Award | 77 |
| x. | Maximum Award | 100 |
| y. | Consecutive "Win" Years | 3 |
| z. | OIA Percentage Point Fee Increase | 11 |
| aa. | OIA Adjustment from Prior Years | 2 |
| ab. | Final OIA Percentage Point Fee Increase | **90** |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

These sections Drill Through from Section B

## C. Detail of Performance Year #6 (2016) - YTD Metrics

*This chart shows selected 2014 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $992,042 | $1,041,402 | $949,213 | $994,067 | $963,873 | $1,044,886 |
| ISL $ | $95,266 | $51,956 | $58,847 | $53,486 | $62,152 | $81,204 |
| Net Debit $ | $773,365 | $854,761 | $768,832 | $812,434 | $778,565 | $831,653 |
| Total Credit $ | $1,612,231 | $1,609,625 | $1,607,381 | $1,608,440 | $1,598,262 | $1,635,668 |
| Member Months | 2,478 | 2,478 | 2,476 | 2,478 | 2,465 | 2,523 |
| Net PMPM Debit $ | $481.96 | $527.93 | $478.67 | $505.75 | $478.68 | $507.76 |
| Average Illness Burden Score | 1.70 | 1.71 | 1.70 | 1.70 | 1.70 | 1.68 |

| Metric | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | 2016 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $977,695 | $976,433 | $1,120,423 | $939,303 | $1,058,039 | $1,054,916 | $12,112,291 |
| ISL $ | $83,204 | $87,569 | $94,969 | $67,422 | $54,256 | $47,101 | $837,434 |
| Net Debit $ | $771,723 | $766,732 | $884,723 | $752,597 | $867,103 | $870,792 | $9,733,281 |
| Total Credit $ | $1,625,388 | $1,587,424 | $1,589,587 | $1,586,699 | $1,590,410 | $1,551,913 | $12,654,571 |
| Member Months | $2,509 | $2,453 | $2,456 | $2,453 | $2,457 | $2,395 | 29,621 |
| Net PMPM Debit $ | $465.56 | $476.79 | $566.49 | $475.53 | $551.18 | $554.44 | $505.89 |
| Average Illness Burden Score | 1.67 | 1.66 | 1.65 | 1.65 | 1.63 | 1.61 | 1.67 |

## C. Detail of Performance Year #5 (2015)

*This chart shows selected 2015 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-15 | Feb-15 | Mar-15 | Apr-15 | May-15 | Jun-15 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $723,215 | $805,221 | $903,461 | $637,856 | $757,494 | $634,855 |
| ISL $ | $36,113 | $143,472 | $97,447 | $44,992 | $44,400 | $7,319 |
| Net Debit $ | $687,103 | $661,748 | $806,015 | $592,864 | $713,094 | $627,537 |
| Total Credit $ | $664,258 | $660,533 | $673,167 | $656,969 | $670,575 | $676,568 |
| Member Months | 2,675 | 2,654 | 2,692 | 2,611 | 2,654 | 2,671 |
| Net PMPM Debit $ | $256.86 | $249.34 | $299.41 | $227.06 | $268.69 | $234.94 |
| Average Illness Burden Score | 0.85 | 0.87 | 0.89 | 0.84 | 0.83 | 0.83 |

| Metric | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | 2015 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $584,742 | $651,946 | $694,232 | $661,365 | $763,983 | $692,851 | $8,511,221 |
| ISL $ | $20,175 | $11,290 | $13,824 | $28,925 | $41,085 | $34,436 | $523,478 |
| Net Debit $ | $564,567 | $640,657 | $680,408 | $632,440 | $722,898 | $658,412 | $7,987,743 |
| Total Credit $ | $680,456 | $681,590 | $682,561 | $684,019 | $685,963 | $685,316 | $8,101,975 |
| Member Months | 2,679 | 2,685 | 2,686 | 2,689 | 2,698 | 2,700 | 32,094 |
| Net PMPM Debit $ | $210.74 | $238.61 | $253.32 | $235.20 | $267.94 | $243.86 | $248.89 |
| Average Illness Burden Score | 0.84 | 0.82 | 0.81 | 0.80 | 0.80 | 0.82 | 0.83 |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

These sections Drill Through from Section B

## C. Outcome Incentive Awards - Detail of Performance Year #4 (2014)

*This chart shows selected 2014 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $723,215 | $805,221 | $903,461 | $637,856 | $757,494 | $634,855 |
| ISL $ | $36,113 | $143,472 | $97,447 | $44,992 | $44,400 | $7,319 |
| Net Debit $ | $687,103 | $661,748 | $806,015 | $592,864 | $713,094 | $627,537 |
| Total Credit $ | $664,258 | $660,533 | $673,167 | $656,969 | $670,575 | $676,568 |
| Member Months | 2,675 | 2,654 | 2,692 | 2,611 | 2,654 | 2,671 |
| Net PMPM Debit $ | $256.86 | $249.34 | $299.41 | $227.06 | $268.69 | $234.94 |
| Average Illness Burden Score | 0.85 | 0.87 | 0.89 | 0.84 | 0.83 | 0.83 |

| Metric | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | 2014 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $584,742 | $651,946 | $694,232 | $661,365 | $763,983 | $692,851 | $8,511,221 |
| ISL $ | $20,175 | $11,290 | $13,824 | $28,925 | $41,085 | $34,436 | $523,478 |
| Net Debit $ | $564,567 | $640,657 | $680,408 | $632,440 | $722,898 | $658,412 | $7,987,743 |
| Total Credit $ | $680,456 | $681,590 | $682,561 | $684,019 | $685,963 | $685,316 | $8,101,975 |
| Member Months | 2,679 | 2,685 | 2,686 | 2,689 | 2,698 | 2,700 | 32,094 |
| Net PMPM Debit $ | $210.74 | $238.61 | $253.32 | $235.20 | $267.94 | $243.86 | $248.89 |
| Average Illness Burden Score | 0.84 | 0.82 | 0.81 | 0.80 | 0.80 | 0.82 | 0.83 |

## C. Outcome Incentive Awards - Detail of Performance Year #3 (2013) Metrics

*This chart shows selected 2013 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $3,109,159 | $2,803,184 | $2,624,685 | $2,826,061 | $2,933,221 | $2,681,279 |
| ISL $ | $92,074 | $109,534 | $31,228 | $69,185 | $41,617 | $6,667 |
| Net Debit $ | $3,017,085 | $2,693,650 | $2,593,457 | $2,756,876 | $2,891,604 | $2,674,612 |
| Total Credit $ | $2,995,913 | $2,985,674 | $2,941,922 | $2,886,891 | $2,872,887 | $2,896,495 |
| Member Months | 6,167 | 6,134 | 6,023 | 5,875 | 5,819 | 5,864 |
| Net PMPM Debit $ | $489.27 | $439.14 | $430.61 | $469.27 | $496.93 | $456.14 |
| Average Illness Burden Score | 1.86 | 1.86 | 1.85 | 1.85 | 1.84 | 1.82 |

| Metric | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | 2013 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $2,714,156 | $2,827,679 | $2,769,726 | $3,041,836 | $2,917,319 | $2,821,039 | $35,205,058 |
| ISL $ | $95,382 | $67,867 | $138,948 | $61,436 | $48,865 | $43,922 | $2,829,000 |
| Net Debit $ | $2,618,774 | $2,759,812 | $2,630,778 | $2,980,400 | $2,868,454 | $2,777,117 | $33,262,618 |
| Total Credit $ | $2,900,683 | $2,889,103 | $2,870,757 | $3,038,103 | $3,016,443 | $2,845,601 | $35,140,470 |
| Member Months | 5,875 | 5,859 | 5,824 | 6,380 | 6,337 | 6,245 | 72,400 |
| Net PMPM Debit $ | $445.76 | $471.07 | $451.72 | $467.13 | $452.64 | $444.69 | $459.43 |
| Average Illness Burden Score | 1.85 | 1.85 | 1.83 | 1.81 | 1.82 | 1.81 | 1.81 |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

These sections Drill Through from Section B

## C. Outcome Incentive Awards - Detail of Performance Year #2 (2012) Metrics

*This chart shows selected 2012 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $4,715,408 | $4,657,181 | $4,331,171 | $4,295,442 | $4,035,203 | $4,656,340 |
| ISL $ | $431,936 | $579,135 | $337,860 | $513,320 | $382,776 | $730,922 |
| Net Debit $ | $4,283,472 | $4,078,046 | $3,993,311 | $3,782,122 | $3,652,428 | $3,925,418 |
| Total Credit $ | $4,069,157 | $4,112,346 | $4,112,815 | $4,103,426 | $4,099,201 | $3,751,811 |
| Member Months | 8,668 | 8,760 | 8,761 | 8,741 | 8,732 | 7,992 |
| Net PMPM Debit $ | $494.17 | $465.53 | $455.81 | $432.69 | $418.28 | $491.17 |
| Average Illness Burden Score | 1.85 | 1.84 | 1.84 | 1.83 | 1.81 | 1.78 |

| Metric | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | 2012 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $3,748,184 | $4,272,864 | $3,767,307 | $4,240,182 | $4,002,141 | $3,139,402 | $49,860,825 |
| ISL $ | $313,026 | $445,888 | $315,488 | $385,015 | $220,412 | $155,673 | $4,811,450 |
| Net Debit $ | $3,435,158 | $3,826,976 | $3,451,820 | $3,855,167 | $3,781,729 | $2,983,729 | $45,049,376 |
| Total Credit $ | $3,756,975 | $3,794,531 | $3,747,117 | $3,764,486 | $3,779,978 | $3,792,653 | $46,884,495 |
| Member Months | 8,003 | 8,083 | 7,982 | 8,019 | 8,052 | 8,079 | 99,872 |
| Net PMPM Debit $ | $429.23 | $473.46 | $432.45 | $480.75 | $469.66 | $369.32 | $451.07 |
| Average Illness Burden Score | 1.75 | 1.77 | 1.75 | 1.74 | 1.70 | 1.68 | 1.78 |

## C. Outcome Incentive Awards - Detail of Performance Year #1 (2011) Metrics

*This chart shows selected 2011 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $2,538,937 | $2,669,451 | $2,791,926 | $2,553,589 | $3,038,554 | $2,932,723 |
| ISL $ | $133,151 | $145,945 | $115,761 | $128,058 | $289,621 | $142,356 |
| Net Debit $ | $2,405,786 | $2,523,506 | $2,676,165 | $2,425,531 | $2,748,933 | $2,790,367 |
| Total Credit $ | $2,580,959 | $2,130,010 | $2,883,484 | $2,819,236 | $2,982,191 | $3,243,539 |
| Member Months | 5,306 | 5,658 | 5,988 | 6,083 | 6,090 | 6,384 |
| Net PMPM Debit $ | $453.41 | $446.01 | $446.92 | $398.74 | $451.38 | $437.09 |
| Average Illness Burden Score | 1.19 | 1.20 | 1.21 | 1.21 | 1.22 | 1.23 |

| Metric | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Nov-11 | Dec-11 | 2011 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $2,679,915 | $2,771,396 | $3,700,307 | $3,260,102 | $3,369,133 | $3,009,756 | $35,315,789 |
| ISL $ | $162,347 | $117,415 | $440,707 | $231,068 | $142,547 | $86,295 | $2,135,271 |
| Net Debit $ | $2,517,568 | $2,653,981 | $3,259,600 | $3,029,034 | $3,226,586 | $2,923,461 | $33,180,518 |
| Total Credit $ | $3,040,972 | $2,699,221 | $3,057,613 | $2,940,791 | $3,173,249 | $3,073,280 | $34,624,545 |
| Member Months | 6,431 | 6,564 | 6,595 | 6,592 | 6,885 | 6,893 | 75,469 |
| Net PMPM Debit $ | $391.47 | $404.32 | $494.25 | $459.50 | $468.64 | $424.12 | $439.66 |
| Average Illness Burden Score | 1.24 | 1.23 | 1.23 | 1.22 | 1.22 | 1.21 | 1.22 |

# IX. Status of Patient Care Account (PCA)

**PCMH SearchLight Report for Panel ABC**

These sections Drill Through from Section B

## D. Detail of Base Year (2010) Metrics

*This chart shows selected 2010 metrics from the Outcome Incentive Award Summary by month.*

| Metric | Jan-10 | Feb-10 | Mar-10 | Apr-10 | May-10 | Jun-10 |
|---|---|---|---|---|---|---|
| Gross Debit $ | $3,087,159 | $2,416,395 | $3,148,925 | $2,965,996 | $3,145,204 | $3,098,908 |
| ISL $ | $154,373 | $147,091 | $227,550 | $141,044 | $203,427 | $113,114 |
| Net Debit $ | $2,932,786 | $2,269,304 | $2,921,375 | $2,824,952 | $2,941,777 | $2,985,794 |
| Member Months | 6,854 | 6,821 | 6,865 | 6,850 | 6,779 | 6,793 |
| Net PMPM Debit $ | $427.89 | $332.69 | $425.55 | $412.40 | $433.95 | $439.54 |
| Average Illness Burden Score | 1.13 | 1.14 | 1.15 | 1.15 | 1.16 | 1.15 |

| Metric | Jul-10 | Aug-10 | Sep-10 | Oct-10 | Nov-10 | Dec-10 | 2010 |
|---|---|---|---|---|---|---|---|
| Gross Debit $ | $2,874,305 | $2,453,349 | $2,675,087 | $2,551,005 | $2,526,595 | $2,403,763 | $33,346,692 |
| ISL $ | $138,659 | $93,850 | $26,093 | $49,811 | $30,018 | -$16,500 | $1,308,530 |
| Net Debit $ | $2,735,646 | $2,359,499 | $2,648,994 | $2,501,194 | $2,496,577 | $2,420,262 | $32,038,161 |
| Member Months | 6,721 | 6,713 | 6,698 | 6,617 | 6,547 | 6,466 | 80,724 |
| Net PMPM Debit $ | $407.03 | $351.48 | $395.49 | $378.00 | $381.33 | $374.31 | $396.89 |
| Average Illness Burden Score | 1.14 | 1.13 | 1.13 | 1.11 | 1.09 | 1.09 | 1.13 |

## E. Savings Impact Performance Year #6 (2016)

*This chart illustrates potential panel fee increase incentives at the Panel and PCP level when savings percentages are increased by 1%, 5%, and 10%. Potential OIA $ are illustrative and assume that 6% of the Panel's Total Net Debit dollars are from claims submitted by the Panel. The Potential OIA shown is subject to a maximum of 100 prior to the consecutive "win" year award and does not include the application of the Alternative OIA.*

| Patient Care Account Savings | Savings Percentage | OIA Percentage Point | Potential Panel Fee $ | Potential Panel Fee $ Increase | Potential Panel Fee $ Per PCP | Potential Panel Fee $ Increase Per PCP |
|---|---|---|---|---|---|---|
| Panel Actual Results - 2016 | 11.4% | 69 | $586,924 | $0 | $90,284 | $0 |
| If Savings percentage increased by 1% | 14.2% | 75 | $651,078 | $64,155 | $99,114 | $8,831 |
| If Savings percentage increased by 5% | 15.3% | 99 | $877,178 | $284,254 | $129,351 | $39,067 |
| If Savings percentage increased by 10% | 20.3% | 120 | $1,094,128 | $507,204 | $157,081 | $66,798 |

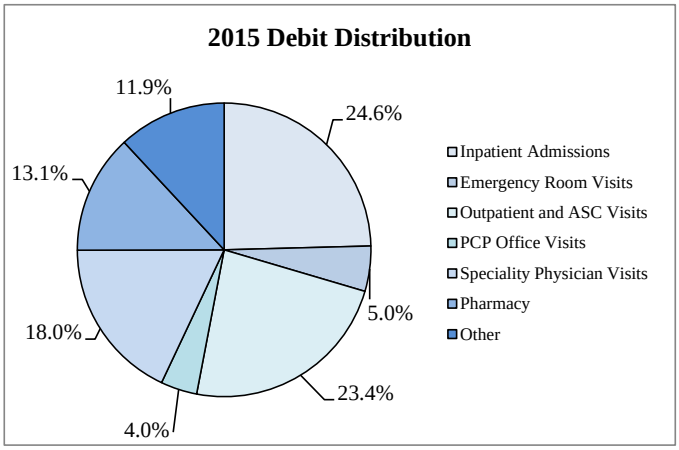
# IX. Status of Patient Care Account (PCA)

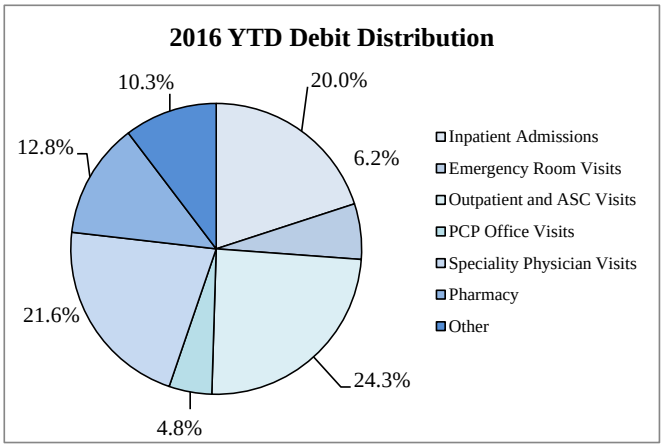
**PCMH SearchLight Report for Panel ABC**

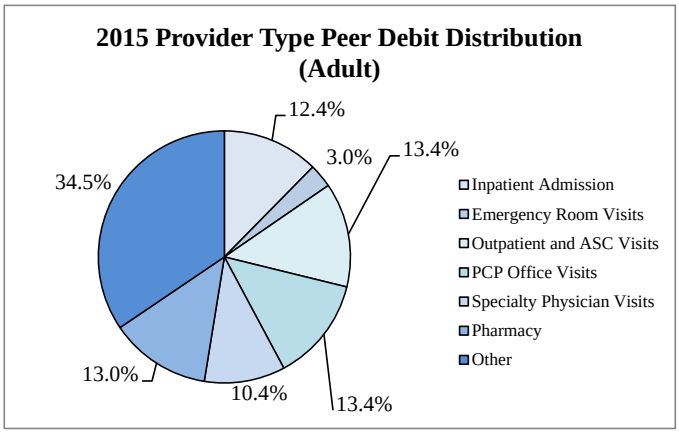
## F. Outcome Incentive Award - Debit Distribution by Type of Service

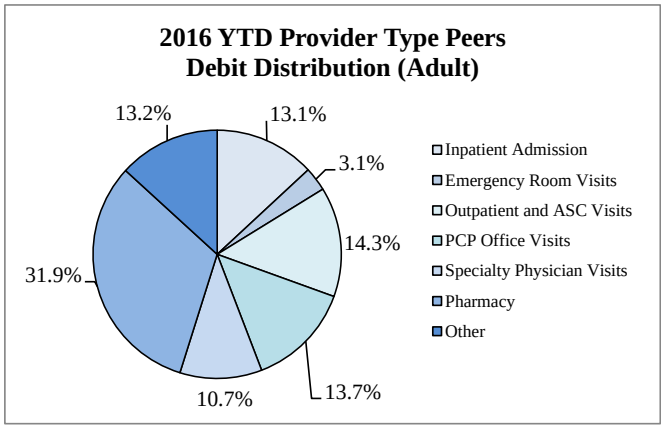
*These views show Panel debits and PMPMs broken out by type of service. It compares the prior year to the current Performance Year distribution for Panels and Provider Type Peers. Specialty Visits include Urgent Care and Convenience Care visits.*

| Type of Service | Debits | | | | PMPM | | |
|---|---|---|---|---|---|---|---|
| | 2015 | | 2016 YTD | | 2015 | 2016 YTD | 2015 - 2016 YTD |
| | $ | % | $ | % | $ | $ | % Change |
| Inpatient Admissions | $3,933,664 | 24.6% | $2,420,962 | 22.7% | $126.35 | $116.64 | -7.7% |
| Emergency Room Visits | $797,613 | 5.0% | $748,006 | 4.9% | $25.62 | $25.25 | -1.4% |
| Outpatient and ASC Visits | $3,751,918 | 23.4% | $2,945,858 | 24.6% | $120.51 | $126.46 | 4.9% |
| PCP Office Visits | $641,253 | 4.0% | $576,737 | 3.8% | $20.60 | $19.47 | -5.5% |
| Speciality Physician Visits | $2,872,850 | 18.0% | $2,613,446 | 18.8% | $92.27 | $96.67 | 4.8% |
| Pharmacy | $2,099,313 | 13.1% | $1,555,620 | 13.5% | $67.43 | $69.40 | 2.9% |
| Other | $1,907,393 | 11.9% | $1,251,662 | 11.5% | $61.26 | $59.14 | -3.5% |
| **Total** | **$16,004,004** | **100.0%** | **$12,112,291** | **100.0%** | **$514.04** | **$513.03** | **-0.2%** |



# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

*This section compares the Panel's Member population with other PCMH Panels in five different ways:*

- ***Size*** *- Average Members in Panel is the average number of attributed members in the panel for the measurement period. Member Months is the sum of months each Member has contributed to their respective panels for the measurement period. This allows the Panel to see how it compares in size with other Panels. The "sweet" spot in maximizing rewards is shown by a cut off line in the rankings. This is usually attained when average Panel size is 10-15 PCPs and/or 2,500+ Members.*
- ***Debits Per Member Per Month (Debit PMPM $)*** *- cost based on the sum of debits divided by Member months. This ranking allows a Panel to see how costly their Members are when compared to other PCMH Panels on an unadjusted basis (for Illness Burden Score).*
- ***Average Illness Burden Score*** *- based on the overall average Illness Burden Score for the Panel's entire Member population compared to the average Illness Burden Scores for all Panels. These scores are then ranked, allowing a Panel to see how 'sick' their Members are when compared to other PCMH Panels.*
- ***Total Quality Score*** *- this shows the cumulative point score of each Panel for the trailing 12 months relative to all other Panel quality scores.*
- ***Medical Efficiency Index (MEI)*** *- adjusts the PMPM Average Debit of the Panel by the overall average Illness Burden among its Members. To do this the MEI starts with a Panel's costs (Debit PMPM $) and divides this by the Panel's average Illness Burden Score. The result is expressed on a Per Member Per Month basis. In effect, MEI reveals/answers the question: for the Illness Burden the Panel was faced with managing, how did its costs look when compared with other Panels using the same methodology? This is the most instructive of the rankings.*
- ***Overall Quartile Cumulative Performance Ranking (3 yrs)*** *- Shows how Panels compare on overall performance based on their cost and quality results combined over the trailing 36 months. This ranking will begin in 2015 for Panels with three full Performance Years of experience.*

*In addition, an overall assessment of Panel performance is provided in a separate "Measures that Matter " section that graphically displays key comparisons of utilization and costs metrics for medical and drug claims, admissions, readmissions, emergency room, and outpatient hospitals (OP Hospital) vs. ambulatory surgery centers (ASCs).*

# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

## A. Panel Size Compared to Panel Peers

*This chart shows the average Panel Membership and cumulative Member months compared to PCMH Panel Peers (with 3 months run out).*

| Measure | Panel | Panel Type Peers (169) | Provider Type Peers (173) | PCMH All (281) |
|---|---|---|---|---|
| Average Members in Panel | 2,468 | 2,405 | 2,451 | 2,402 |
| Cumulative Member Months | 99,621 | 6,031,634 | 8,705,207 | 12,827,498 |

## B. Medical Efficiency Index

*The Medical Efficiency Index (MEI) shows the ratio of a Panel's costs (Medical PMPM) divided by the Panel's Average Illness Burden Score Per Member Per Month (with 3 months of run out).*

| | Panel | Provider Type Peers | PCMH All |
|---|---|---|---|
| Medical PMPM | $436.72 | $391.11 | $329.14 |
| ÷ | ÷ | ÷ | ÷ |
| Average Illness Burden Score | 1.67 | 1.43 | 1.17 |
| Illness Burden Adjusted PMPM | $261.51 | $273.50 | $281.32 |

## C. Ranking Summary by Key Measures

*This chart shows the Panel how their scores on these indexes rank against their PCMH peer group. All rankings are from best to worst (with 3 months run out).*

| Measure | Panel | Panel Type Peers Rank (169) | Provider Type Peers Rank (173) | PCMH All Rank (281) | Provider Type Peers (173) Quartile | PCMH All Quartile (281) |
|---|---|---|---|---|---|---|
| Average Members | 2,468 | 4th | 75th | 108th | 4th | 1st |
| Medical PMPM | $436.72 | 144th | 250th | 200th | 4th | 4th |
| Average Illness Burden Score | 1.67 | 137th | 244th | 212th | 2nd | 4th |
| Quality Score | 77.0 | 45th | 127th | 155th | 2nd | 2nd |
| Illness Burden Adjusted PMPM | $261.51 | 55th | 108th | 120th | 2nd | 2nd |

# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

## D. Quality Score Ranking Summary - Performance Year #6 (through December 2016)

*This chart shows the Panel how their quality scores for each component rank against their PCMH peer groups. All rankings are from best to worst.*

| Measure | Possible Points | Actual Points | Provider Type Peers(173) Rank |
|---|---|---|---|
| **Engagement with and Knowledge of PCMH Program** | 12.50 | 10.14 | 9th |
| **PCP Engagement with Care Plans** | 15.00 | 12.69 | 18th |
| **Practice Transformation** | 22.50 | 18.21 | 8th |
| **Care Coordination / Patient Safety** | 12.50 | 8.02 | 169th |
| **At-Risk Population** | 12.50 | 8.23 | 121st |
| **Preventive Health** | 12.50 | 8.71 | 80th |
| **Patient and Caregiver Experience of Care** | 12.50 | 7.46 | 102nd |
| **Overall Panel Composite** | **100.00** | **73.46** | **72nd** |

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| Measure | Possible Points | Actual Points | Provider Type Peers (103) Rank |
|---|---|---|---|
| **Engagement with and Knowledge of PCMH Program** | 12.50 | 7.55 | 35th |
| **PCP Engagement with Care Plans** | 15.00 | 10.62 | 6th |
| **Practice Transformation** | 22.50 | 14.72 | 61st |
| **Clinical Care** | 40.00 | 21.08 | 71st |
| **Patient and Caregiver Experience of Care** | 10.00 | 5.56 | 25th |
| **Overall Panel Composite** | **100.00** | **59.53** | **31st** |

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# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

## E. Panel Performance Metrics By Year

*The chart shows key cost and quality metrics of the Panel for each Performance year (with 3 months of run out).*

| Metrics | Performance Year Results | | | | | |
|---|---|---|---|---|---|---|
| | Year # 1 (2011) | Year #2 (2012) | Year #3 (2013) | Year #4 (2014) | Year #5 (2015) | Year #6 (2016 YTD) |
| **Enrollment** | 1,739 | 1,742 | 1,632 | 1,636 | 1,323 | 1,323 |
| **Illness Burden Score (Normalized)** | 1.63 | 1.55 | 1.73 | 1.76 | 1.78 | 1.67 |
| **Total Credit $** | $3,255,860 | $8,065,821 | $9,683,095 | $9,148,262 | $1,747,558 | $12,654,571 |
| **Total Debit $** | $3,290,317 | $7,146,176 | $9,026,769 | $9,932,882 | $2,090,355 | $12,112,291 |
| **Savings Percentage** | -1.1% | 11.4% | -0.7% | 8.6% | 12.6% | 6.3% |
| **Overall Medical Trend** | 7.5% | 6.5% | 5.5% | 3.5% | 8.5% | 6.2% |
| **Engagement Score** | NA | 23.9/30.0 | 11.2/30.0 | 28.5/35.0 | 19.1/35.0 | 44.6/50 |
| **Overall Quality Score** | 39.0/70.0 | 38.8/70.0 | 51.0/100.0 | 68.4/100.0 | 43.2/100.0 | 77.0/100.0 |
| **Final OIA Percentage Point Award** | 0 | 51 | 38* | 62 | 55 | 69 |
| **IB Adjusted PMPM (Medical)** | $406.67 | $466.88 | $521.11 | $432.55 | $401.91 | $303.04 |

* Panel was rebased

# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

## F. Year Over Year Measures That Matter - Key Metrics and Comparisons

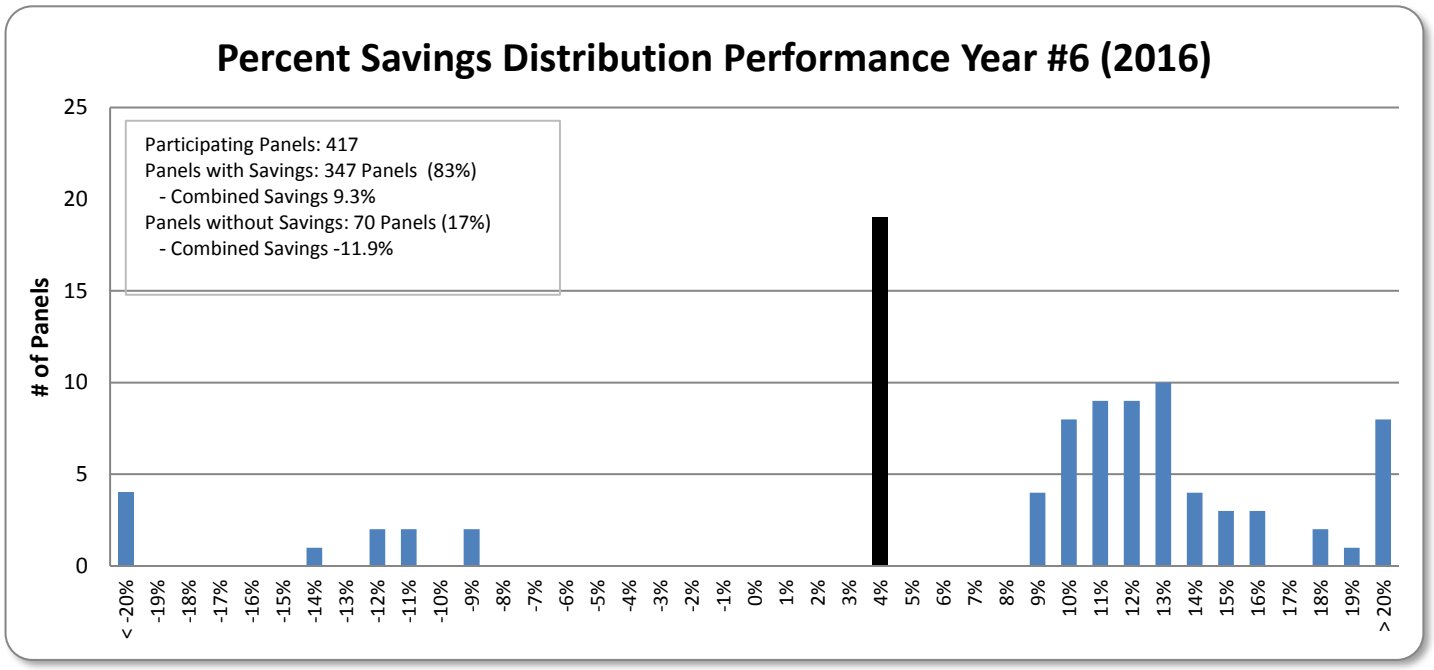
*The chart below illustrates year over year key comparisons of utilization and cost metrics for medical and drug debits, admissions, readmissions, emergency room, outpatient hospital, Ambulatory Surgical Centers (ASC), and office visits. Figures are then weighted: 2013 at 20%, 2014 at 30%, and 2015 at 50%. Current year Provider Type Peers, and Panel year over year metrics are shown as well (with 3 months of run out).*

| | Panel | | | | | Provider Type Peers | Panel % Change | | |
|---|---|---|---|---|---|---|---|---|---|
| Metrics | 2013 | 2014 | 2015 | 3 Year Weighted | 2016 YTD | 2016 YTD | 2013-2014 | 2014-2015 | 2015-2016 YTD |
| 1. Medical Member Months | 27,574 | 30,416 | 31,134 | 19,945 | 29,621 | 29,708 | 10.3% | 2.4% | -4.9% |
| 2. Average Members | 2,583 | 2,688 | 2,709 | 1,662 | 2,554 | 2,660 | 4.1% | 0.7% | -5.7% |
| 3. Average IB Score | 1.79 | 1.76 | 1.78 | 1.76 | 1.67 | 1.77 | -2.0% | 1.3% | -6.0% |
| 4. Total PMPM | $473.08 | $492.61 | $514.04 | $471.28 | $513.03 | $493.24 | 4.1% | 4.4% | -0.2% |
| 5. Medical PMPM | $419.75 | $428.39 | $446.61 | $418.73 | $443.63 | $431.58 | 2.1% | 4.3% | -0.7% |
| 6. IB Adjusted PMPM (Medical) | $237.19 | $244.89 | $253.91 | $238.23 | $265.84 | $245.33 | 3.2% | 3.7% | 4.7% |
| 7. Pharmacy PMPM | $53.33 | $64.22 | $67.43 | $52.55 | $69.40 | $61.66 | 20.4% | 5.0% | 2.9% |
| 8. Pharmacy PMPM w Rx Benefit | $123.99 | $129.06 | $134.21 | $140.82 | $146.17 | $129.08 | 4.1% | 4.0% | 8.9% |
| 9. Inpatient Admissions per 1,000 | 126.9 | 120.0 | 114.2 | 113.7 | 103.6 | 120.4 | -5.4% | -4.8% | -9.3% |
| 10. ALOS | 5.1 | 4.9 | 4.8 | 6.5 | 5.4 | 4.9 | -4.2% | -0.8% | 11.3% |
| 11. Inpatient Days per 1,000 | 658.7 | 603.9 | 538.6 | 734.6 | 587.5 | 600.4 | -8.3% | -10.8% | 9.1% |
| 12. Cost per Admission | $18,736 | $17,655 | $18,727 | $14,128 | $17,634 | $18,373 | -5.8% | 6.1% | -5.8% |
| 13. Admission PMPM | $167.80 | $150.61 | $152.27 | $133.54 | $130.57 | $156.89 | -10.2% | 1.1% | -14.3% |
| 14. 30 Day Readmission Rate | 11.6% | 6.6% | 10.0% | 9.3% | 5.3% | 9.4% | -43.5% | 52.3% | -47.4% |
| 15. Cost per 30 Day Readmission | $11,262 | $11,769 | $11,969 | $11,768 | $33,937 | $11,667 | 4.5% | 1.7% | 183.5% |
| 16. ER Visits per 1,000 | 265.4 | 249.9 | 252.2 | 343.0 | 248.5 | 255.8 | -5.8% | 0.9% | -1.5% |
| 17. Cost per ER Visit | $1,073 | $1,079 | $1,226 | $1,004 | $1,209 | $1,126 | 0.6% | 13.6% | -1.4% |
| 18. ER PMPM | $29.24 | $27.84 | $28.85 | $28.63 | $35.39 | $28.64 | -4.8% | 3.6% | 22.6% |
| 19. Outpatient Visits per 1,000 | 121.5 | 1,201.9 | 1,045.5 | 1,276.2 | 1,063.3 | 789.6 | 889.2% | -13.0% | 1.7% |
| 20. Cost per Outpatient Visit | $1,129 | $1,160 | $1,220 | $972 | $1,238 | $1,170 | 2.7% | 5.2% | 1.5% |
| 21. Outpatient Visits PMPM | $80.55 | $96.72 | $117.51 | $103.88 | $124.68 | $98.26 | 20.1% | 21.5% | 6.1% |
| 22. ASC Visits per 1,000 | 156.2 | 162.5 | 184.5 | 142.9 | 181.0 | 167.7 | 4.0% | 13.5% | -1.9% |
| 23. Cost per ASC Visit | $945 | $988 | $1,043 | $1,011 | $1,085 | $992 | 4.6% | 5.6% | 4.0% |
| 24. ASC Visits PMPM | $11.22 | $12.43 | $12.13 | $12.04 | $9.29 | $11.93 | 10.7% | -2.4% | -23.4% |
| 25. PCP Office Visits per 1,000 | 1218.1 | 1277.7 | 1321.3 | 1287.6 | 1309.6 | 1733.7 | 4.9% | 3.4% | -0.9% |
| 26. Cost per PCP Office Visit | $118 | $123 | $128 | $125 | $120 | $159 | 4.2% | 4.1% | -6.3% |
| 27. PCP Office Visits PMPM | $12.90 | $15.20 | $13.40 | $13.84 | $15.20 | $23.00 | 17.8% | -11.8% | 13.4% |
| 28. Urgent Care Visits per 1,000 | 183.8 | 236.6 | 222.4 | 218.9 | 235.2 | 214.3 | 28.7% | -6.0% | 5.8% |
| 29. Cost per Urgent Care Visit | $126 | $126 | $129 | $128 | $128 | $127 | -0.2% | 2.6% | -1.1% |
| 30. Urgent Care PMPM | $2.30 | $2.70 | $2.80 | $2.00 | $3.01 | $1.59 | 17.4% | 3.7% | 7.5% |
| 31. Convenience Care Visit per 1,000 | 25.5 | 32.2 | 41.1 | 35.3 | 33.1 | 28.3 | 26.3% | 27.6% | -19.5% |
| 32. Cost per Convenience Care Visit | $50 | $56 | $59 | $56 | $71 | $66 | 13.0% | 5.9% | 18.6% |
| 33. Convenience Care PMPM | $0.10 | $0.10 | $0.10 | $0.10 | $0.10 | $0.20 | 0.0% | 0.0% | 0.0% |
| 34. Specialty Office Visits per 1,000 | 7,684.5 | 7,630.7 | 7,921.3 | 7,786.7 | 7,231.0 | 7,745.5 | -0.7% | 3.8% | -8.7% |
| 35. Cost per Specialty Office Visit | $138 | $170 | $185 | $171 | $193 | $164 | 23.4% | 8.5% | 4.3% |
| 36. Specialty Office Visits PMPM | $88.36 | $108.31 | $122.02 | $111.18 | $116.16 | $106.23 | 22.6% | 12.7% | -4.8% |
| 37. Other PMPM | $26.25 | $27.47 | $31.95 | $29.47 | $23.27 | $28.56 | 4.6% | 16.3% | -27.2% |

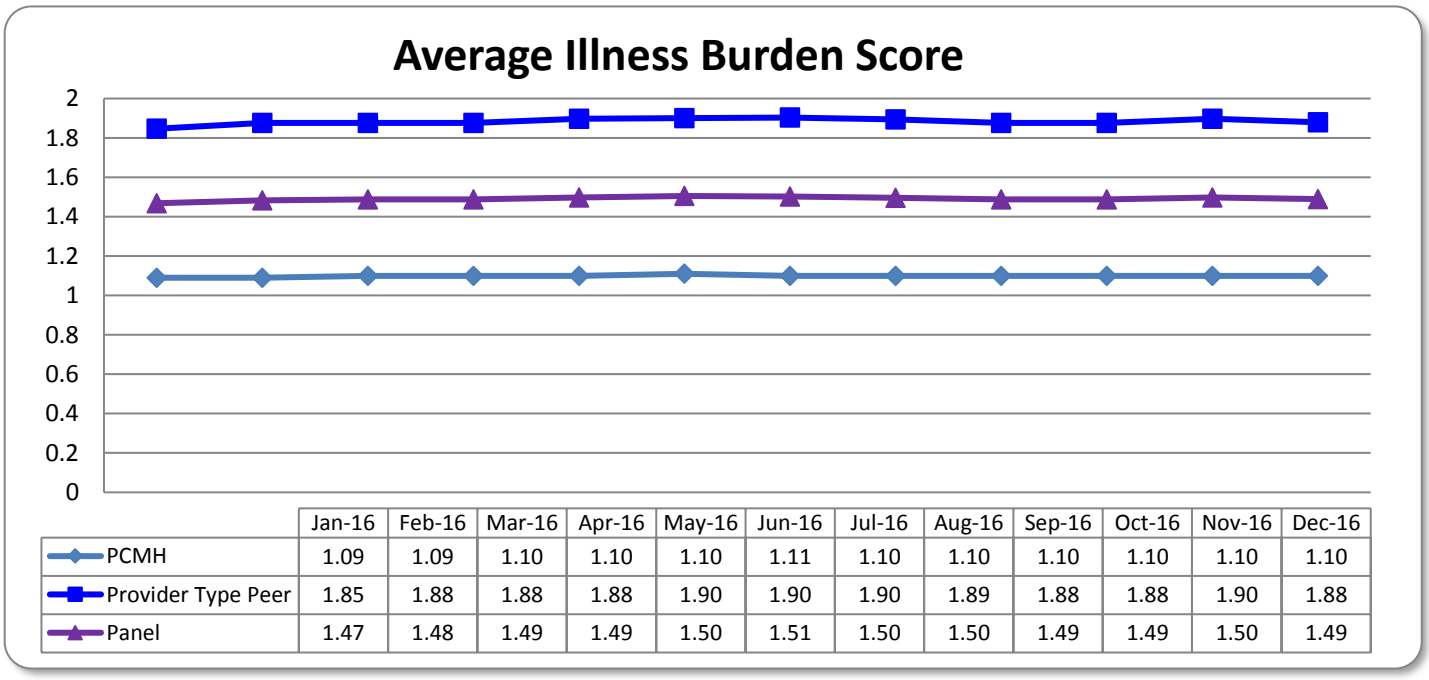
**PCMH SearchLight Report for Panel ABC**

## G. Measures That Matter - Key Metrics and Comparisons

*The graph below illustrates the distribution of percent savings across all PCMH Panels. The average savings is the average of the percent savings for all Panels receiving, or not receiving an Outcome Incentive Award (OIA). The Panel's savings are shown in the black bar below.*



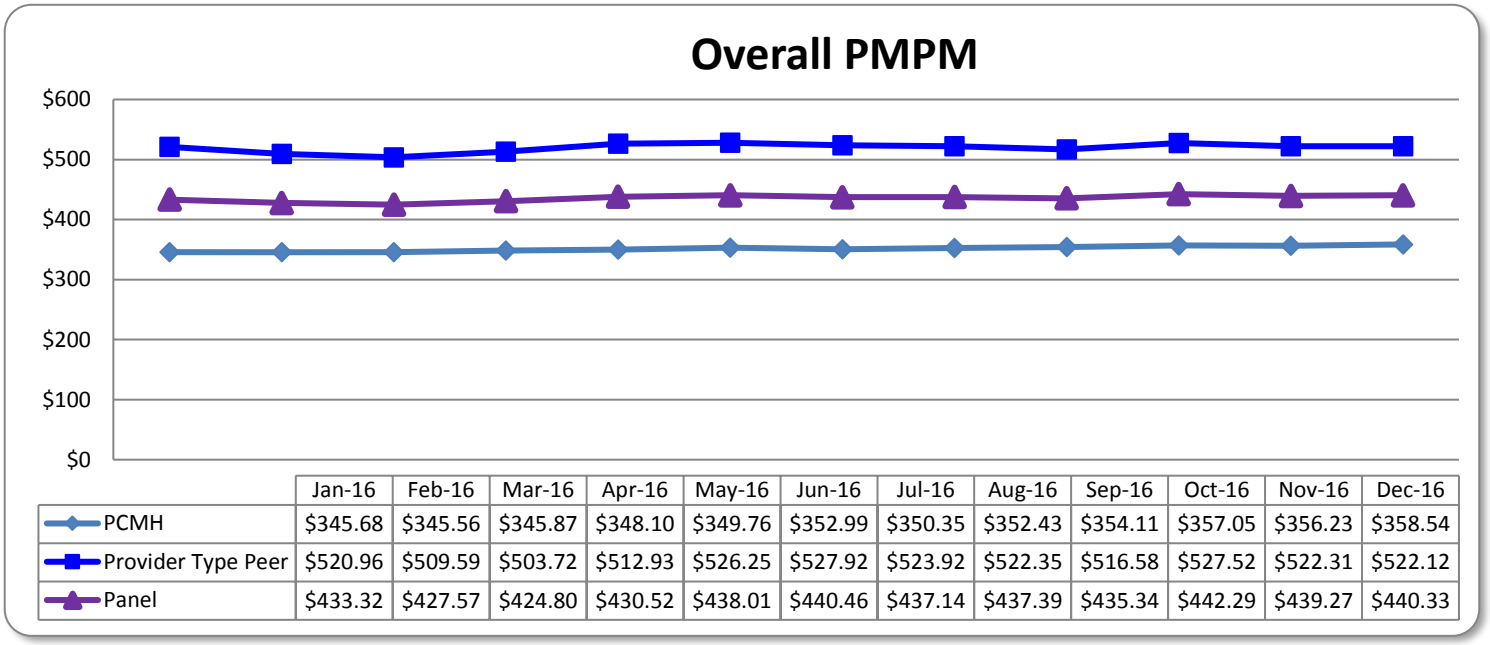

*The graph below illustrates the comparison of average illness burden score for the Panel to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 1.09 | 1.09 | 1.10 | 1.10 | 1.10 | 1.11 | 1.10 | 1.10 | 1.10 | 1.10 | 1.10 | 1.10 |
| Provider Type Peer | 1.85 | 1.88 | 1.88 | 1.88 | 1.90 | 1.90 | 1.90 | 1.89 | 1.88 | 1.88 | 1.90 | 1.88 |
| Panel | 1.47 | 1.48 | 1.49 | 1.49 | 1.50 | 1.51 | 1.50 | 1.50 | 1.49 | 1.49 | 1.50 | 1.49 |

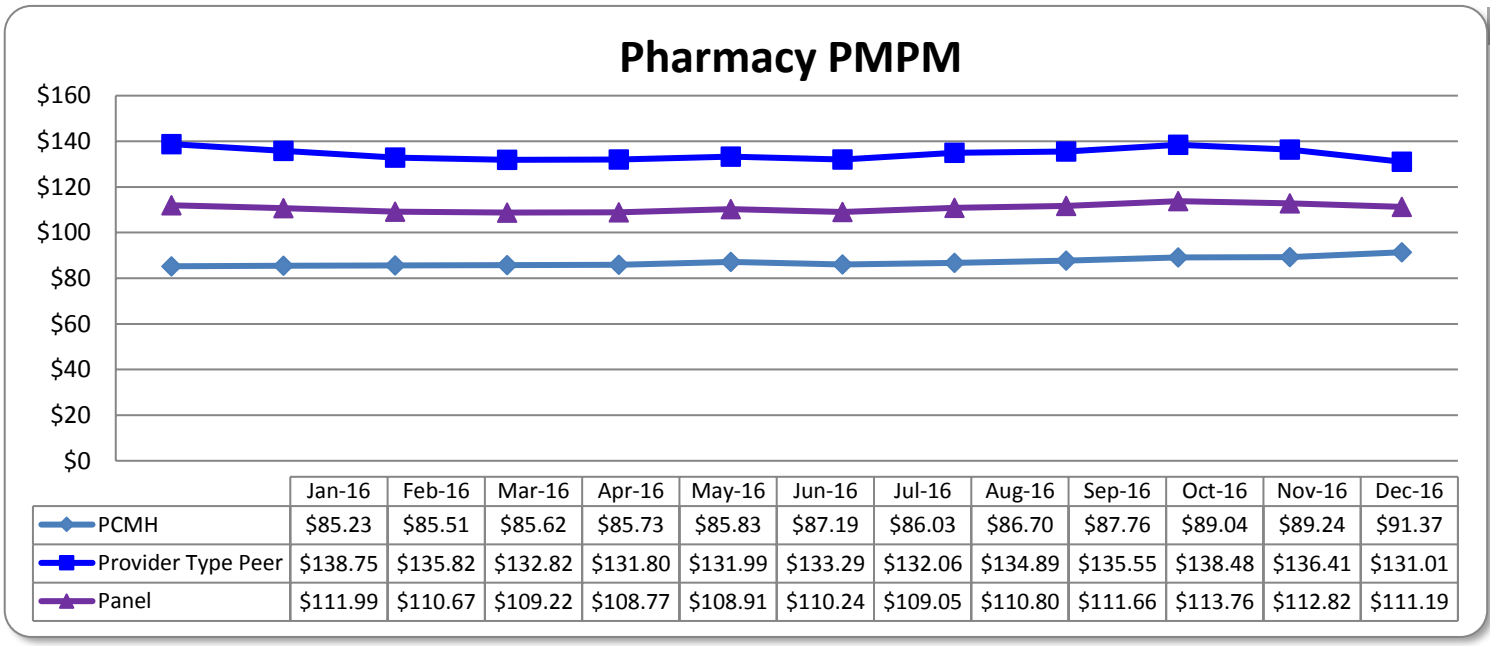
## G. Measures That Matter - Key Metrics and Comparisons (Cont'd)

*The graph below illustrates the comparison of spend per Member per month (PMPM) for the Panel to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | $345.68 | $345.56 | $345.87 | $348.10 | $349.76 | $352.99 | $350.35 | $352.43 | $354.11 | $357.05 | $356.23 | $358.54 |
| Provider Type Peer | $520.96 | $509.59 | $503.72 | $512.93 | $526.25 | $527.92 | $523.92 | $522.35 | $516.58 | $527.52 | $522.31 | $522.12 |
| Panel | $433.32 | $427.57 | $424.80 | $430.52 | $438.01 | $440.46 | $437.14 | $437.39 | $435.34 | $442.29 | $439.27 | $440.33 |

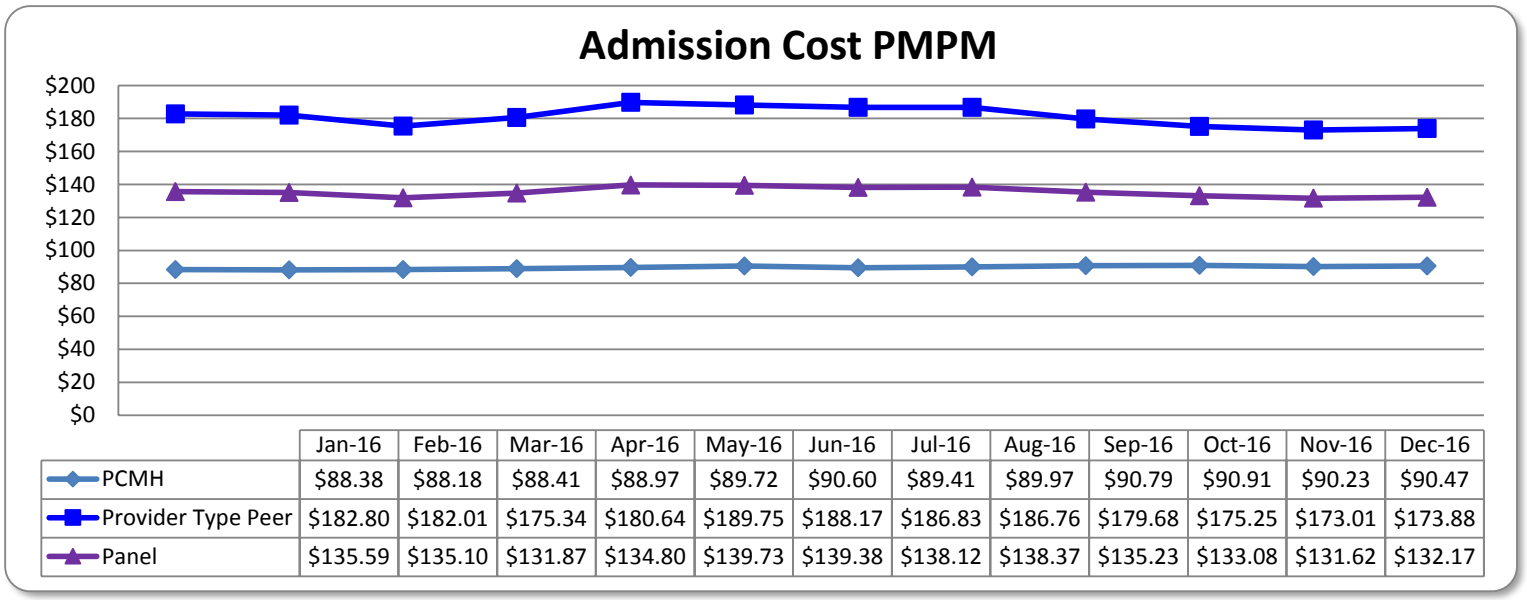
*The graph below illustrates the comparison of spend per Member per month (PMPM) for the Panel to the Provider Type Peer group and PCMH as a whole, for Members with CareFirst's pharmacy benefit. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | $85.23 | $85.51 | $85.62 | $85.73 | $85.83 | $87.19 | $86.03 | $86.70 | $87.76 | $89.04 | $89.24 | $91.37 |
| Provider Type Peer | $138.75 | $135.82 | $132.82 | $131.80 | $131.99 | $133.29 | $132.06 | $134.89 | $135.55 | $138.48 | $136.41 | $131.01 |
| Panel | $111.99 | $110.67 | $109.22 | $108.77 | $108.91 | $110.24 | $109.05 | $110.80 | $111.66 | $113.76 | $112.82 | $111.19 |

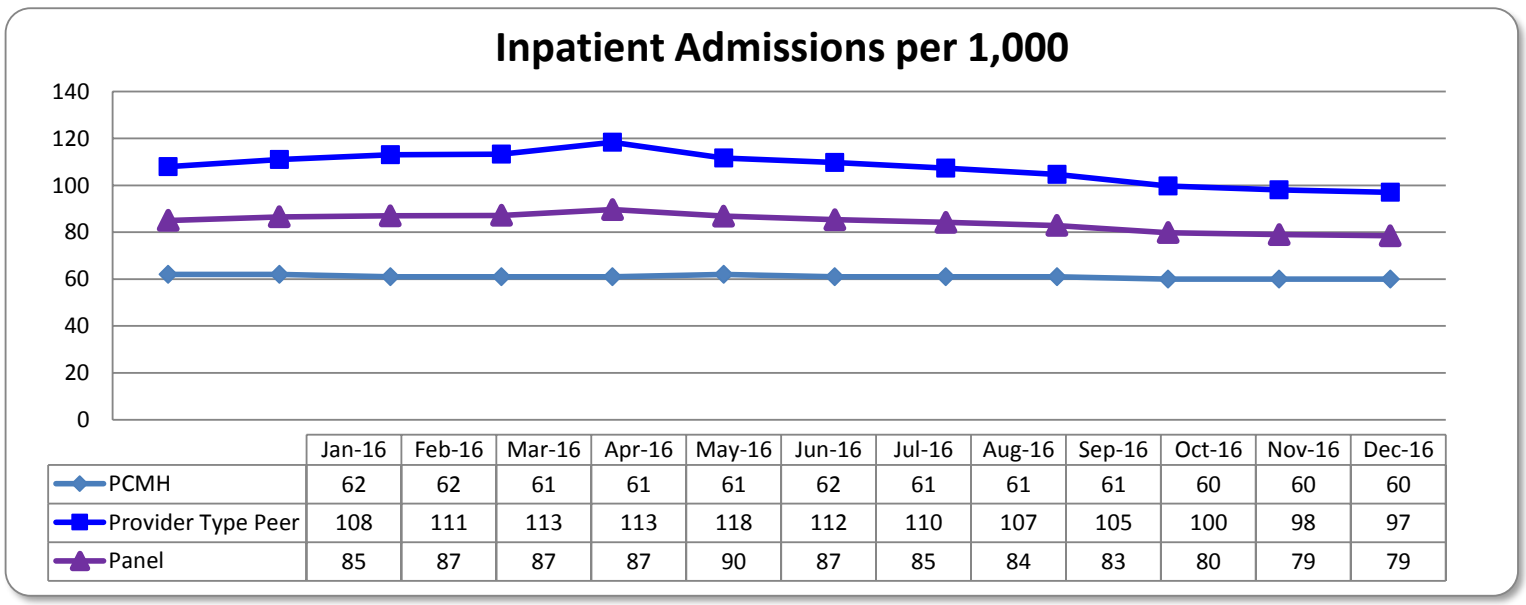
## G. Measures That Matter - Key Metrics and Comparisons (Cont'd)

*The graph below illustrates the comparison of Inpatient Admission spend per Member per month (PMPM) for the Panel as paid under the medical benefi to the Provider Type Peer group and PCMH as a whole.Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | $88.38 | $88.18 | $88.41 | $88.97 | $89.72 | $90.60 | $89.41 | $89.97 | $90.79 | $90.91 | $90.23 | $90.47 |
| Provider Type Peer | $182.80 | $182.01 | $175.34 | $180.64 | $189.75 | $188.17 | $186.83 | $186.76 | $179.68 | $175.25 | $173.01 | $173.88 |
| Panel | $135.59 | $135.10 | $131.87 | $134.80 | $139.73 | $139.38 | $138.12 | $138.37 | $135.23 | $133.08 | $131.62 | $132.17 |

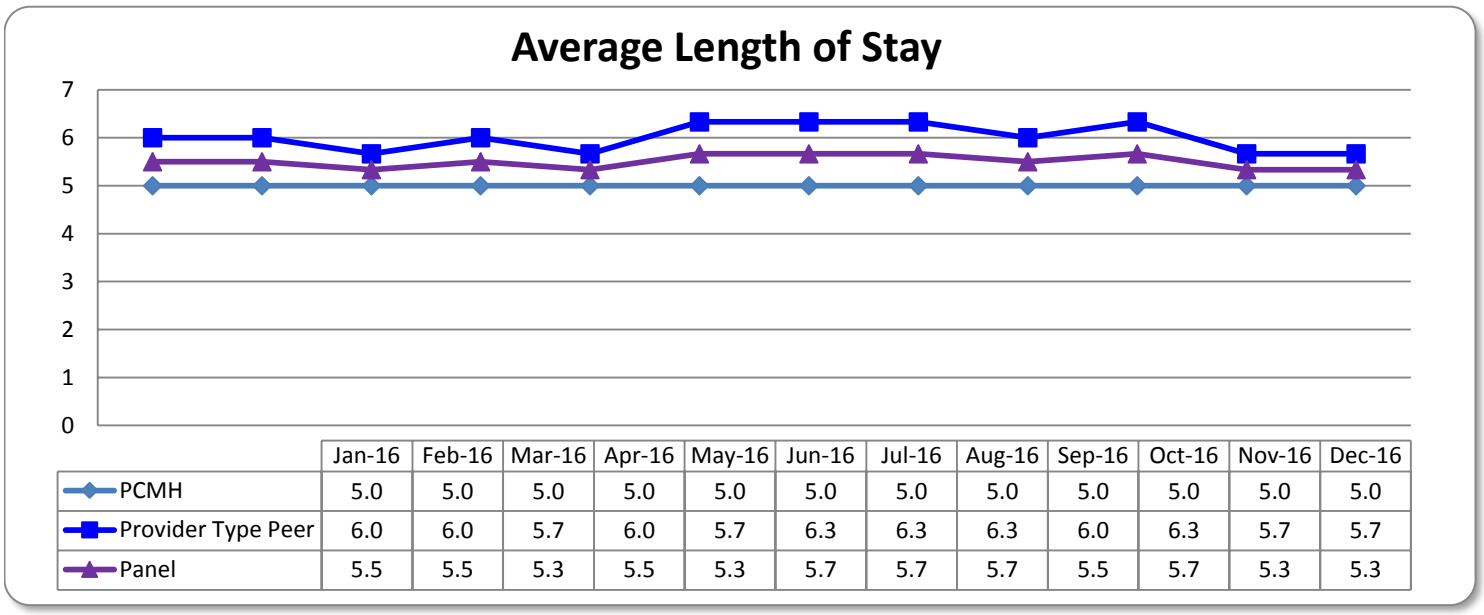
*The graph below illustrates the comparison of annualized inpatient number of admissions per 1000 Members for the Panel to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 62 | 62 | 61 | 61 | 61 | 62 | 61 | 61 | 61 | 60 | 60 | 60 |
| Provider Type Peer | 108 | 111 | 113 | 113 | 118 | 112 | 110 | 107 | 105 | 100 | 98 | 97 |
| Panel | 85 | 87 | 87 | 87 | 90 | 87 | 85 | 84 | 83 | 80 | 79 | 79 |

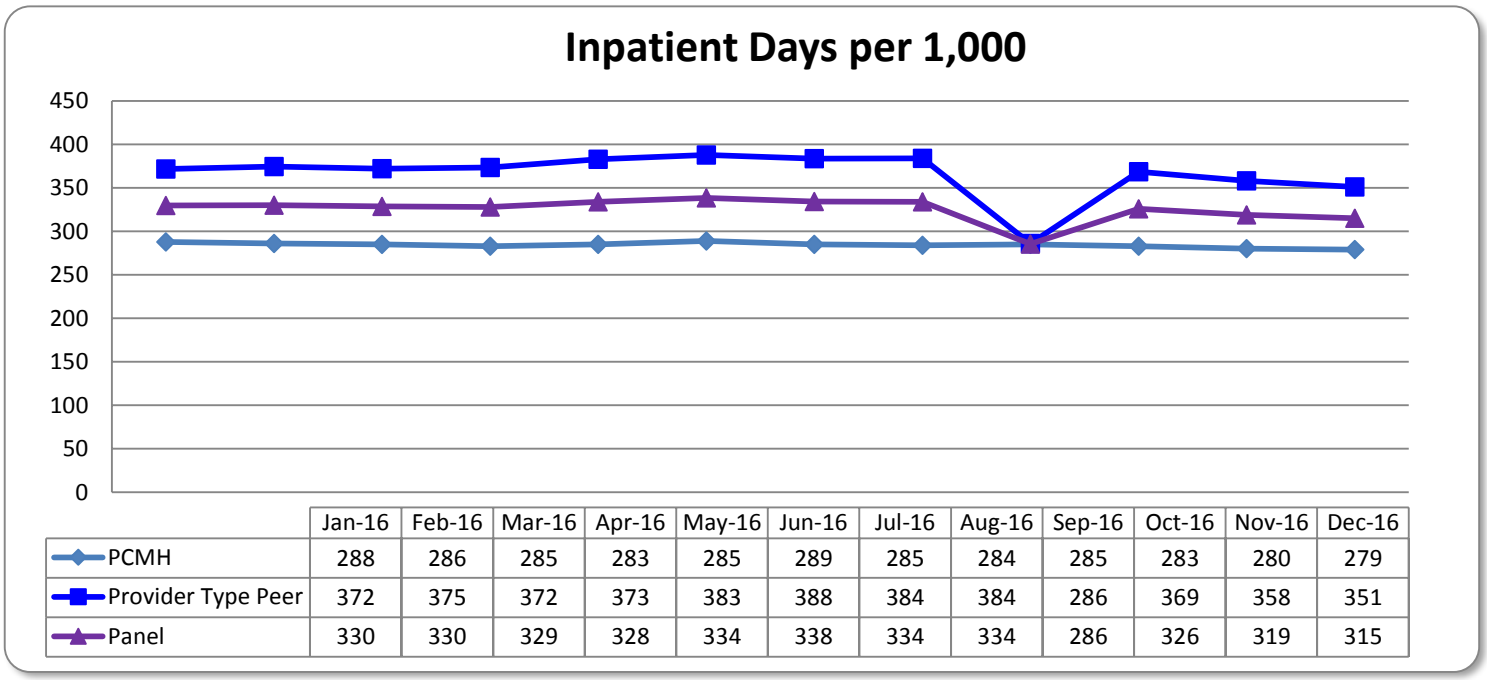
## G. Measures That Matter - Key Metrics and Comparisons (Cont'd)

*The graph below illustrates the comparison of annualized Inpatient number of average length of stay (days) per admission for the Panel to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |
| Provider Type Peer | 6.0 | 6.0 | 5.7 | 6.0 | 5.7 | 6.3 | 6.3 | 6.3 | 6.0 | 6.3 | 5.7 | 5.7 |
| Panel | 5.5 | 5.5 | 5.3 | 5.5 | 5.3 | 5.7 | 5.7 | 5.7 | 5.5 | 5.7 | 5.3 | 5.3 |

*The graph below illustrates the comparison of annualized Inpatient number of admission days per 1000 Members for the Panel to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*



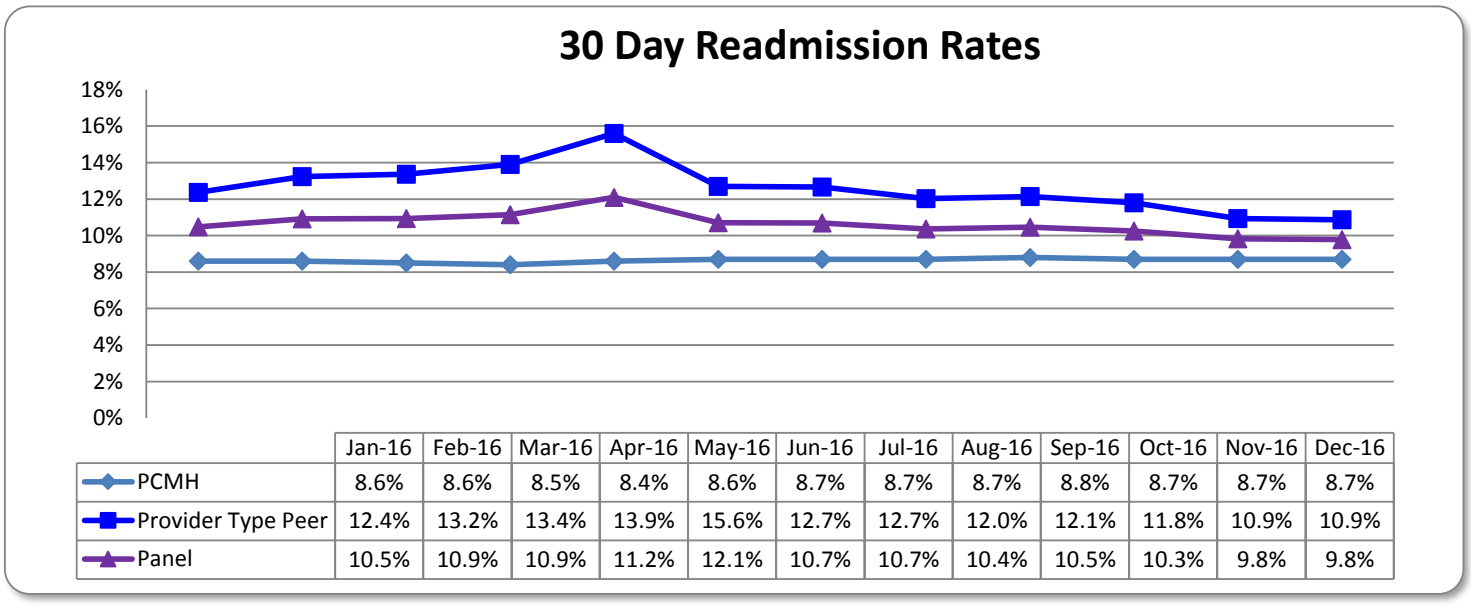

| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 288 | 286 | 285 | 283 | 285 | 289 | 285 | 284 | 285 | 283 | 280 | 279 |
| Provider Type Peer | 372 | 375 | 372 | 373 | 383 | 388 | 384 | 384 | 286 | 369 | 358 | 351 |
| Panel | 330 | 330 | 329 | 328 | 334 | 338 | 334 | 334 | 286 | 326 | 319 | 315 |

# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

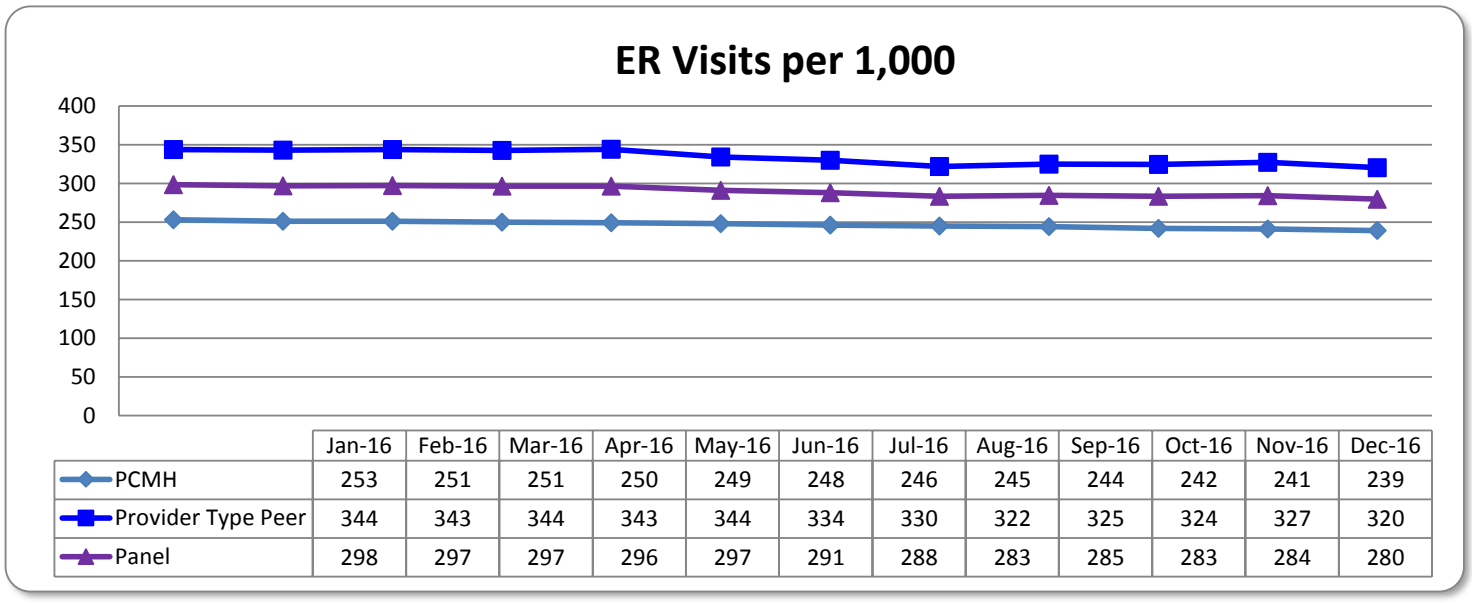
## G. Measures That Matter - Key Metrics and Comparisons (Cont'd)

*The graph below illustrates the comparison of 30 day all cause readmission rates for the Panel to the Provider Type Peer group and PCMH as a whole. Readmissions are defined as any admission occurring within 30 days of a previous discharge. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 8.6% | 8.6% | 8.5% | 8.4% | 8.6% | 8.7% | 8.7% | 8.7% | 8.8% | 8.7% | 8.7% | 8.7% |
| Provider Type Peer | 12.4% | 13.2% | 13.4% | 13.9% | 15.6% | 12.7% | 12.7% | 12.0% | 12.1% | 11.8% | 10.9% | 10.9% |
| Panel | 10.5% | 10.9% | 10.9% | 11.2% | 12.1% | 10.7% | 10.7% | 10.4% | 10.5% | 10.3% | 9.8% | 9.8% |

*The graph below illustrates the comparison of annualized emergency room (ER) utilization per 1000 Members for the Panel to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*



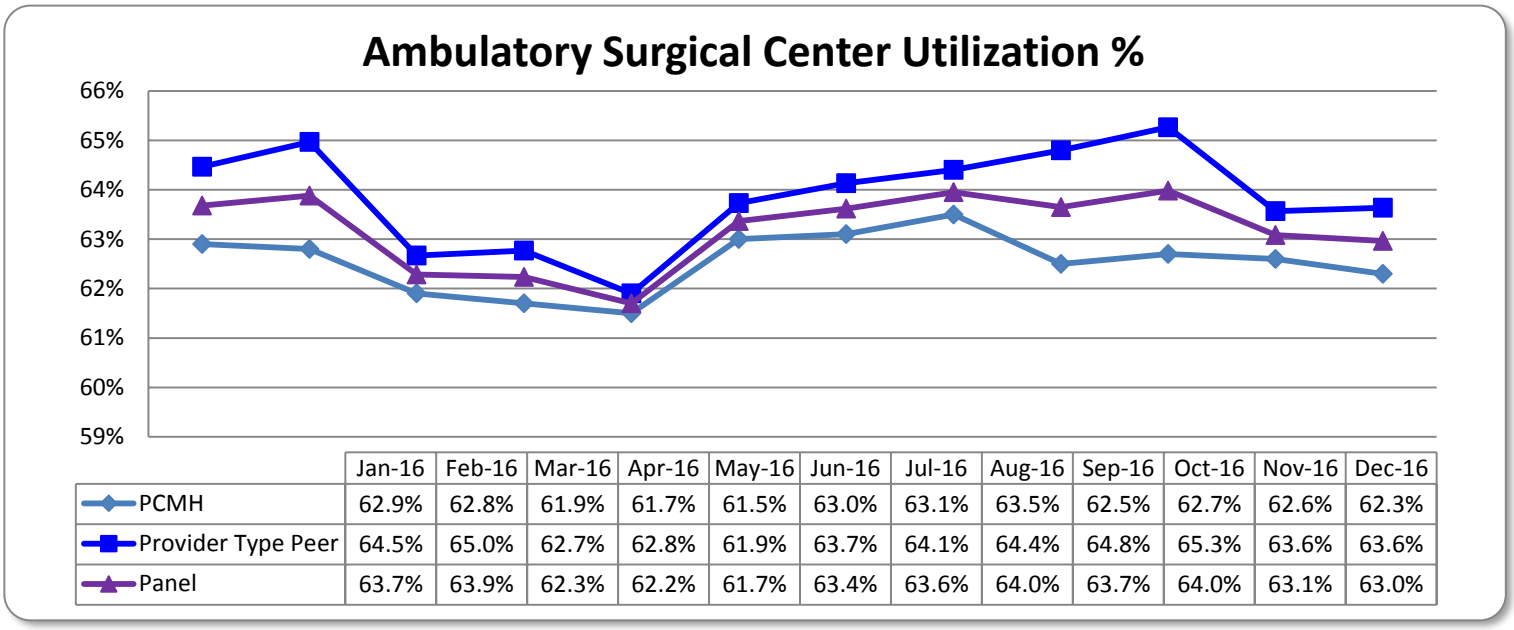

| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 253 | 251 | 251 | 250 | 249 | 248 | 246 | 245 | 244 | 242 | 241 | 239 |
| Provider Type Peer | 344 | 343 | 344 | 343 | 344 | 334 | 330 | 322 | 325 | 324 | 327 | 320 |
| Panel | 298 | 297 | 297 | 296 | 297 | 291 | 288 | 283 | 285 | 283 | 284 | 280 |

# X. Ranking of Overall Performance

**PCMH SearchLight Report for Panel ABC**

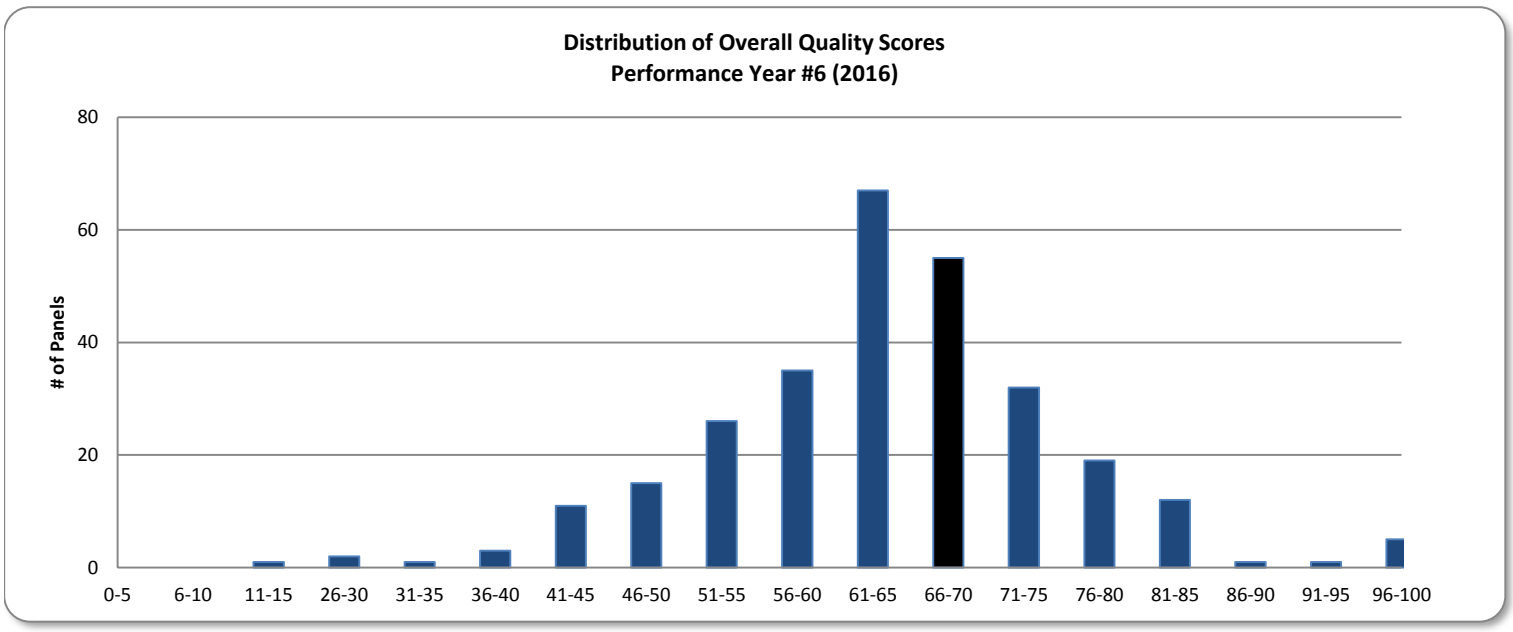
## G. Measures That Matter - Key Metrics and Comparisons (Cont'd)

*The graph below illustrates the comparison of Ambulatory Surgical Center (ASC) Utilization for procedures that are performed routinely in both ASC and Outpatient Hospital settings. Panel data as paid under the medical benefit is compared to the Provider Type Peer group and PCMH as a whole. Each data point represents data for a trailing 12 months, with the most recent data point (with 3 months of run out).*




| | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCMH | 62.9% | 62.8% | 61.9% | 61.7% | 61.5% | 63.0% | 63.1% | 63.5% | 62.5% | 62.7% | 62.6% | 62.3% |
| Provider Type Peer | 64.5% | 65.0% | 62.7% | 62.8% | 61.9% | 63.7% | 64.1% | 64.4% | 64.8% | 65.3% | 63.6% | 63.6% |
| Panel | 63.7% | 63.9% | 62.3% | 62.2% | 61.7% | 63.4% | 63.6% | 64.0% | 63.7% | 64.0% | 63.1% | 63.0% |

*The graph below illustrates the distribution of quality points among the PCMH Panels. Your Panel score is shown in the black shaded bar.*



# Part VIII: iCentric: The Essential Online Integration Of All Elements And Programs

## Preface

The technical systems support for the PCMH and TCCI Program Array is extensive and constantly evolving. In effect, CareFirst has become the hub of a large distributed network of providers tied together – for Program purposes – by a single technical platform through which all Program related activities are carried out and all operating and analytical data relating to the Program array is presented.

The sheer range of activities that must be coordinated to produce a coherent "Program" is staggering and the size and variable content of the data produced and consumed in Program operations compounds this challenge. Data ranging from specific paid claims (at a line level of detail), Member eligibility, demographics and health status to nursing notes, illness indices, lab results and drug reaction profiles all must be correctly processed and presented on demand to meet the needs of a wide array of users.

Hence, the PCMH/TCCI Technical System has been designed to support the essential property of the PCMH Program – namely, that it and its supporting TCCI Programs must operate as an integrated whole despite the fact that thousands of independently practicing providers are involved. This requires a robust technical platform that enables, on the one hand, a display of data of Member specific conditions and diagnoses and on the other, a display of larger patterns for cohorts of Members tracked over time. This requires an extremely high level of data integrity, timeliness and control. All aspects of the System must be operated in a reliable, on demand responsive way on a 24/7 basis.

The iCentric System is the single platform that accomplishes these goals and ties all aspects of Program operation and ongoing analysis together. Over 40,000 users are registered on the System and over 1,500 are active on the System at any point in time. These numbers are growing by about 25 percent every year.

For these reasons, enabling a wide spectrum of users to easily access the iCentric System in a secure way has been a key goal from the start. Given the environment in which the Programs operate and the extreme confidentiality of the data involved, the iCentric System balances ease of access with tight security as explained more fully below.

Since no commercially available third party platform could be found to perform this role, CareFirst undertook to build the platform from the conceptualization stage that now enables the company to modify and iteratively improve it as necessary. Into this single core platform, CareFirst has integrated a number of different specialized third party software packages that perform discrete functions that add to the whole.

The iCentric System is built using current technology and is designed for the web. It assures the uniform operation of the PCMH and TCCI Programs anywhere in the CareFirst service area or more broadly, anywhere in the United States or world. It is viewed by those who use it day-to-day as the essential enabler of all aspects of the PCMH and TCCI Programs.

The description of the iCentric System that follows in this section outlines its design and technical underpinnings as well as its key capabilities. If one were to consider that a managed care organization such as an HMO operates on its own, single internal system, then it is useful to think of iCentric as just such a System that enables a disparate, unorganized and extremely large network of independent providers to operate in a single coherent, informed, connected manner insofar as program integrity is concerned.

Yet, it is also important to understand that the System operates in a way that is independent of – and not dependent on – any Electronic Medical Record (EMR) or Practice Management System (PMS) used by a particular practice. Through a single sign on process, a user is enabled to see and use both their internal EMR/PMS Systems and iCentric. In this sense, iCentric is best seen as a complement to EMR and PMS Systems that performs functions and gathers/displays data that EMR and PMS Systems typically cannot perform or display.

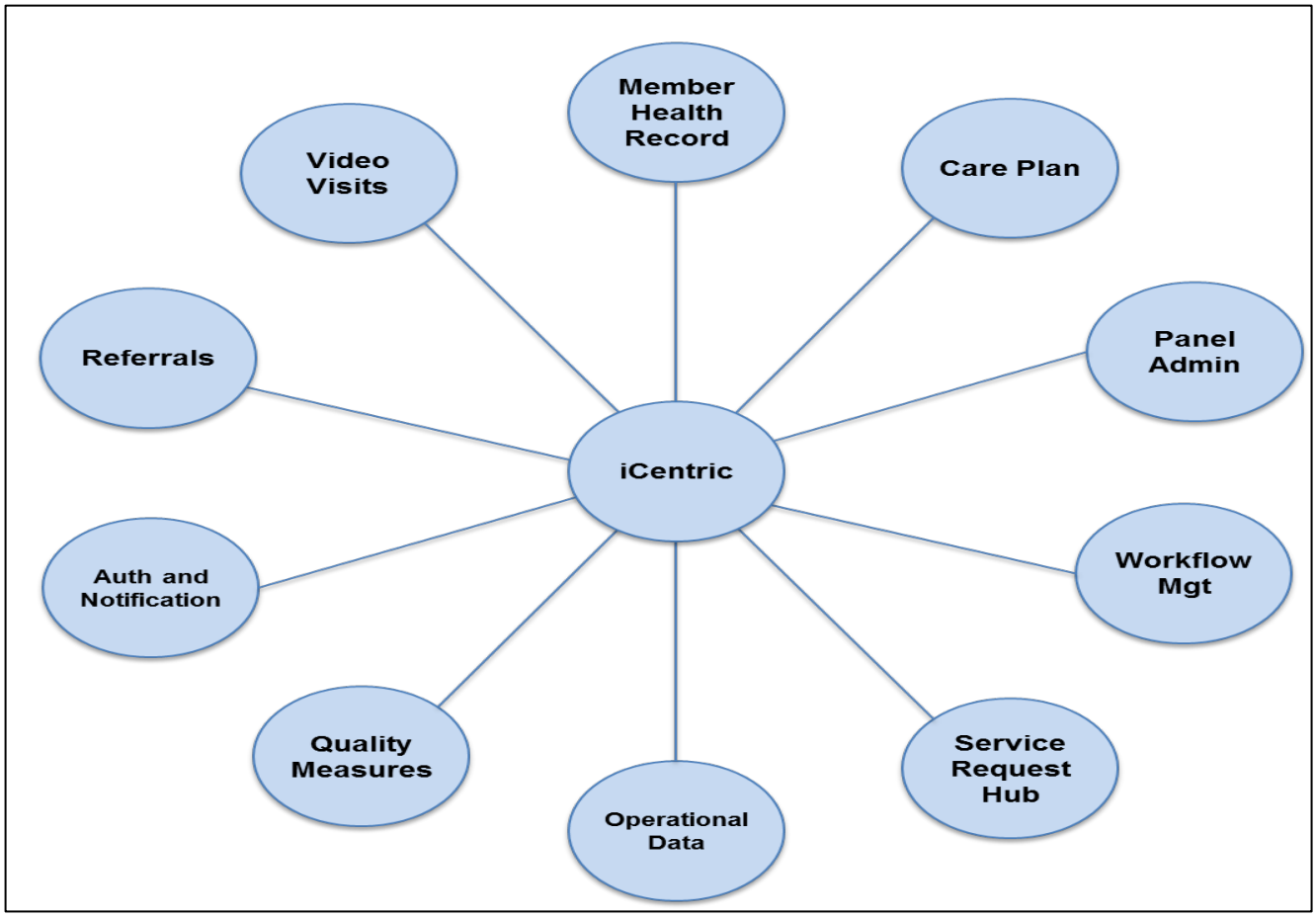
Broadly speaking, iCentric consists of 10 key domains:

1. **Longitudinal Member Health Record**
2. **Care Plan Management, Documentation and Tracking**
3. **Medical Care Panel Administration and Display of Panel and PCP Specific Data**
4. **Care Coordination**
5. **Service Request Hub**

6. **Presentation of Operational Data**
7. **Quality Measurement and Display**
8. **Authorization and Notification Management**
9. **Referral Management and Analytics**
10. **Support for Video Visits**

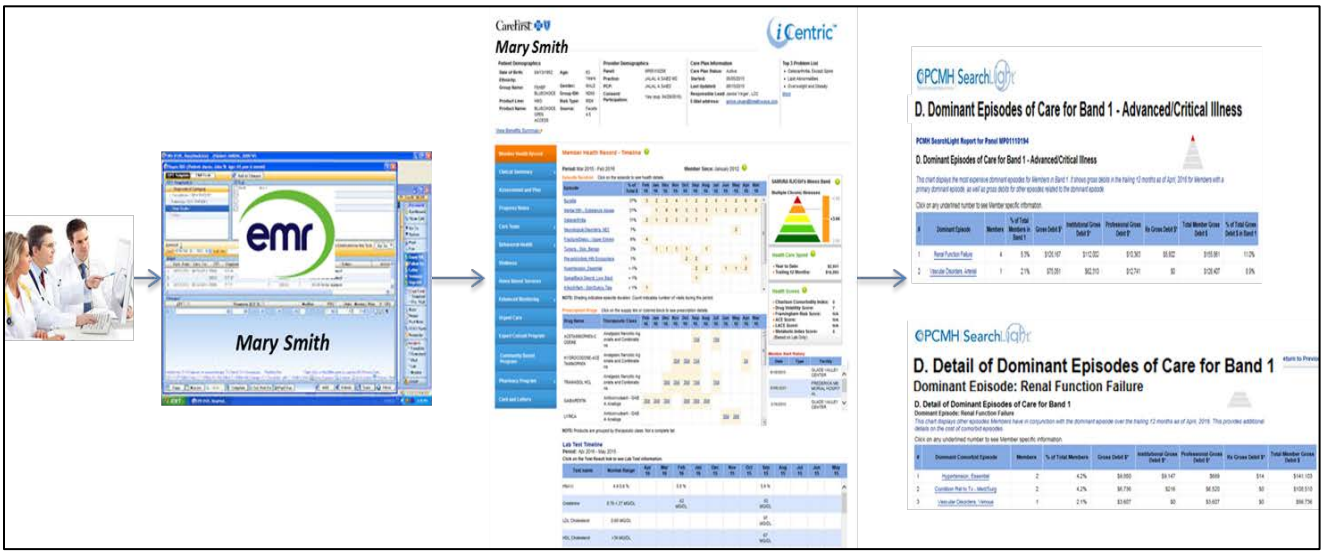
Each of these domains is explained below but, first, **Figure 1** below depicts the iCentric System visually as a hub and spokes design. The data used by all 10 major domains of the System (and all sub-components) comes from a single database that is a "single source of truth" for all components. This single source, in turn, receives data from multiple sources and maintains all data Elements in a way that enables reporting and analysis across all PCMH and TCCI Programs.

**Part VIII, Figure 1: iCentric**



As noted, the iCentric design recognizes that practices operate and carry out their clinical activities in their native systems. Since iCentric is meant to complement these Systems and to perform functions and present data that are simply not available or possible in EMR/PMS Systems, a single login process enables a side-by-side use that is critical to keep in mind when reviewing the description of iCentric that follows. The side-by-side nature of the intended operation of iCentric is further illustrated in **Figure 2** below.

**Part VIII, Figure 2: iCentric/Electronic Medical Record (EMR) Interoperability**




Before describing each iCentric domain, the overall technical design and architecture of the iCentric System is briefly explained below.

## Overall Scope and Architecture of iCentric

### Standard and Non-standard Data

iCentric is built to use industry standard data formats (EDI, CCD, etc.) and interfaces. The core data upon which iCentric relies is based upon industry standard transactions: Claims Processing (837, 835), Rx (NCPDP) and Enrollment/Member demographics (834). This industry standard data is subject to rigorous editing, audit, reconciliation and balancing procedures that are done as part of CareFirst's core health plan operations in paying claims.

In addition, non-industry standard data is ingested and presented as well. This includes a wide range of structured and unstructured data such as nursing notes for those Members in Care Plans, lab values on Members who use CareFirst contracted labs and prescription drug review findings. All CareFirst TCCI Program partners produce a continuous daily feed of data into the iCentric System. An example would be the notes of a Behavioral Health provider who had just completed a Behavioral Health assessment. This data is entered into the native system of the involved practice and then sent pursuant to a standard format and protocol to CareFirst in a continual data stream every day.

The use of industry standard data on the most voluminous enrollment and claims transactions enables the iCentric platform to handle not only CareFirst transactions of these types, but those of other payers – all of which use the same standard industry transaction sets. This has been essential to the successful conduct of the Common Model with CMS since CareFirst was able to receive and present Medicare enrollment and claims data in a manner virtually identical to that for CareFirst Members.

### Architecture

iCentric is a multi-tiered, distributed architecture design that builds upon successive layers of functionality/capability. The System is a server-based System built in the programming languages and tools listed in **Figure 3**.

Like most modern, complex systems, iCentric is architected across multiple logical layers. This layering approach allows iCentric to be flexible and scalable, ultimately aligning to the evolving nature of the unique features of the PCMH and TCCI Programs.

Each layer is highly specialized to perform certain discrete tasks that can be combined to perform higher-level tasks, ultimately resulting in a complete, desired business/clinical function. Layering allows application designers to categorize similar types of tasks and group them together in a single, designated area. Within each layer, there are sub-layers of lower level functions that perform very specific tasks. These lower level functions can be combined in a variety of ways depending on the nature of the task.

- These layers physically reside on distinct hardware that is optimized based upon their technical requirements such as video display, data retrieval or data transmission across a network.
- The physical layers can be added independently as needed, thus allowing the system to scale over time without significant redesign.
- Layers communicate with one another via the CareFirst network, which is depicted as a vertical layer, connecting each of the horizontal, logical layers.
- Each layer is also securely protected, creating multiple defensive perimeters that fend off a variety of constantly changing and evolving cyber-attack threats.

iCentric has maintained this multi-tiered architecture since its inception in 2011. The architecture has held up well and has supported dynamic growth in terms of both capability as well as data volumes and number of users.

In simplest terms, the iCentric System can be described as a three tiered or layered System composed of a User Interface Layer, an Application Layer and a Data Layer. These are described briefly below:

**User Interface Layer**

This layer allows users to view, print, share and update information with PCMH Providers, Care Coordinators and other third parties through web-based user interfaces for data integration and image uploads.

On-demand availability of data allows a Care Coordinator or a provider to retrieve the latest data at any time. Certain data is also made available as an alert on the portal dashboard or as a secure message on a portable device to notify providers of a critical update.

The User Interface Layer supports industry standard web browsers like Internet Explorer, Chrome, Firefox and Safari, which comprise greater than 95 percent of all browser software used on the market today – allowing iCentric to be available to virtually any user, at anytime and anywhere.

The typical peak number of users in 2015 was approximately 1,500 users/hour. This number has been steadily growing and is expected to continue to do so.

**Application Layer**

The iCentric Application Layer orchestrates user actions across a broad spectrum of business functions through systems services that are governed by workflow rules. These are rules typically concerned with the retrieval, processing, transformation, and management of application data or that apply business rules and policies to data to ensure consistency and validity. As an example, to ensure consistent reference to medications, which can be vary depending upon form and dosage, as well as have complicated spellings, iCentric has controls and System edits that ensure a correct spelling and enforce a standard nomenclature for dosage and form.

The workflow features of this layer govern how data flows through the System and routes data interaction based upon decision-making parameters as defined by specific clinical conditions and business rules. This layer contains business objects that encapsulate attributes, characteristics and business rules associated with Members, Care Coordinators, Care Plans, etc.

Additionally, the layer offers a services component that enables discrete units of code to perform specific functions or activities such as performing a Comprehensive Medication Review or saving a Care Plan.

**Data Layer**

The Data Acquisition/Canonical Rules Layer accepts standards based as well as non-standards based data from claims processing (837, 835) and enrollment systems (834), external partners (CCD/CCDA) and Rx (NCPDP). All external partner data flows into iCentric occur via the Data Acquisition Layer where regular audit, balancing and controls are applied to ensure that only the most accurate data is ultimately included in iCentric. Most data is received and ingested on a daily basis. This layer combines, transforms and prepares data for subsequent processing.

**Security**

- General Security of Controls
    - Adoption of the NIST control framework
    - 7x24x365 security monitoring
    - Removable media controls and encryption
    - Advanced threat detection, analytics and containment

All data interfaces with external parties are implemented through secure, encrypted channels enabling CareFirst data processing environments to be fully protected. The non-production environments use obfuscated (or de-identified) data that can be used to simulate real world test cases and scenarios while protecting the confidentiality of the data**.**

In the production environment, data is logically segregated and control is strictly managed. Controls are further augmented by logic that links treating providers with their Member base meeting HIPAA requirements to limit access of PHI to treating providers and other authorized persons.

Comprehensive Audit/Balance/Control processes are used to ensure that the data is properly validated and maintains its integrity as it is loaded into the System.

The following Elements are designed into the System to assure security is maintained:

**Role Based Access Controls**

- A provisioning system is used for setting up security for each user of iCentric.
- This provisioning system administers access to all data and functionality in iCentric.
- Roles are administered based upon each individual's job function or responsibility within the PCMH Program. This includes de-provisioning based on changes in user roles.
- An ongoing access review process ensures that parties accountable for each role periodically review each user's role assignment and attest that access is still appropriate.
- Single sign on functionality uses the industry standard SAML 1.2 or above.

**Web Application/Service Security**

- A code scanning and manual review process is performed prior to new releases as part of the Systems Development Life Cycle (SDLC). The System also undergoes a dynamic (e.g., run-time) scan prior to production deployment. Defects identified are addressed as part of the defect resolution phase.
- Real time scanning is performed dynamically for known web application security vulnerabilities such as SQL injections, cross-site scripting, and session hijacking.
- Application firewalls provide real-time defense-in-depth against application hacking and malicious attacks in production.

**Network Security**

- All data exchanged with external partners is encrypted with security devices using Secure Socket Layer (SSL) or Secure File Transfer Protocol (SFTP) usage.
- The iCentric System resides on a separate network segment from the rest of CareFirst's environment.
    - This allows control of the System to be tightly monitored.
    - All data that flows in or out of the network segment is explicitly defined in the firewalls as trusted exchanges limited to the pre-defined network protocols.
- Intrusion Prevention System (IPS) is provided at the network layer and wireless sensors augment the IPS functions to prevent wireless network intrusions and attacks.
- Monitoring provides real-time and historical information on network activity, system outages and custom alerts.

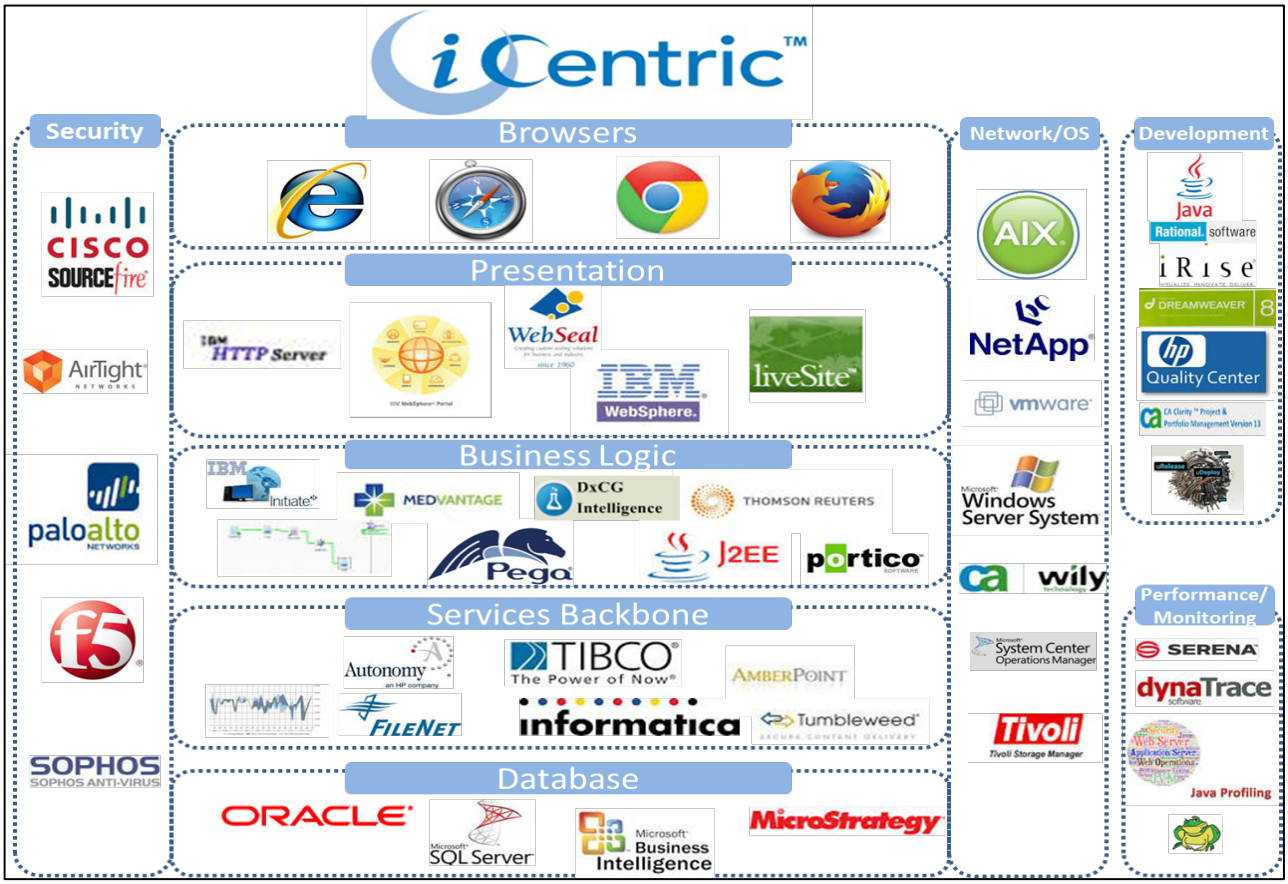
**Governance and Threat Management**

- In implementing iCentric, CareFirst built in all relevant regulatory requirements including, but not limited to, the following:

    - Compliance with HIPAA
    - Auditability of access administration
    - Jurisdictional or state law specific requirements
    - Code review and a complete security design ensure segregation of application data views and functions

The overall architectural design of iCentric along with the principal technologies/software used in development and operation of the System is presented in **Figure 3** below.

**Part VIII, Figure 3: iCentric Architectural Design**




- iCentric has been built iteratively over time in accordance with its master architectural design. Typically, the System has undergone four major releases per year with smaller releases issued in a continuous stream – but all in accord with the master vision of the System.

- The vast majority of the software is custom built using industry standard frameworks, toolkits and technical platforms. The most significant of these software components include:

    - IBM Websphere Application and Portal Servers – provides web enabled capabilities that power the iCentric User Interface Layer;

- TIBCO Middleware – orchestrates the business logic and services flow across the various architectural layers;

- PEGA Business Rules – directs user oriented workflows and decision making;

- Informatica – extracts, transforms and loads all the externally sourced, native data into the iCentric data model;

- Oracle – stores, maintains and accesses the transactional data the flows throughout iCentric user experiences; and

- Microsoft Business Intelligence – warehouses all PCMH/TCCI Program data and makes it available for data analytics, reporting, dashboards, scorecards, etc.

Over time, the development and testing of the iCentric platform has become more and more automated. The Software Development Lifecycle (SDLC) processes that have been used in developing and maintaining the System – such as requirements analysis, design, development, test and deployment - are universally followed by software development teams all over the world.

**iCentric Operational Support**

CareFirst provides three levels of support for the iCentric Platform:

- Data Center Service Desk
    - Resolves iCentric System availability issues
    - Provides awareness and outage notification services via e-mail to specified individuals relative to planned or unplanned System outages and availability impacts

- PCMH Operations Support
    - Handles inquiries relating to business, data and configuration issues
    - Creates, tracks and communicates incidents and service requests
    - Conducts test enhancements and defect resolution

- Technical Support
    - Troubleshoots technical issues, triages defects and implements fixes and workarounds as needed to keep the platform operational

There were approximately 40,000 PCMH registered users as of July 1, 2016, each with a tailored view of their data and workflows defined by their job function. The views and workflows are governed via role based access security controls. Primary user types include:

- Local Care Coordinators
- Regional Care Directors
- Practice Consultants
- Case Managers
- Hospital Transition of Care Nurses
- Service Request Hub Coordinators
- Partners (such as Healthways, Magellan, CVS/Caremark, home care agencies, etc.)
- PCPs and all types of treating providers

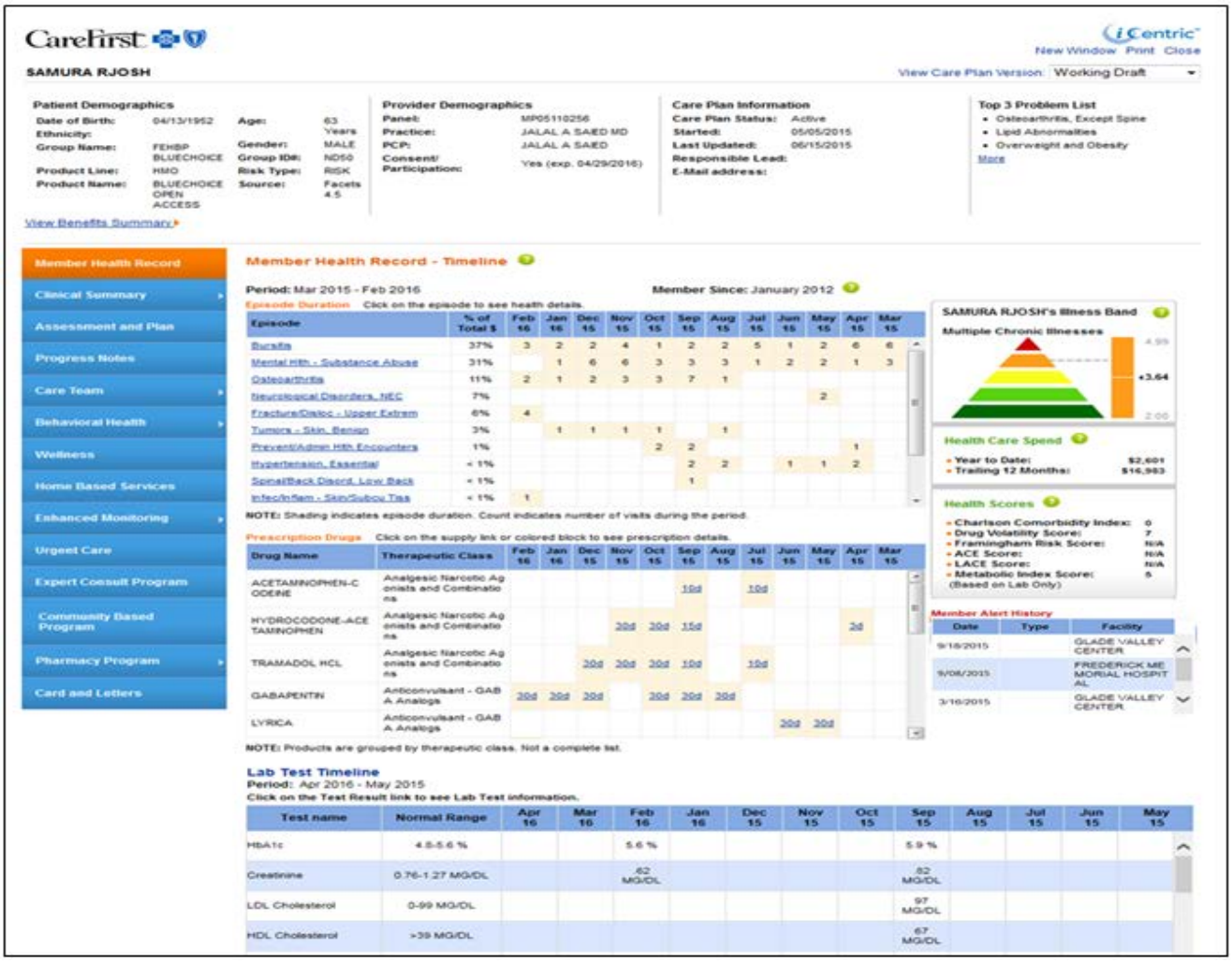
## Overview Of The 10 Major Domains Of iCentric Functionality

### Domain #1: Longitudinal Member Health Record

As discussed in **Part III, Design Element #7 - Online Member Health Record – Information "Home Base"**, one of the greatest stumbling blocks to better Care Coordination and improved cost/quality outcomes is the lack of a single, longitudinal record for each Member that tracks all the services a Member receives over time from any and all providers and that also holds and presents all data applicable to a Member in a single, multifaceted record.

The Member Health Record in iCentric provides a holistic view of all services, prescriptions and lab results in all settings involved in treating a Member as well as all services provided to coordinate, assess, and monitor the care of a Member. It also provides an up to date record on all Care Coordination activities brought to bear for a Member including the Care Plan of a Member if they are in one (or ever were in one). This includes any other services rendered through any of the supporting TCCI Programs that are integrated with the PCMH Program. The Member Health Record also provides key indices of the health status of the Member as these have been determined over time. This is shown in the screen print below.

**Part VIII, Figure 4: Member Health Record**



**Care Coordination Efforts at a Glance**

As can be seen, the Member Health Record screen shows in one view, a quick snapshot of what is relevant about a Member's service history and health status. In addition to the major blocks of data on Member demographics, service history, medications, labs and health indices, the list to the left of the screen contains detail on each of the topics denoted by the tabs shown. This is applicable to Members in Care Plans who often receive a number of different Care Coordination services. Much of the data contained in these tabs is unstructured and is entered into the Member Health Record by CareFirst provider partners as they work to provide the portion of the Member's Care Plan for which they are responsible.

This could, for example, include Behavioral Health Services with notes from the providers performing these services or home based agency services with the notes from the agency staff about the Member gathered during home visits. It is typical that a Care Plan for a Member with multiple conditions, diagnoses, tests and prescriptions will involve some, if not most of the categories shown in the tabs listed on the left side of the Member Health Record. Any provider involved in any of these tabs will typically enter data and notes in their native system and have these automatically sent to iCentric on a real time or daily basis. In this manner, a Care Plan is always kept up to date and any treating provider or Care Coordinator can retrieve the record and get a quick and comprehensive view of the Member's status in all of its various dimensions.

This kind of comprehensive view is typically not available in an EMR or PMS as noted earlier. Hence, it is desirable to use iCentric together with a provider's EMR through which the provider can see data and notes in their own system as well as instantly see what is in the Member Health Record. With single sign on integration in a Windows environment, this can be accomplished by minimizing or maximizing the particular screens one wants in each system.

It is also important to understand that many of the components in the summary view presented in the Member Health Record are drillable and with a single click, the authorized user can access the underlying detailed data views to gain a better understanding of a particular aspect of a Member's care.

Further, it should be noted that when multiple payers are involved in the Common Model as described in **Part IV** of these Guidelines – as was the case with the Health Care Innovation Award with Medicare FFS beneficiaries – all aspects of the Member Health Record and iCentric work in exactly the same manner and display the same information. Once learned by PCPs and other treating providers as well as Care Coordination Team members, this is extremely beneficial to the support of the Member regardless of which payer may be involved.

**Key Characteristics of Member Health Record**

The key characteristics of the Member Health Record include:

- All Member specific claims data, at a line/unit charge level of detail reflecting the edited and final disposition of each claim as adjudicated by CareFirst across all settings, providers, and services both in and out of network;

- All Member specific clinical care information that is entered into a Care Plan maintained for Members. This includes all orders, notes, referrals, and other information entered into the record by the PCMH provider, the Care Coordination Team or any other provider (e.g., a specialist) as a part of the care planning or care giving process;

- All clinical information on laboratory, pathology, imaging, prescription drug or other results that are obtained in furtherance of the Care Plan;

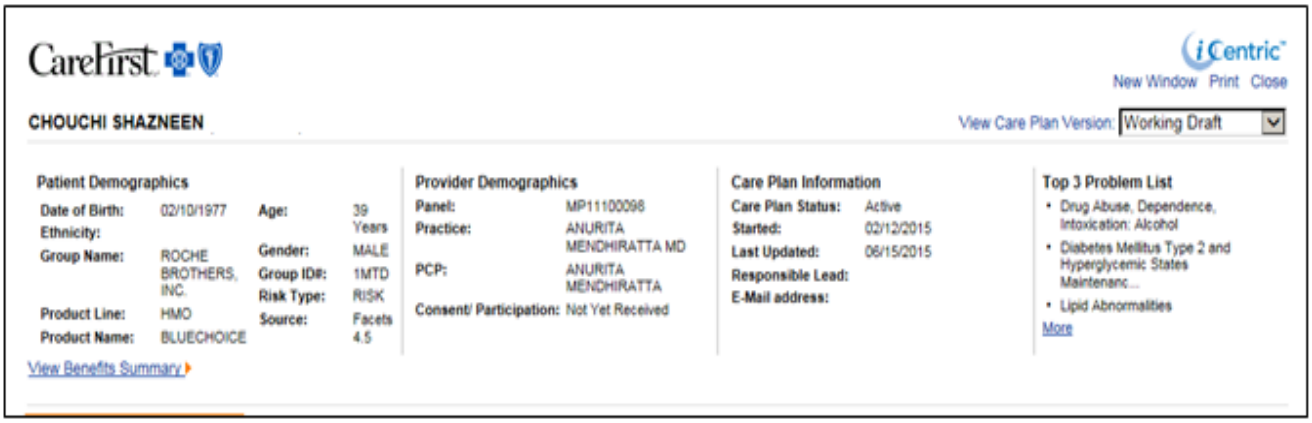
- Information about hospital admissions and hospital based services;

- All Member specific demographic, health risk appraisal and biometric information that is available; and

- The Member's Illness Band Score and trailing 12 months' claims expenses as well as Metabolic Index, LACE, Drug Volatility and other Indices and Scores (if applicable and available).

## Header of Member Health Record

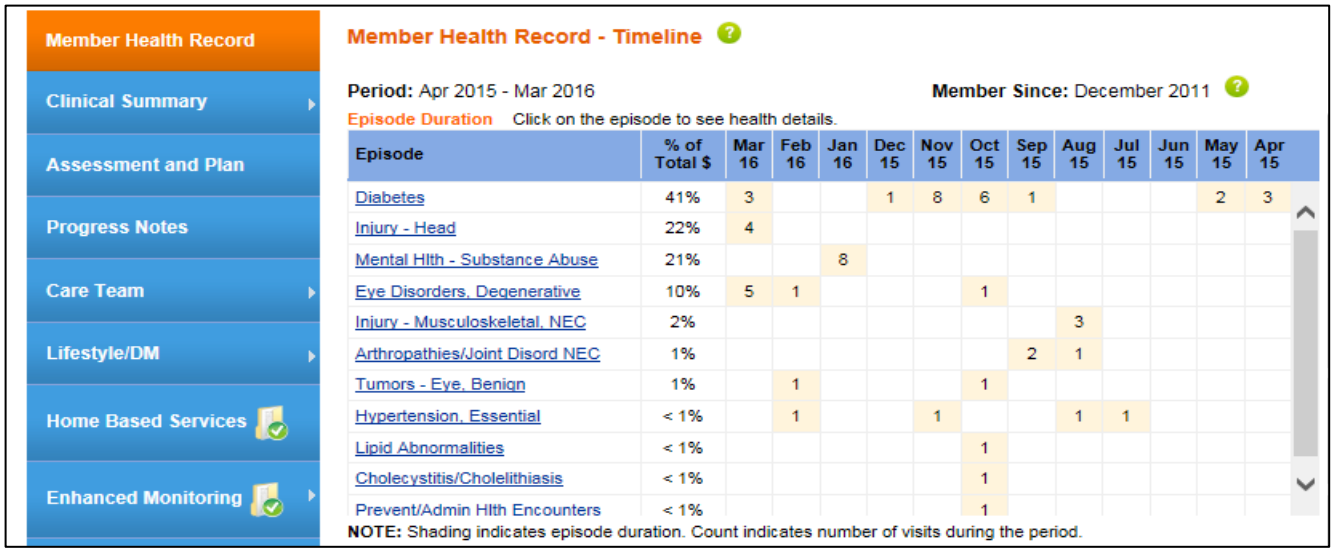
Member and provider demographics, Care Plan information, and the top three Member health problems are displayed along the top of the Member Health Record. The user may see an expanded view of the Member's benefits by clicking on the Benefits Summary link. This is extremely helpful in designing a Care Plan that meets the Member's needs within the context of the services for which they are actually covered under their health plan.




## Timeline of Services

Below the top banner in the Member Health Record is a timeline of the services for which claims associated with a Member were submitted and paid (based on date of service). The time period of these services is listed as well as the length of time the Member has been a CareFirst subscriber. The conditions listed under the Episode column give the user an overview of how frequently the Member has been seen by various providers for their particular conditions or diagnoses along with the cost of treatment for each type of provider and service associated with these conditions and diagnoses (as a percent of the total dollars spent for the Member's care). The user can quickly view the timing of the care provided and assess if any conditions are in an acute phase of treatment. The user may click on the hyperlinks in the Episode column to receive more detailed information on the condition.

As an example, if the user were to click on the Diabetes link, information such as is shown below would be displayed. The user can see the date any service was provided, the name of the provider, the type of service or procedure that was performed, and the diagnosis code. The user can also see any prescriptions associated with the episode of care.




| Episode | % of Total $ | Mar 16 | Feb 16 | Jan 16 | Dec 15 | Nov 15 | Oct 15 | Sep 15 | Aug 15 | Jul 15 | Jun 15 | May 15 | Apr 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | 41% | 3 | | | 1 | 8 | 6 | 1 | | | | 2 | 3 |
| Injury - Head | 22% | 4 | | | | | | | | | | | |
| Mental Hlth - Substance Abuse | 21% | | | 8 | | | | | | | | | |
| Eye Disorders, Degenerative | 10% | 5 | 1 | | | | 1 | | | | | | |
| Injury - Musculoskeletal, NEC | 2% | | | | | | | | 3 | | | | |
| Arthropathies/Joint Disord NEC | 1% | | | | | | | 2 | 1 | | | | |
| Tumors - Eye, Benign | 1% | | 1 | | | | 1 | | | | | | |
| Hypertension, Essential | < 1% | | 1 | | | 1 | | | 1 | 1 | | | |
| Lipid Abnormalities | < 1% | | | | | | 1 | | | | | | |
| Cholecystitis/Cholelithiasis | < 1% | | | | | | 1 | | | | | | |
| Prevent/Admin Hlth Encounters | < 1% | | | | | | 1 | | | | | | |

Period: Apr 2015 - Mar 2016

Return To Previous

Episode: Diabetes

Medical

Filter Details

Procedure: All  Diagnosis: All  Submit

| Service Date | Provider Name | Procedure Code | Principle Diagnosis Code |
|---|---|---|---|
| 11/24/2015 | GAITHERSBURG CRITICAL CARE | 99233 subsequent hospital care | 25010 Db W/Ka Type Ii/Uns Not Uncntrl |
| 11/23/2015 | GAITHERSBURG CRITICAL CARE | 99291 critical care first hour | 25010 Db W/Ka Type Ii/Uns Not Uncntrl |
| 11/23/2015 | HOSPITAL MEDICINE PHYSICIANS O F MARYLAND PC | 99223 initial hospital care | 25010 Db W/Ka Type Ii/Uns Not Uncntrl |
| 11/23/2015 | MEP LLC | 99291 critical care first hour | 25010 Db W/Ka Type Ii/Uns Not Uncntrl |
| 11/23/2015 | SHADY GROVE ADVENTIST HOSP | 3893Venous Catheterization Nec | 25011 Db W/Ketoacidos Type I Not Uncntrl |
| 11/23/2015 | SHADY GROVE RAD CONSULT PA | 71010 chest x-ray 1 view frontal | 7862 Cough |

Prescription Drugs

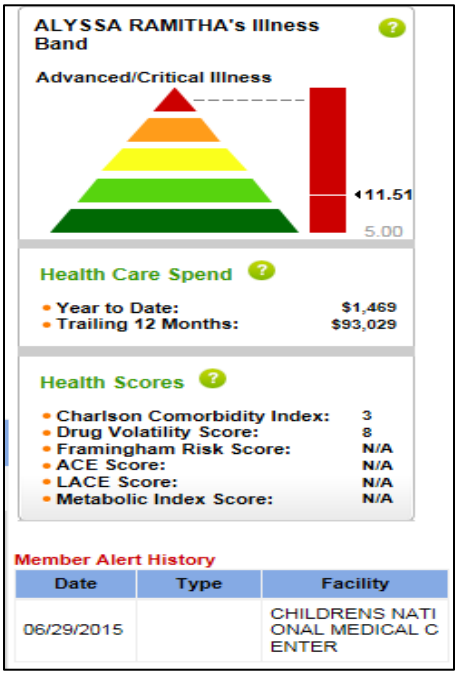
Filter Details

Drug Name: All  Therapeutic Class: All  Submit

| Service Date | Drug Name | Therapeutic Class | Prescribing Provider | Strength | Generic | Days Supply | Allowed Amount | Copay |
|---|---|---|---|---|---|---|---|---|
| 12/02/2015 | SERTRALINE HC L | Antidepressant - Selective Sero tonin Reuptake Inhibitors (SSRI s) | MENDHIRATTA, ANURIT A | 25 mg | N | 30 | $3 | $3 |

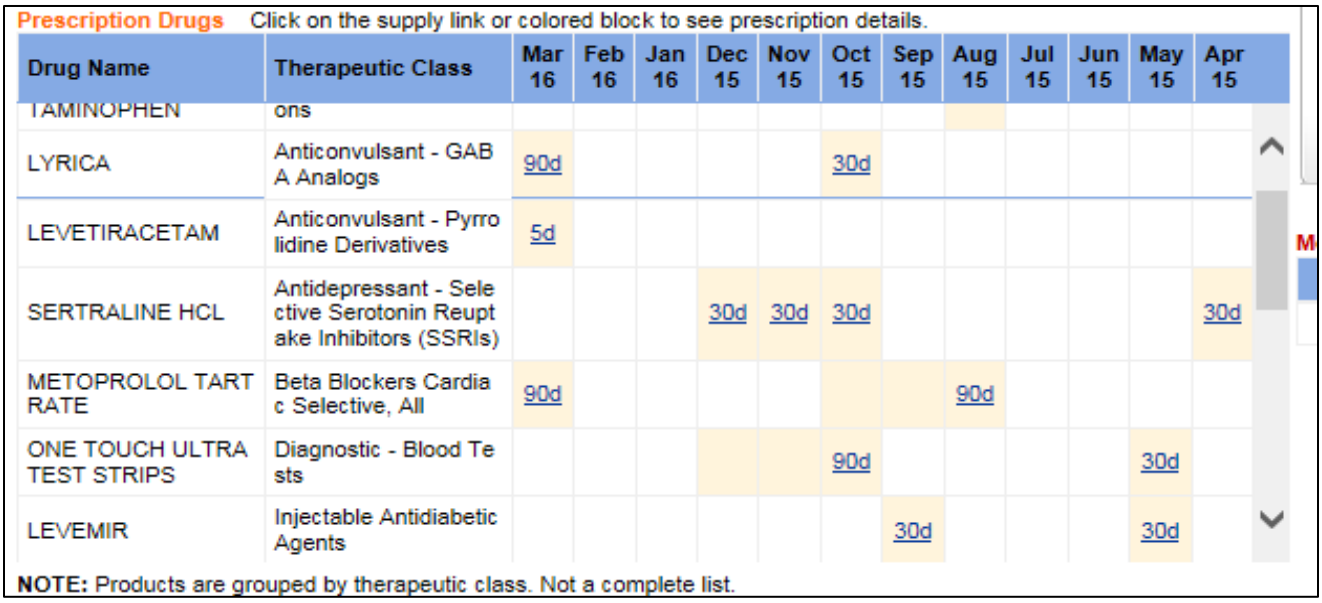
## Member's Illness Band

Located next to the timeline of claims is the Member's Illness Band as most recently calculated as well as a summary of the cost of the Member's care within the last 12 months, and a number of indices/scores that help the reviewer evaluate the level of health or instability and vulnerability of the Member. The user may also see any alert history for the Member. In this case, the alert shows that the Member was hospitalized.



**Member's Medications**

For Members with a CareFirst pharmacy benefit, the Member's medications are listed, as well as the therapeutic drug class of each medication and a snapshot of drug refill activity. The reviewer may click on the hyperlinks to gather more information about each refill.

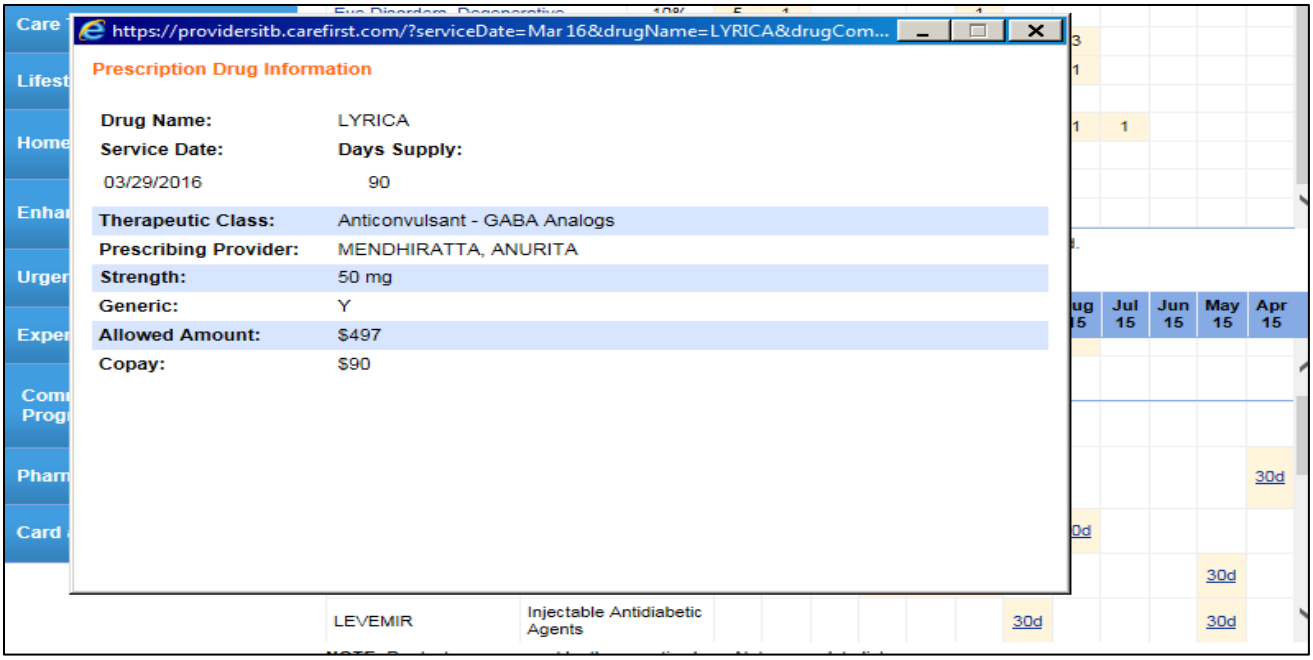


Prescription Drugs Click on the supply link or colored block to see prescription details.

| Drug Name | Therapeutic Class | Mar 16 | Feb 16 | Jan 16 | Dec 15 | Nov 15 | Oct 15 | Sep 15 | Aug 15 | Jul 15 | Jun 15 | May 15 | Apr 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TAMINOPHEN | ons | | | | | | | | | | | | |
| LYRICA | Anticonvulsant - GABA Analogs | 90d | | | | | 30d | | | | | | |
| LEVETIRACETAM | Anticonvulsant - Pyrrolidine Derivatives | 5d | | | | | | | | | | | |
| SERTRALINE HCL | Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRIs) | | | | 30d | 30d | 30d | | | | | | 30d |
| METOPROLOL TARTRATE | Beta Blockers Cardiac Selective, All | 90d | | | | | | | 90d | | | | |
| ONE TOUCH ULTRA TEST STRIPS | Diagnostic - Blood Tests | | | | | | 90d | | | | | 30d | |
| LEVEMIR | Injectable Antidiabetic Agents | | | | | | | 30d | | | | 30d | |

**NOTE:** Products are grouped by therapeutic class. Not a complete list.

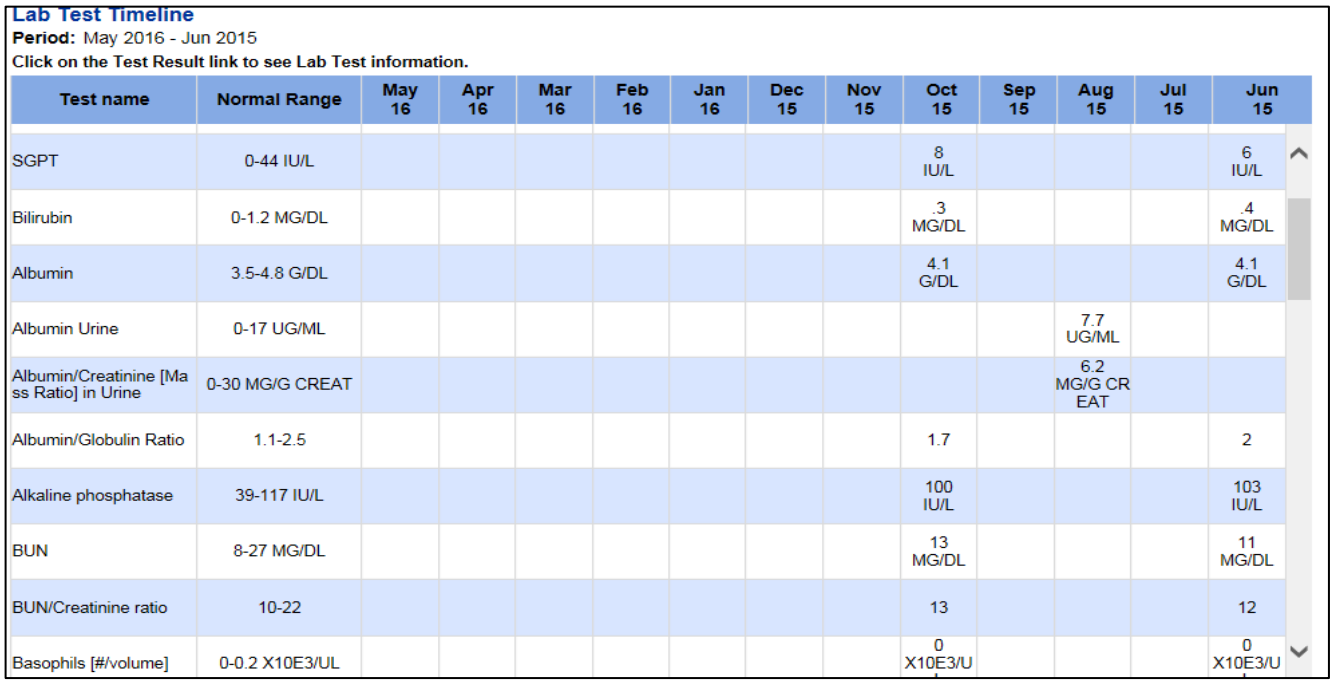
For example, if the user were to click on Lyrica, the following would be visible:




The reviewer would be able to see when the drug was refilled, along with the drug class, prescriber, drug strength, the allowed amount for the drug and the Member's copay.

## Lab Test Timeline

An additional Element of the Member Health Record is the lab test result timeline. The timeline displays the last 12 months of data, including the test name, the range of normal values, and the actual test value displayed in the column for the appropriate month. At a glance, the user can observe if the Member is due for a regular lab test or is missing key tests from the timeline.



**Lab Test Timeline**

**Period:** May 2016 - Jun 2015

**Click on the Test Result link to see Lab Test information.**

| Test name | Normal Range | May 16 | Apr 16 | Mar 16 | Feb 16 | Jan 16 | Dec 15 | Nov 15 | Oct 15 | Sep 15 | Aug 15 | Jul 15 | Jun 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SGPT | 0-44 IU/L | | | | | | | | 8 IU/L | | | | 6 IU/L |
| Bilirubin | 0-1.2 MG/DL | | | | | | | | .3 MG/DL | | | | .4 MG/DL |
| Albumin | 3.5-4.8 G/DL | | | | | | | | 4.1 G/DL | | | | 4.1 G/DL |
| Albumin Urine | 0-17 UG/ML | | | | | | | | | | 7.7 UG/ML | | |
| Albumin/Creatinine [Mass Ratio] in Urine | 0-30 MG/G CREAT | | | | | | | | | | 6.2 MG/G CREAT | | |
| Albumin/Globulin Ratio | 1.1-2.5 | | | | | | | | 1.7 | | | | 2 |
| Alkaline phosphatase | 39-117 IU/L | | | | | | | | 100 IU/L | | | | 103 IU/L |
| BUN | 8-27 MG/DL | | | | | | | | 13 MG/DL | | | | 11 MG/DL |
| BUN/Creatinine ratio | 10-22 | | | | | | | | 13 | | | | 12 |
| Basophils [#/volume] | 0-0.2 X10E3/UL | | | | | | | | 0 X10E3/U | | | | 0 X10E3/U |

## Domain #2: Care Plan Management, Documentation And Tracking

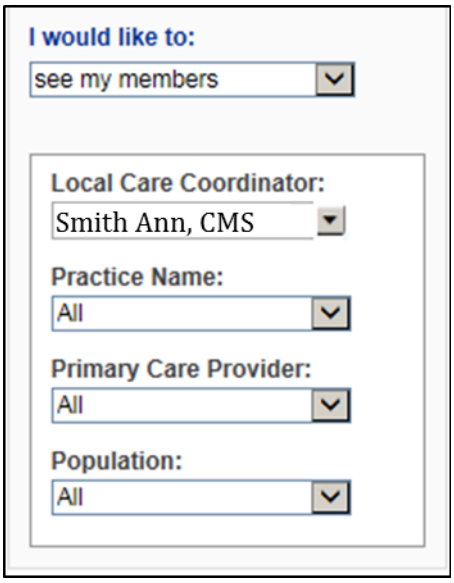
As discussed in **Part III: Design Element #6 - Enhanced Focus On The Chronic Member – Care Plans And Care Teams**, once a Member has been identified for a Care Plan and the Member's needs and circumstances have been carefully considered, the LCC, CCM or BSA will develop the Member's plan of care by developing a comprehensive clinical, social and demographic work up for the Member and assemble this information in the iCentric Care Plan template. Over time, the Member's consent as well as all medical notes, directives, follow-ups etc., are entered by the Care Coordinator on a timely basis into iCentric, thus creating a running longitudinal record – with commentary by the various providers and LCC involved – on how the Member is progressing.

The process for selecting appropriate Members for Care Plans, establishing and monitoring actionable goals for these Members, reviewing the quality of Care Plans and determining when to end a Care Plan is discussed at length in **Appendix E: Standard Operating Procedures For Care Plan and Chronic Care Coordination.**

Care Plan activity is supported by a communication plan that welcomes the Member into the Program, describes the Program and the Member's responsibilities and upon successful completion, congratulates the Member through a graduation letter as an encouragement to maintain the stability of their health.

### Member Queue

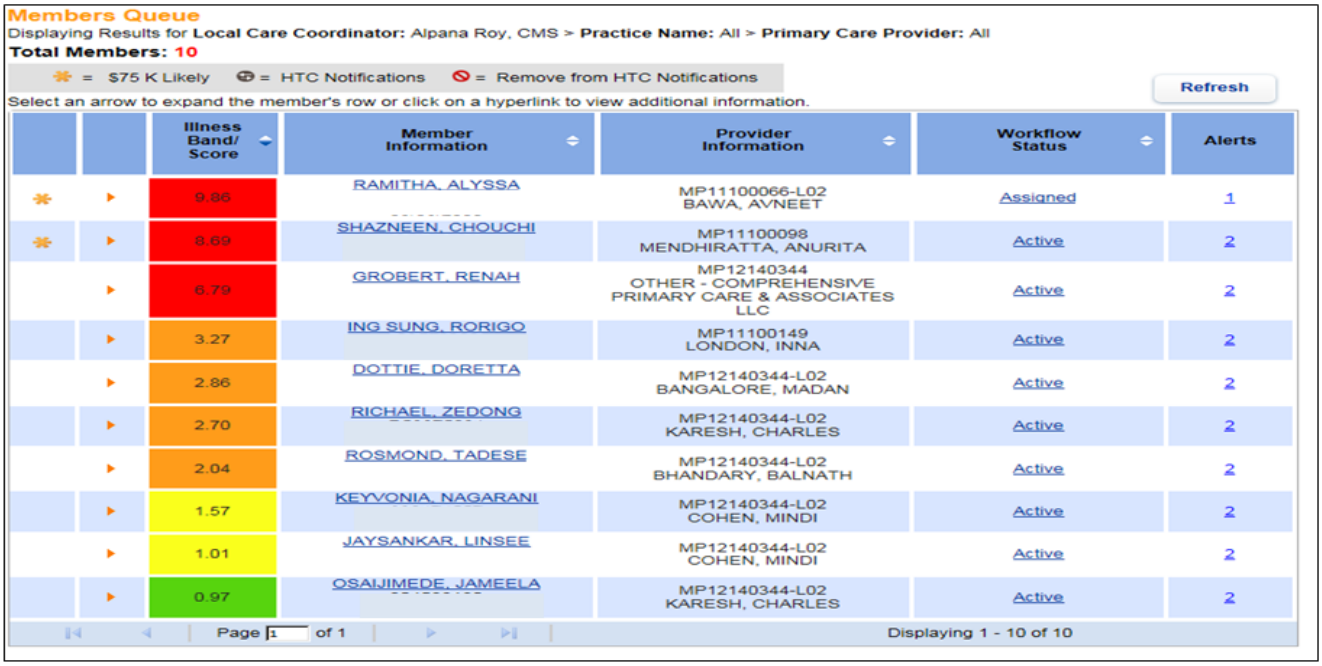
The Member Queue is used in managing and tracking Members receiving Care Coordination. The Care Coordinator can click "see my Members" and then filter by LCC, PCP practice or individual PCP. In a Common Model mode, this is applicable to either the CareFirst or Medicare populations or to any other payer population once set up on the iCentric System.




The user can then see all the Members in various workflow statuses, including which Members have been "Assigned" for review, others who are "Scheduled" to see their PCP, those for whom Care Plans are "In Development" and those who are in "Active" status during the course of their Care Plan. For example, the user can use the Active workflow status filter to be able to see all the Members currently "Active" in a Care Plan.

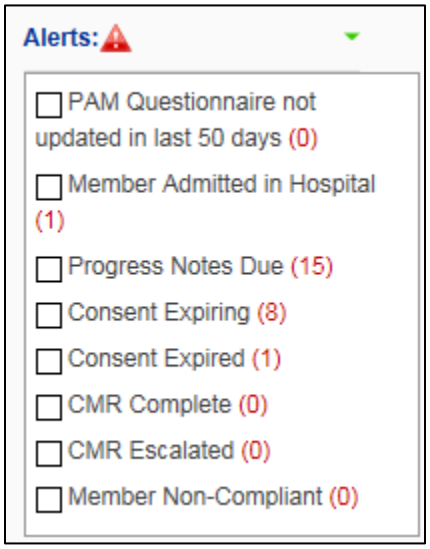
In the screen shot below, the left column in the Member Queue may contain an asterisk. The asterisk indicates that the Member may incur significant cost in the upcoming year. The Members are listed in the Member Queue by highest to lowest Illness Burden Score, with the Members with the highest Illness Burden Scores displayed at the top of the list. Next to the Illness Burden Score is the Member's name, Member ID, and date of birth. Provider information and workflow status are next, followed by the Alert column. This all eases Coordinator action and greatly enhances efficient controls. When one

considers that over 50,000 Care Plans are activated in any given year, a workflow and status management capability such as this is absolutely essential to managing such a large, diverse and far flung case load.




**Alert Column**

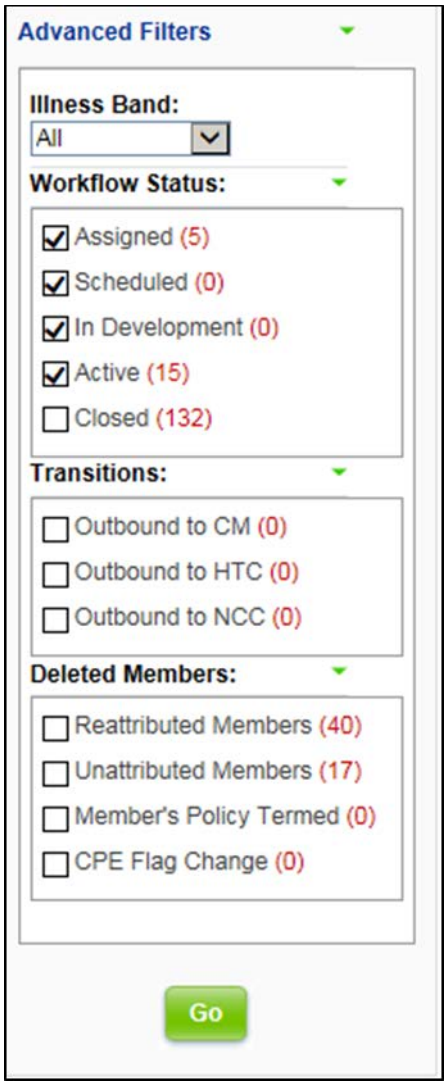
The Alert column allows the user to identify which Members may need extra attention. For example, the user may want to ensure that a Member admitted to the hospital is scheduled for an appointment with the PCP as soon as possible post-discharge. The most common Alert is, “Progress Notes Due.” This also allows the Care Coordinator to understand which Members have been contacted during the past week and which Members still need to be called by the Care Coordinator to check on their status.




The user may also filter by the workflow status of the Member in order to manage various stages of the Care Coordination process. For example, the Care Coordinator can assign Members to the Member Queue, believing that the Member has

potential to benefit from Care Coordination. Once the Member has an appointment scheduled with the PCP, the Care Coordinator may move the workflow status to the "Scheduled" category. Once the PCP and the Care Coordinator have discussed the Member's health status and decide to pursue Care Coordination, the user would move the workflow status to "In Development". Once the Care Plan has been written and the PCP approves, the workflow status moves to "Active". When Care Coordination work is complete, the workflow status is changed to "Closed". The Care Coordinator may also see any pending care transitions from Case Management, Hospital Transitions, or from the National Care Coordination Team. The user may use the Deleted Members section to find Members who have been unattributed or reattributed or to find Members who no longer have active CareFirst coverage, or Members who have had a change in their benefit structure.

In this manner, the workflow of the CCM or the LCC is greatly enhanced in efficiency and accuracy – thereby, better assuring that the Members most in need are properly identified and tracked through each step of the Care Coordinator process.

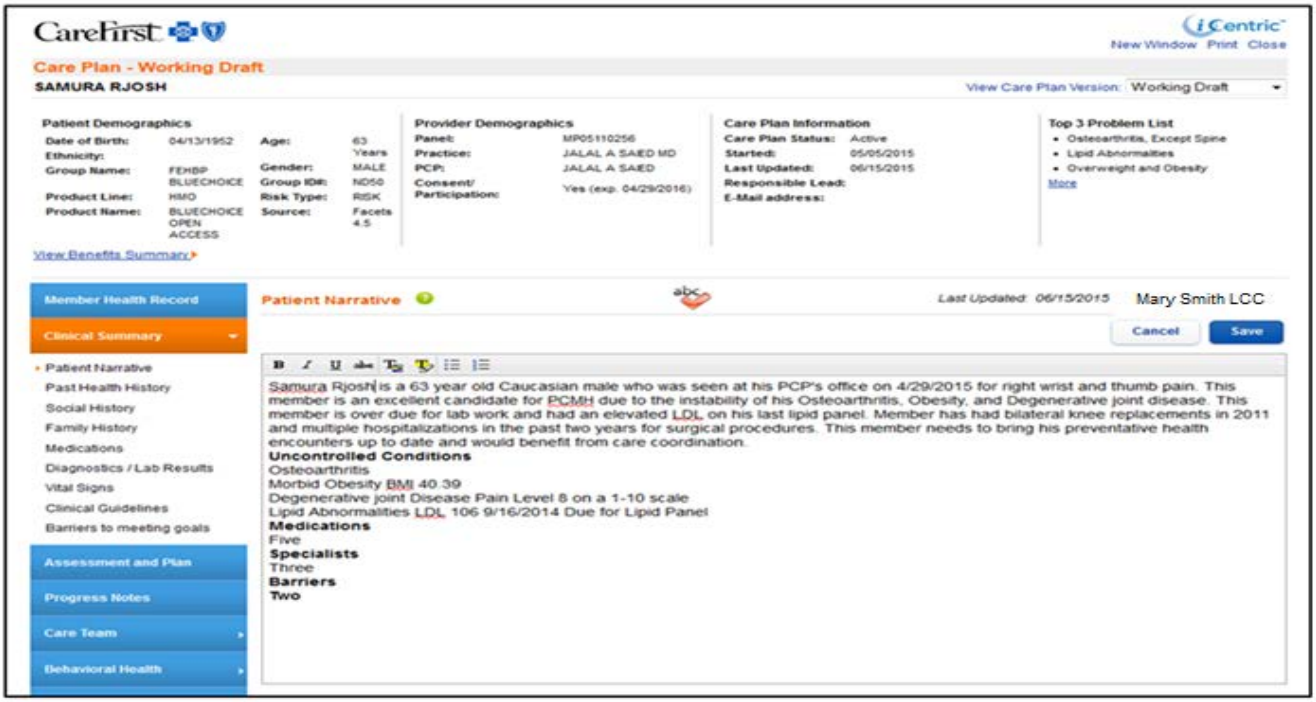



**Clinical Summary – Patient Narrative**

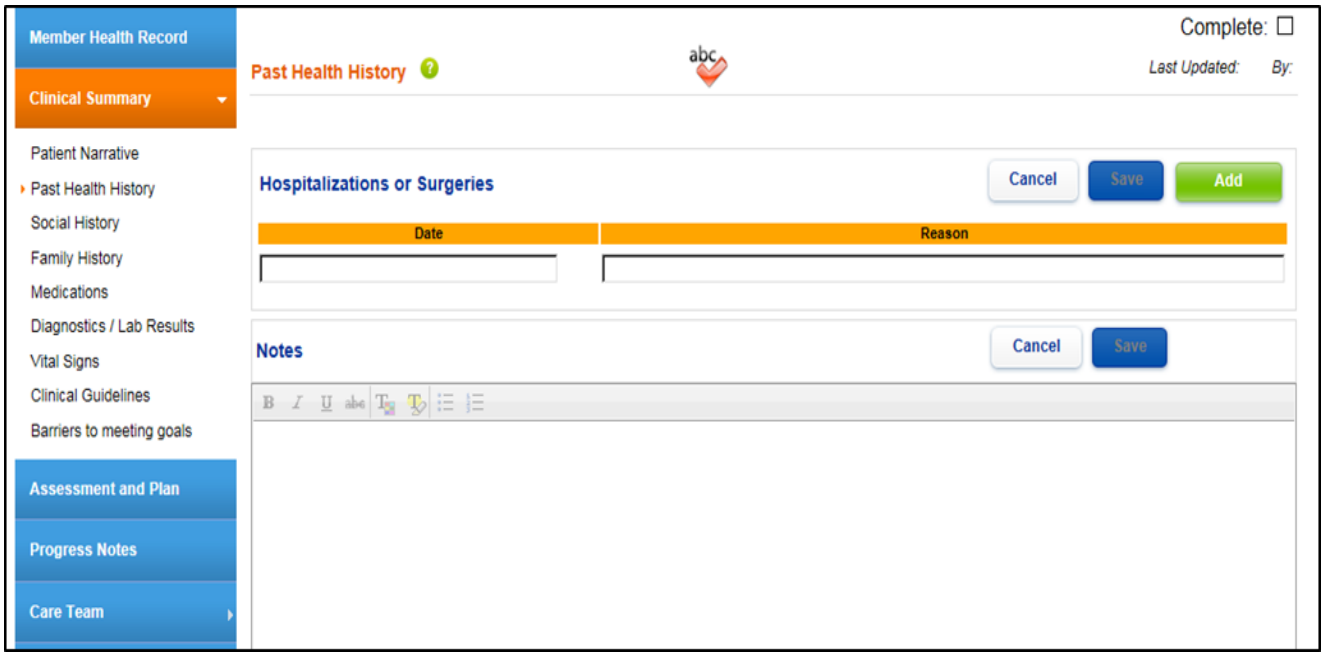
After selecting a Member from the Member Queue, the Care Coordinator completes the various portions of the Care Plan. The Clinical Summary section of the Care Plan template serves as the collection point for clinical, social and demographic history and status of the Member. As shown below, Care Plan navigation is driven through a series of functions on the left-hand side, with the component being worked displayed on the right. The Patient Narrative provides a succinct clinical

summary that describes the Member's circumstances and serves as an introduction for some of the obstacles and challenges facing the Member.

**Past Health History**

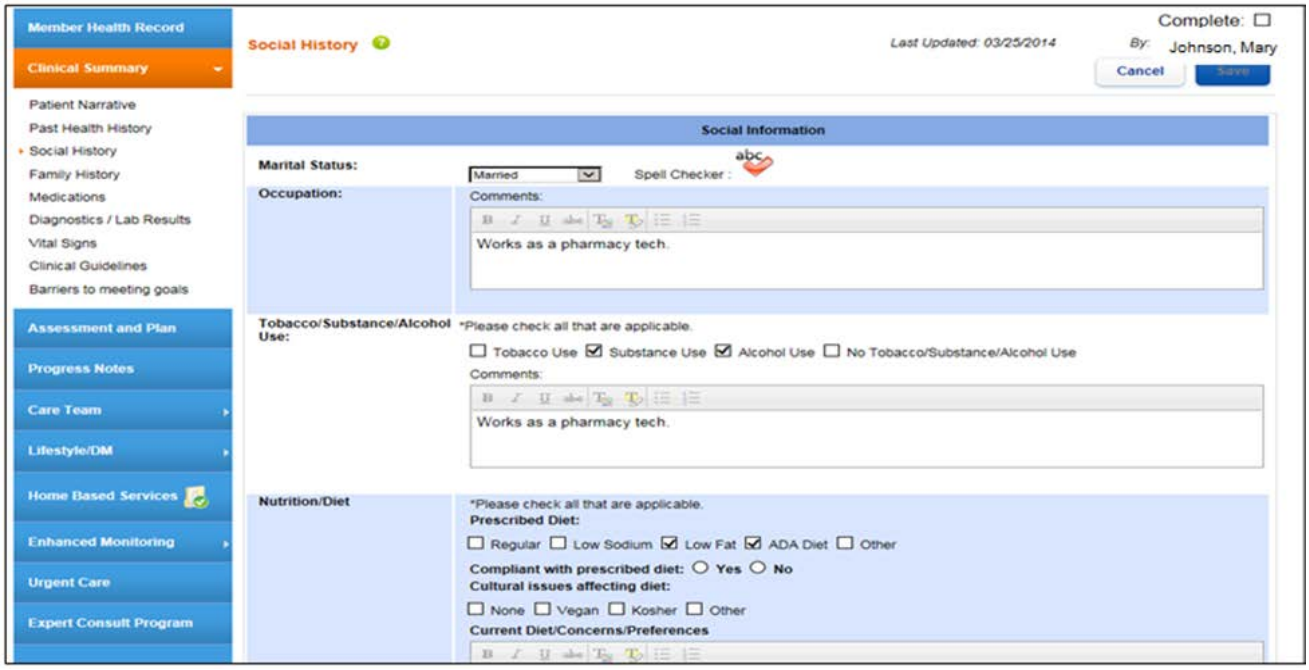



The next Element is the Past Health History. Here the Care Coordinator describes any past hospitalizations, surgeries or medical events in this area, along with any other health history the user is able to gather.



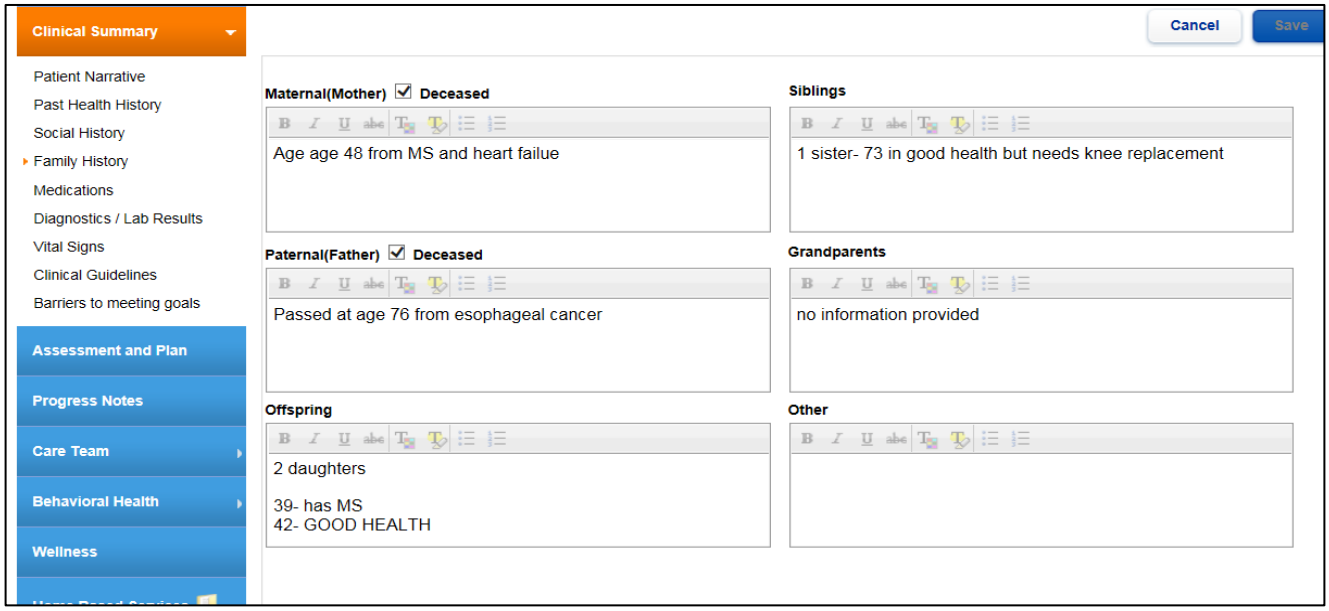
## Social History

The Social History section of the Care Plan contains critical background information on the Member. This is where the occupation, marital status, nutrition level, smoking status, capacity to handle activities of daily living, and use of assistive devices are documented, along with many other important pieces of Member information are entered.



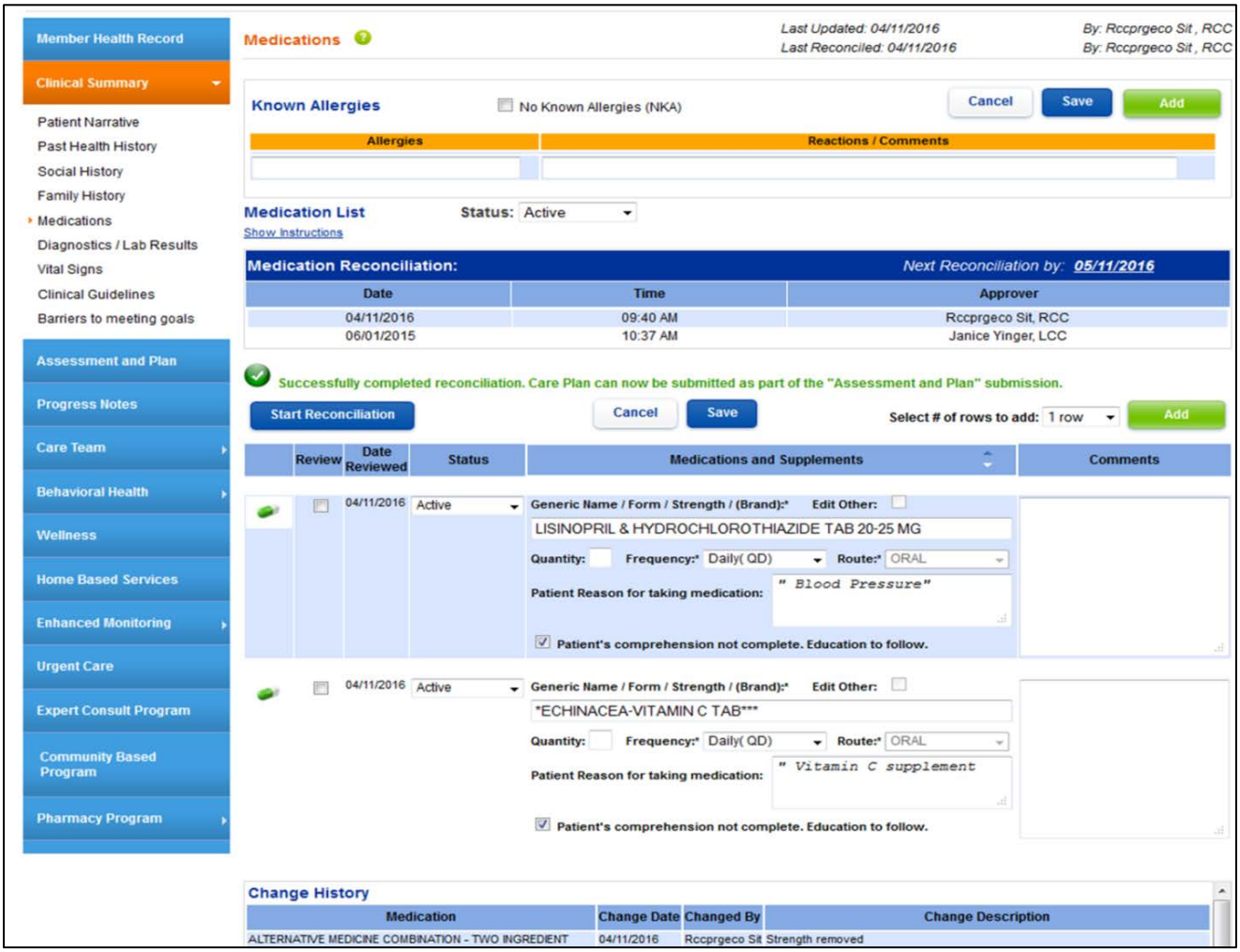

## Family History

The Family History portion of the Care Plan provides the health care team with context for the Member's current conditions. A marked family history of a particular disease may lead the team to start proactive screening or lead to a specific course of treatment.



## Medication Therapy

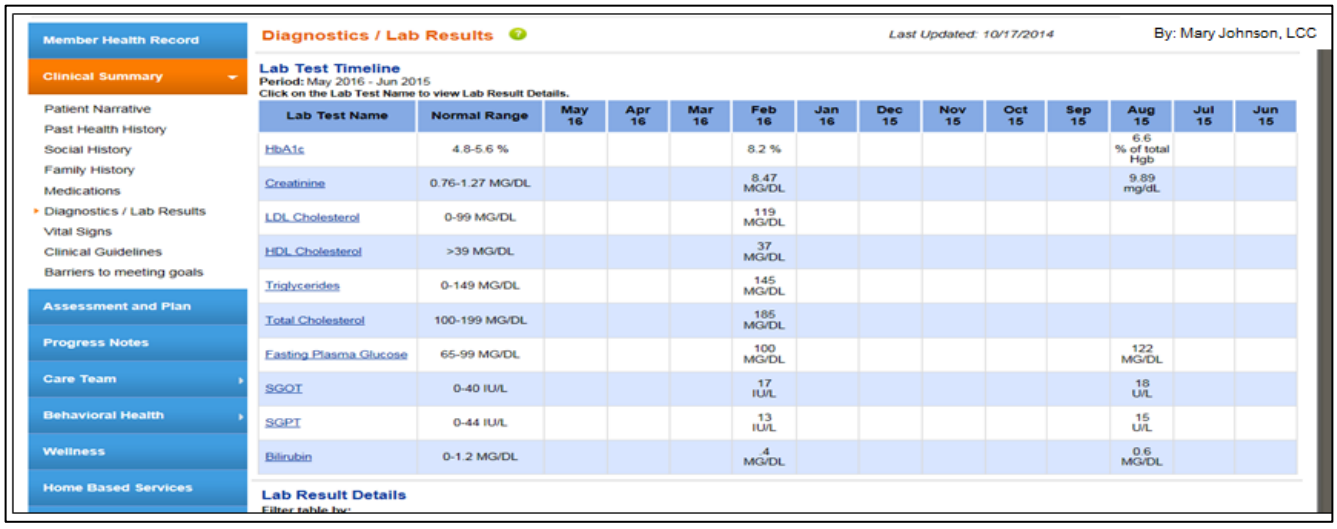
The Medication component of the Care Plan serves as the vehicle for collecting all medications a Member is taking, including Over-The-Counter (OTC) medications or medications that are purchased out of pocket, outside of the Member's medical benefit. At the time of Care Plan activation and on a monthly basis thereafter, the LCC routinely confirms what drugs a Member is taking, as well as noting the Member's understanding of each drug's therapeutic affect and side-affects. When indicated, the Medication Reconciliation information is the basis for triggering a Comprehensive Medication Review that allows a pharmacist to understand what medications a Member is taking and make recommendations for any change necessary due to clinical appropriateness, dosage/administration issues, adherence history or concerns stemming from high risk medications that may create instability or harm given a Member's age or health status.



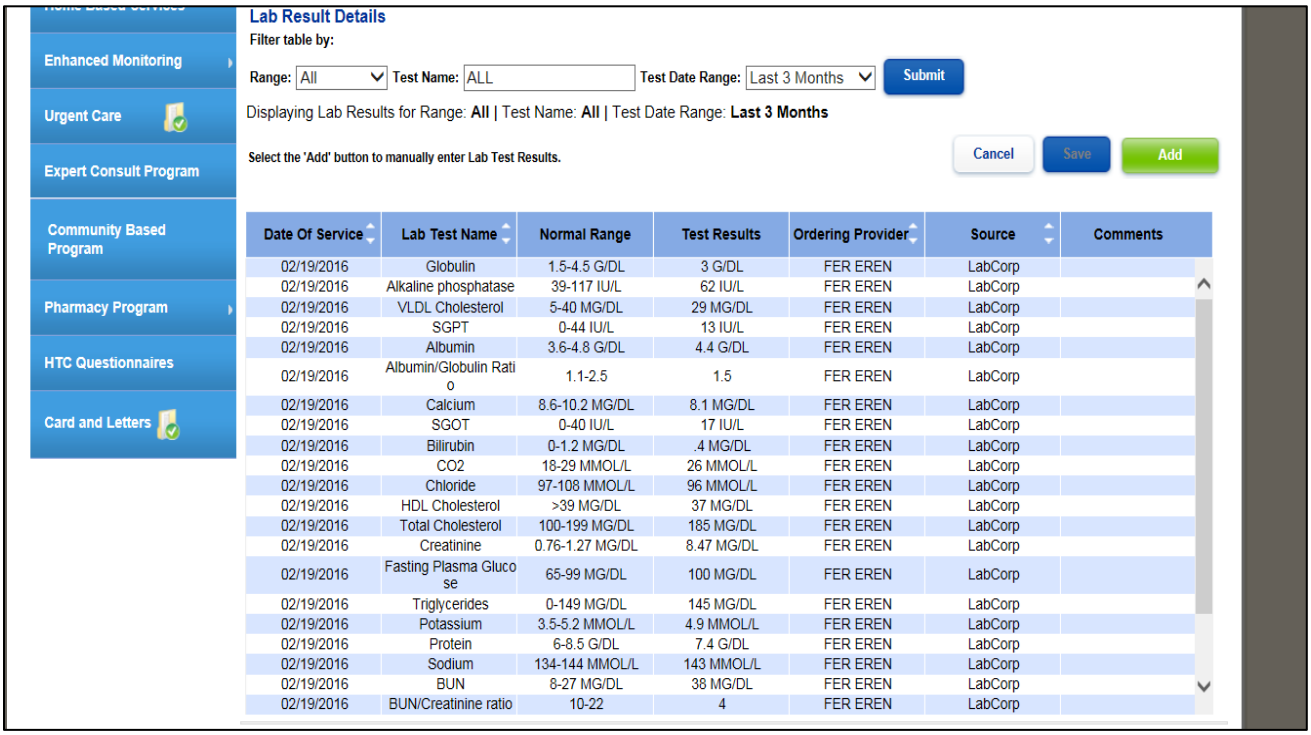

## Diagnostics/Lab Results

The Diagnostics/Lab Results section of the Care Plan contains the Member's recent and historical lab values. The lab test timeline includes the name of the test that was performed, the range of normal values, and the actual results of the test located in the appropriate month column. It should be noted that while CareFirst continuously receives lab results on most Members, it does not receive information on all Members due to the use of specialty or local lab providers not all of whom are yet connected to iCentric. This is being "worked" by CareFirst so that as many Members as possible have their lab results available in the Member Health Record.

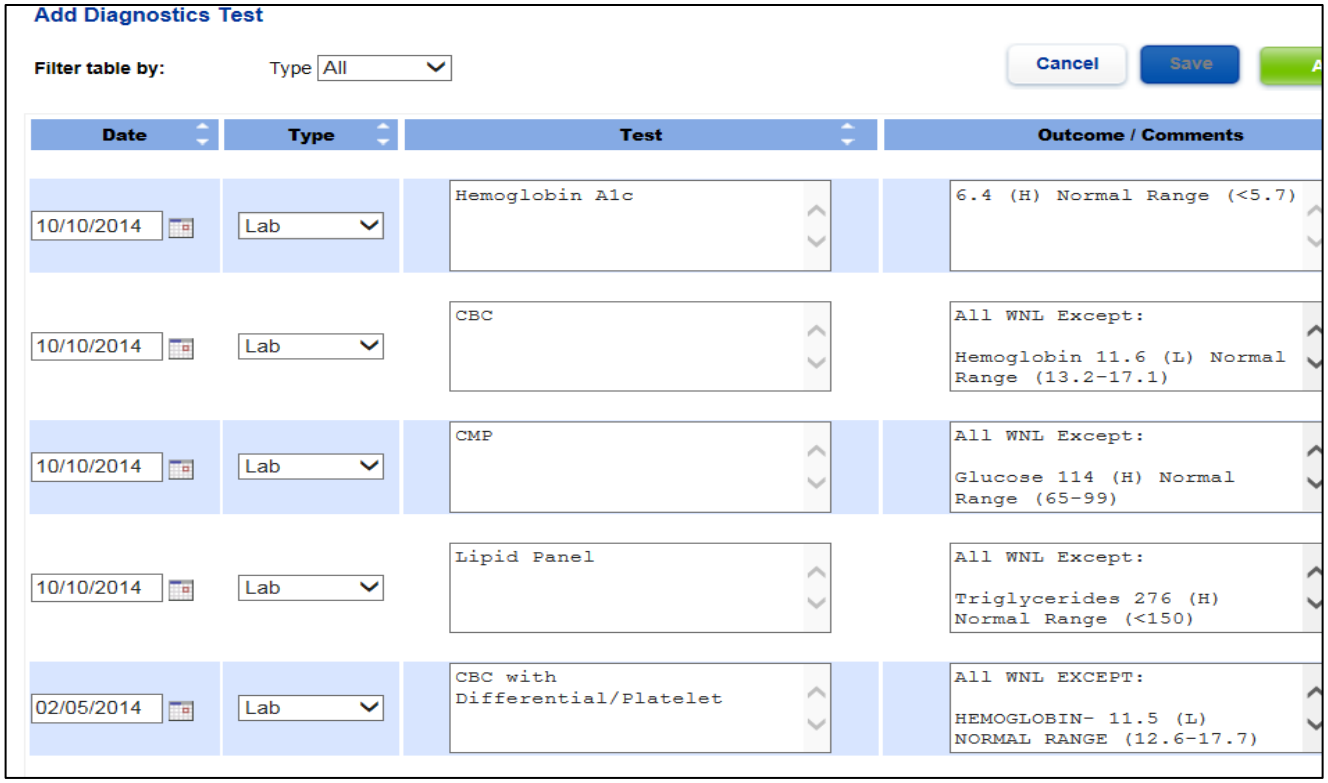
If a Member in a Care Plan has lab work done through a vendor that does not yet provide an automated feed of lab results to CareFirst, the Care Coordinator will enter these results directly into iCentric and keep this data up to date as long as the Member remains in their Care Plan.




Lab result details are presented when the user clicks on the Lab Results Details indicator. Among other things, this allows the user to see the ordering provider and where the test was performed as shown below:

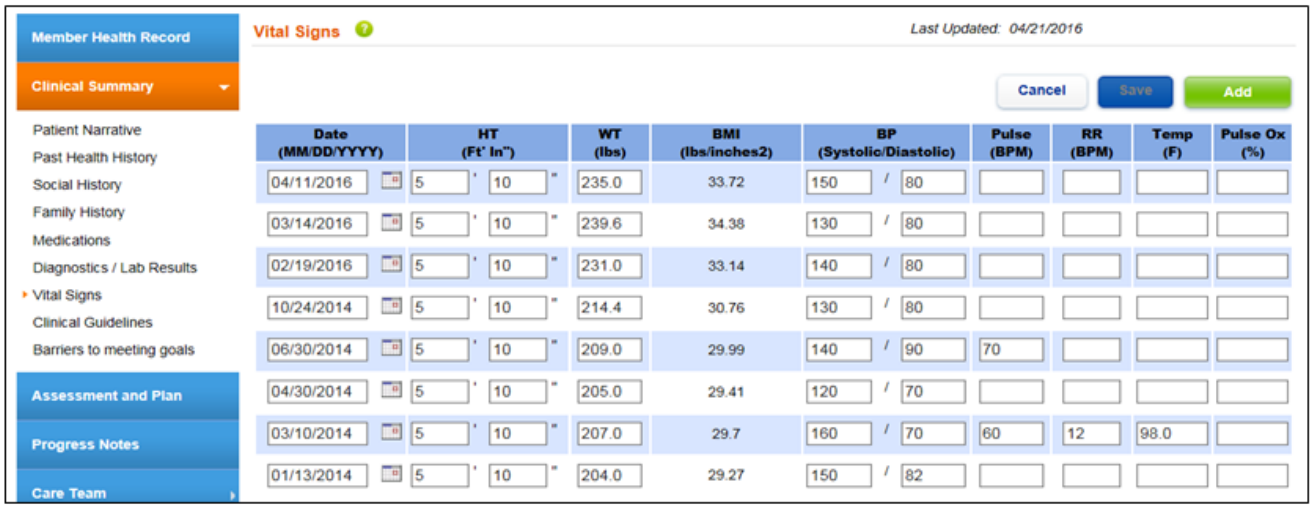


If the Care Coordinator discovers a missing lab result, the Coordinator has the ability to enter in additional lab results using the screen shown below.



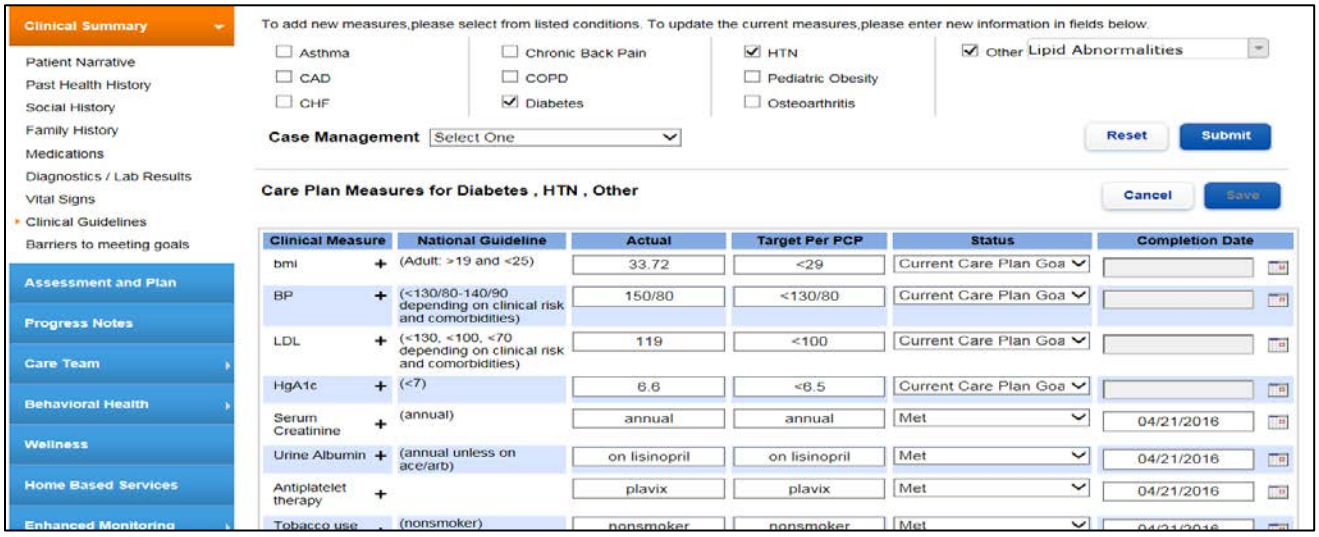

## Vital Signs

The Vital Signs section allows the Care Coordinator to enter the Member's physiologic measures over the course of time. The Member's height, weight, blood pressure, pulse, respiratory rate, temperature, and oxygen saturation are documented here. The Member's Body Mass Index (BMI) is automatically calculated based on the height and weight.



## Clinical Guidelines

The Clinical Guidelines section of the Care Plan Template contains the national recommended guidelines for chronic disease management. The Care Coordinator may select guidelines for the most common conditions and may add options from a drop-down menu. Based on the selections by the user, the clinical measures and national guideline columns will populate. The user can then enter the Member's actual results, status, or values followed by the PCP's recommended target. The status column allows the user to see which measures are still unmet and which measures have successfully been completed.



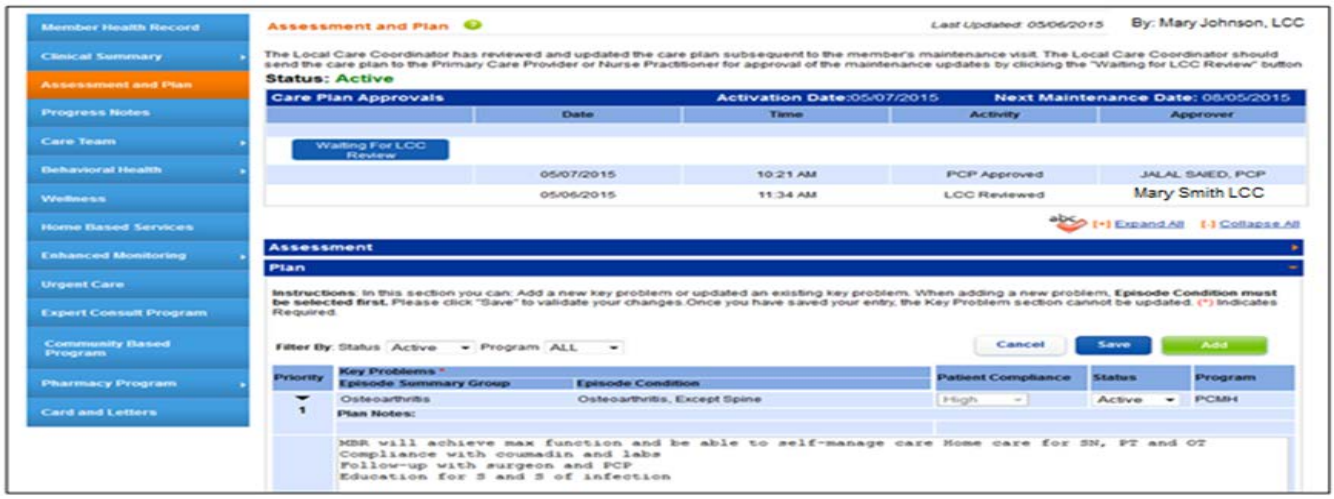

Studies have shown that the typical Member with multiple chronic conditions has an average of seven barriers to health care self-management. Assessing the barriers is a critical step towards Member stabilization. The user documents the barriers in this section, selecting from evidence-based barriers and documenting the detailed information about each barrier in the note box beside the drop-down menu.


## Assessments and Plan Tab

The Assessment and Plan component summarizes the Member's conditions and diagnoses, and articulates the Plan for the Member based upon the Member's most significant problems. Once the Care Coordinator, working in conjunction with the PCP or other treating specialist has fully documented the Care Plan, the Plan can be activated. This section also holds the overall Care Plan activation status and history. The steps to be taken by the Member and their Care Coordination Team are reviewed for actionability.

The goals for the Member are articulated here as is a desired or targeted “State of Being” for the Member when they complete or “graduate” from their Care Plan. This is critical to assuring the Member, Care Coordination Team and PCP are all working toward the same goals.

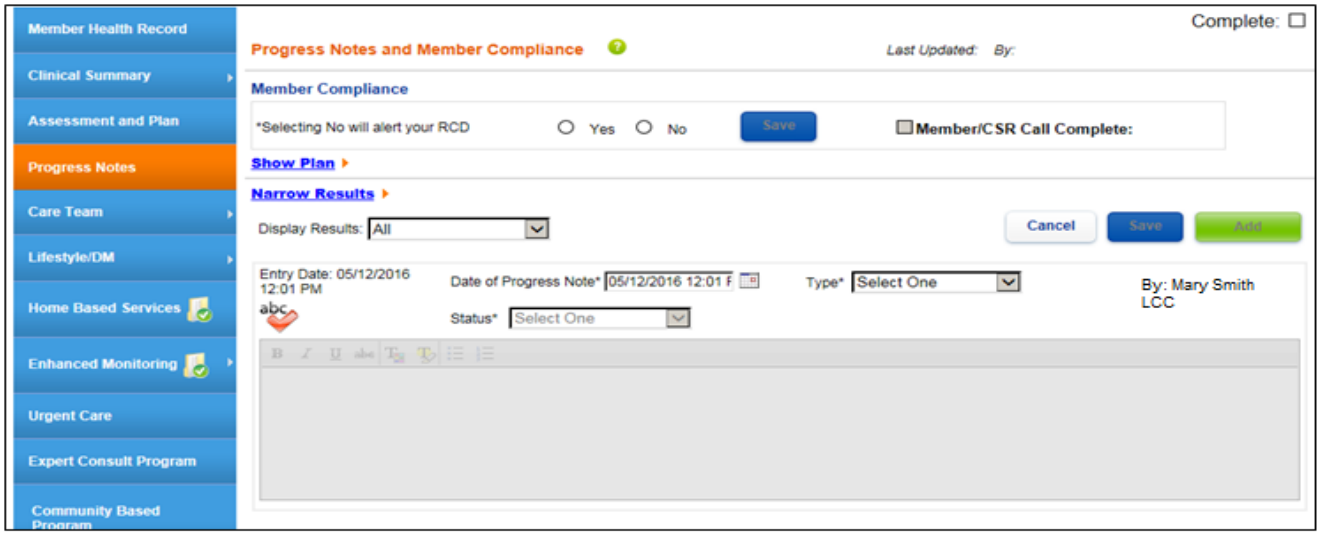
No Care Plan can be activated without the Member’s PCP activating the Care Plan and the Member granting their consent. The System has controls for this.




**Progress Notes**

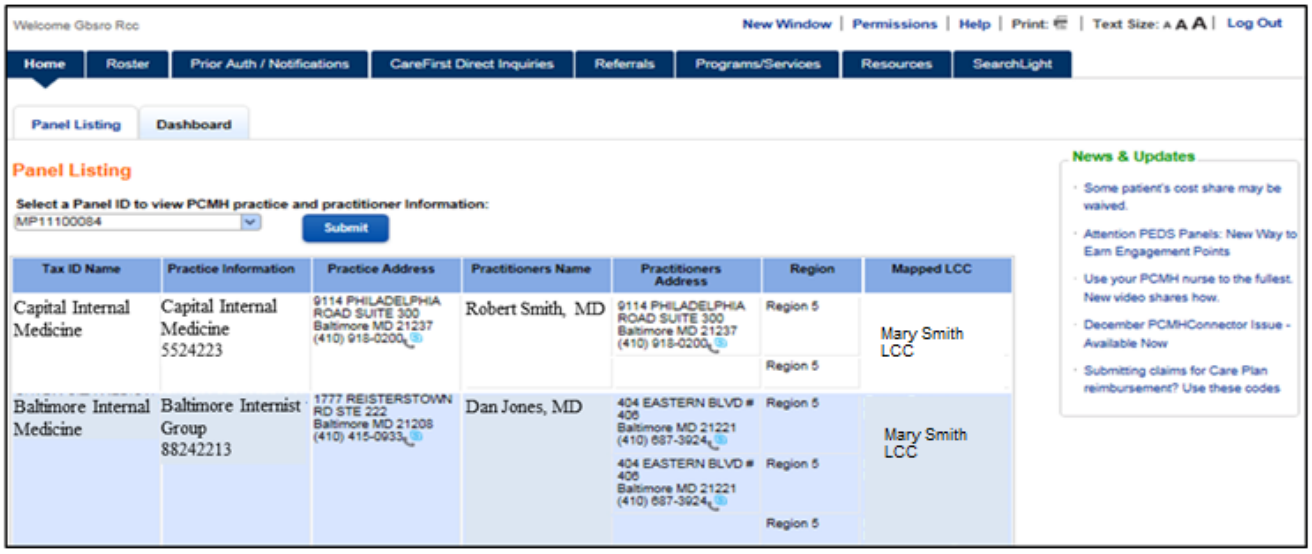
All Progress Notes are entered by the Care Coordinator based on how the Member is progressing toward their targeted “State of Being”. This shows the dates when the note was entered, the dates that contact between the Member and the Care Coordinator occurred, how the contact occurred (phone, face to face, etc.), and whether or not the LCC was able to connect with the Member. The text of the Progress Note includes a summary of the Member’s current status, the LCC’s intervention for the Member, and the plan for the upcoming phone call or in person visit.

Member compliance is a critical Element of Care Coordination. If the Member does not talk with the LCC every week, the LCC indicates that the Member is noncompliant.



## Domain #3: Medical Care Panel Administration And Display Of Panel And PCP Specific Data

As discussed in **Part III, Design Element #1 – The Central Building Blocks and Performance Units**, one of the central precepts of the PCMH Program is that small units or groupings of PCPs should be the basic organizational building blocks of the PCMH Program. These units or groupings are called Medical Care Panels or simply "Panels." A Panel may be formed by an existing group practice or be composed of a number of solo practitioners and/or small independent group practices that agree to voluntarily work together to achieve Program goals. In iCentric, Panel and individual PCP specific data are readily available for viewing.

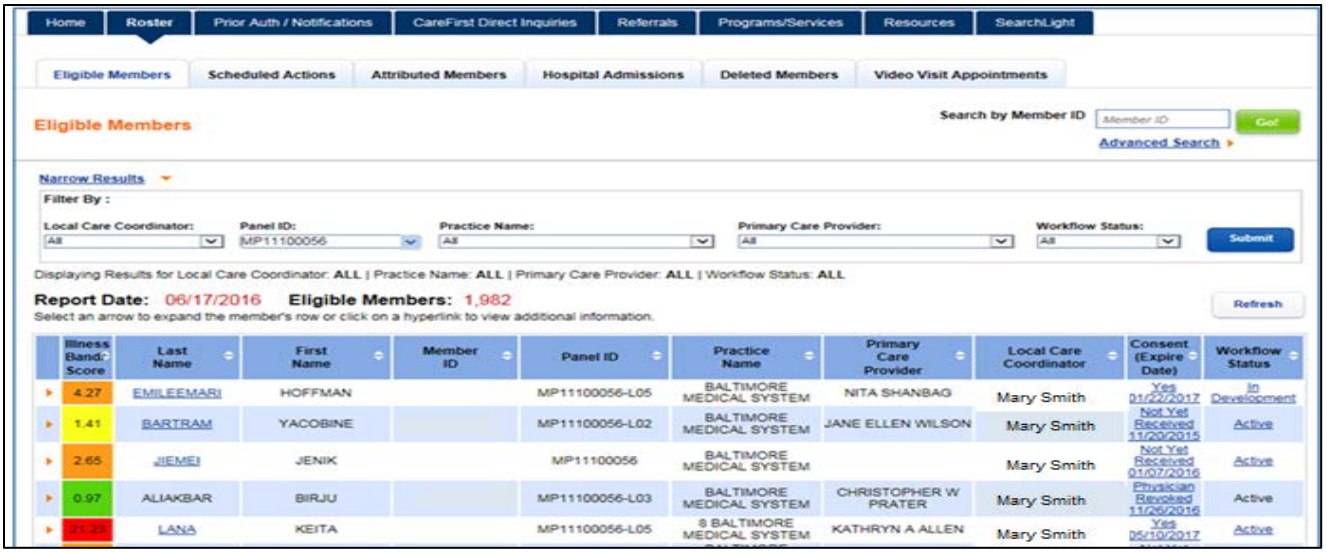



### Medical Panel

Each Panel has a global budget target composed of all health care costs for their attributed Members. Through the SearchLight Reporting System, available online 24/7 in iCentric, Panel Members have access to reports that show the cost, quality, illness and demographic patterns that are most important for Panels to focus on in order to understand how best to improve quality and control costs for their population of Members.

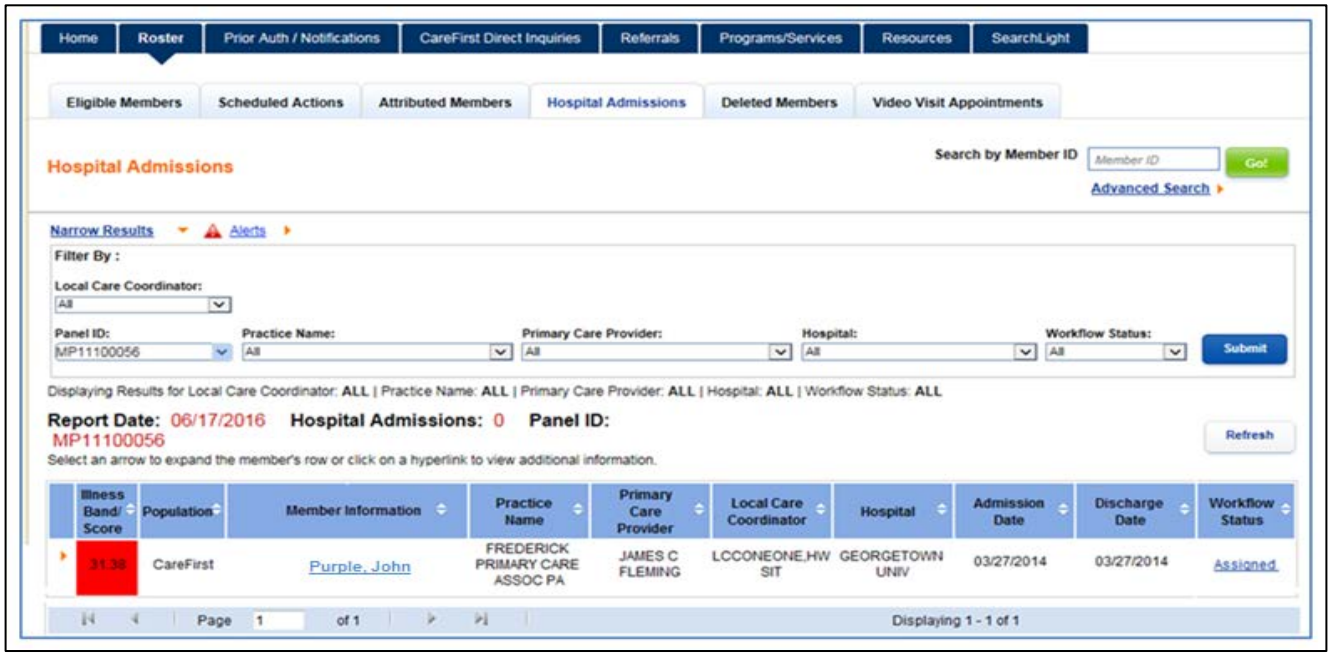
### Member Roster

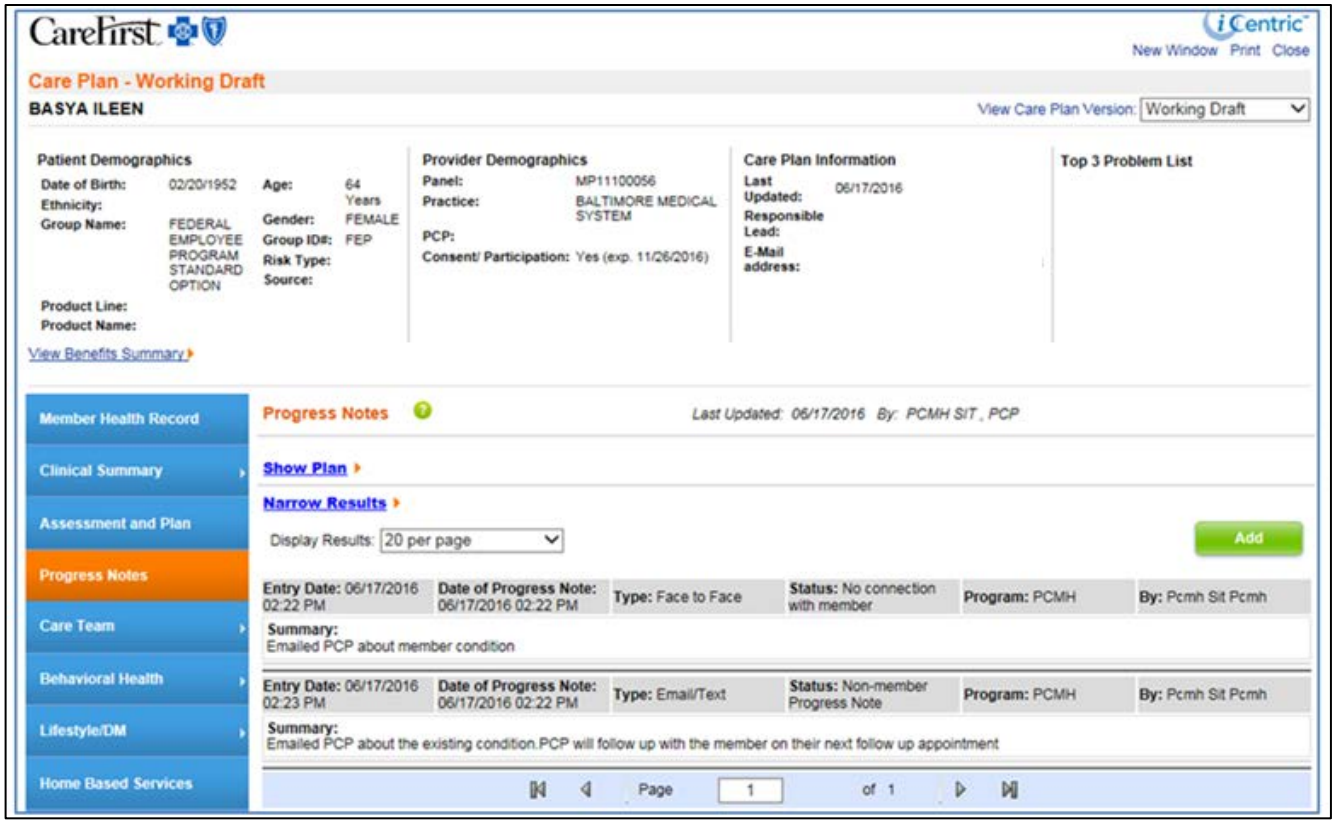
For PCPs, the iCentric portal automatically opens to the Member Roster where a provider may view their PCMH eligible Members. The Roster is sorted by Workflow Status, so that the PCP may easily identify Members whose Care Plans are "In Development" and require review and approval. Next on the Roster are the Members in Active workflow status, followed by Scheduled workflow status, Assigned workflow status, and lastly Eligible workflow status.




**Hospital Admissions Tab**

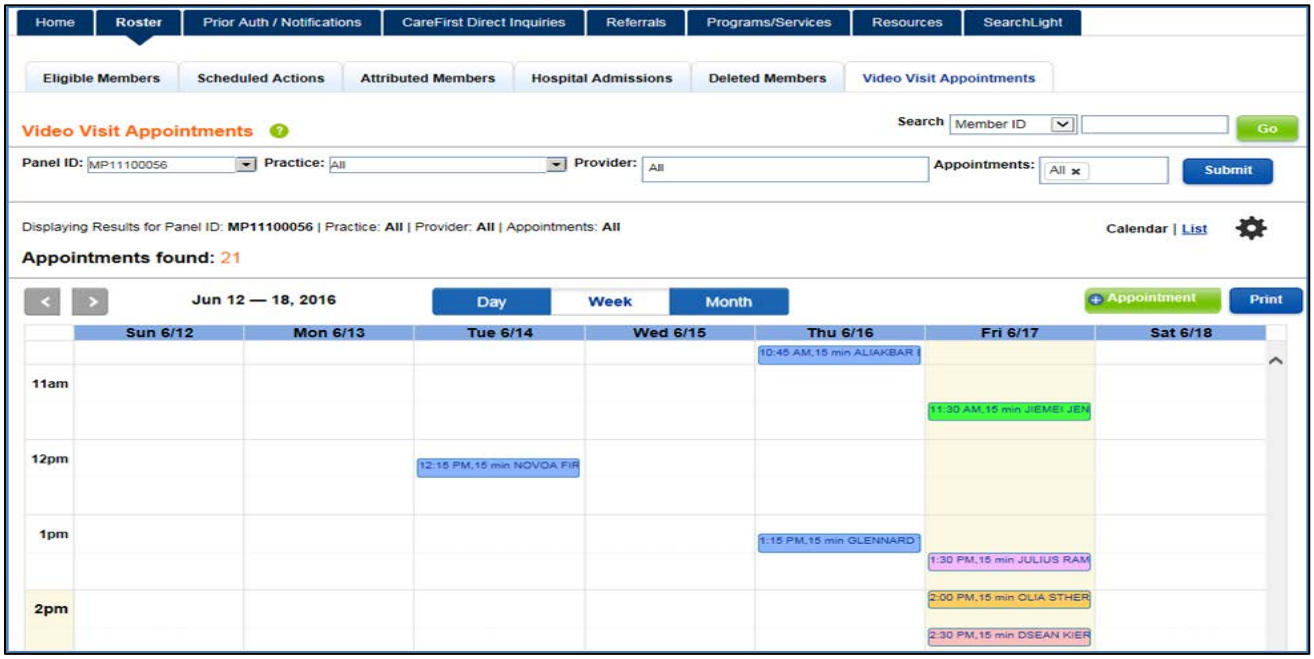
The PCP may navigate to the Hospital Admissions Tab to view the list of Members with recently authorized hospitalizations. This view includes the Member's Name, CareFirst Identification number, Date of Birth, Practice Name, PCP Name, LCC Name (if assigned), Hospital Name, Admission Date, Discharge Date, and Workflow status. When clicking on the hyperlinked Member name, the PCP will be taken to the Progress Notes where he or she may view all progress notes, including notes related to this admission.





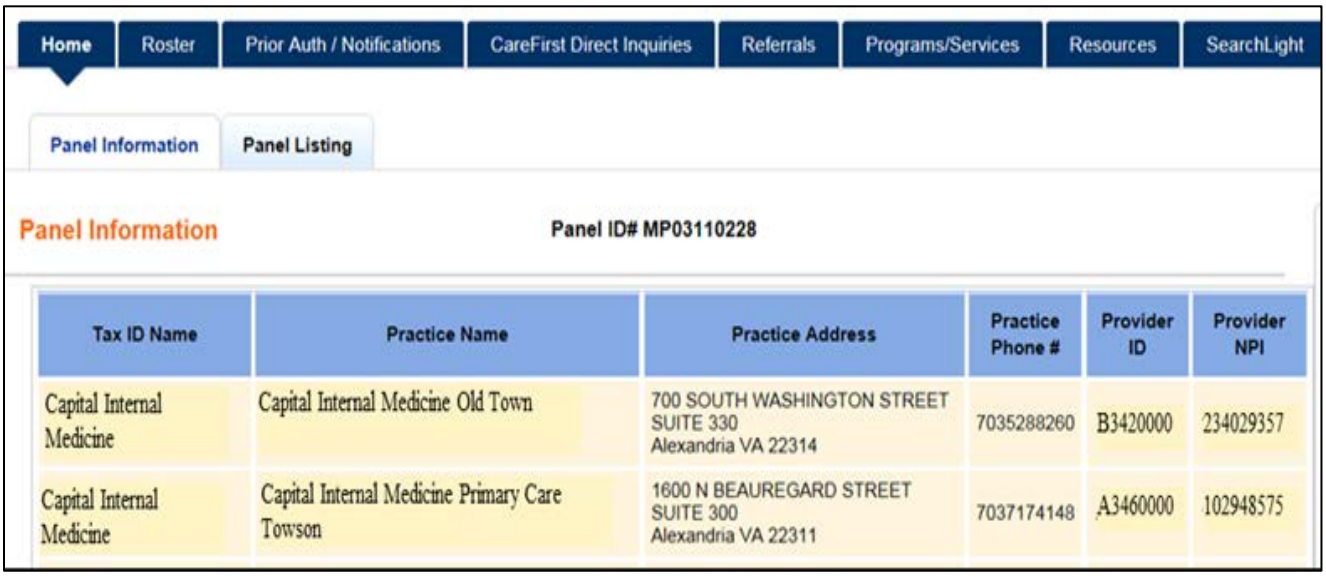

## Video Visit Appointment

The PCP may also navigate to the Video Visit Appointment list to view all scheduled appointments.



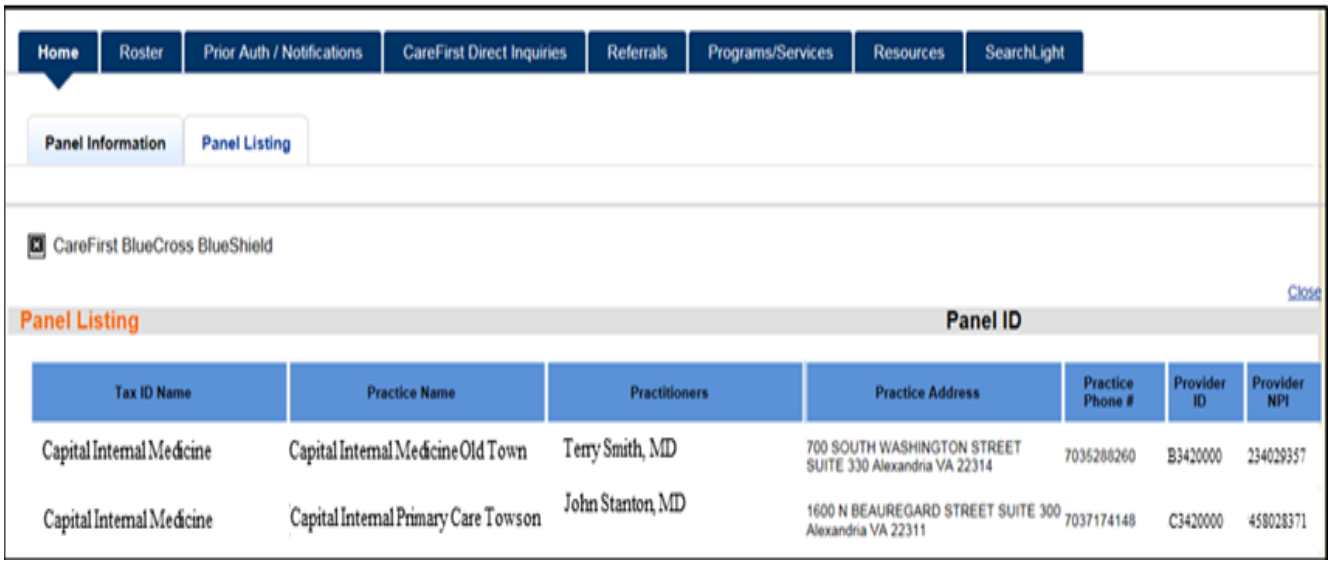
### Panel Information

In addition to Member information, the PCP has access to Panel information in iCentric. For example, when navigating to the Home Tab/Panel Information, the PCP has access to the demographic information of the individual practices in the Panel.



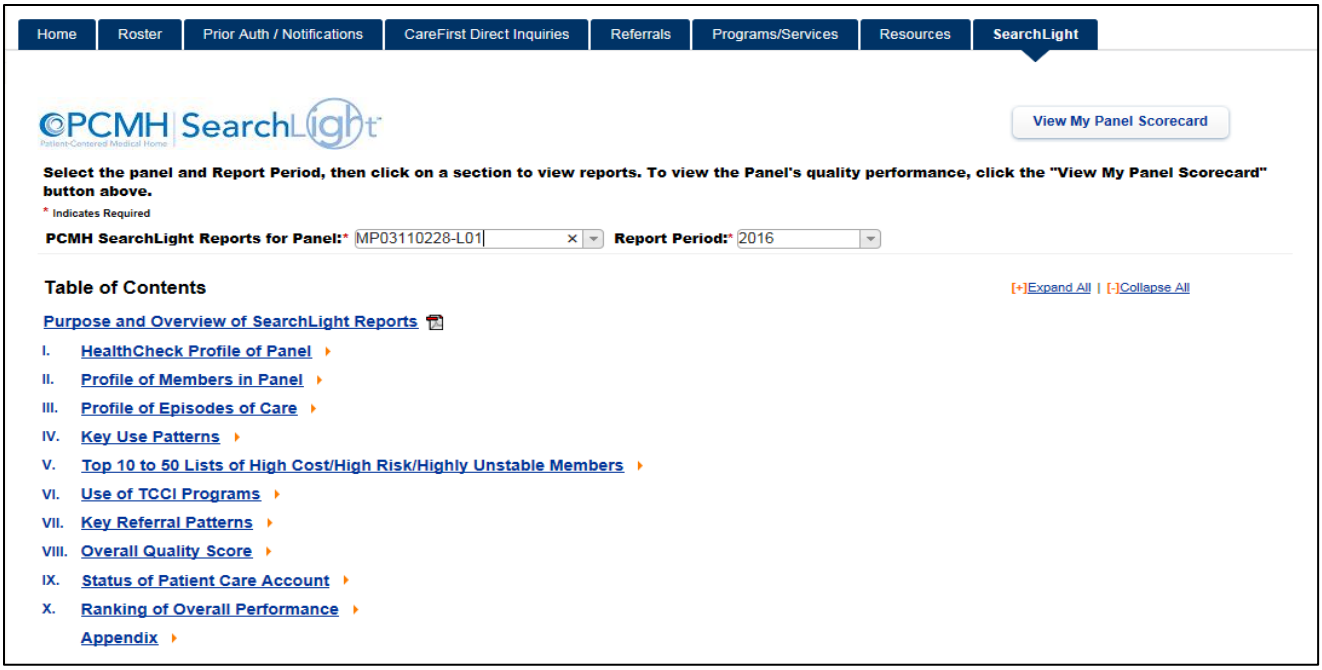

### Demographic Information

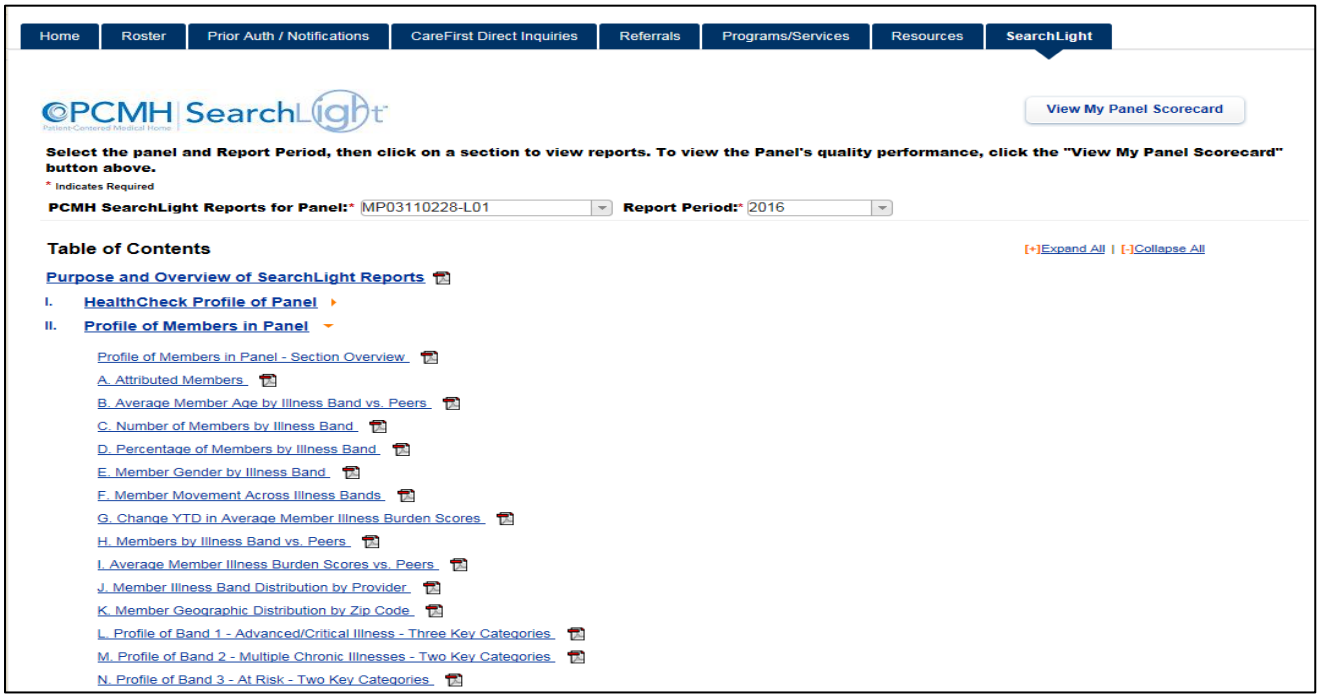
When navigating to the Home Tab/Panel Listing, the PCP has access to demographic information for all PCPs in the Panel.




### Panel Performance Data

Panel performance data is located in the SearchLight section of iCentric. By navigating to the SearchLight Tab, PCPs may view reports related to Panel composition and practice patterns. Each section in SearchLight opens to yield multiple reports to support the Panel's practice transformation. This is shown in two screen shots below.



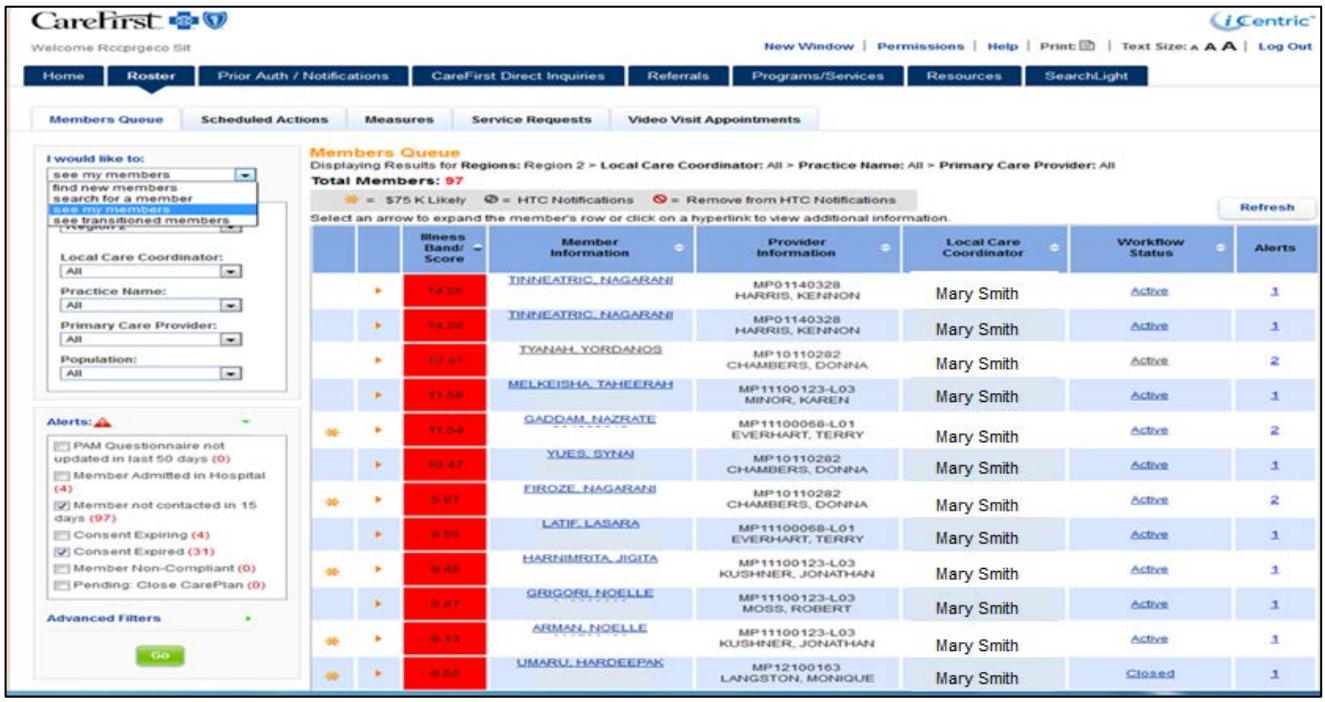
## Domain #4: Care Coordination

Among PCMH registered users, there are a variety of user types, including LCCs, PCPs, RCDs, practice consultants, case managers, HTC nurses, Service Request Hub coordinators and vendor partners. Each of these users has a tailored view of data and workflows defined by their job function. Some example workflows include:

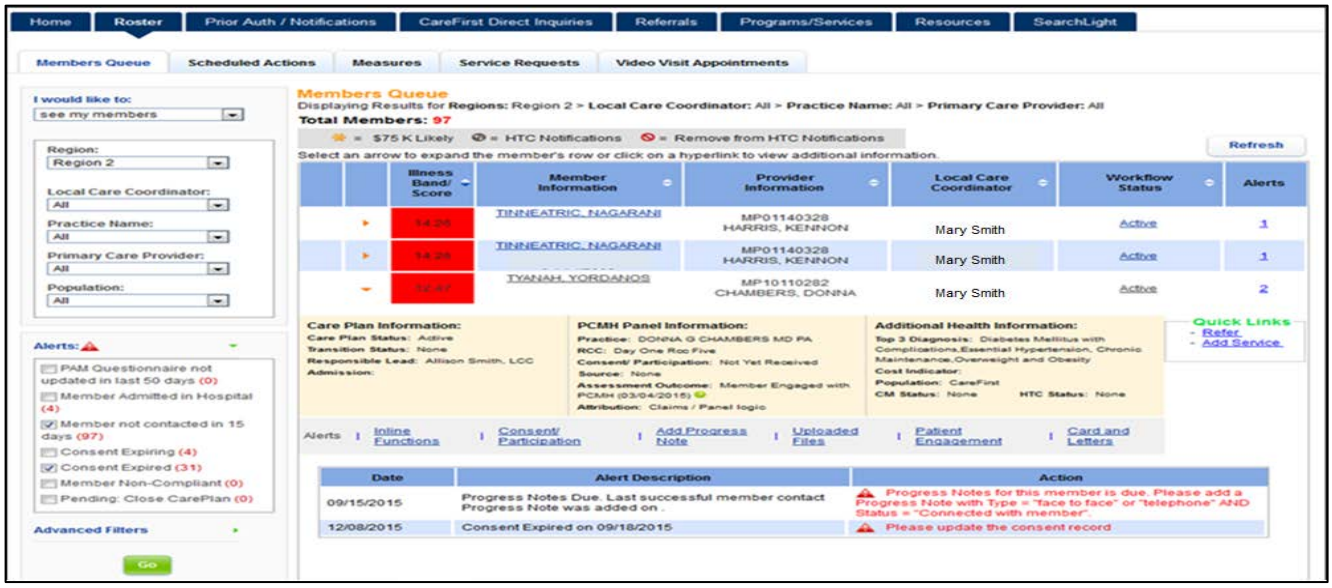
- Identifying Members based upon factors like Illness Burden Score, multiple chronic conditions, multiple admissions/readmissions, high utilization of Emergency Department, use of multiple, often conflicting medications, etc.
- Documenting Member's medical conditions, health history, medication and lab utilization.
- Coordinating care with Member, PCP and specialists.
- Referring to appropriate TCCI services, like CMR, BSA, etc.
- Communicating with Members regarding benefits, Cost Share Waiver, Program compliance, etc.
- Managing a population of attributed Members.
- Staying engaged with "activated" Members, ensuring regular communications, and coordinating activities occurring and are documented within progress notes.
- Reminders to update consent, medical reconciliation or progress notes.
- Monitoring the broader population and documenting their need through a regularly occurring assessment outcome.
- Coordinating care across the spectrum of care settings and other TCCI Programs.
- Performing regular assessments of PCP and Panels via quality measures assessments.

### Using Panel Views, Rosters and Smart Filters to Find Members Most in Need of Care Coordination

Member Rosters represent a disease registry as well as a total population health management data source. Each attributed Member in the Panel Roster is color-coded, reflecting the Illness Burden Band they are in as shown in the Illness Burden Pyramid. The roster is an actionable list of Member level information; each row contains basic information like Name, Member ID, DOB, PCP, Care Coordinator, Color-Coded Stratification, Illness Burden and Care Coordination Status.



At a single click, each row expands to offer a variety of detailed Program related information and functions depending upon a Member's particular Care Coordination status. This allows a Care Coordinator to instantaneously collect consent, see alerts, upload files, add Progress Notes, etc.

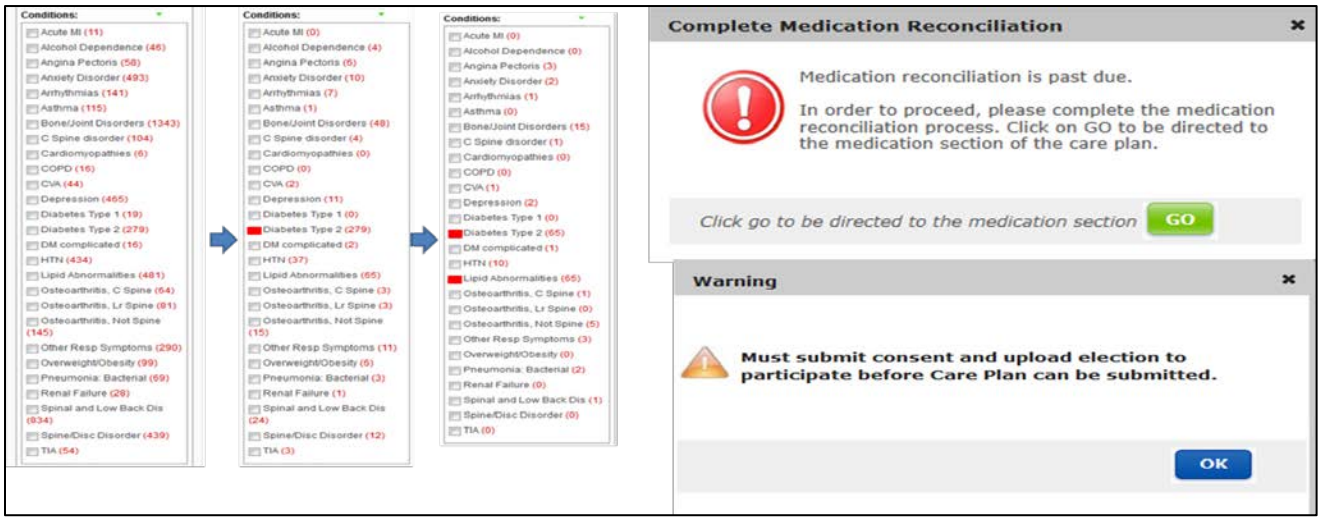



Smart Filters and Alerts are designed to allow a Care Coordinator to quickly see Members who fit specific predefined characteristics for further action.

- Clinical filters show Members who share common conditions such as Diabetes, Depression, COPD, etc., or have common traits such as an LDL or HbA1C results. The filters can be refined so that the membership cohort of interest is readily identifiable.

- Administrative filters allow a Care Coordinator to identify Members who need specific actions such as Care Plan Closure or Expiring Consent Renewal or have other attributes that require attention, such as recent admission to the hospital.

- Alerts serve as a reminder to Care Coordinators of routine events, such as an expiring consent that need attention.



## Domain #5: Service Request Hub

As discussed in throughout **Part VI: TCCI – Twenty Supporting Programs,** CareFirst operates a Service Request Hub as critical part of the iCentric System. Once an assessment of a Member's need is established that indicates the Member could benefit from Care Coordination through one or more TCCI Programs, a request for the service is made by an LCC, CCM or BSA using the Service Request Hub. Acting as the essential means by which Care Coordinators connect Members to specific TCCI Programs, the Service Request Hub is available to quickly facilitate an online referral to targeted preferred providers so that a needed TCCI Element can be quickly and correctly brought to bear for the Member.

Once a referral is made, the Service Request Hub takes it from there – assuring that the right connection is made to the requested Program and confirming that the service request for the Program Element sought has been arranged and delivered as intended.

There are three main components to the Service Request Hub:

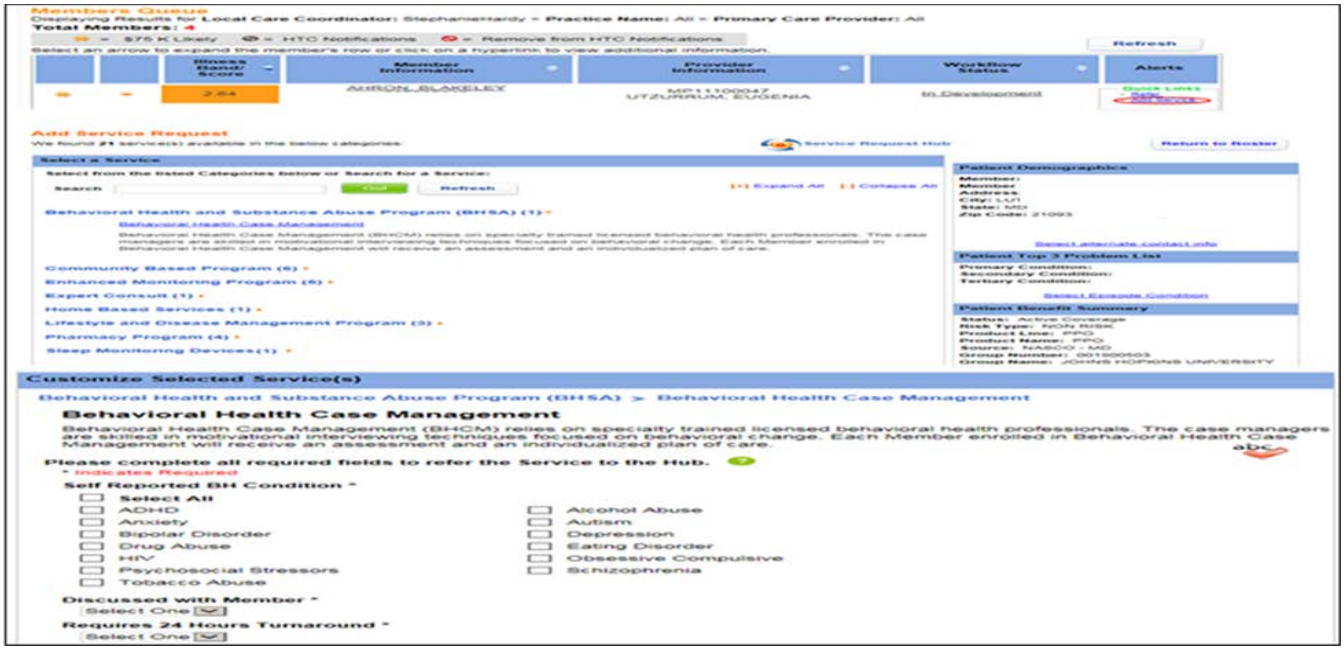
1. **Order** – Care Coordinators quickly navigate to the Hub in a few clicks and select the appropriate clinical service.

2. **Fulfillment** – Hub Managers use iCentric to manage the steady stream of requests across the entire TCCI Program spectrum, ensuring Service Level Agreements (SLAs) are met with preferred providers on behalf of Care Coordinators to assure services are delivered as expected.

3. **Reporting** – The Hub tracks the performance of partners over time and maintains the track record of all partners, identifies issues or problems in fulfillment and shows the volumes of services that have been arranged through the Hub over time.

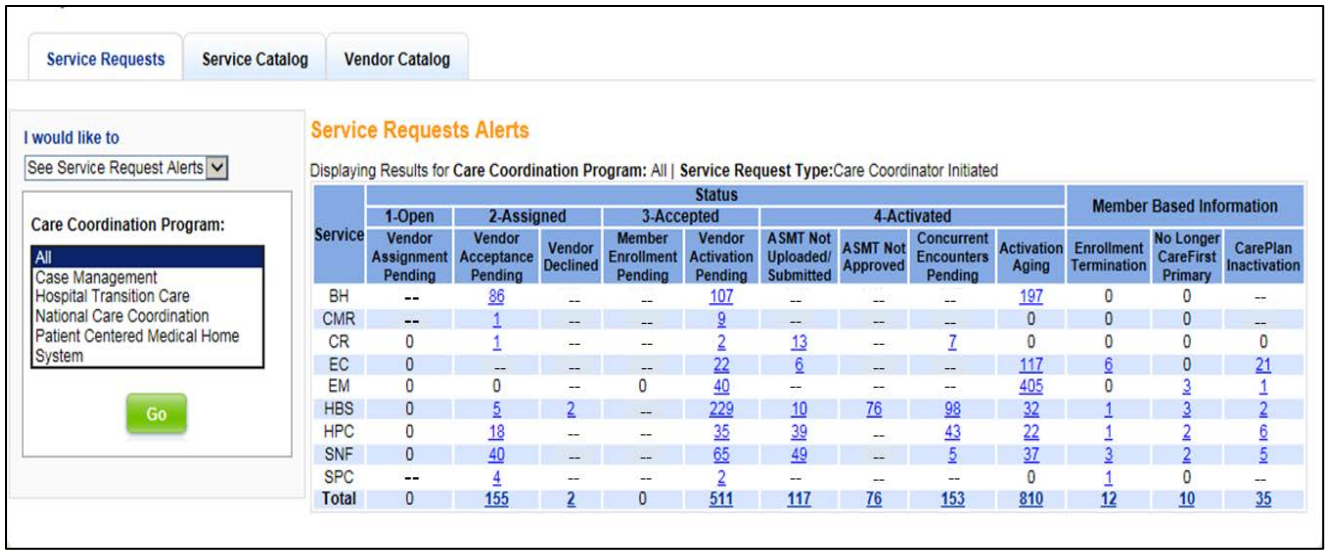
### Service Request Order

As part of the Care Coordinator's normal workflow, within a few clicks, they can see the portfolio of TCCI Services that are available, select those that are medically appropriate for the Member, indicate pertinent clinical information based upon the selected service and order it through the Hub. The Care Coordinator experience is the same across all categories of service.



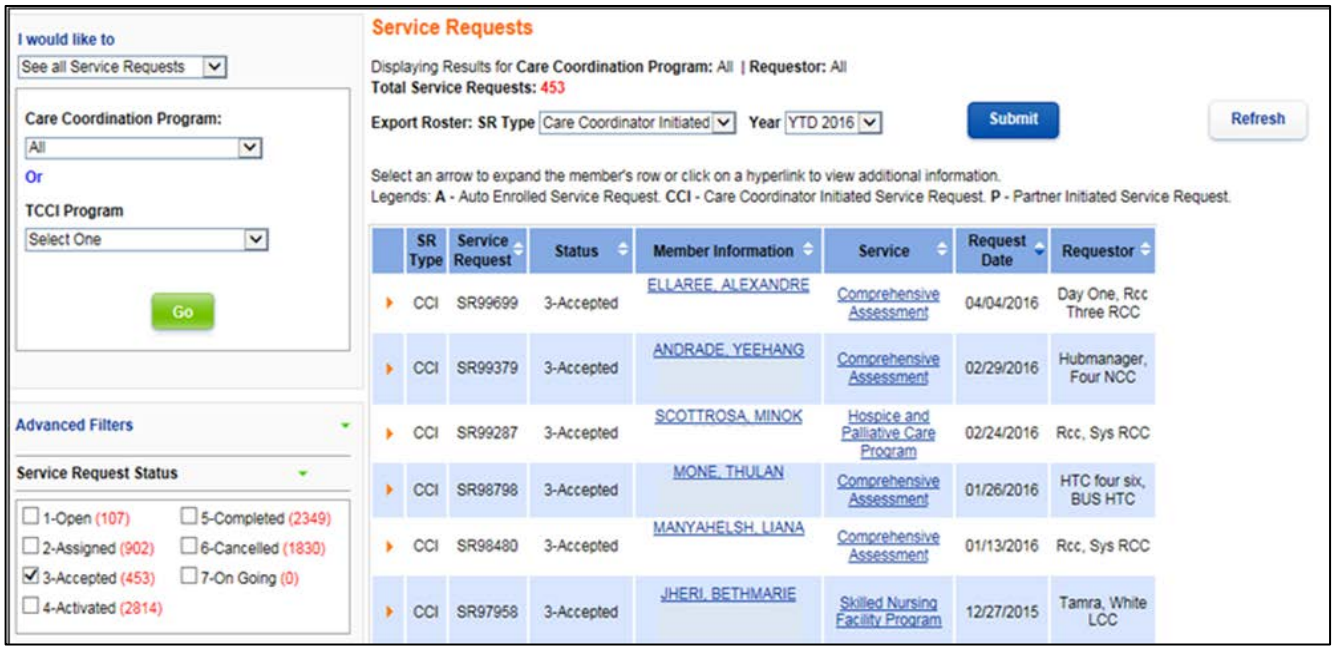
## Service Request Management and Administration

The Hub Coordinator is then able to easily manage the thousands of requests that flow through the Hub using the "Alerts" view for daily management of the referral flow. The Hub Coordinator can filter by TCCI Program and Service Request types and see a high level view of the overall status of all requests.



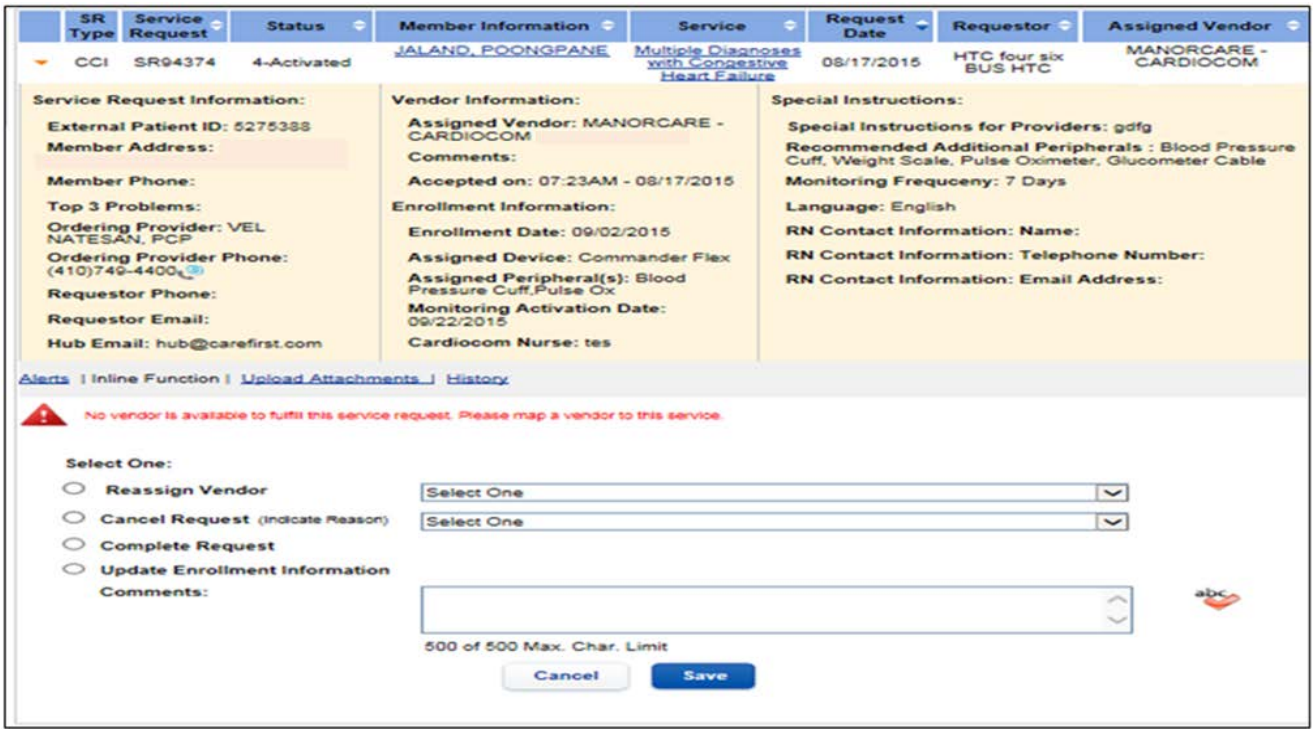

| Service | Status | | | | | | | | | Member Based Information | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1-Open | 2-Assigned | | 3-Accepted | | 4-Activated | | | | | | |
| | Vendor Assignment Pending | Vendor Acceptance Pending | Vendor Declined | Member Enrollment Pending | Vendor Activation Pending | ASMT Not Uploaded/ Submitted | ASMT Not Approved | Concurrent Encounters Pending | Activation Aging | Enrollment Termination | No Longer CareFirst Primary | CarePlan Inactivation |
| BH | -- | 86 | -- | -- | 107 | -- | -- | -- | 197 | 0 | 0 | -- |
| CMR | -- | 1 | -- | -- | 9 | -- | -- | -- | 0 | 0 | 0 | -- |
| CR | 0 | 1 | -- | -- | 2 | 13 | -- | 7 | 0 | 0 | 0 | 0 |
| EC | 0 | -- | -- | -- | 22 | 6 | -- | -- | 117 | 6 | 0 | 21 |
| EM | 0 | 0 | -- | 0 | 40 | -- | -- | -- | 405 | 0 | 3 | 1 |
| HBS | 0 | 5 | 2 | -- | 229 | 10 | 76 | 98 | 32 | 1 | 3 | 2 |
| HPC | 0 | 18 | -- | -- | 35 | 39 | -- | 43 | 22 | 1 | 2 | 6 |
| SNF | 0 | 40 | -- | -- | 65 | 49 | -- | 5 | 37 | 3 | 2 | 5 |
| SPC | -- | 4 | -- | -- | 2 | -- | -- | -- | 0 | 1 | 0 | -- |
| Total | 0 | 155 | 2 | 0 | 511 | 117 | 76 | 153 | 810 | 12 | 10 | 35 |

The Hub Coordinator uses a Roster view to show a list of Members that need to be acknowledged, assigned and completed.

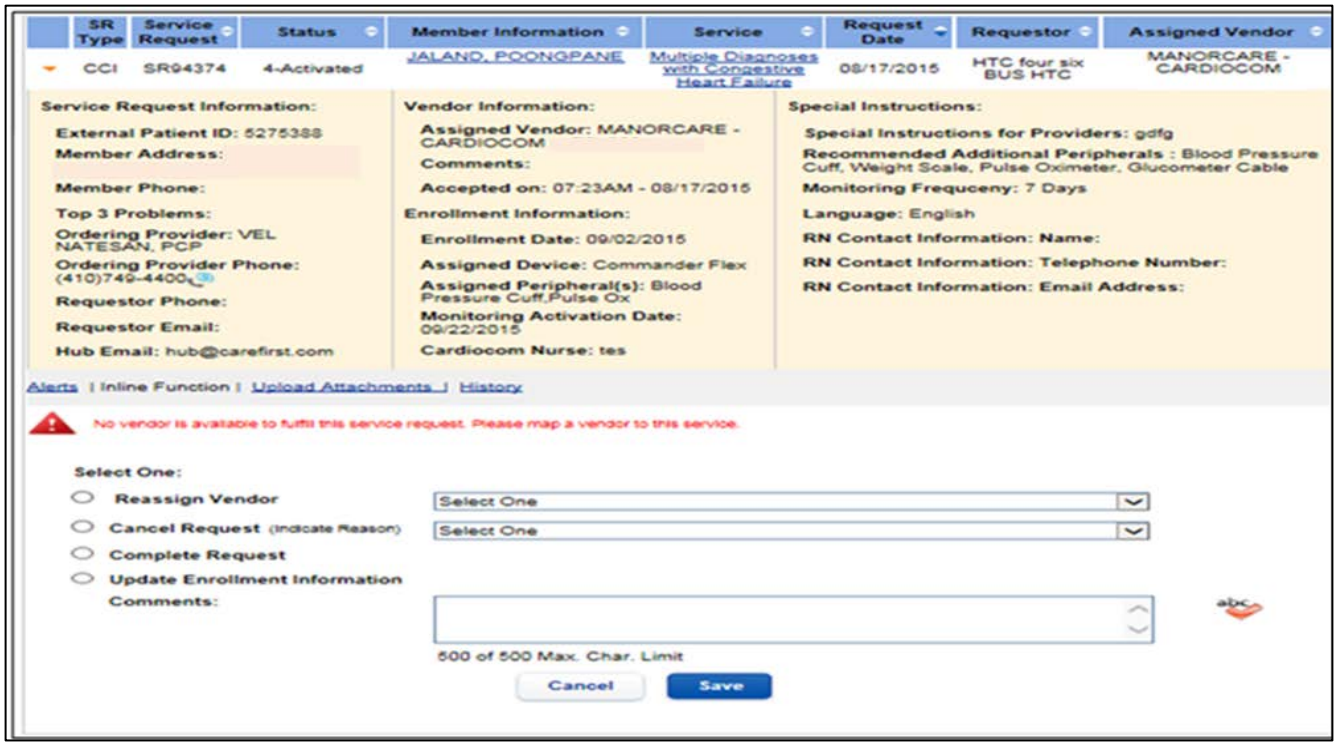



| | SR Type | Service Request | Status | Member Information | Service | Request Date | Requestor |
|---|---|---|---|---|---|---|---|
| ▸ | CCI | SR99699 | 3-Accepted | ELLAREE, ALEXANDRE | Comprehensive Assessment | 04/04/2016 | Day One, Rcc Three RCC |
| ▸ | CCI | SR99379 | 3-Accepted | ANDRADE, YEEHANG | Comprehensive Assessment | 02/29/2016 | Hubmanager, Four NCC |
| ▸ | CCI | SR99287 | 3-Accepted | SCOTTROSA, MINOK | Hospice and Palliative Care Program | 02/24/2016 | Rcc, Sys RCC |
| ▸ | CCI | SR98798 | 3-Accepted | MONE, THULAN | Comprehensive Assessment | 01/26/2016 | HTC four six, BUS HTC |
| ▸ | CCI | SR98480 | 3-Accepted | MANYAHELSH, LIANA | Comprehensive Assessment | 01/13/2016 | Rcc, Sys RCC |
| ▸ | CCI | SR97958 | 3-Accepted | JHERI, BETHMARIE | Skilled Nursing Facility Program | 12/27/2015 | Tamra, White LCC |

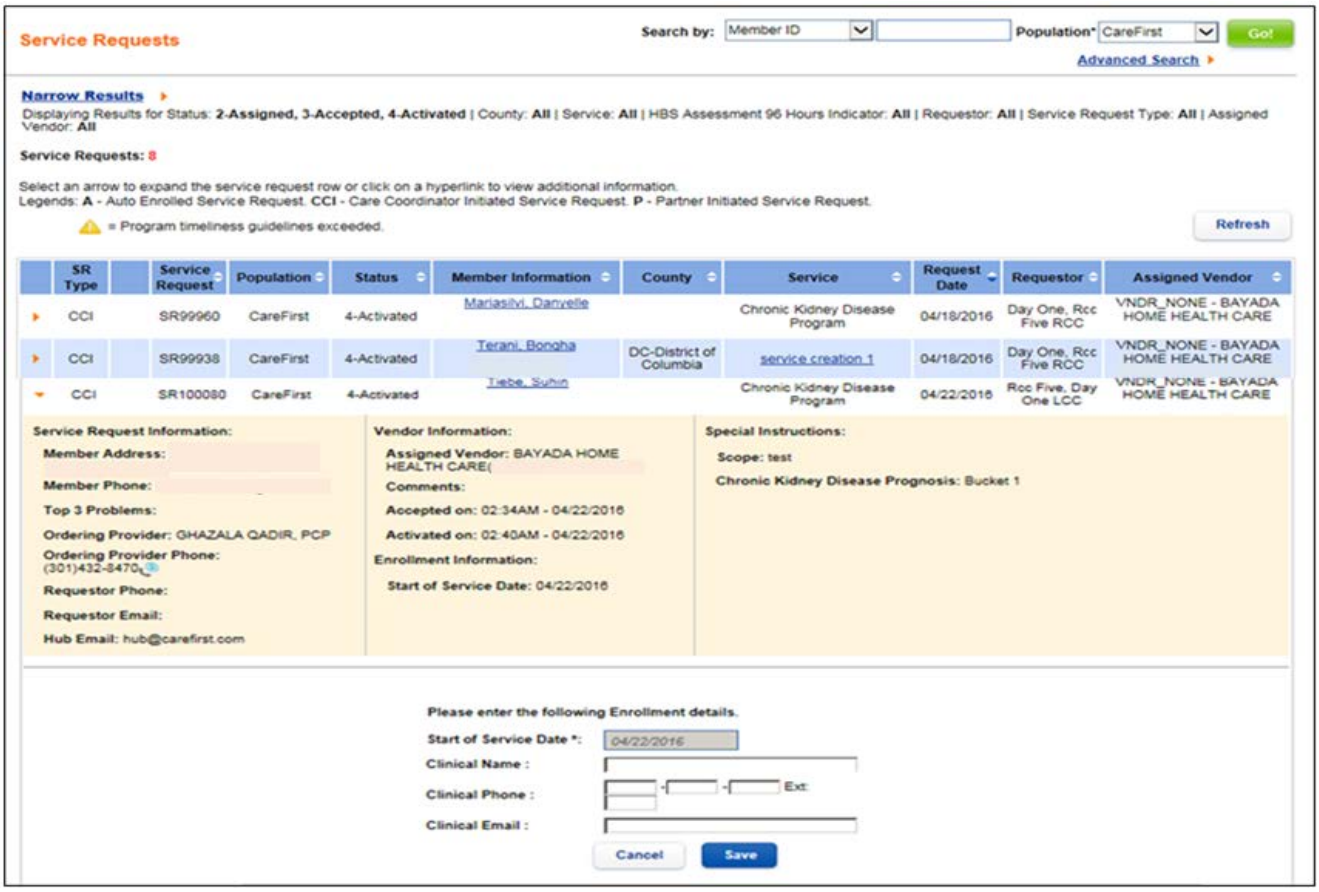
Alerts are “Acknowledged” by the Hub, after an SOP has been followed that assures discipline in the process:




Once a Service Request is “Activated” and the Member receives the service, the Hub Coordinator marks the request “Complete.” This fulfills the basic purpose of the Hub – namely, to assure Members who are referred actually get the service they need from the preferred provider contracted to provide the service.



Upon electronic notification of receipt for a Service Request, the preferred providers who are TCCI Program partners log into iCentric, view their roster of requests and accept and acknowledge receipt of the request. As care is provided, iCentric receives updates from the Hub partners directly through an automated feed from the partner's systems or a direct link into the partner's system. This automatically updates the Care Plan of the Member as well as the MHR.

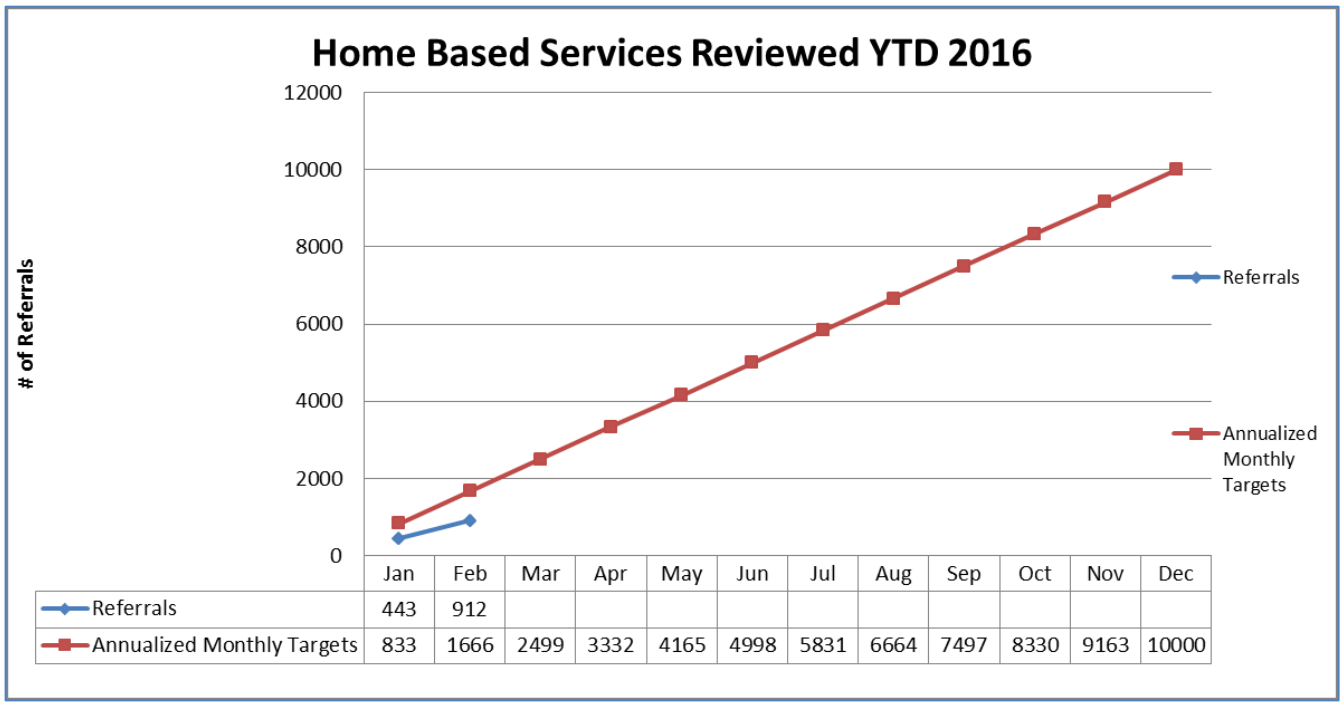


## Domain #6: Presentation Of Operational Data

iCentric has built in tracking and reporting capabilities that provide insight and information to the operating units that are responsible for the execution of the PCMH and TCCI Programs. Each of the Programs has specific metrics, dashboards, stat packs and graphics designed to quickly and easily assess how a Program is functioning. Collectively, the iCentric Operational Reports provide a window of insight into the performance of each Program, allowing managers and supervisors to make adjustments to staffing and identify and correct potential issues early and efficiently. Some report examples are shown below:

| 2016 PCMH Stat Pack Geographic Location All Regions YTD Total – Active – Thru March 2016 (Date Refreshed - 03/31/2016 ) | YTD Total | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 | Region 8 | Region 9 | Region 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Provider Stats** | | | | | | | | | | | |
| Attributed Members | 1,196,967 | 42,052 | 51,904 | 66,482 | 59,678 | 36,647 | 42,891 | 33,828 | 39,027 | 72,686 | 67,007 |
| # of Panels | 608 | 42 | 38 | 54 | 44 | 36 | 37 | 54 | 29 | 39 | 54 |
| # of PCPs/ NPs | 4,250 | 255 | 140 | 194 | 156 | 123 | 124 | 234 | 114 | 147 | 159 |
| # PCPs with Care Plans | 1,735 | 101 | 89 | 122 | 86 | 79 | 64 | 68 | 73 | 99 | 74 |
| *% PCPs with Care Plans* | *40.82%* | *39.61%* | *63.57%* | *62.89%* | *55.13%* | *64.23%* | *51.61%* | *29.06%* | *64.04%* | *67.35%* | *46.54%* |
| **Care Plan Volumes** | | | | | | | | | | | |
| Number of CarePlans | 5,662 | 221 | 346 | 425 | 462 | 470 | 271 | 181 | 281 | 254 | 334 |
| *Number of CPs as a % of members with IBS > 2.0* | *2.83%* | *3.68%* | *4.74%* | *3.96%* | *3.17%* | *3.31%* | *4.15%* | *3.09%* | *5.06%* | *2.16%* | *3.04%* |
| Number of CarePlans Per LCC | 18.87 | 11.05 | 9.61 | 11.49 | 10.27 | 9.22 | 7.32 | 4.89 | 9.69 | 7.26 | 8.56 |
| Number of CarePlans Per PCP | 3.26 | 2.19 | 3.89 | 3.48 | 5.37 | 5.95 | 4.23 | 2.66 | 3.85 | 2.57 | 4.51 |
| Closed Total | 3,659 | 157 | 239 | 257 | 315 | 338 | 214 | 145 | 210 | 190 | 105 |
| Closed - Consent Revoked | 8 | | 1 | 1 | | | 1 | | 1 | | |
| Closed- Non- Compliance | 14 | 1 | | | 1 | 2 | 1 | 1 | 2 | 1 | |
| Closed - Plan Completed | 31 | 1 | 1 | 1 | 3 | 3 | 3 | | 1 | 1 | 1 |
| Closed - No Longer Covered | 10 | 1 | | 1 | | 1 | | | | 1 | |
| Closed - Member Not Engaged | 42 | 2 | 2 | 1 | 9 | 2 | 4 | | 3 | 1 | |
| Closed - Other | 3,554 | 152 | 235 | 253 | 302 | 330 | 205 | 144 | 203 | 186 | 104 |
| **Source of Cases** | | | | | | | | | | | |
| CPE List | 776 | 23 | 51 | 71 | 112 | 40 | 21 | 17 | 58 | 62 | 25 |
| Top 50 List | 2,030 | 121 | 138 | 127 | 103 | 210 | 153 | 75 | 84 | 73 | 120 |
| PCP/NP Initiated | 1,933 | 44 | 97 | 160 | 190 | 159 | 62 | 55 | 97 | 84 | 115 |
| Transition from HTC | 211 | 6 | 12 | 13 | 15 | 17 | 11 | 9 | 13 | 8 | 20 |
| Transition from CM | 711 | 27 | 48 | 54 | 44 | 43 | 24 | 25 | 29 | 27 | 54 |
| **Program Penetration** | | | | | | | | | | | |
| # CPE Members | 157,524 | 4,897 | 5,882 | 8,284 | 12,943 | 11,137 | 5,471 | 4,788 | 4,779 | 9,510 | 8,979 |
| # Referred to Home Based Services | 783 | 13 | 52 | 26 | 97 | 99 | 41 | 41 | 34 | 49 | 56 |
| *% Referred to Home Based Services* | *13.83%* | *5.88%* | *15.03%* | *6.12%* | *21.00%* | *21.06%* | *15.13%* | *22.65%* | *12.10%* | *19.29%* | *16.77%* |
| # Referred to Enhanced Monitoring | 1,467 | 31 | 92 | 54 | 135 | 146 | 57 | 72 | 43 | 65 | 91 |
| *% Referred to Enhanced Monitoring* | *25.91%* | *14.03%* | *26.59%* | *12.71%* | *29.22%* | *31.06%* | *21.03%* | *39.78%* | *15.30%* | *25.59%* | *27.25%* |
| # Referred to Community Based Services | 15 | | | 1 | | | 1 | | | 1 | 2 |
| *% Referred to Community Based Services* | *0.27%* | | | *0.24%* | | | *0.37%* | | | *0.39%* | *0.60%* |
| # Referred to Best Doctors | 183 | 4 | 36 | 17 | 7 | 3 | 7 | 6 | 6 | 10 | 8 |
| *% Referred to Best Doctors* | *3.23%* | *1.81%* | *10.41%* | *4.00%* | *1.52%* | *0.64%* | *2.58%* | *3.32%* | *2.14%* | *3.94%* | *2.40%* |
| **LCC Type and Presence** | | | | | | | | | | | |
| **Healthways** | | | | | | | | | | | |
| # CPE Members with LCC Assignment | 17,805 | 893 | 1,019 | 1,025 | 1,617 | 1,653 | 909 | 834 | 936 | 910 | 892 |
| # of Active LCCs | 282 | 17 | 33 | 36 | 43 | 48 | 33 | 34 | 29 | 34 | 39 |

| TCCI Program Summary - YTD March-2016 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| TCCI Program | Currently Managing YTD March | Reviewed | Approached | Engaged | Completed | 2016 Target | | |
| | | | | | | Actual | Plan | % Plan |
| Hospital Transition of Care *(HTC)* | 3,371 | 21,431 | 21,431 | 11,459 | 11,327 | 100.00% | 99% (Admissions Triaged) | - |
| Complex Case Management *(CCM)* | 4,058 | 13,337 | 15,784 | 8,798 | 8,674 | 12,732 | 40,000 (Managed Cases) | *31.83%* |
| Chronic Care Coordination *(CCC/PCMH)* | 1,250 | 17,023 | 18,023 | 5,201 | 4,502 | 4,204 | 15,000 (Engaged Care Plans) | *28.03%* |
| Home Based Services | 851 | 1,868 | 1,776 | 1,413 | 1,454 | 1,868 | 10,000 (Reviewed SRs) | *18.68%* |
| Enhanced Monitoring *(Cardiocom)* | 1,074 | 677 | 669 | 499 | 691 | 677 | 5,000 (Reviewed SRs) | *13.54%* |
| **Expert Consults** *(Best Doctors)* | **655** | **207** | **175** | **116** | **119** | **207** | 750 (Reviewed SRs) | ***27.60%*** |
| **Community Based Programs** | **302** | **605** | **560** | **536** | **744** | **605** | 5,000 (Reviewed SRs) | ***12.10%*** |
| Comprehensive Medication Review | 95 | 821 | 822 | 580 | 573 | 580 | 7,500 (Engaged SRs) | *7.73%* |
| **Pharmacy Coordination Program** | | | | | | | | |
| Specialty Pharmacy Coordination (SPC) | 586 | 359 | 244 | 88 | 97 | 359 | 11,000 (Reviewed SRs) | *3.26%* |
| Magellan - Behavioral Health Management | 3,005 | 21,900 | 16,538 | 1,547 | 1,063 | 1,547 | 10,000 (Engaged) | *15.47%* |
| Telemedicine Encounters | - | - | - | - | - | - | 15,000 (Engaged) | - |




All statistics on the volumes of work, by Program, as well as the specific statistics that are applicable to each Program are captured and viewed through iCentric. This enables active oversight and a smooth workflow for all Programs and greatly aids in a clear understanding of the impacts that these Programs are having. This, together with the clinical and service detail in SearchLight Reports, provides a clear, detailed and timely picture of how the overall and specific TCCI Programs are performing, who is being served and where any backlogs or breakdowns are occurring.

## Domain #7: Quality Measurement and Display

As discussed in **Part III: Design Element #8 - Measuring Quality Of Care – The Single Most Essential Ingredient**, high quality is essential to the achievement of cost effective results - not at odds with this goal. A core belief in the Program is that one cannot achieve moderation in health care cost growth without improving quality.

In support of the achievement of quality goals, iCentric provides Care Coordinators to have a convenient and easily accessible workflow that allows assessment of each PCP's Engagement with the Program and Care Coordination process as well as presents a clinical Quality Score for every PCP which is also rolled up for each Panel as a whole to derive an overall Quality Panel Score.

The PCMH Program requires all participants to meaningfully engage with the Program Elements in order to realize the financial rewards of the Program. The Engagement Score is measured by ongoing, regular assessments of PCPs by the LCCs, Practice Consultants and RCDs. There are three categories measured for Engagement:

1. Engagement with and Knowledge of the PMCH and TCCI Programs
2. PCP Engagement with Care Plans
3. Practice Transformation

All Engagement data collected in these categories is gathered and displayed within iCentric.

The Overall Clinical Score uses the CMS core clinical measures applied appropriately via different scorecards for adult, pediatric and mixed Panels. There are four domains measured for the Clinical Score:

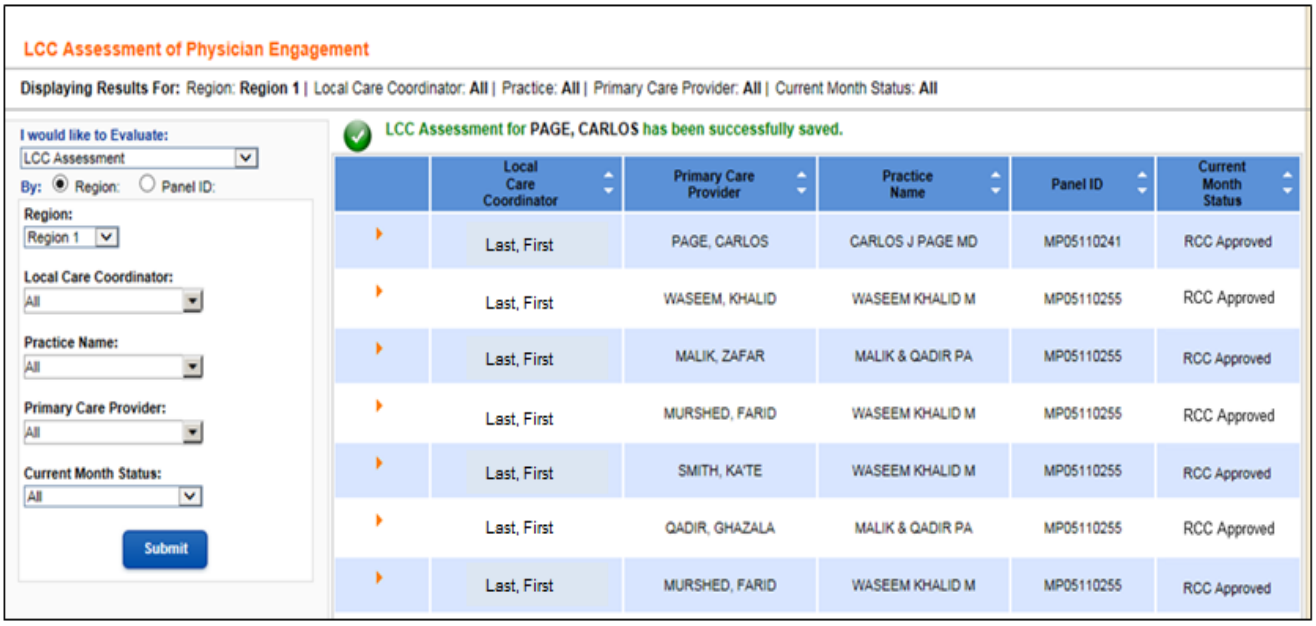
1. Care Coordination/Member Safety
2. At-Risk Population
3. Preventive Health
4. Member/Caregiver Experience

All the data collected for these quality measures is gathered and displayed within iCentric.

### LCC Assessment of PCP Engagement

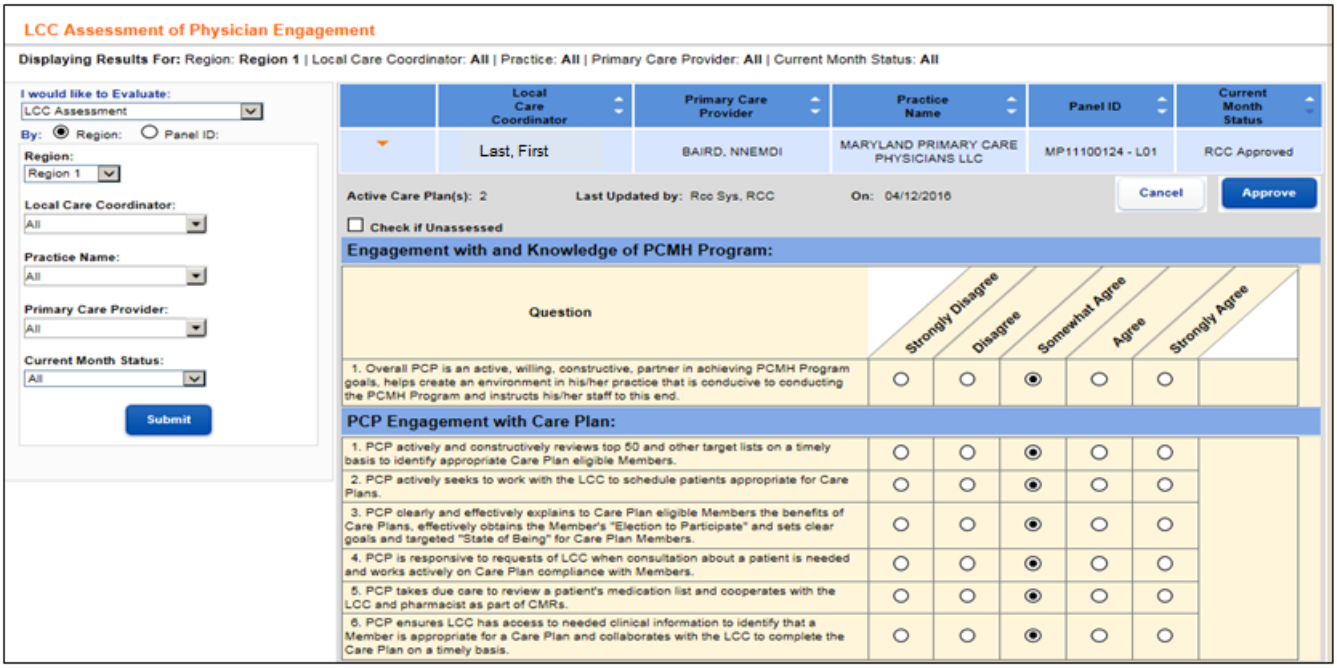
To enter the Engagement assessment of a PCP, the LCC logs into the iCentric portal and finds their assigned PCPs on the "Measures" sub-tab underneath the "Roster" Tab. This results in a list all of the PCPs assigned to the LCC via Panel Mapping for Quality Measures assessment. A PCP who participates in the Common Model, has two supporting LCCs, one who supports the commercial population and one who supports the Medicare population. Each LCC enters the assessments independently of each other.

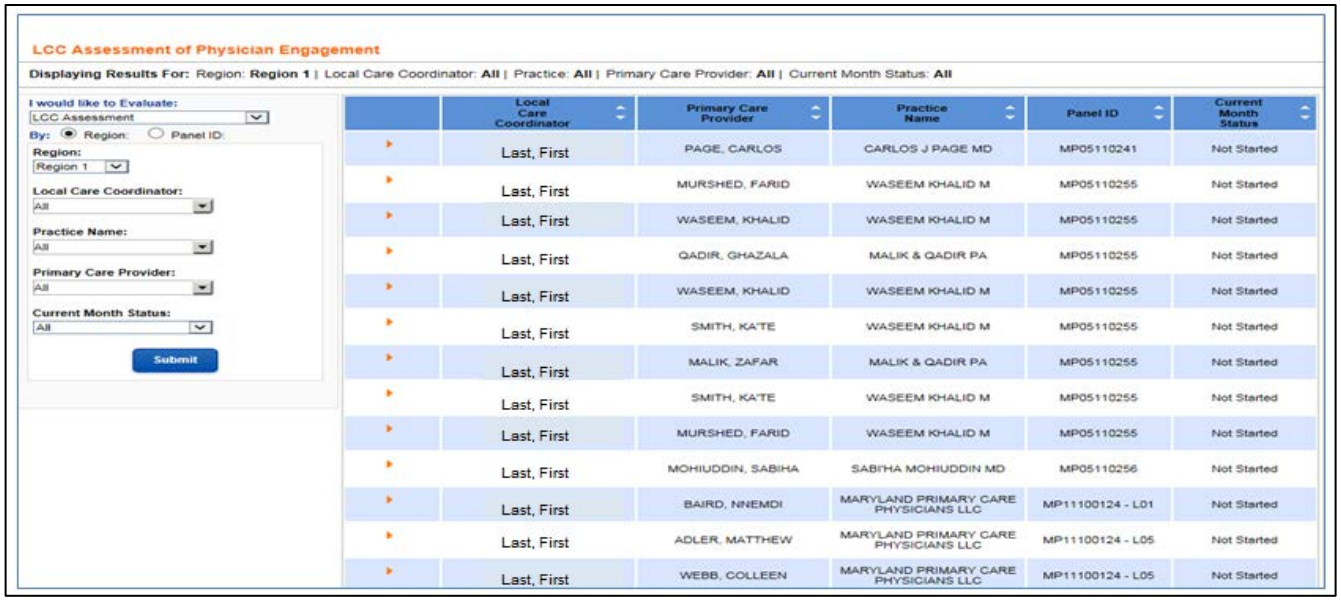
As depicted below, each PCP to be assessed is presented to the LCC for easy reference. Within a few clicks, the LCC selects and assesses the PCP.




For each PCP, the Care Coordinator answers a series of questions designed to represent the PCPs level of Engagement. The easy five point scale can be used to efficiently and effectively rate how the PCP is coordinating care based upon individual Elements like medication reconciliation, communication with the Member and collaboration with the LCC.

To rate a PCP, the LCC clicks an icon to expand the view to see the PCP assessment tool. Under each PCP's name, the LCC finds the Engagement questions for which they are responsible across the three Engagement categories. Each assessment is rated on a Likert Scale of Strongly Agree to Strongly Disagree. The LCC is responsible for submitting the assessments prior to the end of each month.





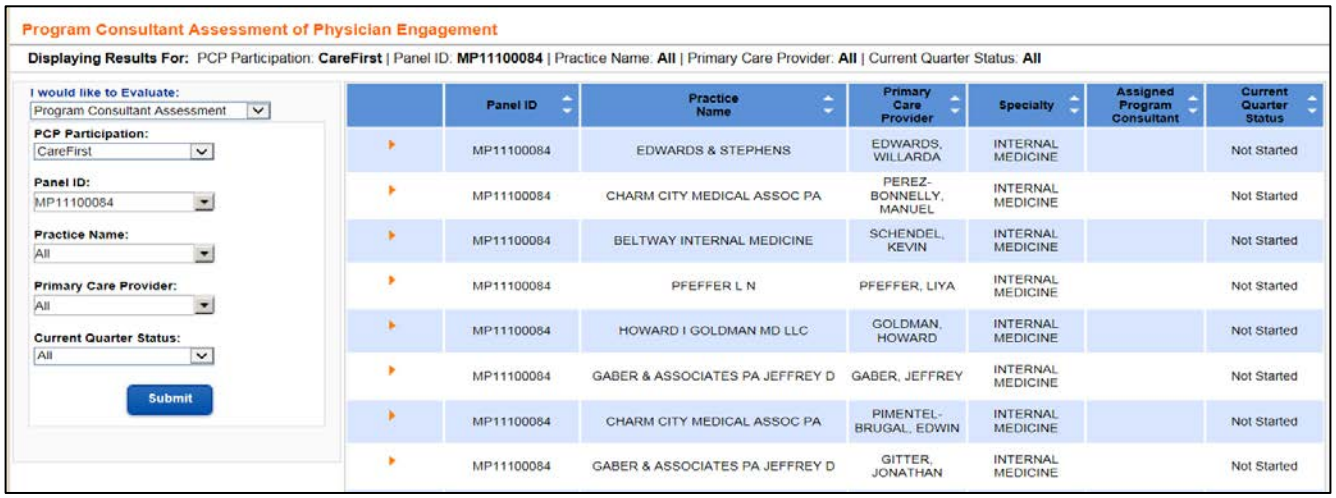

In order to review and approve each LLCs review, each RCD selects the icon to expand the row under each PCP's name. The RCD reviews the LCC ratings and may choose to edit if necessary. The RCD must act on these assessments by the end of the month.

The assessment data is then captured for all assessments and is used in the calculation of the Panel's Quality Score. At this point, the iCentric screens are all refreshed with blank assessment screens for the LCC and RCD to rate the following month.

**Practice Consultant Assessment of PCP Engagement for Quality Measures**

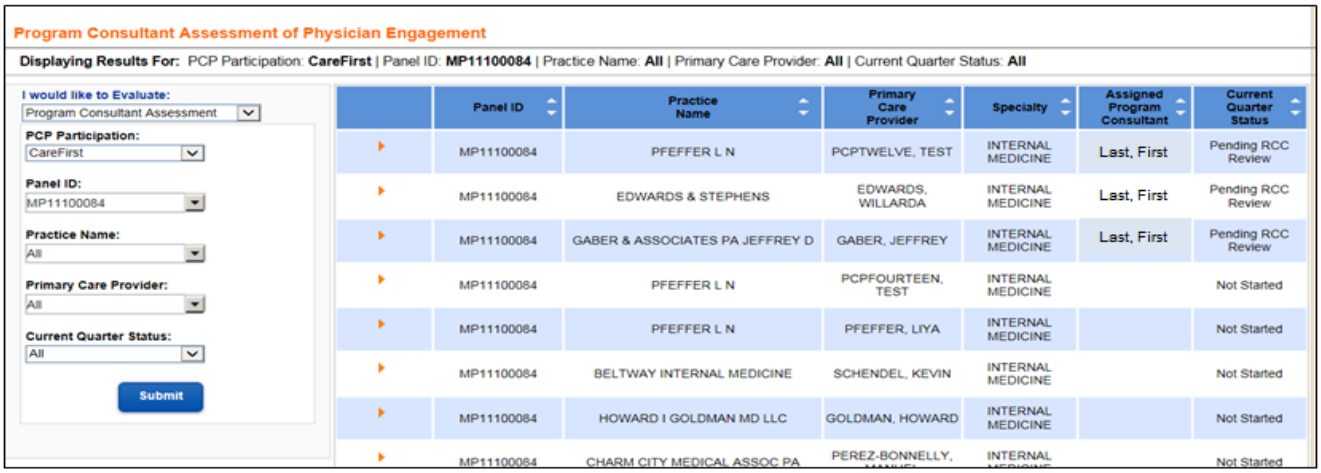
Practice Consultants rate PCPs on certain Engagement measures in the same manner as LCCs.

To rate a PCP, a Practice Consultant selects a PCP and answers the Engagement questions for which they are responsible across two Engagement categories as is shown below.




Once the Practice Consultant submits the scores, the RCD must approve the ratings. The RCD goes to the "Measures" Tab underneath the "Roster" Tab. The RCD selects the Practice Consultant Assessment and the Panel ID to be reviewed. The Practice Consultant Assessments are sorted, based on completion status. Those that have been completed by the Practice Consultant but not approved by the RCD are listed first, with a status of "Pending RCD Review." Next are the assessments

not yet completed by the LCC, with a status of "Not Started." Finally, those approved by the RCD are listed at the end with a status of "Approved," or if the RCD has made any changes to the rating, "Approved with Changes."



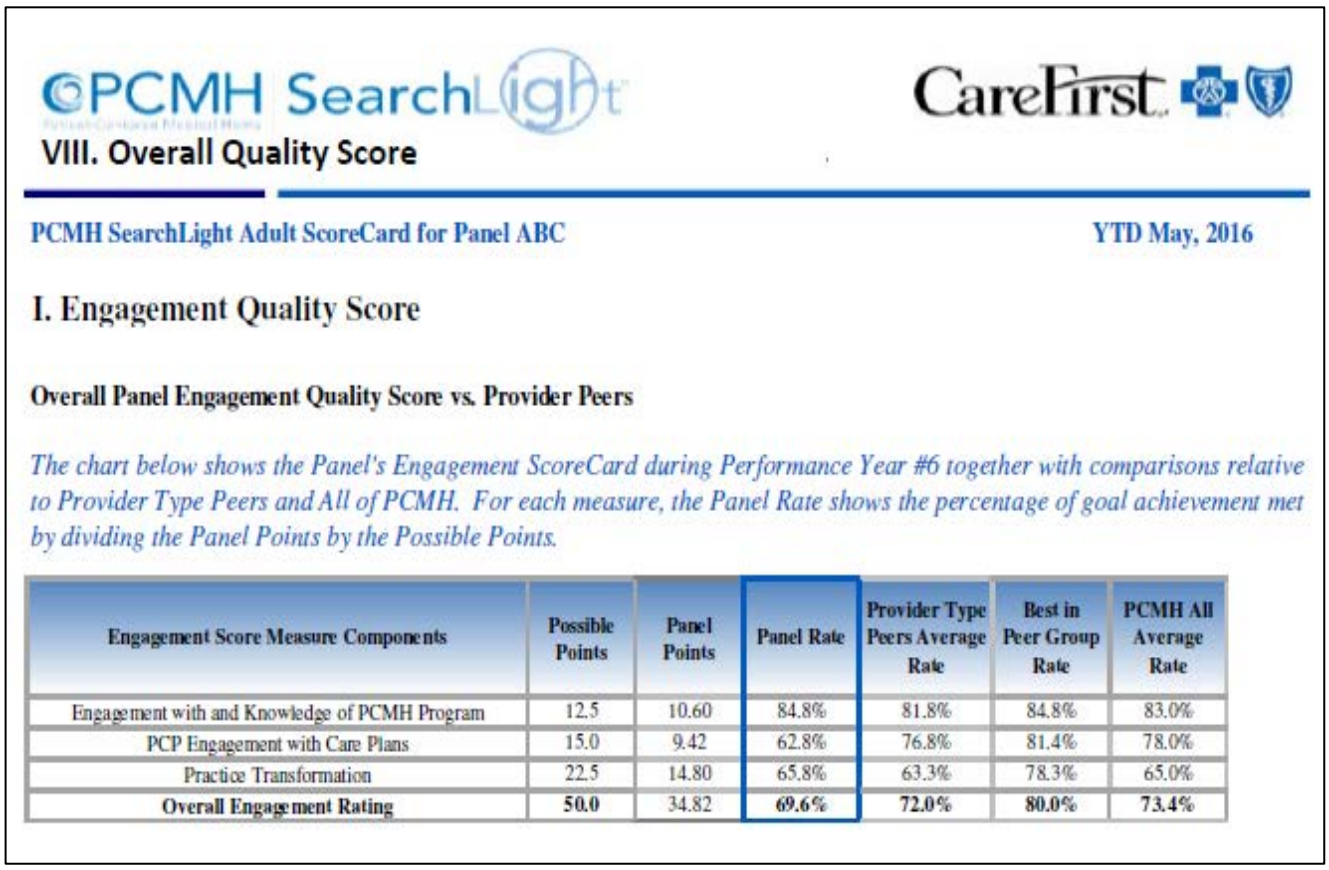

From this screen, the RCD selects the icon to expand the row under each PCP's name. The RCD reviews the Practice Consultant ratings and may choose to edit if necessary. The RCD must act on these assessments by the end of the quarter.

At the end of the quarter, the data is captured for all assessments and used to calculate the Panel's Quality Score. At this point, the iCentric screens are all refreshed with blank assessment screens for the Practice Consultant and RCD to rate the following quarter.

**Display of Quality Scores**

There are several views of PCP and Panel Quality Scores, including both Clinical and Engagement Measures under **Part VIII,** of the SearchLight Tab in iCentric**.**

SearchLight shows the Overall Panel Composite Quality Score, including both Clinical and Engagement Measures.



PCMH SearchLight

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** **YTD May, 2016**

### I. Engagement Quality Score

**Overall Panel Engagement Quality Score vs. Provider Peers**

*The chart below shows the Panel's Engagement ScoreCard during Performance Year #6 together with comparisons relative to Provider Type Peers and All of PCMH. For each measure, the Panel Rate shows the percentage of goal achievement met by dividing the Panel Points by the Possible Points.*

| Engagement Score Measure Components | Possible Points | Panel Points | Panel Rate | Provider Type Peers Average Rate | Best in Peer Group Rate | PCMH All Average Rate |
|---|---|---|---|---|---|---|
| Engagement with and Knowledge of PCMH Program | 12.5 | 10.60 | 84.8% | 81.8% | 84.8% | 83.0% |
| PCP Engagement with Care Plans | 15.0 | 9.42 | 62.8% | 76.8% | 81.4% | 78.0% |
| Practice Transformation | 22.5 | 14.80 | 65.8% | 63.3% | 78.3% | 65.0% |
| **Overall Engagement Rating** | **50.0** | 34.82 | **69.6%** | **72.0%** | **80.0%** | **73.4%** |

Panel Engagement Scores are shown on a year to date basis for each individual assessment measure, for each provider in a Panel and for the Panel's peer group average. This is shown in the screen shots below.

PCMH SearchLight Adult ScoreCard for Panel ABC — YTD May, 2016

# I. Engagement Quality Score

**Panel Engagement Scores**

*The chart below shows the Panel's cumulative Engagement ScoreCard points during Performance Year #6 together with the average Rate for Provider Type Peers. Points are assigned for each question by averaging the scores for each PCP in the Panel.*

| | Engagement Measure | Possible Points | Panel Points | Provider Peer Type Average Points |
|---|---|---|---|---|
| **Engagement with and Knowledge of PCMH Program** | | 12.50 | 10.60 | 10.23 |
| 1. | Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end. | 2.50 | 2.10 | 2.13 |
| 2. | PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. | 2.50 | 2.25 | 2.25 |
| 3. | PCP attends and actively/constructively participates in PCMH Panel meetings. | 2.50 | 2.00 | 1.50 |
| 4. | PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel. | 2.50 | 2.00 | 2.35 |
| 5. | PCP uses the categories in HealthCheck to take action that leads to better cost and quality outcomes. | 2.50 | 2.25 | 2.00 |
| **PCP Engagement with Care Plans** | | 15.00 | 9.42 | 11.53 |
| 1. | PCP actively and constructively reviews top 50 and other target lists on a timely basis to identify appropriate Care Plan eligible Members. | 2.50 | 1.65 | 1.75 |
| 2. | PCP actively seeks to work with the LCC to schedule patients appropriate for Care Plans. | 2.50 | 1.75 | 1.75 |
| 3. | PCP clearly and effectively explains to Care Plan eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and targeted "State of Being" for Care Plan Members. | 2.50 | 1.57 | 1.88 |
| 4. | PCP is responsive to requests of LCC when consultation about a patient is needed and works actively on Care Plan compliance with Members. | 2.50 | 1.45 | 2.00 |
| 5. | PCP takes due care to review a patient's medication list and cooperates with the LCC and pharmacist as part of CMRs. | 2.50 | 1.55 | 2.00 |
| 6. | PCP ensures LCC has access to needed clinical information to identify that a Member is appropriate for a Care Plan and collaborates with the LCC to complete the Care Plan on a timely basis. | 2.50 | 1.45 | 2.15 |
| **Practice Transformation** | | 22.50 | 14.80 | 14.25 |
| 1. | PCP identifies and refers to cost-efficient specialists in the top 10 specialty categories. | 10.00 | 5.80 | 6.00 |
| 2. | PCP has an effective plan for after-hours care, including active use of telemedicine and nurse hotline capabilities to enhance Member access and avoid unnecessary emergency room visits or breakdowns. | 5.00 | 3.35 | 3.00 |
| 3. | PCP actively refers Members to TCCI Program elements through LCCs assigned to Panel. | 5.00 | 3.55 | 3.25 |
| 4. | PCP actively collaborates with hospitalists on patients prior to and after admission. | 2.50 | 2.10 | 2.00 |
| **Average Overall PCP Engagement** | | 50.00 | 34.82 | 36.01 |

PCMH SearchLight Adult ScoreCard for Panel ABC

YTD May, 2016

## I. Engagement Quality Score

**Panel Engagement Rates**

*The chart below shows the Engagement Quality ScoreCard performance rates during Performance Year #6 on a quarterly basis. The average Rate for Provider Type Peers are shown for comparison. The Performance Rate is the percentage actual achievement divided by the maximum possible Score. For each quarter, the Rate is specific to that quarter. The Cumulative Year Panel Rate includes all Year to Date Scores.*
*'NA' indicates that the data is Not Available, because quarterly measures aren't available until the end of the quarter.*
*'Not Scored' indicates that Panel did not receive any Scores for the individual measure during the measurement period.*

| | Engagement Measure | Q1 Rate | Q2 Rate | Q3 Rate | Q4 Rate | Cumulative Year Panel Rate | Provider Peer Type Average Rate |
|---|---|---|---|---|---|---|---|
| **Engagement with and Knowledge of PCMH Program** | | | | | | **84.8%** | **81.8%** |
| 1. | Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end. | 80.0% | 90.0% | | | 84.0% | 85.2% |
| 2. | PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. | 90.0% | NA | | | 90.0% | 90.0% |
| 3. | PCP attends and actively/constructively participates in PCMH Panel meetings. | 80.0% | NA | | | 80.0% | 60.0% |
| 4. | PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel. | 80.0% | NA | | | 80.0% | 94.0% |
| 5. | PCP uses the categories in HealthCheck to take action that leads to better cost and quality outcomes. | 90.0% | NA | | | 90.0% | 80.0% |
| **PCP Engagement with Care Plans** | | | | | | **62.8%** | **76.8%** |
| 1. | PCP actively and constructively reviews top 50 and other target lists on a timely basis to identify appropriate Care Plan eligible Members. | 50.0% | 90.0% | | | 66.0% | 70.0% |
| 2. | PCP actively seeks to work with the LCC to schedule patients appropriate for Care Plans. | 70.0% | 70.0% | | | 70.0% | 70.0% |
| 3. | PCP clearly and effectively explains to Care Plan eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and targeted "State of Being" for Care Plan Members. | 50.0% | 82.0% | | | 62.8% | 75.0% |
| 4. | PCP is responsive to requests of LCC when consultation about a patient is needed and works actively on Care Plan compliance with Members. | 50.0% | 70.0% | | | 58.0% | 80.0% |
| 5. | PCP takes due care to review a patient's medication list and cooperates with the LCC and pharmacist as part of CMRs. | 50.0% | 80.0% | | | 62.0% | 80.0% |
| 6. | PCP ensures LCC has access to needed clinical information to identify that a Member is appropriate for a Care Plan and collaborates with the LCC to complete the Care Plan on a timely basis. | 50.0% | 70.0% | | | 58.0% | 86.0% |
| **Practice Transformation** | | | | | | **65.8%** | **63.3%** |
| 1. | PCP identifies and refers to cost-efficient specialists in the top 10 specialty categories. | 58.0% | NA | | | 58.0% | 60.0% |
| 2. | PCP has an effective plan for after-hours care, including active use of telemedicine and nurse hotline capabilities to enhance Member access and avoid unnecessary emergency room visits or breakdowns. | 67.0% | NA | | | 67.0% | 60.0% |
| 3. | PCP actively refers Members to TCCI Program elements through LCCs assigned to Panel. | 65.0% | 80.0% | | | 71.0% | 65.0% |
| 4. | PCP actively collaborates with hospitalists on patients prior to and after admission. | 80.0% | 90.0% | | | 84.0% | 80.0% |
| **Average Overall PCP Engagement** | | | | | | **69.6%** | **72.0%** |

PCMH SearchLight

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** **YTD May, 2016**

### I. Engagement Quality Score

**Engagement Component Ratings by PCP**

*The chart below shows each PCP's average Performance rate for Engagement measures for Performance Year #6 together with comparison to the Panel Average for these components. The rates displayed represent the PCP's average performance on the individual Engagement measures, and are sorted in order of descending performance rate. The column, '# of Care Plans' displays the total number of Care Plans for each PCP that are active at any time within the Performance Year.*
*The TOP 25% performers are highlighted in green and BOTTOM 25% performers are highlighted in orange.*

| # | PCP / NP Name | Engagement with and Knowledge of PCMH Program | PCP Engagement with Care Plans | Practice Transformation | Overall Engagement Rating | # Care Plans |
|---|---|---|---|---|---|---|
| 1 | FLETCH ORANGE | 84.6% | 82.0% | 72.1% | 78.2% | 4 |
| 2 | CHESTER BLACK | 90.0% | 82.4% | 68.0% | 77.8% | 5 |
| 3 | MICHAEL MAUVE | 89.0% | 76.0% | 68.0% | 75.7% | 7 |
| 4 | MORGAN BROWN | 87.0% | 70.0% | 70.0% | 74.3% | 7 |
| 5 | CARSON GRAY | 83.0% | 74.0% | 65.0% | 72.2% | 5 |
| 6 | CORA WHITE | 87.0% | 68.4% | 64.0% | 71.1% | 3 |
| 7 | MELVIN RUBY | 87.0% | 75.0% | 57.0% | 69.9% | 2 |
| 8 | BONNIE BEIGE | 83.0% | 60.0% | 64.0% | 67.6% | 3 |
| 9 | SARAH GREEN | 79.0% | 40.0% | 70.0% | 63.3% | 9 |
| 10 | VIOLET SMITH | 78.0% | 0.0% | 60.0% | 46.5% | 0 |
| | **Panel Average** | 84.8% | 62.8% | 65.8% | 69.6% | 45 |
| | **Panel Points** | 10.60 | 9.42 | 14.80 | 34.82 | |

PCMH SearchLight

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** **YTD May, 2016**

### J. Clinical Quality Score

**Overall Panel Clinical Score vs. Provider Peers**

*The chart below shows the Panel's Clinical ScoreCard for Performance Year #6 together with comparisons relative to Provider Type Peers and All of PCMH. For each measure, the Panel Rate shows the percentage of goal achievement met by dividing the Panel Points by the Possible Points.*

| Clinical Score Measures | Possible Points | Panel Points | Panel Rate | Provider Type Peers Average | Best in Peer Group |
|---|---|---|---|---|---|
| Care Coordination / Patient Safety | 12.50 | 10.28 | 82.2% | 86.7% | 94.0% |
| At Risk Population | 12.50 | 11.14 | 89.2% | 89.4% | 88.0% |
| Preventive Health | 12.50 | 11.91 | 95.3% | 95.7% | 96.0% |
| Patient and Caregiver Experience of Care | 12.50 | 4.95 | 39.6% | 72.5% | 80.0% |
| **Overall Clinical Score Rating** | 50.00 | 38.28 | 76.6% | 86.1% | 92.0% |

PCMH SearchLight

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** — **YTD May, 2016**

### J. Clinical Quality Score

**Panel Clinical Scores**

*The chart below shows the Panel's Clinical performance on all Clinical Measure during Performance Year #6 together with the average Points for Provider Type Peers. Points are assigned for each measure by averaging the scores for each PCP in the Panel. The greyed out measures will not be included in the scores for the performance year.*

| | | Clinical Measure | Possible Points | Cumulative Year Panel Points | Provider Peer Type Average Points |
|---|---|---|---|---|---|
| **Care Coordination / Patient Safety** | | | **12.50** | **10.28** | **10.84** |
| Appropriate Use of Services | 1. | All-Cause Readmissions | 7.50 | 6.49 | 6.89 |
| | 2. | Use of Imaging Studies for Low Back Pain | 2.50 | 1.99 | 2.01 |
| | 3. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | 2.50 | 1.80 | 1.94 |
| | | Medication Reconciliation | | | |
| **At-Risk Population** | | | **12.50** | **11.14** | **11.17** |
| Chronic Care | 1. | Persistent Beta Blocker Treatment After a Heart Attack | | | |
| | 2. | Medication Management for People with Asthma | | | |
| | 3. | Diabetes Composite | | | |
| | | Controlling High Blood Pressure | | | |

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** — **YTD May, 2016**

### J. Clinical Quality Score

**Panel Clinical Rates**

*The chart below shows the Panel's Clinical ScoreCard performance on all clinical measures during Performance Year #6 together with the average Performance Rate for Provider Type Peers. The Performance Rate is the percentage of goal met by dividing actual result by possible maximum score for each quarter. Rates for Care Coordination/Patient Safety, At-Risk Population and Preventive Health components reflect the cumulative rate up to and including that quarter. The Patient and Caregiver Experience of Care rates reflect end of quarter. The Cumulative Year Rate will always match that in the current quarter which will be finalized at the end of the Performance Year.*
*'NA' indicates that the data is Not Available because the measure is only available at the end of the measurement period.*
*'NR' indicates the measure was Not Rated because the Panel did not meet the minimum threshold for the measure.*

| | | Clinical Measure | Q1 | Q2 | Q3 | Q4 | Cumulative Year Panel Rate | Provider Peer Type Average Rate |
|---|---|---|---|---|---|---|---|---|
| **Care Coordination / Patient Safety** | | | | | | | **82.2%** | **86.7%** |
| Appropriate Use of Services | 1. | All-Cause Readmissions | 82.0% | 86.5% | | | 86.5% | 91.9% |
| | 2. | Use of Imaging Studies for Low Back Pain | 79.2% | 79.5% | | | 79.5% | 80.4% |
| | 3. | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | 60.0% | 72.0% | | | 72.0% | 77.6% |
| | | Medication Reconciliation | 79.0% | 79.2% | | | 79.2% | 79.0% |
| **At-Risk Population** | | | | | | | **89.2%** | **89.4%** |
| | 1. | Persistent Beta Blocker Treatment After a Heart Attack | 93.4% | 93.5% | | | 93.5% | 93.6% |

PCMH SearchLight

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** **YTD May, 2016**

### J. Clinical Quality Score

**Clinical Category Ratings by PCP**

*The chart below shows all Category Scores by PCP for Performance Year #6 together with the relative Performance within the Panel and the Overall Panel results. Points at the PCP level are averaged to create the points for the Panel. The rates displayed represent the PCP's average performance on the individual Care Coordination/Patient Safety measures, and are sorted in order of descending performance rate.*
*The TOP 25% performers are highlighted in green and BOTTOM 25% performers are highlighted in orange.*

| # | PCP / NP Name | Care Coordination / Patient Safey | At-Risk Population | Preventive Health | Patient and Caregiver Experience of Care | Overall Quality Score Rating |
|---|---|---|---|---|---|---|
| 1 | FLETCH ORANGE | 90.0% | 92.0% | 96.0% | 86.0% | 91.0% |
| 2 | VIOLET SMITH | 89.0% | 95.0% | 94.0% | 82.0% | 90.0% |
| 3 | CHESTER BLACK | 87.0% | 90.0% | 96.0% | 82.0% | 88.8% |
| 4 | SARAH GREEN | 84.0% | 94.0% | 97.0% | 78.0% | 88.3% |
| 5 | MICHAEL MAUVE | 86.0% | 92.0% | 95.6% | 76.0% | 87.4% |
| 6 | MORGAN BROWN | 80.0% | 95.0% | 94.0% | 70.0% | 84.8% |
| 7 | BONNIE BEIGE | 79.0% | 86.0% | 93.5% | 75.0% | 83.4% |

The next set of views allow for drill-down capability to the Member level. The example below shows the number of Members eligible for the Low Back Pain measure, the number who met and did not meet goal and the success rate. If a user clicks on any of the numbers in the table, this takes you to a listing of the Members represented by that number. The Measure Detail and drill through report is available for every measure in every category of the Clinical Measures.

PCMH SearchLight

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## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** **YTD May, 2016**

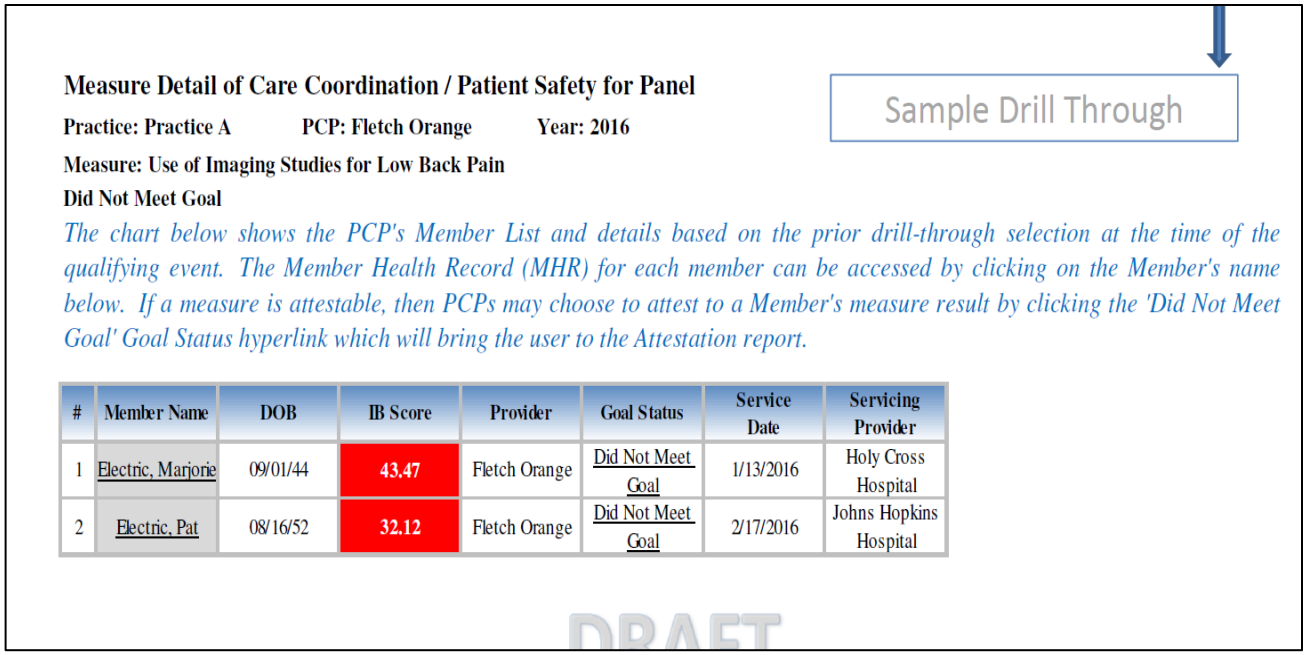
### J. Clinical Quality Score

**Measure Detail of Care Coordination / Patient Safety for Panel**

*The chart below details by measure success rate for the Panel for Care Coordination/Patient Safety Measures. A drill-through report is available by clicking on the hyperlinked number of either Eligible Encounters, Met Goal, or Did Not Meet Goal which will reveal a corresponding event table. This report is filterable by Panel PCPs with default selection to all PCPs.*
*The greyed out measures are not included in the Success Rate as they were not scored for the Performance Year*

FLETCH ORANGE
All PCP's
MICHAEL MAUVE
MORGAN BROWN
BONNIE BEIGE

| # | Measure | Eligible Encounters | Met Goal | Did Not Meet Goal | Success Rate |
|---|---|---|---|---|---|
| 1 | All-Cause Readmissions | 90 | 79 | 11 | 87.8% |
| 2 | Use of Imaging Studies for Low Back Pain | 87 | 85 | 2 | 97.7% |
| 3 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | 80 | 68 | 12 | 85.0% |
| | Medication Reconciliation | 183 | 179 | 4 | 97.8% |



**Measure Detail of Care Coordination / Patient Safety for Panel**

Sample Drill Through

**Practice: Practice A** **PCP: Fletch Orange** **Year: 2016**

**Measure: Use of Imaging Studies for Low Back Pain**

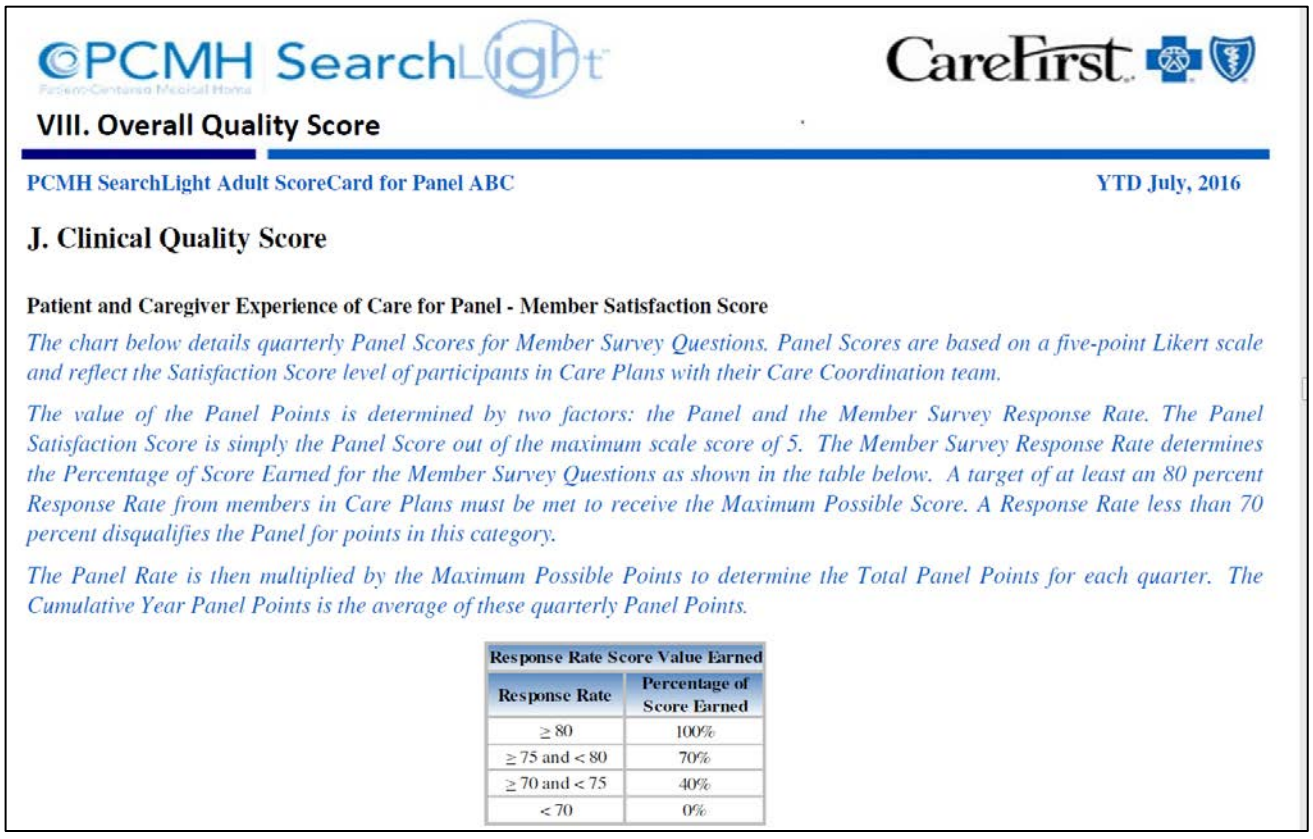
**Did Not Meet Goal**

*The chart below shows the PCP's Member List and details based on the prior drill-through selection at the time of the qualifying event. The Member Health Record (MHR) for each member can be accessed by clicking on the Member's name below. If a measure is attestable, then PCPs may choose to attest to a Member's measure result by clicking the 'Did Not Meet Goal' Goal Status hyperlink which will bring the user to the Attestation report.*

| # | Member Name | DOB | IB Score | Provider | Goal Status | Service Date | Servicing Provider |
|---|---|---|---|---|---|---|---|
| 1 | Electric, Marjorie | 09/01/44 | 43.47 | Fletch Orange | Did Not Meet Goal | 1/13/2016 | Holy Cross Hospital |
| 2 | Electric, Pat | 08/16/52 | 32.12 | Fletch Orange | Did Not Meet Goal | 2/17/2016 | Johns Hopkins Hospital |

DRAFT

The final view shows the Member Satisfaction Scores for each Panel. This shows the response rate for each quarter and the points received for each quarter for the Member Survey.



PCMH SearchLight

CareFirst

## VIII. Overall Quality Score

**PCMH SearchLight Adult ScoreCard for Panel ABC** **YTD July, 2016**

### J. Clinical Quality Score

**Patient and Caregiver Experience of Care for Panel - Member Satisfaction Score**

*The chart below details quarterly Panel Scores for Member Survey Questions. Panel Scores are based on a five-point Likert scale and reflect the Satisfaction Score level of participants in Care Plans with their Care Coordination team.*

*The value of the Panel Points is determined by two factors: the Panel and the Member Survey Response Rate. The Panel Satisfaction Score is simply the Panel Score out of the maximum scale score of 5. The Member Survey Response Rate determines the Percentage of Score Earned for the Member Survey Questions as shown in the table below. A target of at least an 80 percent Response Rate from members in Care Plans must be met to receive the Maximum Possible Score. A Response Rate less than 70 percent disqualifies the Panel for points in this category.*

*The Panel Rate is then multiplied by the Maximum Possible Points to determine the Total Panel Points for each quarter. The Cumulative Year Panel Points is the average of these quarterly Panel Points.*

| Response Rate Score Value Earned | |
|---|---|
| Response Rate | Percentage of Score Earned |
| ≥ 80 | 100% |
| ≥ 75 and < 80 | 70% |
| ≥ 70 and < 75 | 40% |
| < 70 | 0% |

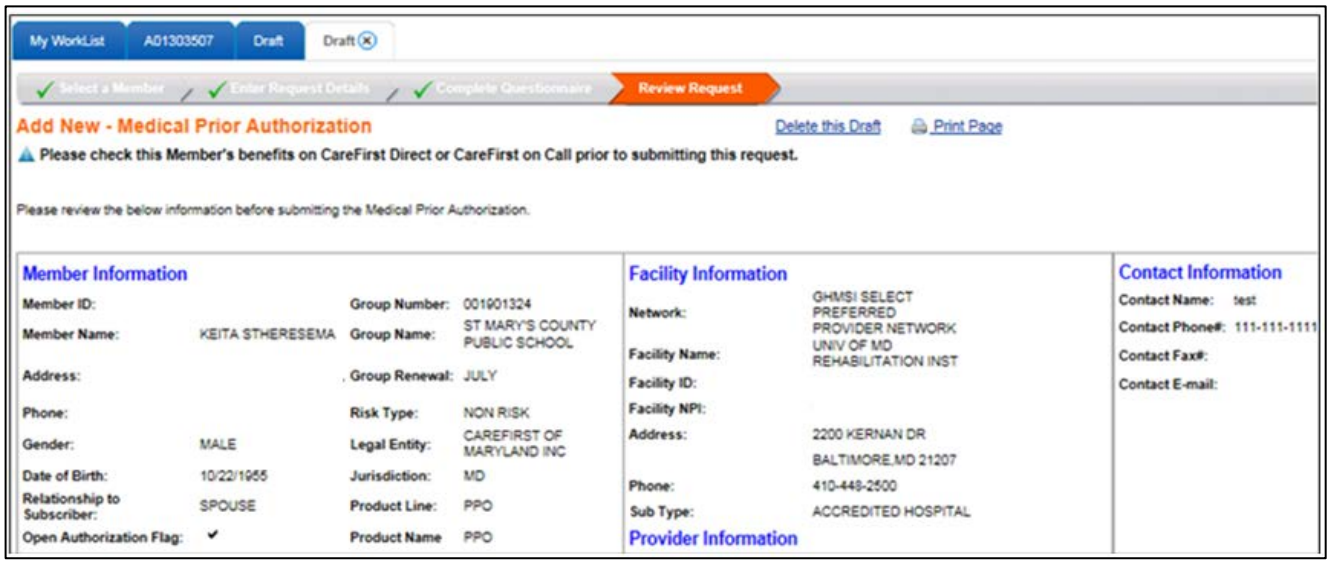
| Member Survey Response Rate | | | |
|---|---|---|---|
| Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
| 72.1 % | | | |

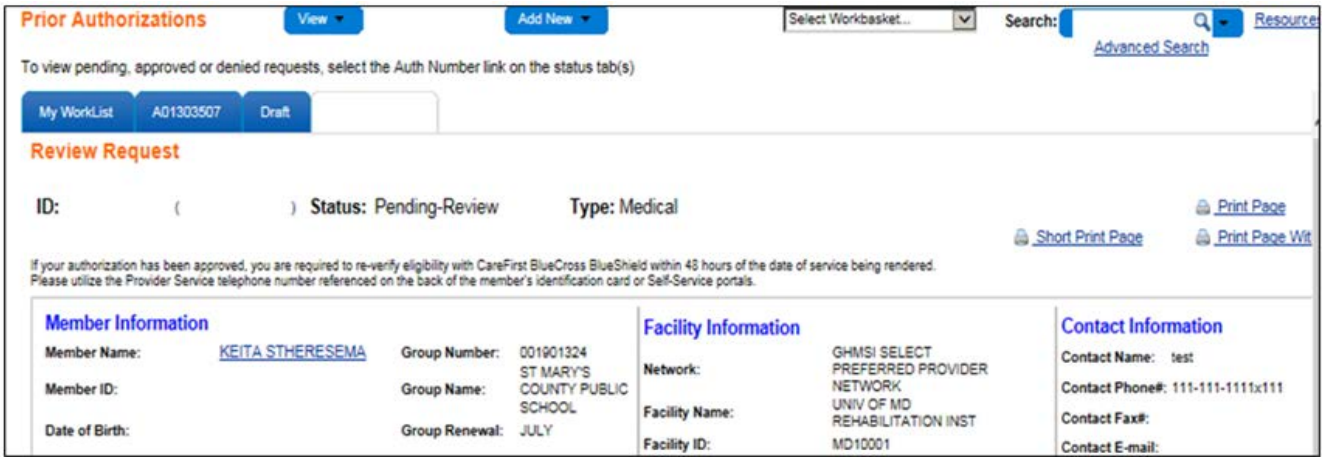
### *Member Satisfaction Score Chart*

| | | | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Average Overall Score |
|---|---|---|---|---|---|---|---|
| | Questions (results are received on a five point Likert scale) | Maximum Possible Score | Panel Score | Panel Score | Panel Score | Panel Score | Panel Score |
| 1 | You understand the Care Coordination Plan, including the actions you are supposed to take. | 5 | 3.25 | | | | 3.25 |
| 2 | Your Care Coordination nurse and Care Coordination team are helpful in coordinating your care. | 5 | 3.38 | | | | 3.38 |
| 3 | Your doctor or nurse practitioner spends enough time with you. | 5 | 3.43 | | | | 3.43 |
| 4 | After starting your Care Coordination Plan, you have had access to information that you need to understand and manage your health better. | 5 | 3.48 | | | | 3.48 |
| 5 | Finally, overall, health is more stable and better managed as a result of the Care Coordination Plan. | 5 | 3.35 | | | | 3.35 |

## Domain #8: Authorization And Notification Management

As discussed in **Part VI: TCCI: Eighteen Supporting Programs**, the Preauthorization Program (PRE) is applicable to certain high cost services and seeks to assure that the right service for the Member in the right setting at the right time is provided. The PRE Program within iCentric not only ensures that a level of thoughtful vigilance is applied to high cost, complex services, but also serves as a notification vehicle for our HTC and CCM Programs, thus ensuring that Members receive a high touch, continuously coordinated level of care throughout their episode of care.



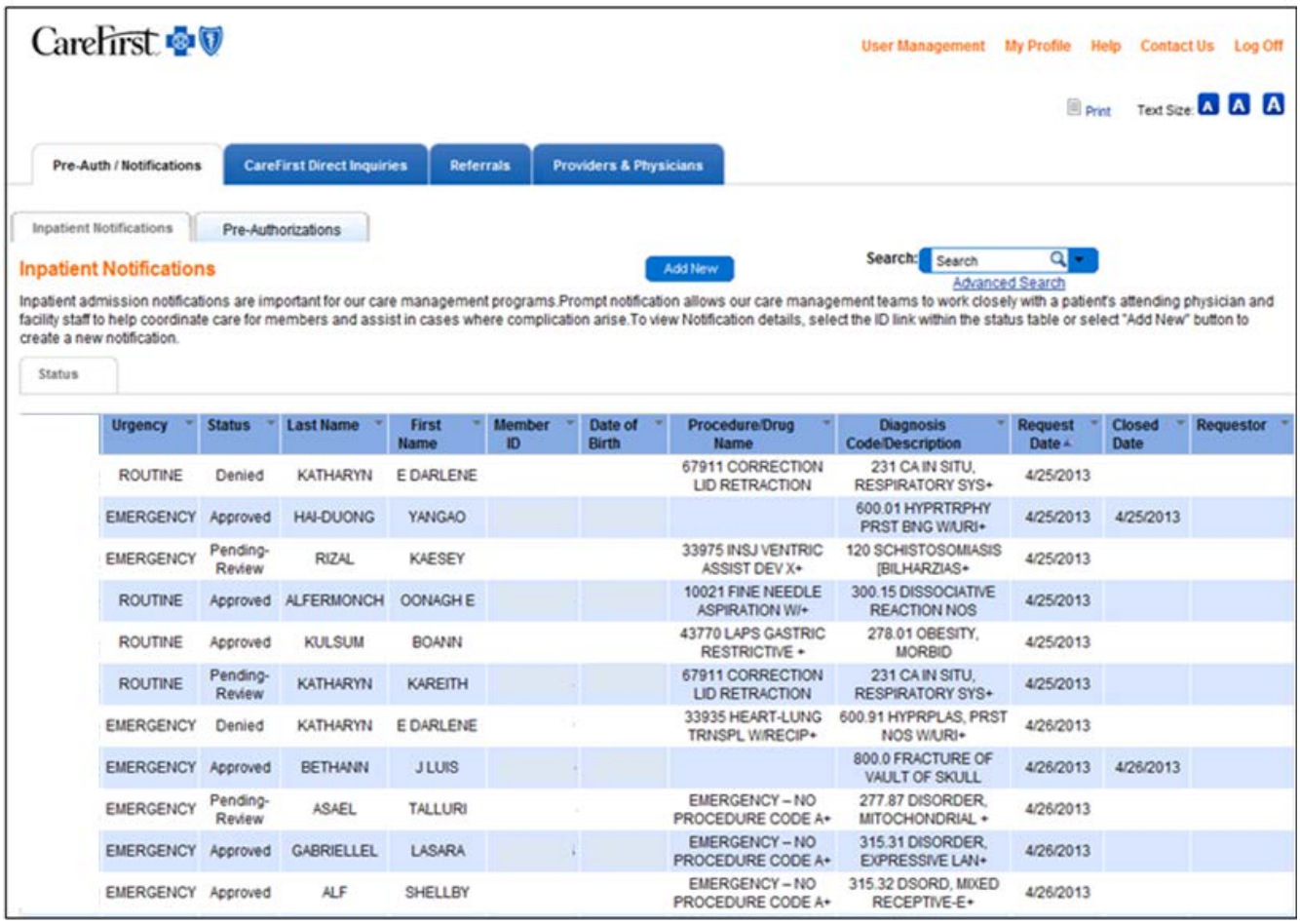




Users are presented with an easy to understand clinical workflow that collects the necessary information to support a medical determination, including:

- Member demographic and contact information
- Provider and Facility Information
- Medical condition and evidence based clinical questionnaire
- Medical records attachment

Upon submission, the request is electronically routed through an extensive pre-service review process of the clinical information. In cases where further judgment is warranted, a medical director will render a determination based upon the documentation submitted, clinical judgment, evidence based criteria and national medical policies. The entire flow is

managed on the iCentric platform, thus ensuring full access to all subsequent Care Coordination efforts that may be required in support of the Member.

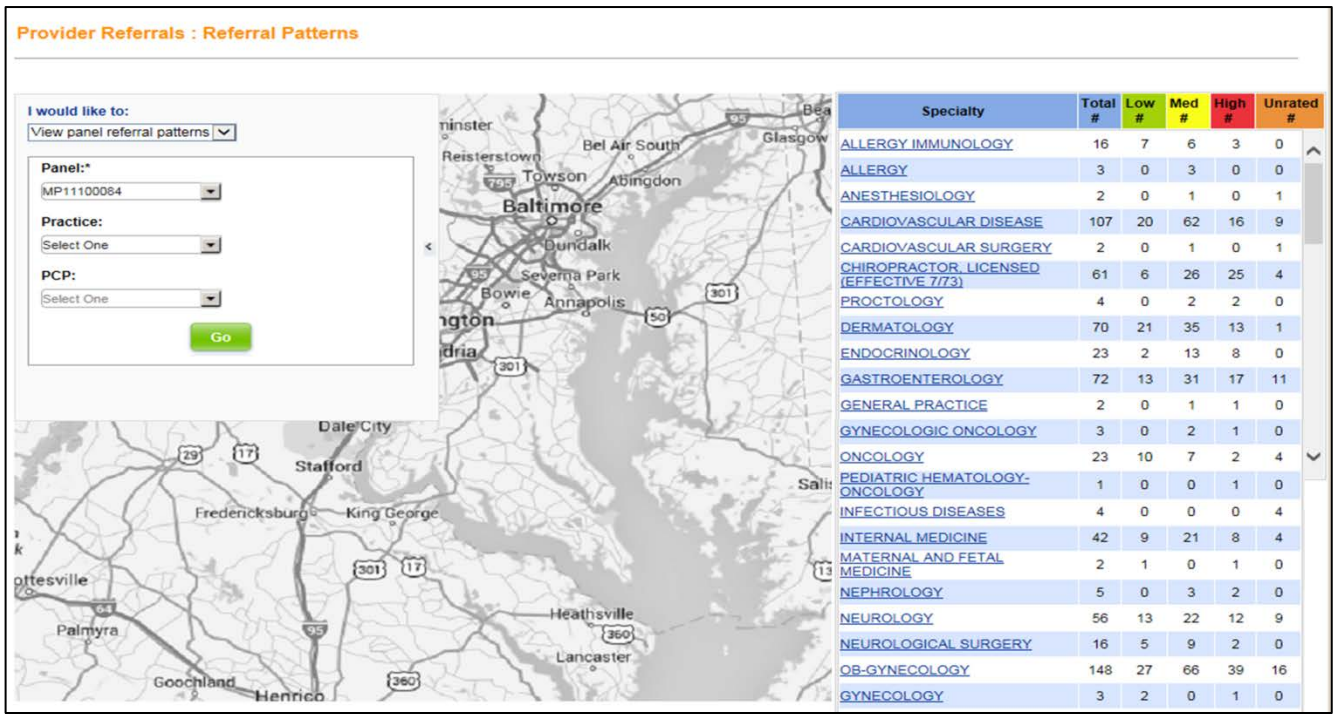



| Urgency | Status | Last Name | First Name | Member ID | Date of Birth | Procedure/Drug Name | Diagnosis Code/Description | Request Date | Closed Date | Requestor |
|---|---|---|---|---|---|---|---|---|---|---|
| ROUTINE | Denied | KATHARYN | E DARLENE | | | 67911 CORRECTION LID RETRACTION | 231 CA IN SITU, RESPIRATORY SYS+ | 4/25/2013 | | |
| EMERGENCY | Approved | HAI-DUONG | YANGAO | | | | 600.01 HYPRTRPHY PRST BNG W/URI+ | 4/25/2013 | 4/25/2013 | |
| EMERGENCY | Pending-Review | RIZAL | KAESEY | | | 33975 INSJ VENTRIC ASSIST DEV X+ | 120 SCHISTOSOMIASIS [BILHARZIAS+ | 4/25/2013 | | |
| ROUTINE | Approved | ALFERMONCH | OONAGH E | | | 10021 FINE NEEDLE ASPIRATION W/+ | 300.15 DISSOCIATIVE REACTION NOS | 4/25/2013 | | |
| ROUTINE | Approved | KULSUM | BOANN | | | 43770 LAPS GASTRIC RESTRICTIVE + | 278.01 OBESITY, MORBID | 4/25/2013 | | |
| ROUTINE | Pending-Review | KATHARYN | KAREITH | | | 67911 CORRECTION LID RETRACTION | 231 CA IN SITU, RESPIRATORY SYS+ | 4/25/2013 | | |
| EMERGENCY | Denied | KATHARYN | E DARLENE | | | 33935 HEART-LUNG TRNSPL W/RECIP+ | 600.91 HYPRPLAS, PRST NOS W/URI+ | 4/26/2013 | | |
| EMERGENCY | Approved | BETHANN | J LUIS | | | | 800.0 FRACTURE OF VAULT OF SKULL | 4/26/2013 | 4/26/2013 | |
| EMERGENCY | Pending-Review | ASAEL | TALLURI | | | EMERGENCY – NO PROCEDURE CODE A+ | 277.87 DISORDER, MITOCHONDRIAL + | 4/26/2013 | | |
| EMERGENCY | Approved | GABRIELLEL | LASARA | | | EMERGENCY – NO PROCEDURE CODE A+ | 315.31 DISORDER, EXPRESSIVE LAN+ | 4/26/2013 | | |
| EMERGENCY | Approved | ALF | SHELLBY | | | EMERGENCY – NO PROCEDURE CODE A+ | 315.32 DSORD, MIXED RECEPTIVE-E+ | 4/26/2013 | | |

As previously mentioned, a CareFirst HTC Nurse receives notification of all new admissions via iCentric. The HTC nurse can quickly and efficiently assess each admission as it occurs and decide which ones will likely need follow-up attention post discharge to best assure recovery to the extent possible with an eye toward avoiding the breakdowns that lead to readmissions and further complications. The HTC nurse captures a LACE (Length of Stay, Acuity of Admission, Charlson Co-Morbidly Index and Number of Emergency Room Visits) or ACE (since length of stay is unknown at the time of admission) Index Score within iCentric. Higher values for either index indicate the need for more intensive post-hospitalization Care Coordination and prioritize the Member for TCCI interventions. Care for these Members is managed through appropriate TCCI Programs, with all data, status and Member conditions captured centrally within the iCentric platform.

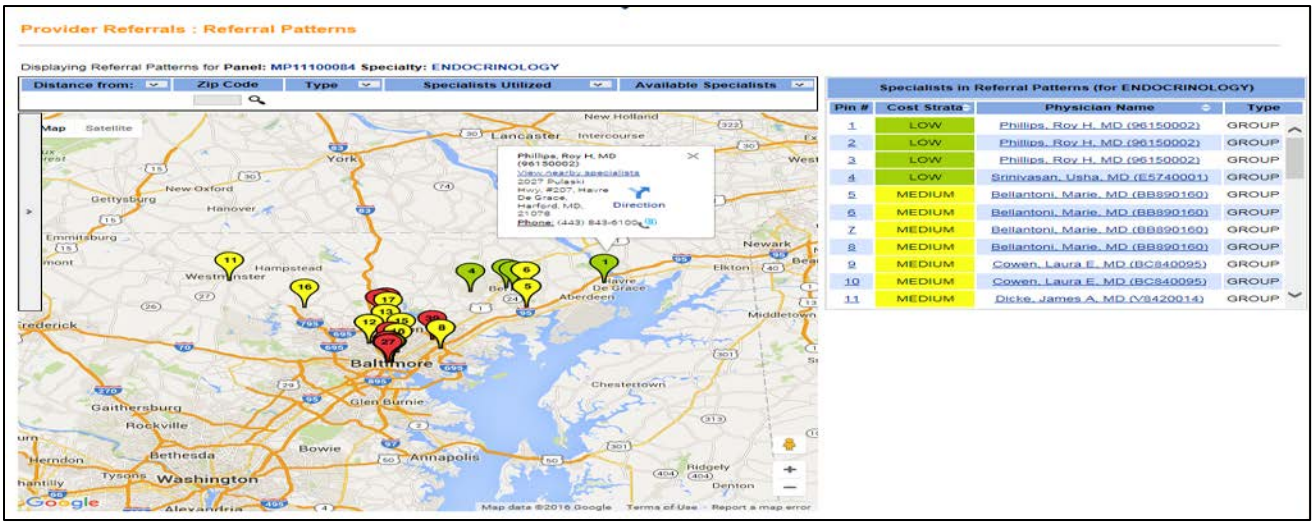
## Domain #9: Referral Management And Analytics

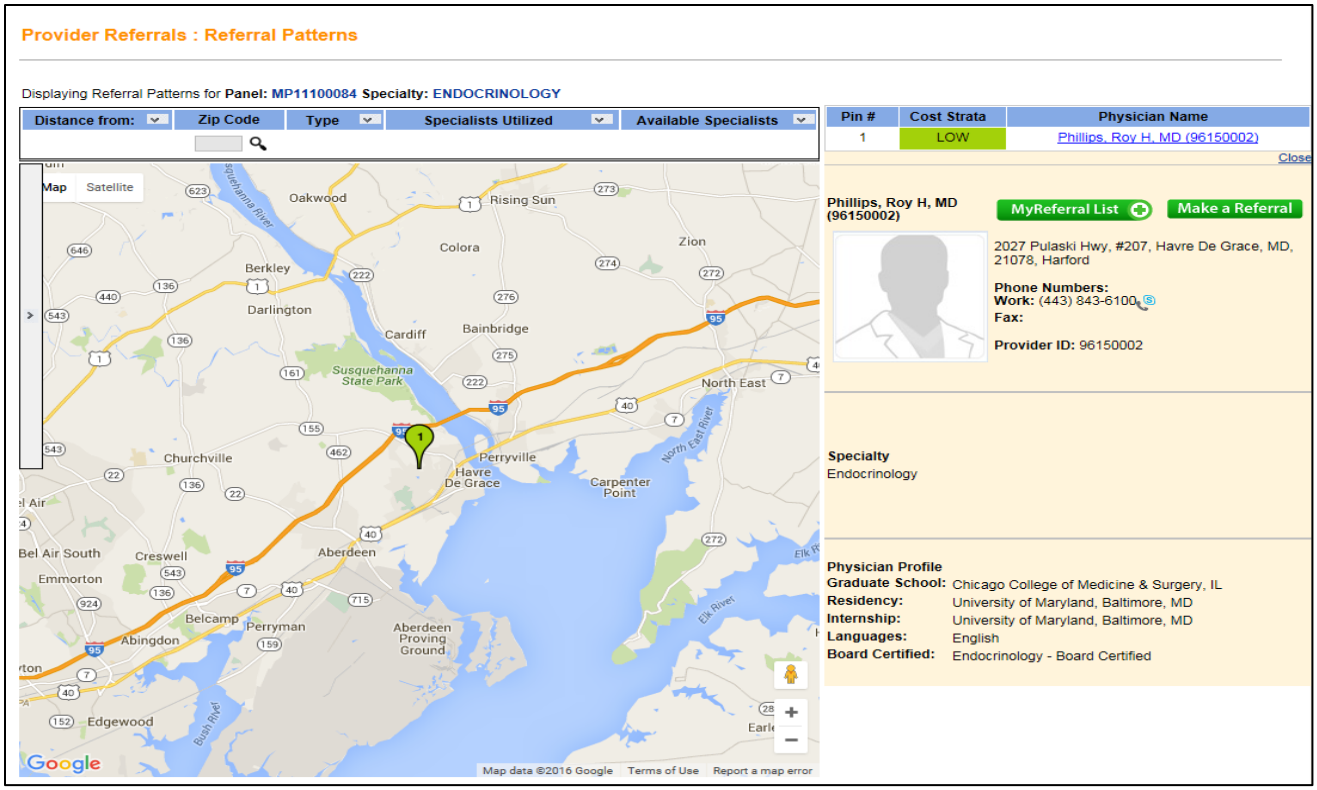
Recognizing the importance of PCP's judgments on when and where to refer Members for specialty care, the iCentric Referral Function provides insight into a Panel's most frequently used specialists and how these specialists rank on a High, Medium, Low cost scale based upon claims history.

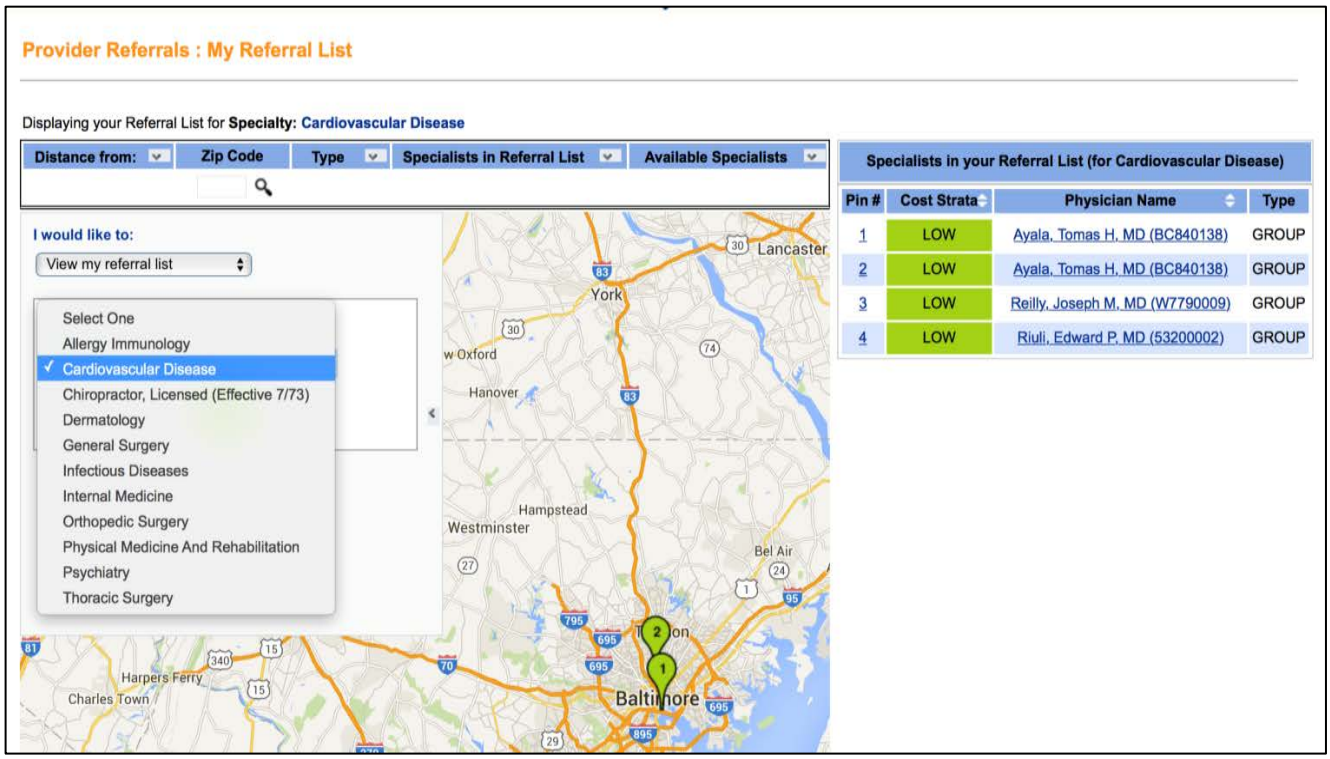



| Specialty | Total # | Low # | Med # | High # | Unrated # |
|---|---|---|---|---|---|
| ALLERGY IMMUNOLOGY | 16 | 7 | 6 | 3 | 0 |
| ALLERGY | 3 | 0 | 3 | 0 | 0 |
| ANESTHESIOLOGY | 2 | 0 | 1 | 0 | 1 |
| CARDIOVASCULAR DISEASE | 107 | 20 | 62 | 16 | 9 |
| CARDIOVASCULAR SURGERY | 2 | 0 | 1 | 0 | 1 |
| CHIROPRACTOR, LICENSED (EFFECTIVE 7/73) | 61 | 6 | 26 | 25 | 4 |
| PROCTOLOGY | 4 | 0 | 2 | 2 | 0 |
| DERMATOLOGY | 70 | 21 | 35 | 13 | 1 |
| ENDOCRINOLOGY | 23 | 2 | 13 | 8 | 0 |
| GASTROENTEROLOGY | 72 | 13 | 31 | 17 | 11 |
| GENERAL PRACTICE | 2 | 0 | 1 | 1 | 0 |
| GYNECOLOGIC ONCOLOGY | 3 | 0 | 2 | 1 | 0 |
| ONCOLOGY | 23 | 10 | 7 | 2 | 4 |
| PEDIATRIC HEMATOLOGY-ONCOLOGY | 1 | 0 | 0 | 1 | 0 |
| INFECTIOUS DISEASES | 4 | 0 | 0 | 0 | 4 |
| INTERNAL MEDICINE | 42 | 9 | 21 | 8 | 4 |
| MATERNAL AND FETAL MEDICINE | 2 | 1 | 0 | 1 | 0 |
| NEPHROLOGY | 5 | 0 | 3 | 2 | 0 |
| NEUROLOGY | 56 | 13 | 22 | 12 | 9 |
| NEUROLOGICAL SURGERY | 16 | 5 | 9 | 2 | 0 |
| OB-GYNECOLOGY | 148 | 27 | 66 | 39 | 16 |
| GYNECOLOGY | 3 | 2 | 0 | 1 | 0 |

As shown above, the user selects the Referral Patterns view which results in a drillable listing of the Specialists the Panel refers to along with their distribution of High, Medium and Low Specialists. As shown below, selecting a specialty of interest allows the user to see the specific specialty practices along with a geographic location of each office. This allows the user to consider factors such as accessibility for the Member when considering a Specialist. The user can drill further to see a Physician Profile which provides information about education, certifications, contact details, etc. The user can easily initiate a referral from this view. Perhaps most importantly, the user can add the Specialist to a customizable "My Referral List", which allows for immediate access to the most cost effective Specialists based upon the preferences of the PCP.





## Domain #10: Support for Video Visits

Telemedicine has emerged as a critical component of an efficient health care system that can improve access to timely, cost-effective care. Due to advances in technology, telemedicine has spread rapidly and is becoming integrated into the ongoing operations of physician offices.

The CareFirst Video Visit tool is fully integrated into the iCentric portal to facilitate the goals of encouraging practices to extend office hours and provide flexible primary care services by encouraging real-time, integrated audio and video telecommunication between a Member and their PCP through the Telemedicine Program (TMP), discussed in **Part VI: TCCI: Eighteen Supporting Programs**.

Video Visit functionality is integrated into iCentric and allows PCPs to extend their office support to a variety of situations where traditional brick-and-mortar practices encounter challenges with gaining Member Engagement. Eight scenarios where the Video Visit tool excels at engaging Members are described below.

**Medical Follow-up:** A PCP can conduct a Video Visit with a Member to follow-up on a broad range of conditions after an initial diagnosis. The Video Visit platform is particularly effective for reducing the need of a Member to travel for follow up care.

**Maintenance Visit:** During business hours, after hours and on weekends, PCPs can schedule Video Visits with Members and Care Coordinators to review progress and setbacks in achieving Care Plan objectives.

**PCP Specialist Consult:** A PCP can conduct a consult with a specialist remotely via a Video Visit appointment and involve a Member or an LCC.

**After-hours Care:** A PCP can provide after-hours coverage through a Video Visit with a Member to improve diagnosis and triage urgent conditions to improve coordination of care.

**Remote Location Access:** A PCP in a rural area can use a Video Visit to improve access to medical care for Members who are unable to travel to the office or need the services/consultation of a specialist who would otherwise be unavailable.

**Coordination of TCCI Services:** A Video Visit can be used for all aspects of TCCI Care Coordination, including but not limited to performing CMRs, reviewing results of Expert Consults, conducting pain management review sessions, and evaluating the results of Enhanced Monitoring.

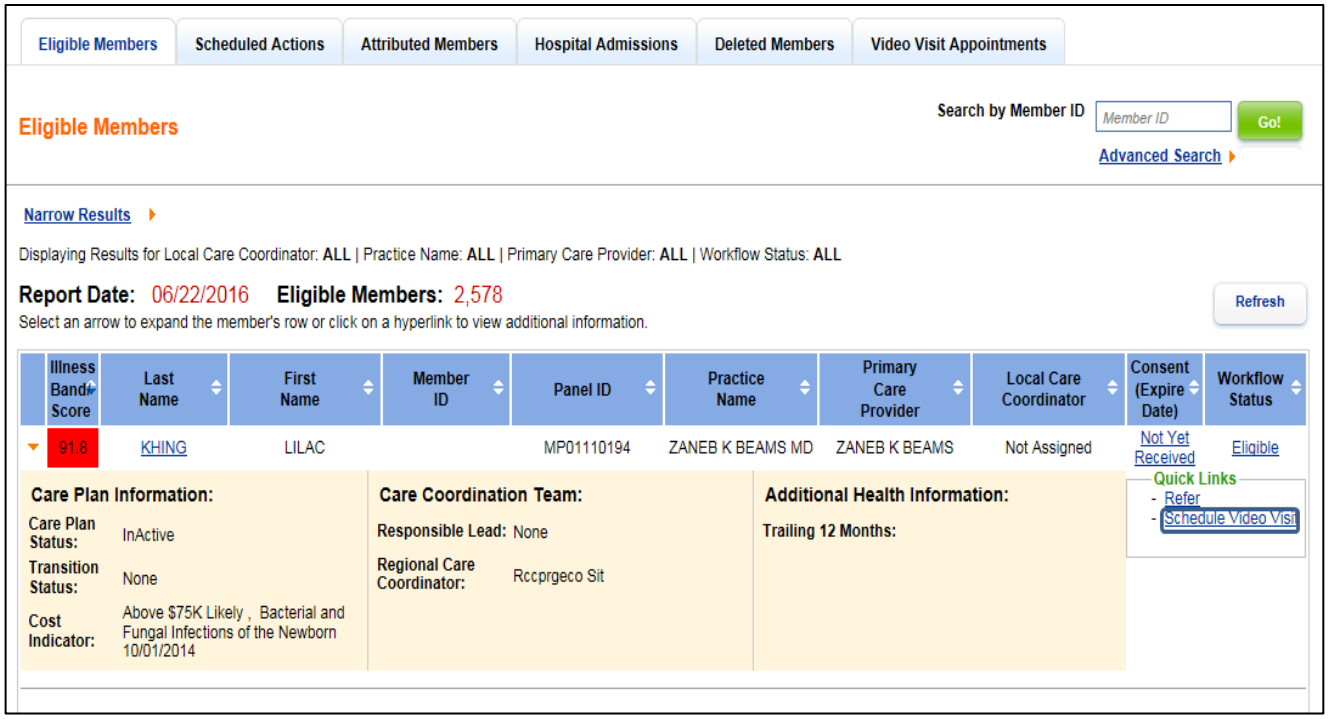
**Hospital Discharge Follow-up:** A PCP can use a Video Visit to perform seven-day and 14-day Transitional Care Management assessments on Members recently discharged from the hospital.

**Chronic Care Management:** A PCP can monitor progress of Members with chronic conditions in a convenient manner by conducting a Video Visit for routine follow-up care of Members.

### Scheduling a Member within iCentric

Video Visits can be easily scheduled directly from the Panel roster view.

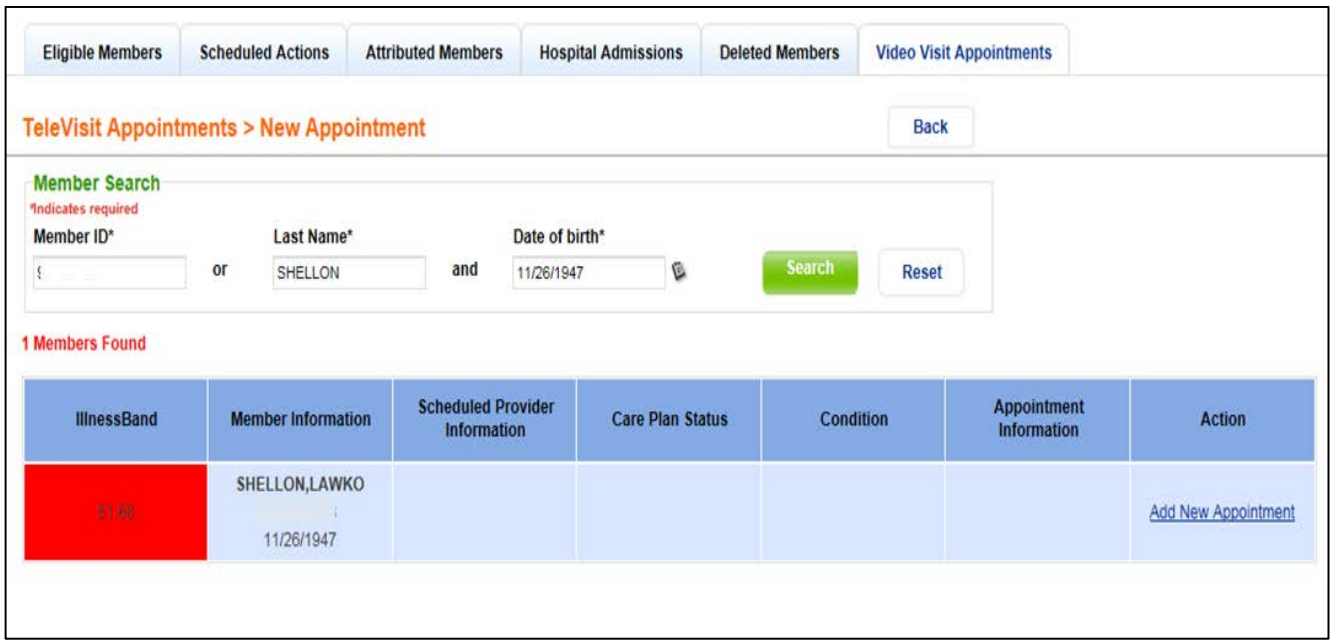
Within iCentric, the PCP or their designee can locate the appropriate Member on their practice roster or by using the Search box. Once the Member row is located, the user can click to expand the information visible about the Member. This expanded view includes the option to schedule a Video Visit.




**Reviewing an existing Appointment and Adding a New Appointment**

The TeleVisit Appointments screen shows all of the upcoming and recent Video Visits scheduled for the selected Member. This screen is available after finding the Member through the Panel's roster view or from using the Search functionality.

From this screen, the user can click the "Add New Appointment" link to begin entering the information for the new Video Visit. Other Video Visits scheduled for that Member, both past and future, are also visible here.



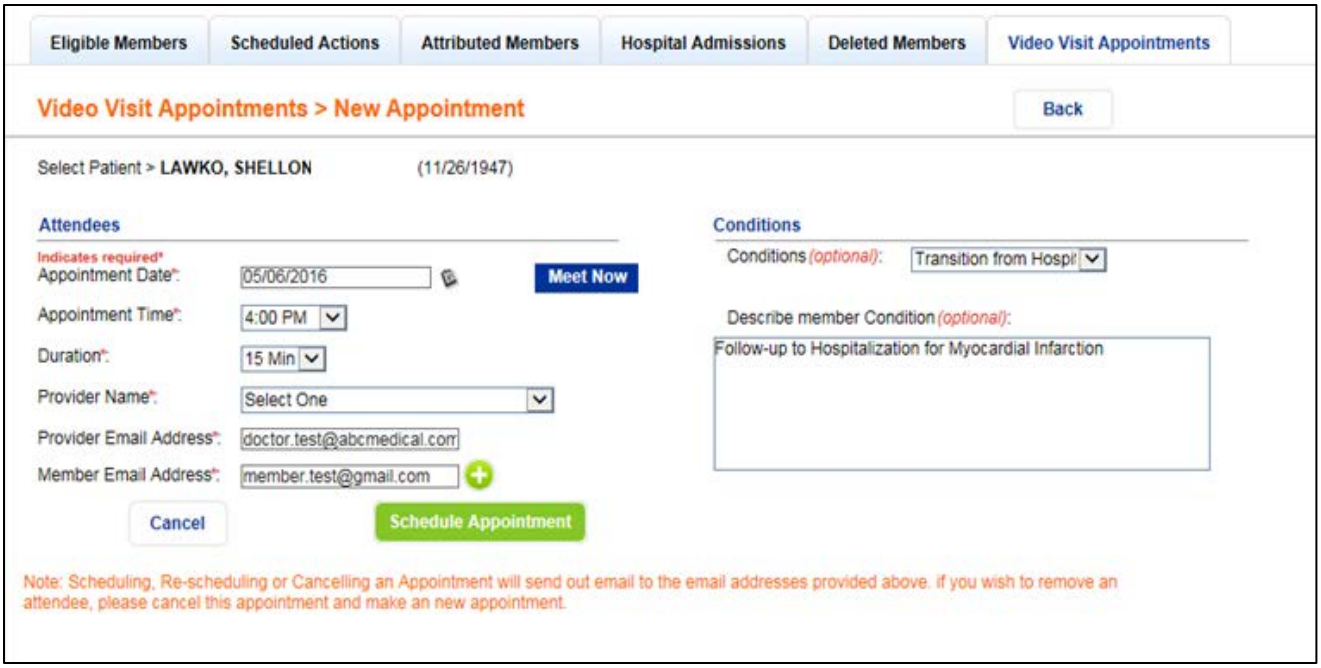
**Entering Appointment Details**

The Appointment Details screen is accessible from the Member's appointment screen and the Panel's appointment calendar. Once the user has opened the Appointment details, they enter basic information about the Video Visit to finish the appointment Setup.

- The date of the Video Visit
    - A Video Visit can be scheduled up to two months in the future.
- The time the Video Visit is scheduled to start
    - A Video Visit appointment cannot be scheduled in the past.
- The approximate duration of the Video Visit
    - This information is used for scheduling only, and will not cause a Video Visit to end preemptively.
    - To ensure meeting security, meetings cannot exceed 60 minutes.
- The Provider's name
    - The user is able to view and create Video Visits for any PCP in a Panel. This allows an office administrative staff to schedule Video Visits on behalf of a PCP.
    - The Provider's email address.
    - This email address will receive confirmation and reminder emails for the Video Visit.
    - The Provider's email address is not distributed to the Member.
- The Member's email address
    - This email address will receive confirmation and reminder emails for the Video Visit.
    - CareFirst does not retain Member email addresses through the Video Visit tool for any purpose beyond scheduling Video Visits.

Two optional fields are available as well.

- Condition
    - Used to specify the type of appointment being conducted.
- Member Condition Description
    - A free-text field to allow a Provider to enter notes about the reasons for the Video Visit.

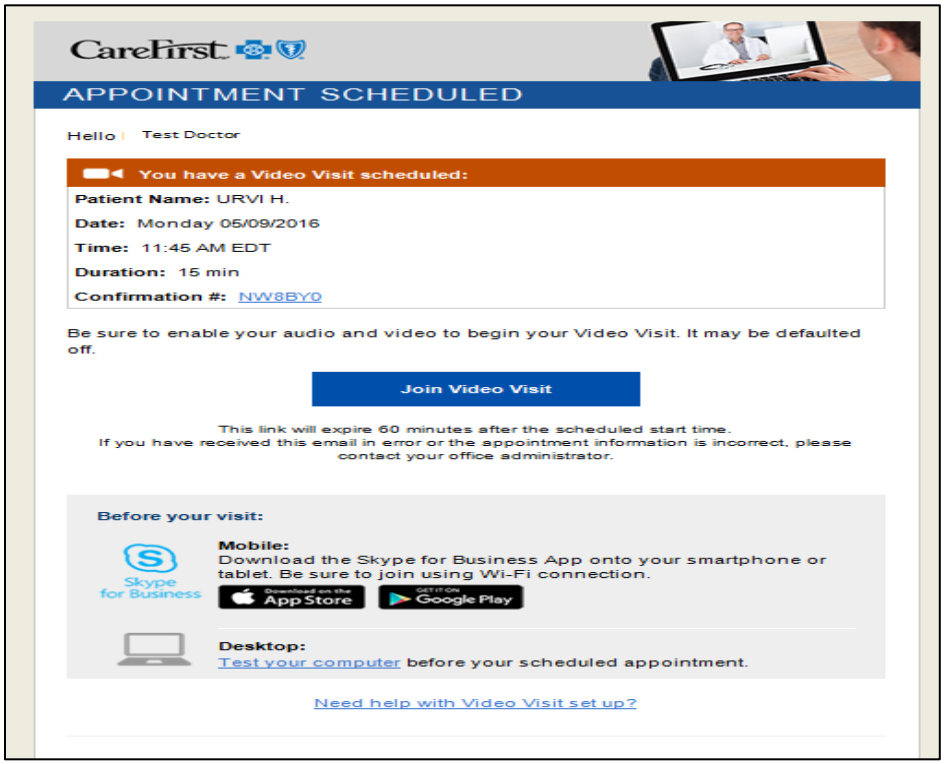



**Confirmation emails received**

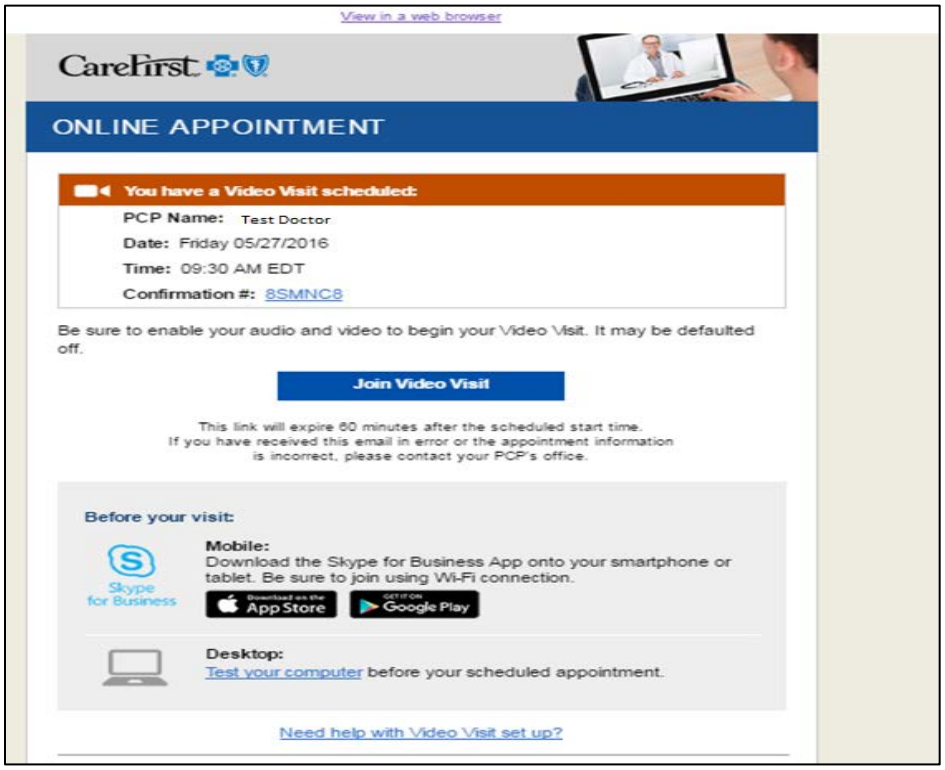
After the appointment is scheduled, both the Provider and the Member receive confirmation emails at the address entered on the scheduling page. The email messages contain instructions for joining the Video Visit, a unique code that automatically registers the caller to the meeting, and hyperlinks to install Video Visit apps for mobile devices. The confirmation email is sent from a CareFirst email address. The PCP's email address is not sent to the Member through the confirmation emails.

The information contained in the confirmation email is unique to the caller. If multiple people are invited to the Video Visit, they each receive a unique code. This prevents one Member from being admitted to another Member's on-going Video Visit, and ensures each Video Visit's privacy.

**PCP confirmation Email**




**Member Confirmation Email**

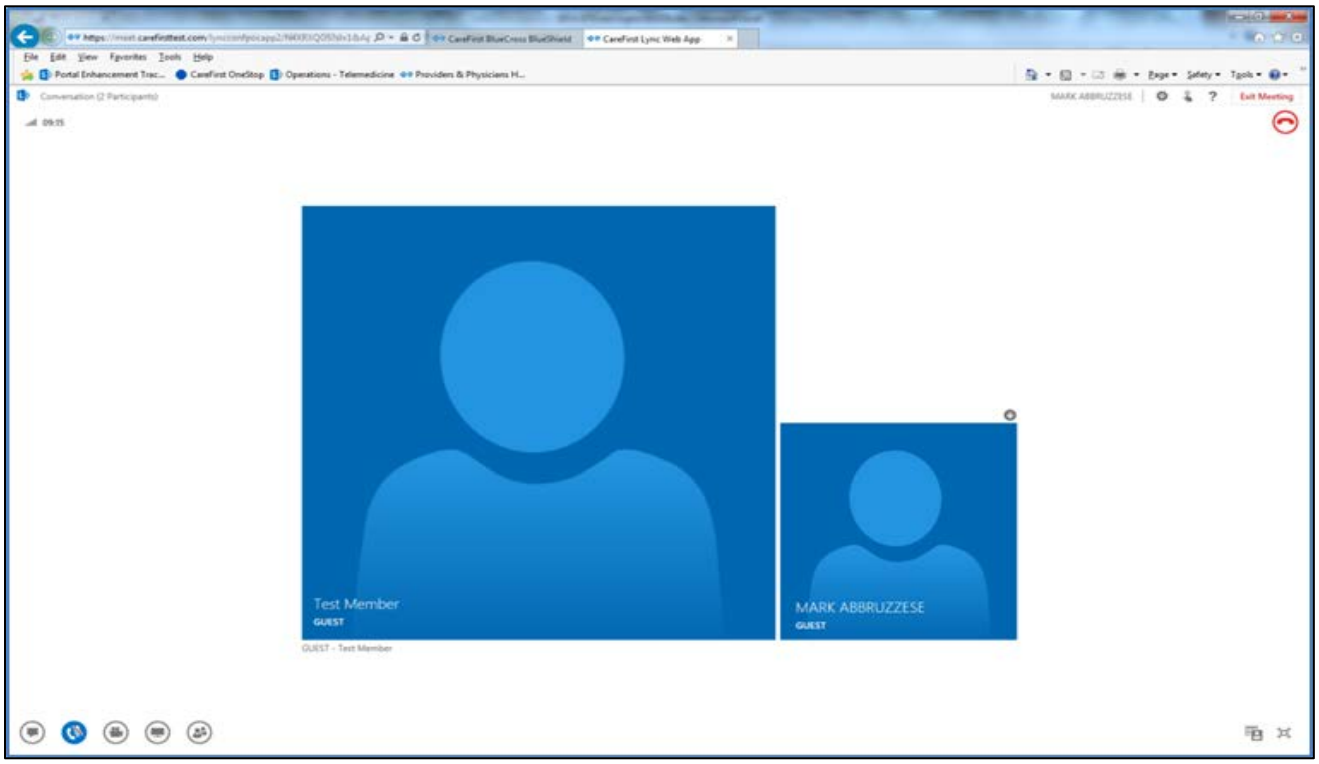


**Joining the Video Visit**

At the scheduled appointment time, both the Member and the PCP use the "Join Video Visit" button contained in the confirmation email to join the Video Visit. The PCP is also able to join the Video Visit directly from the iCentric portal by viewing the scheduled appointment from the Video Visit section of the Roster view.

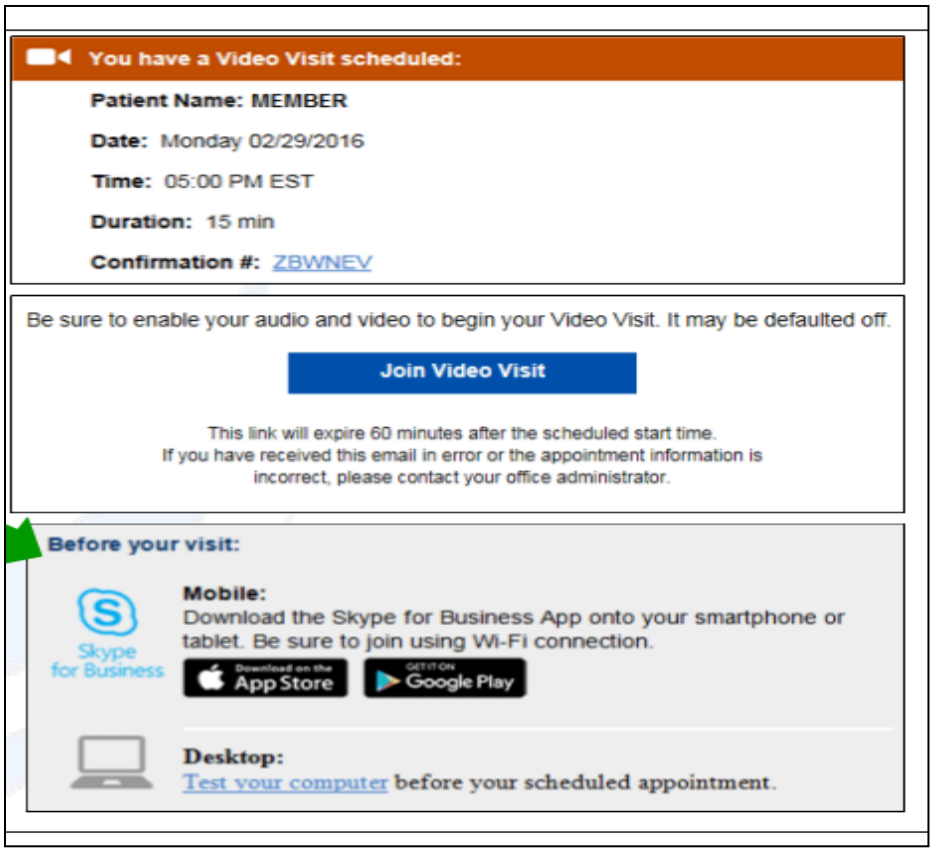
If the Member joins the Video Visit prior to the PCP, the Member sees a virtual "Waiting Room" until the PCP is able to log in to the appointment.

Once both PCP and Member are logged in to the Video Visit on a mobile device or a laptop with a camera and microphone, they see the easy-to-use Video Visit platform. This platform is based on the Microsoft Skype for Business software, and uses industry-standard functionality, so the majority of Members will be familiar with the meeting controls. Both the PCP and the Member are able to engage directly by video, share contents from other software on their computer, and engage in the same manner as they would during a face-to-face appointment.




**Help is available**

If a user needs technical assistance with scheduling or joining a Video Visit, they can call Technical Support at 844-839-9231, Monday-Friday 7:00 A.M.–6:00 P.M. (EST).



# Appendices

## Appendix A: PCMH PCP Contract Addendum

**ADDENDUM TO**
**MASTER GROUP PARTICIPATION AGREEMENT**

***PATIENT-CENTERED MEDICAL HOME***

This Addendum to the Master Group Participation Agreement is entered into by and between Group and Corporation on the ___ day of _____, 201_ (the "Effective Date").

**A. Background and Purpose**

Group and Corporation are parties to a Master Group Participation Agreement ("Agreement") whereby Group participates in the Participating Provider Network and Regional Participating Preferred Network maintained by Corporation, which has established a voluntary Patient-Centered Medical Home Program (the "Program") for the purpose of rewarding Primary Care Providers ("PCPs", which may include Medical Doctors, Doctors of Osteopathic Medicine and Nurse Practitioners) for providing, arranging, coordinating and managing quality, efficient, and cost-effective health care services for individuals enrolled in health benefit plans issued or administered by Corporation ("Members").

The Program is based on the premise that PCPs can most effectively assist Members by encouraging them to take appropriate steps to maintain their health, by spending time with them in proportion to their health care needs, by helping them to navigate through the complex range of medical treatment options when they are seriously ill, and by suggesting and arranging timely referrals to efficient, quality specialists, hospitals and other health care providers; and that Members, who have strong relationships with their PCPs, will seek them out for needed primary care and for assistance in finding the most appropriate health care services.

**B. Definitions**

**Patient-Centered Medical Home:** A Patient-Centered Medical Home, also referred to as a "PCMH" or "Medical Care Panel", is a group of PCPs formed in one of the following Panel types, which must meet the requirements on size and composition established in the PCMH Program Guidelines:

1. A Virtual Panel is a self-selected team of PCPs, consisting of two or more practices (separate legal entities), that, in total, is comprised of at least five (5) PCPs and not more than fifteen (15) PCPs.

2. An Independent Group Practice Panel consists of at least five (5) but no more than fifteen (15) PCPs, all of whom practice as members of a single group practice.

3. A Multi-Panel Independent Group Practice is a group practice consisting of more than fifteen (15) PCPs segmented into Panels of five (5) to fifteen (15) PCPs for tracking performance (Debits and Credits in a PCA at the Panel level) and pooling experience at the Panel level for the purpose of calculating an OIA.

4. A Multi-Panel Health System is under common ownership or control of a hospital or health system and consists of more than fifteen (15) PCPs segmented into Panels of five (5) to fifteen (15) PCPs for the purpose of tracking performance (Debits and Credits in a PCA at the Panel level) and pooling experience at the Panel level for the purpose of calculating an OIA.

**Primary Care Provider or PCP**: A Primary Care Provider or PCP under this Program is a healthcare provider who: (i) is a full time, duly licensed medical practitioner; (ii) has a primary specialty in internal medicine, family practice, general practice, pediatrics, geriatrics, and/or family practice/geriatrics medicine; and (iii) 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").

**Patient-Centered Medical Home Participants**: Patient-Centered Medical Home Participants ("Participants") are all PCPs within the Medical Care Panel who must agree to participate in the Program and comply with the terms and conditions of the Program Requirements and Expectations and Program Description and Guidelines (See Items C and D below).

**Patient-Centered Medical Home Care Coordination Team:** A Patient-Centered Medical Home Care Coordination Team ("PCMH Care Coordination Team") includes the PCP, the PCP's Group, all Participants on the PCP's Medical Care Panel, other treating providers and health care professionals who provide PCMH services to the Medical Care Panel and/or Corporation's Members.

## C. Program Requirements and Expectations

Participants agree to put forth good faith efforts to meet all Program requirements, goals and expectations. This means that each Participant agrees to:

1. obtain and maintain valid patient consent and authorization for the Member's participation in the PCMH Program including the sharing of medical information between Corporation and the PCMH, including the PCMH Care Coordination Team;

2. actively engage with Members identified in need of care management, including the development, maintenance and oversight of Care Plans for such Members;

3. timely communicate and cooperate with the PCMH Care Coordination Team and other involved providers in furtherance of Care Plans and Member health risk mitigation efforts;

4. use high quality, cost-efficient institutions and specialists who are participants in Corporation's HMO and RPN networks;

5. electronically submit all HIPAA administrative transactions through Corporation's approved EDI clearinghouse(s) and use best efforts to adopt other web-based electronic information and related information exchanges offered by Corporation in support of the PCMH Program;

6. use Corporation's web portal capabilities for referrals, Care Plan development (including Care Plan templates) and monitoring and retrieval of the Member Health Record and electronic submittal of credentialing information through CAQH (unless credentialing has been delegated);

7. cooperate with other Group Members in their Medical Care Panel in arranging health care service coverage for each other's Members and in sharing information about Members in their Medical Care Panel upon receipt of appropriate consent;

8. deliver high quality and medically appropriate care in a cost-efficient manner;

9. cooperate with Corporation in its efforts to carry out Program rules and requirements as set forth in this Addendum and the Program Description and Guidelines; and

10. not withhold, deny, delay, or provide any underutilization of medically necessary care, nor selectively choose or de-select Members.

**D. Program Description and Guidelines**

The Group and its PCPs agree to comply with the Patient-Centered Medical Home Program Description and Guidelines (the "Program Description and Guidelines") as established by Corporation and as may be amended from time to time.

**E. Program Incentives**

Measurement criteria established by the Corporation and the methodology used in the determination of all Program incentives are set forth in the Program Description and Guidelines which are available to Group, the terms of which are incorporated herein by reference. The Program incentives are designed to reward PCPs for taking actions that are consistent with the delivery of medically appropriate care in a cost-efficient manner and are available only to Participants in the Program. All Program Incentives will be determined on a Panel by Panel basis.

**F. Termination**

A PCP may terminate his/her participation in the Program upon ninety (90) calendar day's prior written notice to Corporation for any reason. If this termination causes a Medical Care Panel to fall below minimum participation requirements, then this termination will result in the termination of the entire Medical Care Panel from the Program unless the Medical Care Panel sends notice to Corporation of its intent to replace the terminating PCP prior to the PCP's termination date. In this case, the Medical Care Panel will have up to one (1) year to do so and avoid the termination of the entire Medical Care Panel from the Program. If a PCP in the Group terminates participation in the Program, but does not terminate from the Group, the Group will be terminated from the Program.

A Medical Care Panel may terminate participation in the Program with ninety (90) calendar day's prior written notice to Corporation for any reason. This will terminate all Participants within such Medical Care Panel from the Program unless they join another Medical Care Panel.

A Virtual Panel may change its self-selected team of PCPs at any time as long as it continues to meet the minimum size requirements of the Program and notifies Corporation. No Practice(s) may be removed from a Virtual Panel without the consent of at least three fifths (3/5ths) of the PCPs in the Virtual Panel.

Corporation may immediately terminate the Group, a PCP and/or a Medical Care 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 ninety (90) calendar days prior written notice:

1. the Group, PCP and/or Medical Care Panel repeatedly fail to comply with the terms and conditions of the Program;

2. the Group, PCP and/or Medical Care Panel has substantial uncorrected quality of care issues;

3. upon termination of either the Master Group Participation Agreement, Appendix A-RPN/Group or the Primary Care Physician Participation Agreement which terminates the Group's, PCP's and/or Medical Care Panel's participation in Corporation's RPN or HMO networks; or

4. for 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 all incentives will immediately terminate upon the effective date of the PCP's, Group's or Medical Care Panel's termination from the Program regardless of the reason for termination.

**WHEREFORE, as of the Effective Date:**

Agreed to by Group:

By: _____

_____
Printed Name

_____
Title

_____
Practice Name

_____
Date

Agreed to by Corporation:

By: _____

_____
Printed Name

_____
Title

## Appendix B: Member Data Sharing, Election To Participate And Related Forms

Member awareness of the PCMH Program and its benefits as well as the protection and privacy of Member health information are of utmost importance to the PCP and to CareFirst.

The PCMH and TCCI Programs comply with all applicable state and federal privacy and security laws. Although the Programs are considered health care operations and treatment activities under the Privacy Rule and do not require a valid HIPAA authorization, CareFirst requires Members who participate in Care Plans to execute a consent – *Election to Participate form* – to meet certain state requirements, mental health, and drug and alcohol abuse records laws that require a consent before sharing such records.

Effective October 1, 2012, Maryland Law allows a treating health care provider and a carrier to share medical information solely for the purposes of enhancing or coordinating care without obtaining affirmative authorization/consent from a Member if the Member has received a *Notice of Information Sharing* and has not opted-out of information sharing. Such sharing is permitted in Virginia and the District of Columbia.

The information available to treating providers for all PCMH Program attributed Members includes health care claims as a result of: Medical encounters, treatments, diagnostic tests, screenings, prescriptions, Patient-Centered Medical Home, and other case management activities. This information is available on iCentric (the PCMH Portal) and in SearchLight Reports that are accessible on the portal.

Members for whom a Care Plan will be developed must voluntarily "elect" to participate in the PCMH Program by completing an *Election to Participate* form. The form must be obtained to enable the PCP and the Care Coordination Team to initiate a Care Plan.

Certain mental health records, including drug and alcohol abuse records, psychotherapy notes and any other information protected under federal, state and local privacy laws may not be shared without a signed written consent. This consent is now included in the *Election to Participate form* and is valid for one year from the date it is signed. It must be renewed on an annual basis, similar to the annual HIPAA Privacy Disclosure regularly obtained by Providers.

It is critical to the success of the PCMH Program that the PCP explains to the Member the benefits of the Program and obtain an *Election to Participate* form. If at any time the Member determines that he/she no longer wishes to participate in a Care Plan or have their medical information shared, he/she may submit the *Opt-Out of Information Sharing* form. By doing so, the Member will also end participation in any CareFirst TCCI Programs and activities (PCMH, Care Management, Care Coordination, Disease and Case Management, etc.) that require data sharing to enhance or coordinate care. Treating providers will not be able to access important CareFirst claims data if a Member chooses to opt-out of medical information sharing.

If a Member opts-out of medical information sharing, a PCP or any treating provider may ask them to complete a *Reversal of Opt-Out of Information Sharing* form if they wish to continue participation in, and obtain the advantages of the Program.

As required by Maryland law, CareFirst sends a notice every three years to all its Members regarding this right to elect to opt out of information sharing.

CareFirst will honor an opt-out from any CareFirst Member, regardless of jurisdiction. However, the Notice and the ability to opt-out of information sharing apply only to information shared by CareFirst with treating providers for Care Coordination purposes. In Maryland, all treating providers are responsible for providing their own Notice and opportunity to opt-out of information sharing to their Members, with respect to any information the treating provider shares with CareFirst for enhancing and coordinating care.

This Notice and opportunity to opt-out does not apply to information necessary for health insurance claims processing and other information necessary to administer a Member's health insurance benefits.

It is also the responsibility of the PCP to obtain the signature of Members as a valid Election to Participate form and to make signed forms available to the Member and CareFirst upon request. CareFirst will provide PCPs who participate in the Program a template letter which describes the benefits of the Program.

A copy of the *Template Letter, Notice of Information Sharing, Election to Participate, Opt-Out* and *Reversal of Opt-Out* forms are included in this Appendix.

## Appendix C: PCMH Plus Addendum to PCP Participation Agreement

**PCMH PLUS ADDENDUM**
**TO**
**PRIMARY CARE PHYSICIAN PARTICIPATION AGREEMENT**

This PCMH Plus Addendum (the "PCMH Plus Addendum") is entered into by and between _____ (hereinafter "Group") and Group Hospitalization and Medical Services, Inc. and CareFirst of Maryland, Inc., both doing business as CareFirst BlueCross BlueShield (collectively hereinafter referred to as "Corporation") as of January 1, 20__ (the "Effective Date").

**WHEREAS**, Group and Corporation are parties to a Primary Care Physician Participation Agreement (the "Agreement") whereby Group agreed to participate in Corporation's provider network; and

**WHEREAS**, Group and Corporation are parties to an addendum to the Agreement (the "PCMH Addendum") whereby Group agreed to participate in Corporation's voluntary Patient-Centered Medical Home Program ("PCMH"); and

**WHEREAS**, Corporation wishes Group to participate in Corporation's voluntary PCMH Plus Program (the "PCMH Plus Program") and Group wishes to so participate.

**NOW THEREFORE**, in consideration of the mutual promises and covenants hereinafter set forth, the parties agree to the following:

### A. Definitions

All terms not defined herein have the same meaning as in the PCMH Addendum, the Agreement or the Program Description and Guidelines.

### B. Group Obligations

Group is entering into this PCMH Plus Addendum applicable to its Medical Care Panel(s) listed on Attachment A hereto. As detailed in the program Description and Guidelines, Group acknowledges that a Panel may not participate in the PCMH Plus Program unless the Panel meets the conditions of participation in the PCMH Plus Program and all of the Panel's PCPs agree to participate in the PCMH Plus Program.

During the term of this PCMH Plus Addendum, the Group's Panel or Panels listed on Attachment A hereto shall:

1. Maintain the capacity to accept and timely see new Members;

2. Establish by January 1 of each Performance Year and maintain throughout the term of this PCMH Plus Addendum a list of designated specialists and specialty groups in the top 10 specialist types designated by Corporation in the Guidelines to whom Panel PCPs generally refer and with whom the Panel PCPs develop referral relationships that promote an enhanced level of Care Coordination;

3. Review, access and determine a course of action regarding the health needs of Members each month who appear on the Panel's top 50 lists as identified in Corporation's monthly SearchLight Reports;

4. Achieve during each Performance Year the greater of (a) ten (10) active Care Plans per PCP or (b) fifty percent (50%) of all Panel's Care Plan Eligible Members in Care Plans;

5. Achieve at least seventy percent (70%) of available points for the Panel's Engagement and Quality Scores during each Performance Year;

6. Achieve and maintain a HealthCheck score in the upper half of all peer Panels during each Performance Year; and

7. Maintain a rate of growth in its Illness Burden Score adjusted PMPM cost that is less than or equal to 0.75 of the Overall Medical Trend used for all Panels in the most recently completed Performance Year.

**C. Corporation Obligations**

Corporation shall pay Group the additional compensation and incentives as called for in the Program Description and Guidelines only with respect to Group's Panels that participate in the PCMH Plus Program.

**D. Term**

This PCMH Plus Addendum shall take effect on the Effective Date and continue for one (1) year. Thereafter, this PCMH Plus Addendum shall automatically renew for additional one (1) year terms unless terminated in accordance with this PCMH Plus Addendum.

**E. Termination**

1. Corporation may terminate this PCMH Plus Addendum immediately upon termination of the Agreement or the PCMH Addendum.

2. On or about June 1st each year, Corporation shall notify Group in writing if the Group's Panel or Panels listed on Attachment A hereto meet the conditions for participation in the PCMH Plus Program in the next Performance Year, based upon the Panel or Panels' performance in the prior Performance Year. If the Panel or Panels do not meet the conditions of participation in the next Performance Year, such Corporation shall terminate this PCMH Plus Addendum with respect to such Panel or Panels as of the end of the then current Performance Year.

3. If the Panel or Panels meet the conditions of participation in the PCMH Plus Program for the next Performance Year, Group shall notify Corporation in writing prior to August 1st of each year if it intends to have such Panel or Panels participate in PCMH Plus in the next Performance Year.

    a. If a Panel is currently participating in the PCMH Plus Program and Group no longer wishes to participate in the next Performance Year, Group's notification to Corporation shall indicate Group's intent to terminate the Panel's participation in the PCMH Plus Program as of the end of the current Performance Year.

    b. If Group's notification to Corporation provides that none of Group's qualifying Panels intend to participate in the PCMH Plus Program in the next Performance Year, this PCMH Plus Addendum shall terminate at the end of the current Performance Year.

4. Corporation and Group acknowledge and agree that Corporation shall pay Group for any Panels terminated from participation in the PCMH Plus Program (a) compensation in accordance with the PCMH Addendum as of the Panel's effective date of termination and (b) Outcome Incentive Award earned under the PCMH Plus Program through July 31st of the next Performance Year.

**F. Terms and Conditions**

All other terms and conditions of the Agreement and the PCMH Addendum are incorporated herein by reference and remain in full force and effect.

IN WITNESS, WHEREOF, the parties have caused this PCMH Plus Addendum to be signed by their duly authorized representatives as of the Effective Date.

| **GROUP**: | **CORPORATION**: |
|---|---|
| By: _____ | By: _____ |
| Name: _____ | Name: _____ |
| Title: _____ | Title: _____ |
| Date: _____ | Date: _____ |

## Appendix D: Patient-Centered Primary Care Collaborative ("PCPCC") Joint Principles Of The Medical Home

CareFirst's PCMH Program fully supports and fulfills all aspects of nationally-endorsed Patient-Centered Medical Home principles developed over many years by authoritative sources, including the most highly respected primary care specialty societies and quality improvement organizations. The foundational document, *Joint Principles of the Patient-Centered Medical Home*, provides guidance and direction to developers and evaluators of PCMH Programs. CareFirst's PCMH Program is consistent with these principles, and requires participating PCPs to commit "to accept the Joint Principles of the Medical Home to transform the practice into a PCMH."

The following narrative provides:

- a chronology of key milestones in the development of PCMH principles,
- the original *Joint Principles* themselves,
- an adapted version of the Principles by the Agency for Healthcare Quality and Research, and
- references to a set of useful resources.

***Milestones in the development of the PCMH***[1]

**1967** The American Academy of Pediatrics (AAP) introduces the term "medical home" to describe primary care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.

**1996** The Institute of Medicine (IOM) publishes Primary Care: America's Health in a New Era and redefines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with Members, and practicing in the context of family and community." The publication also mentions medical home.

**2002** The seven national family medicine organizations launch The Future of Family Medicine (FFM) project and produce The Future of Family Medicine: A Collaborative Project of the Family Medicine Community. The report recommends that health system change will "include taking steps to ensure that every American has a personal medical home [... and] developing reimbursement models to sustain family medicine and primary care." Additionally, the *Chronic Care Model* is born and emphasizes the critical role of primary care to prevent, manage, and treat chronic illness.

**2005** Renowned researcher and primary care champion Dr. Barbara Starfield publishes Contribution of primary care to health systems and health, a seminal work that acknowledges the six primary care mechanisms that benefit health: (1) greater access to needed services (2) better quality of care (3) a greater focus on prevention (4) early management of health problems (5) the cumulative effect of primary care delivery; and (6) the role of primary care in reducing unnecessary or harmful specialty/inpatient services.

**2006** The American College of Physicians (ACP) develops The Advanced Medical Home: A Member-Centered, Physician-Guided Model of Health Care and proposes fundamental changes in the way primary care is delivered and paid for.

**2006** The Patient-Centered Primary Care Collaborative (PCPCC) is founded by a group of large employers, including IBM, and the major primary care physician associations: American Osteopathic Association (AOA), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American Academy of Pediatrics (AAP). The organization is charged with building a national movement that promotes widespread adoption of the Patient-Centered Medical Home.

**2007** The major primary care physician associations develop and endorse the *Joint Principles of the Patient-Centered Medical Home*.

[1] *Adapted from Patient-Centered Primary Care Collaborative at http://www.pcpcc.org/content/history-0*

**2008** The National Committee for Quality Assurance (NCQA), URAC, Joint Commission, and the Accreditation Association for Ambulatory Health Care (AAAHC) launch medical home accreditation Programs. In addition, The Commonwealth Fund launches the five-year Safety Net Medical Home Initiative designed to help 65 community health centers in five states transform into Patient-Centered Medical Homes.

**2008** CareFirst launches three-year pilot PCMH Program patterned after Joint Principles, simultaneously creating a comprehensive extensive Program model across the entire service area.

**2011** CareFirst launches full-scale PCMH Program throughout Maryland, District of Columbia and Virginia.

**2012** According to the National Academy for State Health Policy, 47 states have adopted policies and Programs to advance the medical home.

## Joint Principles of the Patient-Centered Medical Home[2]

The CareFirst PCMH Program is consistent with and is designed to fulfill the Joint Principle of the Patient-Centered Medical Home as published by the:

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)
February 2007

***Introduction***

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual Members, and their personal physicians, and when appropriate, the Member's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

***Principles***

***Personal physician*** - each Member has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of Members.

***Whole person orientation*** – the personal physician is responsible for providing for all the Member's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.

***Care is coordinated and/or integrated*** across all Elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the Member's community (e.g., family, public and private Community-Based Services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that Members get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

***Quality and safety*** are hallmarks of the medical home:

- Practices advocate for their Members to support the attainment of optimal, Patient-Centered outcomes that are defined by a Care Planning process driven by a compassionate, robust partnership between physicians, Members, and the Member's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary Engagement in performance measurement and improvement.

[2] *The Joint Principles as published on the American Academy of Family Practice website at. http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf*

- Members actively participate in decision-making and feedback is sought to ensure Members' expectations are being met.
- Information technology is utilized appropriately to support optimal Member care, performance.
- Practices go through a voluntary recognition process by an appropriate non-governmental.
- Entity to demonstrate that they have the capabilities to provide Member centered services.
- Consistent with the medical home model.
- Members and families participate in quality improvement activities at the practice level.

***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between Members, their personal physician, and practice staff.

***Payment*** appropriately recognizes the added value provided to Members who have a Patient-Centered Medical Home. The payment structure should be based on the following framework. It should:

- Reflect the value of physician and non-physician staff Patient-Centered care management work that falls outside of the face-to-face visit.
- Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- Support adoption and use of health information technology for quality improvement.
- Support provision of enhanced communication access such as secure e-mail and telephone consultation.
- Recognize the value of physician work associated with remote monitoring of clinical data using technology.
- Allow for separate fee-for-service payments for face-to-face visits.
- Recognize case mix differences in the Member population being treated within the practice.
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- Allow for additional payments for achieving measurable and continuous quality improvements.

***Agency for Healthcare Quality and Research Definition of the Patient-Centered Medical Home***

The Agency for Healthcare Quality and Research has further refined the joint principles to describe five functions and attributes of the PCMH as follows[3]:

The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.

[3] *Agency for Healthcare Quality and Research definition of the medical home can be found at http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_defining_the_pcmh_v2*

The medical home encompasses five functions and attributes:

**1. Comprehensive Care**

The Patient-Centered Medical Home is accountable for meeting the large majority of each Member's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and Care Coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their Members, many others, including smaller practices, will build virtual teams linking themselves and their Members to providers and services in their communities.

**2. Patient-Centered**

The Patient-Centered Medical Home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with Members and their families requires understanding and respecting each Member's unique needs, culture, values, and preferences. The medical home practice actively supports Members in learning to manage and organize their own care at the level the Member chooses. Recognizing that Members and families are core Members of the care team, medical home practices ensure that they are fully informed partners in establishing Care Plans.

**3. Coordinated Care**

The Patient-Centered Medical Home coordinates care across all Elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when Members are being discharged from the hospital. Medical home practices also excel at building clear and open communication among Members and families, the medical home, and members of the broader care team.

**4. Accessible Services**

The Patient-Centered Medical Home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to Members' preferences regarding access.

**5. Quality and Safety**

The Patient-Centered Medical Home demonstrates a commitment to quality and quality improvement by ongoing Engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with Members and families, engaging in performance measurement and improvement, measuring and responding to Member experiences and Member satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

***Conclusion***

CareFirst's PCMH Program is entirely consistent with the principles and guidelines developed over several decades by the leading medical associations, government agencies and academic institutions in the United States. The CareFirst PCMH Program draws on this heritage by requiring providers to commit "to accept the Joint Principles of the Medical Home to transform the practice into a PCMH" and, more importantly, by working at a detailed level to operationalize these concepts in a way that produces measurable improvements in health care quality, outcomes and cost.

***Resources***

Joint Principles Primary Care Specialty Societies

American Academy of Family Physicians
http://www.aafp.org/online/en/home.html

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians:
http://www.acponline.org

American Osteopathic Association
http://www.osteopathic.org

Patient-Centered Primary Care Collaborative (PCPCC)

PCPCC describes its mission as follows: Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the Patient-Centered Medical Home (PCMH) Their website provides extensive PCMH resources. http://www.pcpcc.org/

**Quality Improvement Organizations**

The following organizations have Programs that define and certify or accredit PCMH Programs.

National Committee for Quality Assurance (NCQA) http://www.ncqa.org/
URAC https://www.urac.org/

The Joint Commission http://www.jointcommission.org/
Accreditation Association for Ambulatory Health Care (AAAHC) http://www.aaahc.org/

## Appendix E: Standard Operating Procedures For Care Plans And Chronic Care Coordination (CCC)

I. Interviewing, Selecting And Assessing Newly Hired Local Care Coordinators (LCCs)

II. Professional Expectations Of Local Care Coordinators

III. Administrative Responsibilities Of Local Care Coordinators

IV. Training And Certification Of Local Care Coordinators

V. Selecting The Appropriate Member For A Care Plan And Care Coordination

VI. Concise And Actionable Care Plan Documentation And Care Coordination

VII. Carrying Out Care Coordination Called For In Care Plans and Tracking/Assessing Post Graduation Member Performance

VIII. Care Plan Quality Reviews

IX. Using The CareFirst Service Request Hub

X. Evaluating Primary Care Provider (PCP) Engagement With The PCMH Program And Assessing Practice Access And Structural Capabilities

## Introduction

These Standard Operating Procedures (SOPs) for the CareFirst Patient Centered Medical Home (PCMH) Program provide the framework that guides all PCMH Field Operations and the implementation of Total Cost and Cost Improvement (TCCI) Program Elements. The SOPs are to be followed by and inform the conduct of Care Coordination activities carried out by LCCs under the oversight of Regional Care Directors (RCDs).

CareFirst provides Medical Panels (Panels) with the capabilities necessary to conduct Care Coordination activities through the support of Local Care Coordinators (LCCs). LCCs are either employed by Sharecare (formerly Healthways), a CareFirst contracted vendor, or CareCo, a CareFirst subsidiary. These SOPs apply equally to both situations.

These SOPs govern and apply equally to all aspects of Care Coordination whether provided by Sharecare LCCs or CareCo LCCs. This assures uniformity in carrying out PCMH and TCCI Program requirements that is essential to serving employer groups who purchase the PCMH Program. This uniformity also assures consistency in reporting that is essential to understanding and properly interpreting results.

Further, such uniformity is critical in the calculation of Outcome Incentive Awards (OIAs) since the data developed through adherence to these SOPs is used in the calculation of Panel- and provider-specific Quality Scores.

Finally, uniformity enables more efficient training of LCCs and enhances oversight of the Care Plan process and all related processes in the day-to-day operation of the PCMH Program. In so doing, it better assures that standards are met and the quality of Care Plans and Care Coordination is uniformly high.

The requirements and processes outlined in these SOPs are not discretionary and cannot be waived or modified except by the explicit direction of the appropriate senior management at CareFirst responsible for carrying out the PCMH Program. The SOPs are periodically updated with the most recent effective date appearing on the cover sheet and each page herein.

## Interviewing, Selecting And Assessing Newly Hired Local Care Coordinators (LCCs)

## Purpose

**To outline the process for screening, interviewing, and hiring new LCCs, as well as assessing LCC performance during their initial training period.**

### *Interviewing Registered Nurses (RNs) for the Position of LCC*

Each candidate is screened by Sharecare or CareCo, starting with a review of the candidate's resume and educational background. At a minimum, this includes a telephone conversation with the candidate.

If the result of the initial screening is successful, the candidate is then interviewed by a panel of RCDs, not to include the specific RCD to whom the applicant would be assigned, if selected. After careful consideration and discussion among the interviewing RCDs, the candidate is either recommended to advance to another interview round or not recommended to advance. If advanced, the RCD to whom the LCC would be assigned would interview the candidate and make a final recommendation to the appropriate PCMH Senior Director.

During each of the phases of the job interview process, the job expectations of the LCC position are reviewed, with an opportunity for the candidate to ask questions. The candidate is made aware of the job requirements, including productivity and caseload goals. The LCC candidate will be encouraged to read the *PCMH and TCCI Program Description and Guidelines* and is expected to have a strong awareness of the Program upon entering an interview. He/she should be able to articulate questions and comments to the interviewers in order to demonstrate a basic understanding of the PCMH Program.

Per Sharecare and CareCo human resources policies, any offers of employment are contingent upon completion of a successful background check, which includes references, education history, criminal activity and a drug screening.

#### Selecting RNs for the Position of LCC

All successful LCC candidates *must* be a RN with an active license in the state where he or she practices and have a minimum of three years of nursing experience. Experience in the home health, hospital or community-based setting is preferred. Strong consideration is given to a RN who has experience with a PCMH Program or similar Program, such as HTC, home health or case management.

During the application and interview process, a successful candidate must provide a credible basis to believe that they have the following skills:

- Strong clinical skills
- Excellent verbal and written communication
- Problem solving
- Decision making
- Organization and planning
- Proficiency in the use of technology

To assess the candidate's abilities, the interviewer(s) will ask the candidate a series of behavioral-based interview questions that will require the candidate to describe situations and examples from previous work experiences that illustrate their approach and skill set. The response to these questions will assist the interviewer(s) in assessing the candidate's judgment and requisite skills.

The candidate is expected to come prepared for the interview, demonstrating that he or she has read and understood the concepts in the *PCMH and TCCI Program Description and Guidelines*. In addition, the candidate should be able to articulate his or her understanding of the LCC position and demonstrate interest in the larger PCMH Program design and goals as well as in the role and expectations of an LCC.

A candidate will not be considered for the job if he or she arrives late for the interview without proper explanation, is disorganized during the interview, is unable to clearly answer questions addressed to him/her, has not read the *PCMH and TCCI Program Description and Guidelines* or cannot generally explain the role of the LCC in an effective, clear way.

## *Assessing LCC Performance*

### Productivity and Quality Expectations

LCCs are expected to maintain a case load of 33 active Care Plans when fully mature in their role (8-10 months), while maintaining, at a minimum, an average Quality Score of four on a five-point scale, as outlined in Section VIII: *Care Plan Quality Review*s. The goal for each LCC is to attain a consistent score of four or better on quality performance reviews following the training period. LCCs will communicate at least once per week with each Member in an active Care Plan, either via telephone or in person.

All LCCs are assigned to an RCD, who is responsible to oversee LCC performance in each PCMH sub-region. The RCD will consult with Sharecare and then give feedback to the LCC on his or her progress toward meeting productivity and quality goals. If any LCC is struggling to meet the productivity goals, the Senior LCC, under the direction of the RCD, will provide coaching and counseling to the LCC and arrange additional coaching and counseling from the RCD review teams, precepting team, training team, RCD, and/or Senior Directors, as appropriate or needed.

If this is not effective in improving the LCC's performance, then the RCD will recommend to Sharecare or take action directly in the case of CareCo that the LCC be placed on a performance improvement plan, with an established timeline for improvement. If this is not effective in improving the LCC's performance, he or she will be removed from the PCMH Program after consultation with Sharecare or Senior Director if a CareCo LCC.

### Behavioral Expectations

LCCs are expected to behave in a professional manner at all times and to follow all SOPs.

If a LCC exhibits a behavioral problem, the RCD to whom the LCC is assigned will assess the severity of the problem and whether it should be addressed with coaching and counseling, a performance improvement plan or a recommendation for removal from the PCMH Program, with the latter two requiring advance notification to the Senior Director, PCMH Program as well as to Sharecare. Depending on the nature or severity of any misconduct, an LCC may be immediately considered for removal from the PCMH Program, without progressing through a performance improvement plan.

### Mentoring and Performance Improvement Plans

The Senior LCCs will provide ongoing feedback to all LCCs assigned to them and offer appropriate coaching when needed. The Senior LCC will maintain documentation of any performance issues, including a description of the issue, dates and description of coaching and counseling, and any follow-up action, if indicated. The Senior LCC will keep the RCD fully informed of the progress or lack thereof each LCC. The Senior LCC, under the direction of the RCD, will fully discuss with each LCC, any aspect of their performance that relates to the quality and performance goals for which they are responsible. If the Senior LCC role is vacant, the RCD will perform these duties. RCDs will fully discuss this with the LCC. The RCD also will discuss any concerns with Sharecare.

If coaching and counseling are ineffective, the Senior LCC will inform the RCD. The RCD and Senior LCC collaborate to notify the appropriate Senior Director and Human Resources (Sharecare or CareFirst) to write a performance improvement plan for the LCC, which includes performance expectations, the current level of performance, what needs improvement, specific recommended action steps the LCC can take to improve performance, and expected time frames for improvement.

### Removal from PCMH Program

If any LCC fails to meet the expectations within the time frame established in the performance improvement plan, the RCD will notify the Senior Director, PCMH. The LCC will then be removed from the PCMH Program with written notice from CareFirst to Sharecare.

## Professional Expectations Of Local Care Coordinators (LCCs)

## Purpose

**To define the expectations of LCCs in carrying out their responsibilities.**

### *Expectation and Standards:*

All LCCs will represent the PCMH Program in the highest professional manner. All LCCs must:

- Be exclusively dedicated to the PCMH Program on a full-time basis.
- Maintain a current and active Registered Nurse license.
- Practice within the scope of their assigned role and license.
- Provide services without discrimination to every Member and with respect for each Member's autonomy, dignity, privacy, and cultural differences.
- Comply with standard business and meeting etiquette (example: arrive on time to meetings, participate in a constructive, professional manner and appearance).
- Keep current on the strategy, direction, and goals of the PCMH Program through ongoing contact with other Members of the team, meeting attendance, email communications, and participation in other CareFirst communications pertaining to the PCMH Program.
- Demonstrate the utmost professionalism, both in behavior and appearance, at all times (example: positive, can-do attitude, team oriented approach).
- Protect the confidentiality of Member information and comply with all privacy and security requirements of the PCMH Program. Among other things, LCCs will have access to SearchLight Reports in the PCMH Provider Portal. It is expected that the LCC will only access and view data related to his or her assigned PCPs or Members. Violation of this will result in corrective action and/or removal of the LCC from the PCMH Program.
- Complete all reporting requirements by the established deadline, including but not limited to the quarterly assessment of PCPs for the Quality Measures.
- Perform all activities, tasks, and actions required by the PCMH Program including Care Plan documentation, daily, weekly, monthly reporting and adherence to PCMH Program workflow processes and standards, including, but not limited to, PAM assessment, medication reconciliation, quarterly Member survey, and Care Plan extension requests.
- Represent the PCMH Program as a proactive, productive solution to restrain healthcare cost trends and improve quality when with PCPs and CareFirst Members.
- Convey any process or technical barriers to their RCD and Senior LCC in a timely, constructive manner.
- Relay provider concerns about the PCMH Program to their RCD and Senior LCC in a timely, constructive manner.

## Administrative Responsibilities Of Local Care Coordinators (LCCs)

## Purpose

**To define responsibilities of LCCs regarding day-to-day administrative matters.**

### *Communication and Coordination of Administrative Processes:*

The LCC is expected to:

- Communicate frequently with the RCD to whom they are assigned. The mode of communication may be via phone, in-person, unified communications or secure email, depending upon the mutual decision of the RCD and LCC. This communication will include the sharing of details regarding the interactions, progress or issues with the PCMH Program to include Member selection and engagement issues, recalcitrant PCP issues, Care Plan documentation, iCentric portal issues, obstacles to working with PCPs' office staff, quality measures and case load management.

- Maintain ongoing timely communication with the RCD regarding the number of Care Plans that are active or in development and any issues, observations and concerns that may be pertinent to these plans.

- Provide the Senior LCC and RCD full access to his or her calendar.

- Promptly and completely respond to the quality review team recommendations for Care Plan changes as outlined in the Section VIII: *Care Plan Quality Reviews.*

- Attend weekly meetings with their assigned RCD and team to discuss goals, understand barriers, communicate changes in processes and provide updates.

- Attend all routine, scheduled PCMH meetings, including RCD/LCC weekly status call (huddles), LCC advisory group meetings and meeting with Senior LCC, RCD or Senior Director, or Senior Vice President.

- Place timely orders for any Program materials needed.

- Support the PCP to whom they are assigned, and other PCMH staff in keeping "Election to Participate" documentation accurate and current, as described in Section V: *Selecting the Appropriate Member for a Care Plan and Care Coordination*.

- Serve as first line of support for provider Portal activity including proactively verifying provider Portal access and setup prior to Care Plan activation attempts.

- Make timely, complete accurate and appropriate referrals to TCCI Programs in accordance with Program Guidelines.

## Training And Certification Of Local Care Coordinators (LCCs)

### Purpose

**To define the training Program for LCCs, so that the expectations for the role are clear and that LCCs are prepared to practice to their full scope within the PCMH Program. This policy applies to all LCCs .**

**The training Program has two major goals:**

1. **To assure that LCCs are knowledgeable about the fundamentals and goals of the PCMH Program** so that they are able to effectively work with providers, Members, the care team, as well as other interested parties toward the two overall goals: better quality of care and better cost control for CareFirst Members in the PCMH Program.

2. **To assure that LCCs are able to effectively identify appropriate Members, develop and write clear, concise, actionable Care Plans and coordinate care for their Members** with the goal of improving their health outcomes and reducing breakdowns resulting in hospitalization or emergency department visits.

New LCC training class dates are pre-set and are offered periodically in a small classroom setting. Small class size enables collaboration among each new cohort of LCCs and an opportunity for hands-on instruction.

The intensive, structured Program begins with an initial six weeks of classroom and field training led by the training team, followed by field work and mentoring by the assigned RCD and Senior LCC. The RCD and the training team work together to provide the necessary support for each trainee LCC.

### *Grounding in the PCMH Program and LCC Role*

To be well versed in the basic components of the PCMH Program, LCCs will be instructed in the tenets and key aspects of the CareFirst PCMH Program and will review such documents and resources as the *PCMH and TCCI Program Description and Guidelines*, SearchLight Reports, Program Evaluation framework and Design Elements in the TCCI Program. To successfully conclude training, LCCs must demonstrate a sound working knowledge of all PCMH and TCCI Program Elements.

LCCs must also be proficient in Care Plan development through demonstrated achievement of the standards embodied in the SOPs for Member Selection, Care Plan Documentation, Care Coordination and Care Plan Quality Reviews. These skills – as evidenced in active Care Plans and interaction with PCPs to which the LCC is assigned – will be evaluated and scored in accordance with the Section VIII: *Care Plan Quality Reviews* as well as through oversight by the assigned RCD and Senior LCC.

Classroom learning includes:

- Lecture and interactive sessions on the components of the PCMH Program (fundamentals) that closely follows the Elements included in the *PCMH Program Description and Guidelines.*
- Lecture and practice on the skills in writing effective Care Plans.
- Instruction and field work on how to effectively coordinate the care of the Member.

During the training period, the new LCC will have an opportunity to shadow a Senior LCC in the ordinary conduct of their work. This enables experienced LCCs to share their insights with the new LCC in order to assist in their learning. Being a successful LCC requires an ability, among other things, to prioritize and manage time. Field shadowing provides the opportunity for learning through example and first-hand observation – in effect, through a journeyman experience as a critical adjunct to classroom training.

This approach to training reflects the realization that Care Plan development requires collecting relevant, practical information and knowledge relating to how best to carry out the work within one or more PCP offices.

### *Training Schedule*

### Week 1: The Foundation of the PCMH Program

During the first week, the LCC is exposed to key documents and the key concepts within each of these documents – specifically, the *PCMH and TCCI Program Description and Guidelines*; underlying Program beliefs, assumptions and theories.

Additionally, the management structure of the PCMH Program is reviewed including the functioning of the 20 PCMH sub-regions and associated workflows, operations, processes and procedures, as well as, operational reporting. The roles and responsibilities of each key position in the PCMH organizational structure are taught. These key roles include the following: LCC, Senior LCC, RCD, Clinical Quality Specialist, PCMH Operations, PCMH Practice Consultant, PCMH Provider Representative, Hospital Transition Coordinators (HTCs) and the Customer Service Advocates (CSAs).

The role of the CareFirst Service Request Hub is explained as are all Elements in the CareFirst TCCI Program that surround and support the PCMH Program.

In addition, all elements of the PCMH Program including OIAs, Care Plan development, Care Coordination, and the use of the iCentric Portal to support all of these activities are reviewed and taught. The use of SearchLight Reports is explained, including a review of the nature and content of the various views contained in the report. Key assists to Panels and LCCs such as the HealthCheck summary provided in the reports and use of Core Target and "Top 10-50" lists to focus Care Plan activity are also taught.

Other major aspects of training during the first week include the foundations for culturally competent care, identifying cultures present in our regions and tools to support cross cultural interviewing and care delivery; service excellence expectations, based on the bedrock of demonstrating and communicating empathy when interacting with Members; and motivational interviewing, supporting Members develop their own intrinsic desire to improve health related behaviors.

### Week 2: Member Selection, Care Plan Documentation, and Field Training

During the second week of training, a deeper development of concepts introduced during fundamentals begins. Member selection and program eligibility are taught, including how the Core Target population identifies at risk Members, expectations related to reviewing those Members with the PCPs (Clinical Status Review), and the documentation of the needs of the Member (Assessment Outcome). The new LCC are taught how to select the appropriate Care Plan Eligible Member. Variables that make a Member an appropriate candidate for Care Coordination are reviewed. The iCentric Portal, including Core Target Lists, SearchLight Reports, explanation of and practice in using the roster and the MHR are shared with the LCC. The LCCs are taught the process for obtaining an Election to Participate, including obtaining the Member's written signature.

Insurance basics are taught to the LCC; including, how do identify if a Member has the TCCI benefit, and the expectations of the 3-way phone call among the LCC, Member, and Customer Service Advocate. Care Plan components and documentation expectations are covered and an unfolding Case Study is introduced to support the LCC's exposure to the functions of the role in the training environment. This Case Study follows the LCC through the remainder of training, offering an opportunity to simulate the concepts and skills covered in class.

A full description of the design, workings and functions of the PCMH Provider Portal is provided with hands-on use of the Portal in practice sessions. Essentially, the Portal provides the working environment and tool set for the LCC. This must be fully understood and effectively used by all LCCs. Therefore, in order to successfully complete training, a new LCC must demonstrate proficiency in the use of the iCentric Portal and System. A review of other supportive computer systems such as Microsoft Office and Skype for business will also be provided.

Engagement strategies for use with PCPs are covered, outlining Provider expectations in the Program, how LCCs can support Provider engagement, and how to assess and document the engagement of PCPs in iCentric.

During the second week, the LCC begins integrated field training. Working closely with the assigned RCD and Senior LCCs, the LCC observes the day-to-day working of the role. A total of seven field days are built into the first six weeks of training. The goal is to have the LCC see and apply concepts that have been covered in class as well as have an opportunity to interact with his/her assigned Providers and Members. The LCC has an opportunity to observe at least 10 Care Coordination calls by LCCs in his/her region.

While in the field, the new LCC meets with their assigned RCD – one on one – to ensure the LCC understands the professional expectations and standards of the PCMH Program. During this time, the RCD provides the new LCC with specifics about the Panels in their region (for example, engaged, need to be reengaged), weekly goals and performance expectations, SearchLight and weekly Dashboard reports, the use of such reports in day-to-day regional operations, team communication, the competency assessment process, and regional coverage.

In addition, the new LCC accompanies a Senior LCC to observe the home office set up that helps keep the experienced LCC organized. The new LCC is expected to set up a home office to include phone and fax lines, internet service, printer, etc.

### Week 3: Care Plan Development, Care Coordination, and Managing a Caseload

Week 3 begins with information on engaging Members. This subject builds on the previously covered motivational interviewing process and introduces the LCC to the Patient Activation Measure (PAM).

The new LCC is taught how to write each component of the Care Plan. The training class writes a full and complete Care Plan for the unfolding Case Study introduced in week two. This includes reviewing simulating the Clinical Status Review with a PCP, interacting with a Member at an initial appointment, and conducting a follow-up interview with the Member. The trainers review available resources, Preventive Service Guidelines, and clinical guidance documents from PCMH Medical Advisors and/or PCMH Quality Department as tools to ensure a solid, evidence-based foundation for all Care Plans.

The Elements of Care Coordination are taught including how to turn the Plan into successful actions. Examples, resources, and guidelines will be shared. The goal of Care Coordination are reviewed and emphasized. Member incentives (the Cost Share Waiver) and the expectation of compliance with the elements of the Plan are outlined for the LCC.

The best approach for managing an individual Member's Care Plan is taught; including, how to plan the first interaction with the Member and ensure all planned interventions support the realization of the desired "State-of-Being." How to set expectations, planning for graduation from the first meeting, what ongoing PAM assessments entail, and how to conduct medication reconciliations, Member survey responses, Maintenance Visits, and preparing a Care Plan for closure are also taught.

### Week 4: TCCI Programs, Transitions, and Care Calls

Week 4 introduces, in detail, some of the Member facing TCCI Programs and provides an opportunity for the LCC to hear about each program from a representative of each respective Program. The LCC hears from Behavioral Health and Substance Use Disorder Program (BSD), Community-Based Programs (CBP), Comprehensive Medication Review (CMR), Enhanced Monitoring Program (EMP), Wellness/Disease Management (WDM), HTC, and CCM representatives. Following the presentations, the LCC has an opportunity to review a sample Member and identify which programs are appropriate for the Member and simulate entering the requests for that Member in the Service Request Hub.

The LCC is taught how to prepare for, conduct, and document Care Coordination calls, and simulates doing so with the unfolding Case Study. His/her experiences observing Care Coordination calls with the LCCs in the field is reflected upon.

Managing transitions from other TCCI Programs including CCM, HTC, and NCC is covered including promoting conversion to an active Care Plan, establishing an initial appointment, and coordinating hand-off between coordinators.

### Week 5: Demonstration of Skills and Concepts

A second unfolding Case Study, simulated as an HTC transition, is presented to the LCC. This case requires simulation of a Clinical Status Review with the PCP, and initial appointment with the Member, and a follow-up interview. Over three days, the Care Plan and all components are documented by the LCC individually to aid for learning. A one-on-one review of the Care Plan is then provided to each LCC to support the development of their skills in Care Plan writing.

The LCC spends three days in the field working in his/her assigned practices and conducting the appropriate reviews of attributed Members and attending initial appointments. Optimally, the LCC is able to obtain an Election to Participate from a Member for the first time during these three days. This enables the LCC to begin doing the work he/she has learned while being observed by his/her field partner.

### Week 6: Closure and Recap Activities

During the final week of classroom training, the LCC receives presentations from the remainder of the TCCI Programs including Expert Consult and Telemedicine. A representative from the Service Request Hub teaches the LCC what is required to follow up on a service request after it has been submitted. Additionally, TCCI Programs available for Members outside of Care Plans are reviewed.

The details of Care Plan closure are covered during the final week and the LCC has the opportunity to simulate closing both unfolding cases. Handling inherited cases form other LCCs is covered as well as a review of Maintenance Visits and time management and organizational strategies.

Overall, Week 6 is devoted to honing skills, clarifying questions, and assimilating all of the learnings from the previous weeks. It is a time to refine, through practice, the skills and knowledge acquired. Highlights from each week are reviewed for the purpose of answering questions, providing clarifications and engaging in discussions to help the LCC have a higher-level knowledge and be grounded in the essential Elements of the PCMH Program and his or her role within it.

Week 6 is a time for the new LCC to begin transitioning from the class room to the field on a permanent basis. New LCCs have the opportunity to participate in their Region-specific huddle meetings, begin scheduling future Care Plan appointments with the assistance of the RCD, and begin to receive the “hand-off” of Members with established Care Plans from HTCs and Complex Case Manager’s or a current LCC in their region. During this “hand-off” established Care Plans and actionable Care Coordination activities are reviewed and discussed. Any successful appointments from their previous field days are worked by the LCC, with the support of the trainer, during his/her last days in the classroom environment.

## *Competency Assessment*

There are two levels of completion of competency assessment each LCC must achieve:

- **Level 1** is the successful completion of the training Program. This certifies that the new LCC has acquired a working knowledge of the PCMH Program and understands the key aspects of their role. A competency assessment takes place after the new LCC has completed the initial six-week training.

- **Level 2** is passed when the LCC has demonstrated full competency in the application of what has been learned. Passing this level means the LCC writes actionable, clear Care Plans (i.e., achieves an average score of “4” on Care

Plan quality); is an effective and contributing team member; communicates effectively with peers, PCPs and Members; manages increasing caseloads while effectively coordinating the care of each Member.

The Level 2 competency assessment takes place at three intervals following classroom training: 30 days after graduation, three months after hire, six months after hire, and twelve months after hire. These assessments occur in the field, where the LCC has an opportunity to demonstrate competence in necessary skills for the role, and are conducted by the RCD or Senior LCC to whom the LCC is assigned and thereby has a basis upon which to make an assessment.

The progression of the LCC along a continuum of competence is measured during these ongoing assessments. The RCD or Senior LCC will identify areas of practice that are either progressing appropriately or are not meeting targets. If an area of support is identified during these assessments, the RCD and Senior LCC will prepared an educational plan for the LCC. The evaluation tool used by the RCD and Senior LCC to assess and evaluate the LCC's practice is displayed below:

| Rating Key | Skill Level | Rating |
|---|---|---|
| | Novice | 1 |
| | Competent | 2 |
| | Proficient | 3 |
| | Expert | 4 |
| **Category** | **Elements** | **Rating** |
| Knowledge of the PCMH Program | State the Philosophy, Mission and Vision of the PCMH Program | |
| | Describe the importance and role of a Medical Panel | |
| | Describe the importance and role of a Program Representative | |
| | Describe the importance and role of a Practice Consultant | |
| | Define IBS and state how the IBS is used in the Program | |
| | Define OIA, its influencers, and how it is distributed | |
| | Identify the ways Quality (Clinical and Programmatic) is measured and the LCC's role in Quality Measurement | |
| | Define attribution, how it is determined, and what it affects | |
| | Define Care Coordination and the role of TCCI | |
| PCP Engagement | Articulate the importance of Provider engagement | |
| | Utilize multiple strategies of engagement with Providers | |
| | Demonstrates collaboration with Providers and their office staff | |
| | Participates appropriately in Panel Meetings | |
| | Completes Quality Measures accurately and timely | |
| | Demonstrates service excellence in relationship with Provider and office staff | |
| | Responds timely to requests from Providers | |
| | Demonstrates professionalism and preparedness when in offices | |
| | Has regularly scheduled meetings with Providers for Clinical Status Review of Members who may benefit from CCC (Core Target/Top 50/etc.) and review of current caseload status (active and in development) | |
| Member Selection and Care Plan Documentation | LCC is able to identify Member's Benefits to determine eligibility for TCCI Programs (CareFirst Direct and Benefits Summary) | |
| | Appropriately verifies Member benefits during three-way call with CSA within the first two weeks following Care Plan activation | |
| | LCC understands the Core Target populations, including how Members are categorized (CT1, CT2, CT3) | |
| | Completes Clinical Status Review (and AO) on 100 percent of CT1 and CT3 population, referring to appropriate TCCI Programs as needed | |
| | Identifies Members for Care Coordination appropriately | |

| | | |
|---|---|---|
| | Writes narratives that clearly identify the Member's clinical instability and adherence to selection criteria | |
| | Collaborates with Provider to develop individualized and actionable Care Plans | |
| | Conducts a thorough assessment of the Member, their conditions, and their social history to support an individualized Care Plan | |
| | Care Plans are complete prior to timely submission for activation | |
| | Care Plans are updated as needed and no less than at Maintenance visits | |
| Member Engagement | Able to effectively explain the program and benefits to Members, obtaining a written election to participate for the PCMH program and communicates Member requirements of participation (weekly calls, Member survey, etc.) | |
| | Demonstrates empathy and knowledge regarding Member's condition and needs | |
| | Explain the role and use of PAM, completes at initial visit and every six to eight weeks | |
| | Utilizes Motivational Interviewing techniques to assist in goal setting and progression towards Future State of Being | |
| | Assesses Members for barriers and facilitators to change and incorporates those into planned interventions | |
| | Enables Members to complete Member Survey during quarterly reviews | |
| | Is able to move through the phases of a Therapeutic Relationship throughout the lifecycle of a Care Plan and establishes clear professional boundaries | |
| | Sets appropriate standards for engagement with Members | |
| | Demonstrates flexibility in work hours and is able to meet Members' needs related to LCC availability | |
| | Demonstrates comfort and ease when reaching out to Members telephonically without having met them | |
| | Participates in Provider, Specialist, and other medical visits appropriately for Members in Active Care Plans | |
| | Connects with Member as frequently as necessary based on Clinical and Engagement assessment, no less than once weekly, in a meaningful way that supports the Member's movement towards their Future State of Being | |
| | Conducts an accurate medication reconciliation every 30 days and with any change in prescribed medications or change in level of care | |
| | Refers Members for TCCI Programs appropriately and documents in Partner Connections | |
| | Communicates effectively with all Care Team Members and across TCCI Programs as needed | |
| | Fosters Health Literacy and independence in management of chronic conditions in Members | |
| | Reports changes in Member's status/condition with appropriate urgency to Providers | |
| | Provides Members high quality, evidence-based education | |
| | Facilitates movement along Activation Levels during course of Care Plan | |
| | Manages transitioned Members appropriately in iCentric and with Care Coordination steps | |
| | Demonstrates and documents appropriate steps to prepare Member for, and complete graduation from, a Care Plan | |
| | Utilizes Specialist List tool appropriately | |

| | | |
|---|---|---|
| Technology, Privacy, and Security | Logs into Skype calls appropriately from phone | |
| | Logs into Skype calls appropriately from computer | |
| | Demonstrates ability to mute devices and monitor for audio feed | |
| | Demonstrates use of resources available on www.carefirst.com | |
| | Demonstrates use of resources available on Nursing Reference Center Plus | |
| | Utilizes Microsoft applications, including Outlook and Excel appropriately (using filters, setting recurring appointments, etc.) | |
| | Navigates iCentric using filters appropriately and moves Member through workflow status appropriately | |
| | Does not copy and paste from Microsoft product into iCentric | |
| | Demonstrates successful use of Service Request Hub | |
| | Demonstrates appropriate reporting of issues to the correct department | |
| | Understands and demonstrates "minimum necessary rule" | |
| | Secures all PHI, physical and electronic, appropriately | |
| | Navigates iCentric to locate and print Cards and Letters | |

## *Successful Completion of Training and Competency Assessment Period*

Upon successful completion of Level 2 competency, a new LCC can independently function and is on the desired course to becoming a fully functioning LCC. The LCC is expected to demonstrate competence in his/her role by the end of the six-month evaluation. If the LCC does not meet the standard in the multiple skills required, he/she will be placed in a performance improvement plan that will provide a timeline for achieving competency. Failure to achieve this will result in removal of the LCC from the PCMH Program.

To complete the training period, the LCC must successfully demonstrate acceptable performance in all the core skills and abilities of the role. The *PCMH Competency Assessment*, used during Level 1 and Level 2 competency assessments, defines the specific elements that are expected of the LCC and the parameters on which the LCC is expected to perform. Additionally, the LCC must have met all expected performance metrics for the period of time they have been in the field to graduate from Level 2. This includes but is not limited to encounter rates, caseload volume, and average Care Plan score.

Only competent LCCs who are in good standing with performance metrics receive a Certificate of Completion. This certificate is their evidence of having successfully completed the two required levels of training. The process is the same for all LCCs whether delegated or not.

## *Post Training Feedback*

LCCs who have successfully completed 30 days in the field post classroom training will be asked to provide feedback on their training and field experiences. A survey is emailed to LCCs to confidentially complete. This feedback is used to improve the LCC training Program and initial learning experience of new LCCs.

## *Ongoing Training*

Ongoing training is provided to LCCs at regular intervals:  weekly conference calls, forums, and refresher training.

### *Weekly Calls*

Each week, LCCs from each region join a conference call led by an RCD and/or member of the senior leadership team to discuss new information, program enhancements, and upcoming issues that the LCCs may experience. The agenda is developed by incorporating direct LCC feedback solicited on the LCC advisory call.

### *Refresher Training*

Refresher training is offered regularly to all LCCs. These are offered by the RCDs, Clinical Quality Specialists, and/or PCMH Leadership on a small group (10-15 LCCs) basis. The content of the refresher training is focused on ensuring all LCCs understand important aspects of the PCMH program. In light of the continual evolution and improvement of the PCMH program, the refresher training is an opportunity to ensure all LCCs understand all Program requirements and expectations as they evolve.

### *Mandatory Forums*

Ongoing periodic in-service training sessions are required for the entire field team, including RCDs and LCCs. Topics on the agenda include issues of importance to the PCMH Program, as well as any topics that have been identified as helpful in closing gaps in knowledge and performance in the role of the LCC as identified in actual field experience.

## Professional Resources For Local Care Coordinators

### *Clinical Quality Specialists*

The PCMH Care Coordination Clinical Quality Specialist role exists for the purpose of clinical quality improvement. Clinical Quality Specialists guide and mentor LCCs in the PCMH program to produce clinically effective Care Coordination and to document the care according to professional practice standards. The Clinical Quality Specialist Team works collaboratively with the Training Team, Senior LCCs, and RCDs to provide support and assistance in the development of effective Care Coordination by newly trained LCCs as well as by seasoned LCCs.

Given the informal leadership role of the Clinical Quality Specialist, the Clinical Quality Specialists always has several years of CareFirst PCMH experience, serving as an LCC or Trainer. This foundation of experience is critical to the success and credibility of the Clinical Quality Specialist. In addition, Clinical Quality Specialists typically have several years of management experience inclusive of accountabilities such as training, mentoring, coaching, providing feedback for improvement, planning and organizing the work.

The Clinical Quality Specialist's role is to support and shape critical-thinking skills, and in conjunction with the appropriate RCD, evaluate clinical performance and give feedback for improvement. The Clinical Quality Specialist will act as another resource to the RCDs to facilitate the LCC's achievement of effective Care Coordination and documentation following classroom- based orientation and formal training.

Each Clinical Quality Specialist is partnered with five RCDs. The Clinical Quality Specialist meets regularly with each assigned RCD and suggests quality improvements opportunities to the RCD. The RCD and Clinical Quality Specialist discuss the opportunities and identify next steps for the LCCs in the RCD's region. The Clinical Quality Specialist has no direct reports, but has a direct impact on the success or failure of LCCs providing Care Coordination work in the field. The Clinical Quality Specialists provides positive feedback, feedback for improvement and working as an additional resource to the RCD who remains as the LCC's direct manager.

The Clinical Quality Specialist is responsible for mentoring and evaluating the quality of the clinical work performed by the Senior LCCs and LCCs in the field. As a member of the CareFirst PCMH team, the Clinical Quality Specialist bears a special responsibility to model positive behavior for the LCCs. Examples of Clinical Quality Specialist responsibilities include review of weekly Progress Notes, low IBS Care Plan activations, aging Care Plan review, review of TCCI program use and identify opportunities to support Member stabilization through the TCCI Programs, and individual coaching for documentation improvement. The Clinical Quality Specialist help LCCs improve weekly calls with Members and how to move the Member toward the envisioned State of Being.

## *Senior Local Care Coordinators*

The role of the Senior LCC is to strengthen the oversight and mentoring of the LCCs. Each Senior LCC oversees 8 to12 LCCs. The Senior LCC reports to the RCD in their respective Region. The number of Senior LCCs in each Region is dependent on the total number of LCCs working in the region and is adjusted within and across Regions as necessary by CareFirst PCMH leadership. The role of the Senior LCC is to improve productivity, quality and timeliness of the work of each LCC within each Region.

The Senior LCC must have successfully fulfilled all aspects of the LCC role and have an interest and aptitude for training, mentoring, leading and holding others accountable in a positive way in order to be placed in this role.
RCDs identify potential candidates for the role of Senior LCC. The interview process consists of a committee of 3 RCDs inclusive of the hiring RCD with responsibility in the region within which the Senior LCC is assigned. A review of the candidate's performance, including but not limited to his or her organizational and clinical skills, his or her interpersonal skills and his or her relationships with Primary Care Providers is made.

Based on this review process, the RCD recommends each Senior. LCC candidate to the appropriate Senior Director in PCMH. Following approval, the candidate is promoted to Senior LCC. Only LCCs may be candidates for Senior LCC positions.

The Senior LCC works under the direction of the RCD. Each Senior LCC carries a reduced case load of 15 active Care Plans in order to split their duties between his/her Care Plan Members and overseeing the work of the LCCs in their charge. The Senior LCC abides by and adheres to all performance and quality standards for the LCC role as well all behavioral requirements stated in this **Appendix E**.

The Senior LCC also is responsible for LCC performance specific to case load and productivity, effective Care Coordination and timeliness requirements of the LCC role, including but not limited to clinical documentation and quality score card inputs. Senior LCCs will attend training on coaching and mentoring.

The effectiveness and performance of the Senior LCC is assessed by the RCD. If performance issues arise, the RCD will work with the Senior Director and follow the same process outlined above for poor performing LCCs.

## Population Health - Selecting the Appropriate Member For A Care Plan And Care Coordination

### Purpose

To select the most vulnerable, needy and appropriate Members for Care Plans.

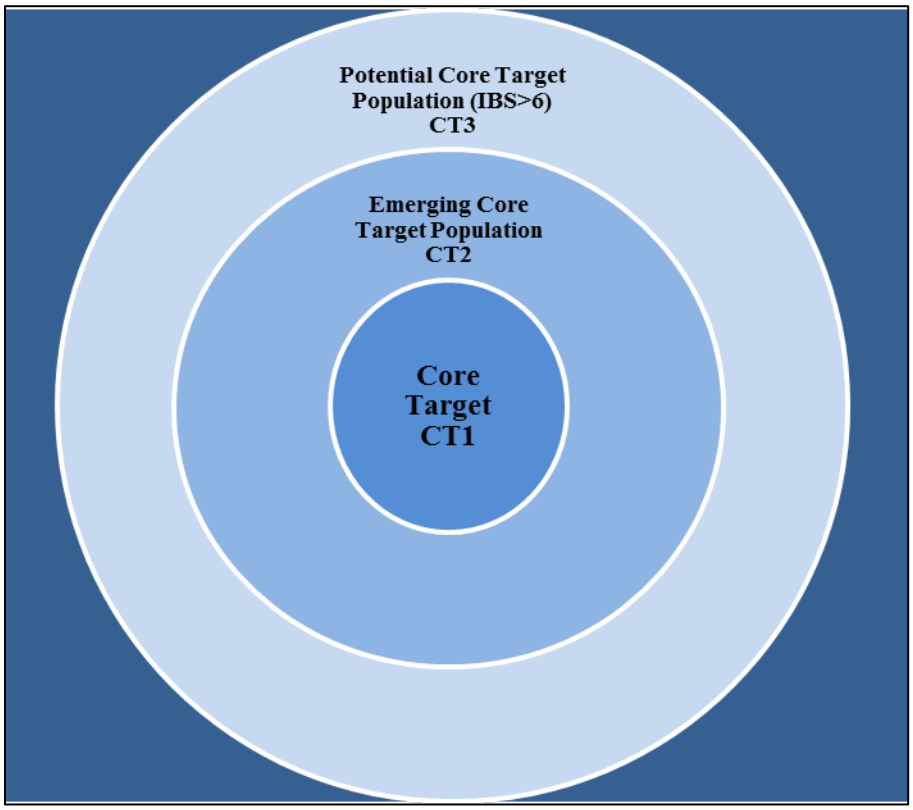
The Members who may be appropriate for care coordination are identified as being in one of three groups, and are depicted in the three concentric rings shown below. These Members – collectively - are considered to be in the "Core Target" population most in need of coordinated care due to their level of illness and vulnerability for breakdown.

The highest priority Members for Care Coordination are the Members in the Core Target Population in the inner ring. These Members are reviewed before all others under consideration for Care Coordination.

After all the Members in the inner ring have assessed, the second level of priority for Care Coordination is given to Members who are classified in the middle ring as the Emerging Core Target Population. These are Members who have serious emerging conditions or diagnoses that may have recently or suddenly appeared and are not yet reflected in their IBS but, without intervention, are likely to experience breakdown and incur high levels of medical cost.

The third level of priority for Care Coordination are Members in the outer ring with an IBS greater than six. These are Members who, while not as ill as those in the Core Target Population, should be assessed to make sure they are not headed toward a costly breakdown in their health. Each of these populations is shown in the chart below.

**Identifying Members In Need Of Care Plans**



## *The Core Target Population (CT1)*

The Core Target Population is comprised of between 45,000-50,000 CareFirst Members in any given month who have been identified through specific criteria that are characterized as having high costs, high hospital utilization, and health instability. These costly, unstable Members are the top priority to assess for Care Coordination needs. There are five routes to being identified as a Core Target Member:

- Members who were flagged on hospital admission by an HTC as "High Cost" Level 1 admissions in the last 12-months and/or members assigned a LACE score between 11 and 19 following admission.
- Members with known high readmission rates for any reason within 30-days of a previous discharge in the last twelve months.
- Members with consistent high cost over six or more months at $5,000 or more per month in medical spend in the last 12 months.
- Members in Band 1: Acute - Return to Chronic category who have an Illness Burden Score between 10-24.99.
- Members with multiple high-risk indicators of progressive disease or instability in the last 12 months. These indicators include Overall PMPM $, Hospital Use, Multiple Comorbidities, Specialty Rx PMPM $, Advanced Chronic Kidney Disease (CKD), and a Drug Volatility Score (DVS) of at least eight (on a scale of 1-10).

The Core Target list is updated on a monthly basis. Members who have Medicare as the primary insurer are excluded from the Core Target Population.

## *Emerging Core Target Population (CT2)*

The second priority group of Members that are assessed for Care Coordination is comprised of Members who do not yet meet the criteria for inclusion on the Core Target Population but have been identified by the PCP, in collaboration with the LCC, as needing Care Coordination. These Members have come to the attention of the PCP and LCC through alternative means, as opposed to being included on the Core Target or the Top 10-50 lists.

These Members have significant and often sudden complexity in their health care treatment regimen. For Members with an IBS less than six who are unstable or prone to break down and whose condition is expected to worsen, documentation is necessary to support this conclusion. Examples include Members with seriously aberrant laboratory values and Members with significant behavioral health and psychosocial barriers in addition to other co-morbid medical conditions that, if not addressed, will likely lead to costly breakdowns.

The PCP often finds Members in this category through scheduled office visits. Members may be new to CareFirst and have not yet accrued sufficient evidence for inclusion on the Core Target List. Along similar lines, the Member may have neglected to follow through on prescribed care, resulting in a lack of data by which to evaluate the Member. The PCP, however, recognizes the warning signs of impending breakdown and identifies the Member as in need of Care Coordination.

The PCP or LCC may also find Members who have shown physiologic deterioration over time. For example, a Member's hemoglobin A1c might have risen significantly in three months in addition to evidence of hypertension. The Member might also be exhibiting early signs of renal failure, a symptom not present three months ago. This deterioration signals to the PCP and LCC that the Member will need intensive coordination and support to ensure an emergency department visit, a hospitalization, or irreparable loss of function is prevented.

The PCP, with assistance from the LCC, determines if the Member could benefit from Care Coordination by determining that the Member is close to or obviously headed for significant clinical breakdown. Signals of an impending breakdown may include emergency department visits, multiple PCP and specialist visits, and/or concerning physiologic indicators of health decline. The PCP reviews these factors and makes the considered judgment that the Member's condition warrants Care Coordination.

### *Potential Core Target Population (IBS > 6) (CT3)*

Once all the Emerging Core Target Members have been assessed, the PCP and LCC evaluate Members who have the potential to enter the Core Target Population.

These Members, who have an IBS greater than six, may be identified through Top 10 to 50 SearchLight reports or through office visits or declining physiological or behavioral health indicators. If the PCP identifies a Member as being appropriate for Care Coordination, the LCC then begins the process of Care Coordination with the Member.

### *Clinical Status Review and Assessment Outcome*

Each LCC reviews the Core Target Population with the Member's PCP on a monthly basis to assess Care Coordination needs. The LCC discusses the Core Target Members with the PCP during the weekly visits to the PCP's office and during the regularly scheduled monthly face-to-face meetings. The PCP and LCC must perform this function together, incorporating clinical judgment throughout the process.

The purpose of this review is to reach a considered judgment on the Member's clinical status and assure the Member receives the appropriate services necessary to stabilize the Member. The review must consider all aspects of the Member's health and social/psychological situation, thereby making an informed decision about the Member's care needs the central objective.

When reviewing the Core Target List, the LCC reviews each Member's MHR, EMR, and any additional clinical documentation in the practice EMR or paper record with the PCP. This review provides the LCC and PCP with the necessary information to determine the next steps for the Member. When a Member is identified as needing Care Coordination, the PCP and LCC discuss how to approach the Member to explain this and obtain consent. If the Member has specific needs such as Behavioral Health Care Coordination, a Comprehensive Medication Review, or any other needs that could be addressed by TCCI services, the PCP will need to direct the LCC to refer the Member to the desired service by submitting a service request through the Service Request Hub.

After ensuring that Members with Care Coordination or other needs have been identified, the LCC and PCP then assess and document the status of all other Members on the Core Target List. The process of reviewing and documenting the status of Members is called a "Clinical Status Review". The result of this review is called an "Assessment Outcome". Examples of clinical status include the Member being already stable, the Member having a single chronic condition that is being well managed, or the Member having an acute condition that is highly likely to resolve on its own.

A comprehensive list of possible Assessment Outcome statuses is available in iCentric and is shown below. The PCP determines which clinical status to document in iCentric. The LCC finds and selects the dropdown option that corresponds with the status determined by the PCP. This drop-down list contains the following options:

- Member is stable at this time; no Chronic Care Coordination needed.
- Single controlled chronic condition; no Chronic Care Coordination needed.
- Acute condition that will resolve.
- Active treatment underway that is sufficient.
- Pregnancy and/or delivery; no Chronic Care Coordination needed.
- Newborn; no Chronic Care Coordination needed.
- Planned surgery, post-op care being provided; no Chronic Care Coordination needed.
- Sufficient support in place; no Chronic Care Coordination needed.
- Member could benefit from Chronic Care Coordination—working to schedule appointment.
- Member could benefit from Chronic Care Coordination—scheduled for appointment.
- Member referred to Behavioral Health Care Coordinator.
- Member referred to Complex Case Management.
- Member referred to Comprehensive Medication Review.
- Member referred to Enhanced Monitoring Program.
- Member referred to Expert Consult.
- Member referred to Specialty Pharmacy.

- Member referred to Wellness/Disease Management.
- CKD disposition: (disposition populates here)
- Member not actively seeing PCP; PCP is actively reaching out to the Member.
- Member is actively followed by specialists; Member unwilling to see PCP at this time after multiple attempts by the PCP to communicate with the Member.
- Member could benefit from Care Coordination, but refuses to engage/schedule appointment.
- PCP refuses to engage Member in Care Coordination.
- Member declined due to high deductible benefit plan or cost sharing being too great.
- Member's PCP not in PCMH.
- Member's PCP not known or active.
- Member became eligible for Medicare Primary coverage.
- No longer CareFirst Member.
- Member deceased.
- Member attributed but not eligible by not having PCMH benefit in coverage plan.

A completed Assessment Outcome remains in place for 90 days from the date the Assessment Outcome is first entered. After the Assessment Outcome is documented, the LCC and PCP continue to monitor the Member every month, although the documentation of the Assessment Outcome is required once every 90 days. An updated status is required before the expiration of the 90-day period. The Assessment Outcome for a deceased Member is a permanent status, meaning that this status is selected once and remains present until the deceased Member's enrollment is updated.

## *Selection Criteria for Clinically Appropriate Care Plans and Care Coordination Members*

Within the context of the Core Target Population, the best Care Plan candidates are those with multiple, chronic conditions, who require special attention from PCPs and LCCs. Such Members are at a high risk of breakdown in health status, ER visits and hospital admissions and readmissions. These Members typically require Care Coordination over a long duration across many care settings involving multiple providers.

**Adult Member Selection Criteria**

The LCC will use judgment to select clinically unstable Members, demonstrated by many factors, including but not limited to:

- Multiple hospitalizations or ER visits in the last three to six months.
- Multiple PCP/specialist visits (more than one visit per month).
- Multiple urgent care visits for chronic condition management (example: COPD or asthma exacerbation).
- Medication non-adherence (may include non-adherence due to financial constraints).
- Deteriorating physiologic indicators.
- Deteriorating behavioral health status.
- Other indicators of instability identified by the PCP.

In addition to clinical instability, the Member needs to meet *four or more* of the below criteria

- Three or more abnormal clinical indicators (example: elevated hemodynamic measurements, elevated tests or diagnostics, etc. such as BMI >50, uncontrolled HTN, Hemoglobin A1C >9. These indicators must demonstrate instability (trending towards poorer values).

- Two or more specialists involved in care (excludes: dentists, optometrists, gynecologists unless the Member has significant clinical conditions in these specialties).

- Eight or more prescribed medications – Polypharmacy with evidence that the Member does not adhere to or understand medication regimen (excludes: vitamins, over-the-counter).

- Two or more barriers to care (example: financial, psychosocial, cultural, language, access, etc.).

- LACE score (within the last 60 days) of 10-19.
- Charlson Comorbidity Index Score (CCI) of three (3) or more.
- Pharmacy Burden Score (PBS) of five (5) or more.
- Member has little understanding of their disease and/or is non-compliant with self-care management (example: diet, exercise, medication, interventions, preventive screenings, etc.)
- Little evidence of social support system.
- Members with known diagnosed psychiatric conditions such as bi-polar disorder, schizophrenia, paranoia, depression, anti-social disorder, personality disorders, etc.
- Need for home-based interventions (example: home O2, assistive devices, PICC lines, G-tube, etc.).
- Vision or hearing impairments that impede the ability to execute self-care measures.
- New diagnosis of a chronic condition within the last three months.

**Pediatric Member Selection Criteria**

The PCP and LCC will use judgment to select clinically unstable pediatric patients, demonstrated by many factors, including but not limited to:

- Multiple hospitalizations or ER visits in the last three to six months.
- Multiple PCP/specialist visits (example: more than one visit per month).
- Multiple urgent care visits for chronic condition management with no PCP follow-up afterwards (example: diabetes or asthma exacerbation).
- Medication non-adherence (may include non-adherence due to financial constraints).
- Treatment recommendation non-adherence (example: not completing lab work, not getting x-rays, failing to follow through with referrals, not following up with the PCP as recommended, not getting the therapies recommended such as Occupational Therapy (OT), Physical Therapy (PT), Speech and Language Pathologist (SLP); may include non-adherence due to financial constraints).
- Deteriorating physiologic indicators.
- Deteriorating behavioral health status.
- Poor psychosocial supports (example: parents are overwhelmed, parents not following up with treatment recommendations, financial constraints).
- Other indicators of instability identified by the PCP.

After considering these factors, selection of a Member for a Care Plan must meet five or more of criteria below:

- Two or more abnormal clinical indicators (elevated hemodynamic measurements, elevated tests or diagnostics, etc. such as BMI > 95$^{th}$ percentile, uncontrolled HTN, Hemoglobin A1C >7.4. These indicators must demonstrate instability (trending towards poorer values).

- Two or more specialists involved in care (excludes: dentists, optometrists, gynecologists unless the Member has significant clinical conditions in these specialties).
- Three or more chronic prescribed medications – Polypharmacy with evidence that the patient does not adhere to or understand medication regimen (excludes: vitamins, over-the-counter).
- Recent (within the last 60 days) LACE score of 10-19.
- Pharmacy Burden Score (PBS) of five (5) or more.
- Charlson Comorbidity Index Score of three (3) or more.
- Significant barriers to care (example: financial, psychosocial, cultural, language, access, etc.).
- Member/caregiver has little understanding of their disease and/or is non-compliant with care management (example: diet, exercise, interventions, preventive screenings, etc.).
- Little evidence of social support system.
- Member/caregiver with known diagnosed psychiatric conditions such as bi-polar disorder, schizophrenia, depression, ADHD, anxiety, autism, other neurodevelopmental disorders, personality disorders, etc.
- Need for home-based interventions (example: home O2, assistive devices, PICC lines, G-tube, etc.).
- Vision or hearing impairments that impede the ability to execute care measures.
- New diagnosis of a chronic condition within the last six months (example: three months for adults).
- New diagnosis that involves coordination with multiple ancillary providers (example: therapists, infants and toddlers, community resources, 504 plans, IDPs, etc.).

The Care Plan narrative will include documentation of each of the criteria applicable to the Member, including unstable status and progression toward decompensation and/or hospitalization.

### *Approval Process for Low IBS Care Plans*

In general, Chronic Care Coordination is focused on Members who have an IBS greater than or equal to six. These Members are typically chronically unstable and have significant complexity in their health care treatment regimen. From time to time, exceptions can be made for Members with an IBS less than six who are unstable and prone to break down and whose condition is expected to worsen or remain unstable without Care Coordination support. Examples include Members with seriously aberrant laboratory values and Members with significant behavioral health and psychosocial barriers in addition to chronic medical conditions that, if not addressed, will likely lead to costly breakdowns.

Members with IBS greater than four often display early signs of breakdown. When a PCP and/or LCC identifies a Member with an IBS greater than four demonstrating current or impending breakdown, Care Coordination may begin without additional approvals. In the event that a PCP and/or LCC identify a Member with an IBS less than four whom they deem appropriate for Care Coordination, the LCC must seek approval before developing the Care Plan. To do so, the LCC must prepare a written summary in iCentric of why the Member is unstable and needs Care Coordination. The LCC must then submit the summary to the RCD who assesses the summary and reviews the MHR to ensure the Member will benefit from Care Coordination. If approved, the RCD will so note in iCentric. If the RCD does not think the Member would benefit from Care Coordination, the RCD will call the LCC to discuss the case and make a determination of next steps which may include talking with the PCP to understand the expected plan of care, revising the written summary to reflect the full extent of the Member's instability, keeping the Member on a list to review in a few months, or other options as appropriate.

## Concise And Actionable Care Plan Documentation And Care Coordination

### Purpose

**To define the standards for appropriate documentation of Care Plans and Care Coordination.**

The purpose of a Care Plan is to capture pertinent information about why a Member needs a Care Plan, to lay out the steps for managing the Member's care, and to track the progression of the Member's Care Coordination as well as their clinical and behavioral response to their care. The Care Plan is not designed to replace the Member's medical record, but to highlight critical Elements related to the Member's health and Care Coordination efforts. This policy is intended to provide guidance to ensure that Care Plan components are clear, complete, concise, actionable and appropriately documented.

When a Member becomes engaged in a Care Plan, the Member and the LCC will discuss and outline an envisioned "State-of-Being" that, when reached, will constitute completion and graduation from the Member's Care Plan. This "State-of-Being" is comprised of the goals that demonstrate that the Member has achieved stability in their health (e.g. controlled glucose levels in a manner that does not require insulin) as well as the ability to self-manage their chronic conditions (e.g., the Member will know how to recognize the signs and symptoms of hypoglycemia.)

The development of this targeted "State-of-Being" and its effective communication to the Member as well as their full agreement and Engagement in seeking to achieve it over the course of their Care Plan is one of the central elements of the entire Care Plan process.

The Local Care Coordinator (LCC) is responsible for ensuring that the Care Plan is fully and appropriately documented. The LCC will collaborate with the Member's PCP and the Member on the Care Plan content, Care Coordination activities, and any other items involving the plan of care and course of treatment for the Member. The PCP will guide and approve the Care Plan.

The LCC must complete all the Care Plan required elements in the PCMH Provider Portal within three days of the Member's Care Plan visit. Care Plans entered later than three working days from the Member's initial Care Plan appointment will be reviewed by the RCD to ascertain the reasons for delay. Patterns of delayed entries will be dealt with through the performance review process.

### *Care Plan Standards*

The LCC will document all aspects of each Care Plan in the Portal. No notes or documentation will be considered applicable to a Care Plan except those documented in the Portal.

To be selected for a Care Plan, Members will be Care Plan Eligible, have elected to participate in Care Coordination as part of the PCMH Program, and not opted out of information sharing.

The LCC will collaborate with the PCP to gather all pertinent information to develop a Care Plan for those clinically appropriate Members. The LCC will use professional judgment to determine the appropriate and pertinent health information to document in the Care Plan. The information should be relevant to the Members active clinical problems and care and must be ultimately under the direction of the PCP.

A complete Care Plan includes the Member Narrative, Social and Family History, Barriers to Meeting Goals, Medications, Allergies, Diagnostics/Lab Results, Vital Signs, Encounter History, Partner Connections, Assessment and Plan, Care Coordination Team information, and Family Circle information. The Care Plan must be complete at the time of activation. The LCC will ensure that the Care Plan documentation is clear, complete, concise and actionable according to the definitions below:

- **Clear** – no use of abbreviations or acronyms, except as defined in the *PCMH Approved Abbreviations*, spelling and grammar are correct and the content is logical and presented in an organized fashion.

- **Complete** – contains relevant medical history and current condition descriptions that inform the need for a Care Plan and how the LCC will provide Care Coordination.

- **Concise** – the information documented is accurate, contains only the pertinent facts.

- **Actionable** – the steps for carrying out the Care Plan must be specific, measurable and consistent with the Member's condition(s) and be clearly committed to stabilizing or improving the Member's condition(s) and illnesses.

The ultimate test of a good Care Plan is that an uninformed reviewer can quickly read and grasp the reasons for and the content of the steps to be taken to assist the Member.

The quality review process in Section VIII: *Care Plan Quality Reviews,* applies to all Care Plans. A rating scale is used with five possible scores: 5 "Perfectly Clear, Complete, Concise, Actionable," 4 "Expected Standard," 3 "Minimum Acceptable," 2 "Well Below Standards," or 1 "Completely Unsatisfactory."

## *Clinical Summary*

The LCC will gather information from the medical record, interviews/discussions with the Member and PCP, as well as information from the specialists treating the Member. A synthesis of this information is documented in the Clinical Summary section of the Care Plan.

The "Clinical Summary" section of the Care Plan includes the following tabs, which will be documented according to the following guidelines:

**Member Narrative:** The first section of the "Member Narrative" should provide the reader with a summary of the key facts about the Member: age, gender, ethnicity, height, weight, and body mass index (BMI). The LCC should enter the date of the Care Plan initiation in the narrative in order to identify the chronology of entered information. In addition, the LCC documents the Member's targeted State of Being in the Narrative.

The remainder of the Member Narrative provides relevant information about the Member's health status that demonstrates the need for a Care Plan and Care Coordination, including compliance/adherence issues (for example, with medications, diet, treatments). Major health problems are addressed here. This includes significant related events (example: ER visits, in-Member admissions, procedures, changes in level of care). The narrative will also contain a list of the Member's past medical and surgical conditions that are pertinent to managing the Member's current clinical conditions.

In the narrative, the LCC identifies the barriers that the Member confronts in reaching targeted goals, as well as information about the Member's risk for an acute event (for example, hospitalization or emergency department visits). An example might be that the Member is at a very high risk of having a cardiac event with uncontrolled hypertension, hyperlipidemia, extreme obesity, failure to eat healthy foods, sedentary lifestyle, smoking habit and strong family history of myocardial infarcts and strokes.

The narrative should include not only the current uncontrolled conditions, but all relevant past medical history. For example, if a Member's main concern is obesity, history of osteoarthritis should be documented, since it could potentially impact the Member's ability to exercise. The narrative, therefore, is a concise and current view of the Member's overall condition and is written at the beginning of the Care Plan.

The LCC should update the Care Plan by documenting the maintenance visit or any major updates or changes in the Member's condition, along with the date of the newly input information in the Progress Notes. If there have been no changes since the prior visit, this should be stated in the Progress Notes as well.

Thus, the narrative is the "summary" of all the information presented in other sections and should pass the test that an uninformed reader could understand the Member's need for the plan proposed and gain familiarity with all relevant information regarding the Member's condition. As a general rule, the Member Narrative should be approximately 500 words in length.

The narrative should focus upon the core needs of the Member that have been distilled from all the information gathered about the Member's health, such that a concise, directed, actionable plan can be developed to address the Member's immediate needs and to stabilize the Member in the home.

**Past Health History:** The "Past Health History" tab of the *Clinical Summary* section of the Care Plan need not be used if all relevant information is entered in the Member Narrative Section.

**Social History:** The "Social History" tab of the *Clinical Summary* section of the Care Plan is used to document demographic and societal information about the Member. This section includes an assessment of the Member's marital status, occupation, nutritional status, ability to perform activities of daily living, evaluation of behavior health, and other important elements related to psychosocial health. LCCs are expected to assess all aspects of social history and document the findings of the assessment. The LCCs do not need to complete the Evaluation of Available Benefits box. LCCs document the three-way conversation with a Customer Service Advocate in the Progress Notes section. As part of the Social History assessment, the LCC screens the Member for the presence of depression by using the PHQ-2 assessment tool. If the Member has a positive finding suggesting that the Member may be experiencing depression, the LCC consults with the PCP and, if appropriate, refers the Member to the Behavioral Health/Substance Use Program/BHCC for a full behavioral health assessment.

**Family History:** The "Family History" tab of the *Clinical Summary* section of the Care Plan contains information about the known health conditions of the Member's close family, including parents, grandparents, siblings, and offspring. This section is completed with as much information as the Member is able to provide. If the Member is unable to provide any family history, the LCC documents this fact in the Family History section.

**Medications:** The "Medications" tab of the *Clinical Summary* section of the Care Plan is a critically important component of the Care Plan. This section contains documentation of all allergies, including medication and food allergies as well as environmental allergies. All prescribed medications are documented in this section, all supplements, vitamins, and over-the-counter medications are listed as well. The quantity, route, frequency and Member's stated reason for taking the medication are found here. Also, if the Member is not taking medications as prescribed, the LCC notes this information with a check of "Medications not taken past two weeks."

**Diagnostics/Lab Results:** The "Diagnostics/Lab Results" tab of the *Clinical Summary* section of the Care Plan contains all relevant laboratory values and diagnostic results. LCCs are expected to update this section each time new laboratory values and/or diagnostic results are available.

**Vital Signs:** The "Vital Signs" tab of the *Clinical Summary* section of the Care Plan contains a history of the Member's vital signs while in a Care Plan. At a minimum, every Member must have an initial and final result of the following vital signs: blood pressure, pulse, respirations, height, and weight. Vital signs are updated with every maintenance visit. Pulse oximetry and temperature are included when applicable to the Member's chronic conditions.

**Clinical Guidelines:** The "Clinical Guidelines" tab of the *Clinical Summary* section of the Care Plan show the national guidelines for a variety of clinical measures related to chronic condition management. The LCC documents the Member's actual values (e.g. BMI, tobacco use, etc.) as well as the PCP's recommended target. Then, the LCC indicates the status of the goal, whether the goal has been met or if it is still a current goal. This section provides a longitudinal perspective on the Member's clinical measures over the course of the Care Plan. The LCC updates this section every three months, typically in conjunction with the maintenance visit.

**Barriers to Meeting Goals:** The "Barriers to Meeting Goals" tab of the *Clinical Summary* section of the Care Plan supports a comprehensive assessment of a Member's barriers to achieving the envisioned State of Being. The LCC assesses the Member for personal, psychosocial, medication adherence, cognitive, and environmental barriers. Based on this assessment, the LCC develops a plan to help the Member overcome the identified barriers.

## *Assessment and Plan*

### Care Plan Approvals

- The Care Plan is considered ready for activation when all sections of the Care Plan are complete and the consent has been signed and uploaded. The LCC sends the Care Plan to the Provider for approval and activation by clicking the "Waiting for LCC Review" button.

- Once the LCC has indicated that the Care Plan is complete and accurate and has clicked the "Waiting for LCC Review" button, the Provider reviews the Care Plan contents. When satisfied with the Care Plan, the Provider activates the Plan by clicking on the "Activate Care Plan" button.

- The PCP will use the Care Plan Development S-Code (S0280) for submitting a claim for Care Plan activation. In order to use this Care Plan Development code, the visit must be a face-to-face office visit or a telemedicine visit between the Member and Provider. The service date included on the claim is the date of the visit where the Provider determined the need for the Care Plan. This code is used only after the Care Plan has been activated. The date of service should be within 90 days of the Care Plan activation date.

### TCCI Program Connections

- While performing the initial interview with the Member, the LCC assesses the Member's need for Total Cost and Care Improvement (TCCI) Programs such as Comprehensive Medication Review, Enhanced Monitoring, Expert Consult, Home-Based Services, and Behavioral Health and Substance Use Programs. The assessment is documented in "Partner Connection."

- The LCC and PCP discuss which programs are appropriate for the Member and the LCC then initiates the referral process through the CareFirst Service Request Hub, which will make a connection with the appropriate CareFirst provider or contracted vendor. The LCC conducts a three-way call with the Member and their dedicated CSA to determine the Member's applicable insurance coverage. No Service Request will be processed without confirming insurance coverage.

- The LCC documents whether or not a program was offered to the Member. If yes, the LCC documents whether or not the program was accepted by the Member. If the LCC did not offer the program to the Member, the LCC documents the reason for not offering the program in the free text box. If the Member declines an offered program, the LCC also documents the reason in the free text box.

## *Special Note*

**General Assessment** – This "General Assessment" section of the *Assessment and Plan* tab of the Care Plan need not be used if the information entered in the Narrative section of the Care Plan is complete.

**Medication Assessment** – This "Medication Assessment" section of the *Assessment and Plan* tab of the Care Plan need not be used if the information entered in the Narrative section of the Care Plan is complete.

### The Plan

When a Member becomes engaged in a Care Plan, the Member and their LCC will discuss and outline an envisioned "State-of-Being" that, when reached, will constitute completion of the Member's Care Plan and will enable graduation from the Care Plan. This "State-of-Being" is comprised of goals that demonstrate that the Member has achieved a state of stability in their health as well as the ability to self-manage their chronic conditions. There must always be a target date that is set for graduation in every Care Plan. This may be modified if circumstances change as confirmed by the PCP during maintenance visits.

The "Plan" section should demonstrate urgency to get uncontrolled conditions managed, to provide needed resources to meet the Member's needs, and to direct coordination of care to prevent acute events such as hospitalizations and Emergency Department visits. Avoidance of such acute events is the key continuing focus of the LCC once a Care Plan is activated.

- The PCP, LCC and the Member select the three to five most unstable chronic conditions to manage. For each condition, the PCP, LCC, and Member establish four reasonable, actionable, achievable goals for each clinical condition.

- The LCC and the Member jointly establish interventions to stabilize the chronic conditions. They also work together to develop strategies to overcome barriers identified in the Clinical Summary. The LCC plans the education necessary for the Member to sustainably self-manage their chronic conditions and prepares a preventive plan to reduce the likelihood of clinical breakdown. The overall target date for Care Plan graduation (typically six months after activation) should be prominently known and focused upon by the Member, LCC and PCP.

- In the "Plan" section, the LCC identifies and prioritizes the Member's key problems. Each problem must have a corresponding plan to address the condition, which includes the guidance by the PCP for managing the Member's care, as well as the steps the LCC will take to carry out the PCPs instructions. The problem(s) are selected from the drop-down list populated with an industry standard Medical Episode Groups (MEGs) list (570+ episodes of clinical conditions).

- The core actions needed to address the Member's clinical conditions must be described in order to fully develop the plan and specific actions to carry it out. These core action steps focus on the immediate needs of the Member with urgency to stabilize the Member to avoid breakdown and progression of the disease. Once Care Coordination progresses and stabilization of the immediate concerns is secured, the LCC can address longer term needs of the Member.

- In addition to items identified in the Clinical Guidelines section, the plan should provide clear direction on how each problem will be managed and should be based upon nationally accepted standards of care when available. Goals result from collaboration between PCP and LCC, with buy-in from the Member. The plans should be actionable, with goals set to stabilize the Member, keep them in their home/community, avoid unnecessary hospitalizations, and provide the highest possible functioning of the Member in the context of their conditions and circumstances.

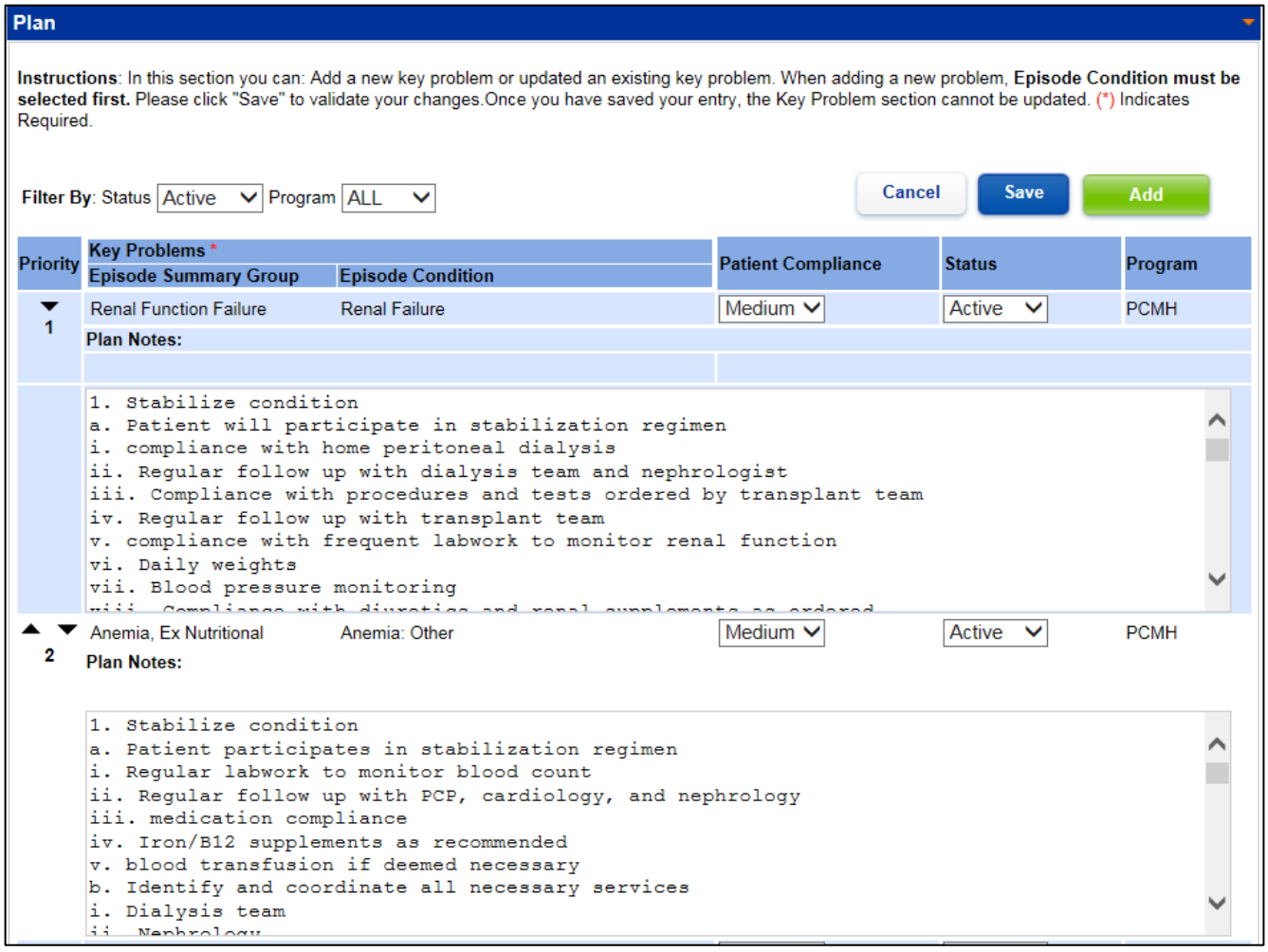
- The plan includes all items to coordinate the Member's care. This includes ensuring recommended referrals are completed, appointments are scheduled and kept, necessary equipment is delivered, information from consultations is secured and documented, Member information is communicated to the PCP, lab/radiology results are entered into the Care Plan, and Member compliance with medications is assessed along with progress on lifestyle modifications (for example, diet, exercise).

- The LCC conducts a three-way call with the Member and their dedicated CSA to determine the Member's applicable insurance coverage.

- The LCC and PCP must review the plan at each maintenance visit (at a minimum) to ascertain progress toward or achievement of the State-of-Being. The LCC must also evaluate completion of planned interventions and progress toward the State-of-Being during Care Coordination activities. A targeted date for the next maintenance visit should be set at each maintenance visit. If goals are not met by the targeted date, then the LCC will discuss this with the Member and PCP and set a new goal date which may involve modifying the plan to reach the goal.

A sample screenshot of the documentation of a goal, plan and action is shown on the next page.

**Sample Screen Shot Of Acceptable Documentation**




## *Progress Notes*

The "Progress Notes" is the section where the LCC documents interactions with the Member, PCP, Member's family/caretakers, specialists, care team members or any others involved in the management of the Member's condition and Care Coordination. Although the LCC is the primary author in the Progress Notes, other care team members may document in this section (e.g. physical therapist, occupational therapist, behavioral health care coordinator). This section serves to document a running record of what is happening with the Member, why decisions are made, interactions with the care team, progression toward goals or lack thereof, barriers that may be confronted, and any communication that helps understand the Member's clinical conditions and ability to reach their goals.

Encounters include any and all office visit interactions, phone call conversations, email exchanges, electronic communications, and any other source of communication where information about the Member is obtained or exchanged. The LCC will document all nursing interventions here, including education. Progress notes must be documented in the Portal the same day that the interaction or activity occurred.

When the LCC follows up on PCP referrals to specialists and other providers, the results should be recorded in the Progress Notes section of the Care Plan. This is also true for referrals to other members of the care team, such as behavioral health consultants, pharmacy consultation, and home health services consultants.
All care team members have access to the iCentric Portal to directly input their notes. The LCC will not be responsible for documenting other team member findings but must assure their timely, complete and accurate entry. The LCC must also assure that other team member's actions align with the plan of care and carry out steps in keeping with the Member's needs.

The LCC should summarize the correspondence as a means of keeping track of the coordination of care. The LCC should not copy and paste the e-mail into the Progress Notes. The Progress Notes should not be a literal copy of a note from the PCP or the specialist, but should be the summary of important findings, referrals, new medications, treatment or diagnosis as understood by the LCC. The notes should be easy to read and understand with only relevant information included. For example, "Member visited endocrinologist on June 1, 2012 for management of his diabetes. Medications were reviewed and Metformin was increased from 500 mg BID po to 1000 mg BID po."

The LCC documents the weekly care call using the Status/Intervention/Plan (SIP) framework. The call begins with an assessment of the Member's current health status, including a review of any recent vital signs, medication changes, PCP or specialist visits, and updates on how well the Member was able to meet the goals set the previous week. This information is documented the "Status."

The LCC then implements interventions from the Plan section of the Care Plan. These actions are specifically designed to advance the Member toward the envisioned State of Being. All actions implemented by the Member and LCC are documented as "Intervention." The LCC and Member collaboratively set goals related to the Member's self-management for the following week. The LCC documents the goals and probable scheduled for the upcoming week in the Plan. Calls among other care team members, administrative notes, missed contacts with Members, and similar non-care call notes do not need to be documented in the SIP format.

## Carrying Out Care Coordination Called For In Care Plans

### Purpose

**To clarify the process of carrying out a properly documented Care Plan following the activation of the Plan.**

### *Activating the Care Plan*

- Once the LCC clicks the "Waiting for LCC Review" button, this indicates that the Care Plan is complete and accurate in the LCCs view.

- This action then allows the Provider to click the "Activate Care Plan" button in the "Care Plan Approvals" section of the Care Plan in the PCMH Provider Portal, which indicates that the PCP agrees with the Care Plan and its contents. The Care Plan status then becomes active. Neither the LCC nor the Portal Administrator can click the "Activate Care Plan" button for the PCP. Only a PCP in the Panel responsible for the Member can do this.

- Once activated, the Care Plan may be sent to the RCD review team for review as outlined in the *Care Plan Quality Reviews Section.* Care Plans that do not score higher than a three must be corrected, as advised by the review team. .

- The PCP will use the Care Plan Development S-Code (S0280) to submit a claim for Care Plan development, once the Care Plan has been activated. The service date included on the claim is the date of the Member visit. To use this S-code, there must be a related office or telemedicine visit with the PCP. The date of service should be within 90 days of the Care Plan activation date.

- Sharecare and CareCo will use the Care Coordination T-Code (T2022) to submit a claim for Care Coordination. This claim can be submitted every month that the Member is in an active Care Plan and receiving Care Coordination.

### *LCC Maintenance of the Care Plan*

- Once the Care Plan is activated, the LCC will develop a schedule to follow-up and communicate with the Member-based on the activities needed to carry out the Care Plan. At a minimum, voice-to-voice or face-to-face communication should occur at least once every week. The frequency of interactions with the Member will be determined by the Member's needs.

- The LCC will continually update the Care Plan with any information regarding the Member in the appropriate section of the Care Plan describing any direct Member communications, information obtained, discussions with the Member's providers, etc. Continual communication and coordination with other services, such as behavioral health, home-based services, and pharmacy consultants may well be necessary and the LCC must keep them up to date. The LCC's documentation should reflect the coordination and collaboration with all services being received by the Member.

- The LCC must promptly communicate any significant new information related to the Member's health to the PCP and request direction from the PCP when necessary.

### *PCP Maintenance of the Care Plan*

Maintenance visits are those PCP office or telemedicine visits by the Member that deliberately focus on the progression of clinical conditions that are addressed in the Care Plan. They do not include brief, episodic visits for incidental conditions unrelated to the chronic conditions addressed in the Care Plan. In order to qualify as a maintenance visit, the PCP must review the Care Plan components and provide an updated status on the Member's conditions, such that improvement or deterioration can be assessed. Plans may be modified for the Member's care based upon this updated assessment. The LCC and PCP should discuss any changes in the Care Plan that are needed and these should be documented in the updated Care Plan. Updates to the plan should be reviewed with the Member.

The LCC will assist the PCP in updating the Care Plan at each maintenance visit when changes to the plan are necessary. The targeted date for follow-up maintenance visits should be set when the Care Plan becomes activated and at each subsequent maintenance visit. The frequency of the Care Plan Maintenance visit is dependent upon each Member's individual clinical needs. In general, given the needs of Care Plan Eligible Members, maintenance visits should be no less frequent than every three months.

- The Care Plan is considered updated when actual additions, revisions, or changes occur to the Member's plan of care based upon the assessment at the maintenance visit. The Progress Notes section should be updated with each such visit and upon any major changes in the Member's status between office visits (include date of new entries to view Member's progression). There should also be updates to the medications, diagnostics and labs as needed, as well as the plan to keep the Member stabilized in their home or community.

- To verify that a maintenance visit has occurred, the LCC will click the "Waiting for LCC Review" button that indicates the updated Care Plan is complete and accurate. The PCP will click the "Maintenance/Complete Assessment" button which indicates that the PCP agrees with the updated Care Plan and its contents. Only a PCP in the Panel responsible for the Member can click the "Maintenance/Complete Assessment" button following a maintenance visit.

- The PCP will use the Care Plan Maintenance S-Code (S0281) for submitting a claim for the maintenance plan update, when there is a significant assessment of the Member not just a minor update (for example, to review lab/imaging results updates). In order to use this Care Plan Maintenance code, the visit must be a face-to-face office or telemedicine visit between the Member and PCP. The service date included on the claim is the date that the Member and PCP met for the maintenance visit. In general, maintenance visits occur every three months. Instances of higher frequency are subject to review.

## *LCC Monthly Clinical Status Review Meetings with PCP*

The LCC will review all Care Plans with the responsible PCP at least monthly during a face to face meeting, to assess progress with the Care Plans. More frequent reviews are determined by the Member's health status and needs.

During monthly review meetings, the LCC will review the Core Target lists with the responsible PCP to assess whether there are Members in need of Care Plans and whether those Members already in a Care Plan still need Care Coordination services.

In addition, the LCC and PCP should review the SearchLight Reports, including the Top 10 – 50 lists, during this time to access patterns of care and to identify additional actions that may be needed to assist with any aspect of Care Coordination for Members in the practice – whether or not the Members of the Panel are in a Care Plan. The assigned Senior LCC, RCD and PCMH Practice Consultants can be called in to assist with this activity at the initiation of the LCC.

## *Member Compliance with the Care Plan*

To be considered in compliance with the Care Plan, the following must be true:

**Programmatic requirements**

- The Member must speak with the LCC every calendar week (Sunday to Saturday), including weeks during which there are holidays and vacations. Texts, e-mails, and voicemails do not meet this requirement. This must involve direct LCC to Member verbal communication, not email or text contact.

- If the Member has a one-week period of no contact, the LCC must send a warning letter to the Member the same week of no contact. If the LCC has not connected successfully with the Member and does not have a call scheduled with the Member on Saturday, the LCC sends out the warning letter the Friday of the same week of no contact. The LCC will remind the Member at the next contact of the necessity of talking every week and will collaborate with the Member to confirm a time for communication. The LCC should supplement the discussion with e-mail, text and/or mailed reminders regarding the agreed-upon time for communication.

**Clinical requirements**

LCC and Member must work actively together to establish a targeted "State-of-Being" for the Member that is necessary to graduate from the Care Plan. This serves as the vision of the Member's clinical and psycho-social level of self-sufficiency and well-being that will be attained for "graduation" from Care Coordination and includes the level of clinical stability, increased accountability, and sustainable changes in lifestyle and behaviors necessary for graduation.

- The LCC and the Member must jointly establish reasonable, actionable, achievable goals for the Member's most important conditions. The purpose of these goals is to stabilize the Member in order to avoid hospitalizations or ER use.

- The LCC and the Member must jointly establish timelines and tasks for each goal. They also work together to identify barriers to meeting the goals and will develop strategies to overcome these barriers. The goals, timelines and barriers must be kept up to date based on the Member's progress.

- The Member must actively participate in activities that stabilize their chronic conditions such as taking prescribed medications correctly, complying with referral recommendations, keeping health care team appointments as well as taking active steps toward their improved health, such as changes in diet and exercise, in order to be considered in compliance with their Care Plan.

## *Discontinuing a Care Plan*

Care Plans should be closed if the goals of the Member's plan have been met, the Member is stable in their home/community, and the PCP and LCC mutually agree that the plan is appropriate for closure. If the LCC believes that all goals have been met and that there are no Care Coordination activities needed for the Member, but the PCP refuses to close the Care Plan, the LCC should discuss this with their RCD. The RCD will have a discussion with the PCP and come to an appropriate resolution.

Care Plans should be closed after six months of Care Coordination, unless a justification is provided by the LCC in conjunction with the Member's PCP. If the PCP and LCC believe the Member needs to continue in a Care Plan for more than six months, the LCC submits the justification to the RCD by the administrative request function in iCentric. The RCD approves or declines the extension, based on the clinical justification provided by the LCC.

Care Plans may also be closed prior to the Member's goals having been met for a number of reasons, including, but not limited to:

- Member Consent is revoked by Member submitting "Revocation of Election to Participate" form or "Opt Out of Information Sharing" form.

- Member is deceased.

- Member is no longer a CareFirst Member or those who have become covered by Medicare.

- Member not responding – Member will not communicate with LCC, even after repeated attempts and outreach by PCP, including Members who will not submit an "Election to Participate" form at expiration of initial election.

- PCP change – Member becomes attributed to a PCP who is not participating in PCMH.

- Transitioned to CM – Member is being managed by case management due to acuity and specialty basis of care needs.

- Member is no longer PCMH benefit eligible due to being in an employer group whose benefit plan does not include PCMH.

- Member is non-compliant and refuses to adhere to the approved Care Plan setup by the PCP or does not make themselves available for the weekly discussions with the LCC.

If a Member receives a warning letter and non-engagement remains an issue after 30 days, the LCC must contact the PCP and RCD and let them know that every attempt was made to attain Member Engagement and recommend that the Care Plan be closed. If the LCC, PCP and RCD are in agreement that every attempt has been made to engage the Member, the RCD will send the termination notice after the 30-day notice period has passed and close the Care Plan in the Portal.

The LCC will document in the Care Plan Progress Notes the reason for closing the Care Plan, any remaining actions to address unmet goals/actions, and that the PCP and Member were engaged in this decision. The PCP's approval to close the Care Plan is required. The LCC cannot independently close the Care Plan without the PCP's approval. After gaining approval for closure, the LCC will select the closure reason and the RCD will then close the Care Plan in iCentric.

### *Reactivating a Care Plan*

In rare or exceptional circumstances, a Care Plan may be reactivated if the PCP believes this is clinically appropriate. Care Plans reactivated within 90 days after closure require RCD review and approval.

The LCC will consult with the PCP to update the Care Plan to be activated as evidenced by revisions and/or changes to the Member's plan based upon a new assessment. The narrative will be updated with the date of the new entry in the "Narrative" section. This allows the reader to see the progression of the Member's condition and the reason(s) for re-activation of the Care Plan. The other tabs in the Clinical Summary should be reviewed and updated as appropriate. The "Medications" and "Plan" sections must be revised.

The LCC and PCP must both affirm agreement with the Care Plan by clicking the "Waiting for LCC Review" and "Activate Care Plan" boxes, respectively, located in the "Care Plan Approvals" area of the Portal.

The PCP will use the Care Plan Maintenance S-Code (S0281) for submitting a claim once the Care Plan has been submitted and reactivated. In order to use this code to reactivate the Care Plan, there should be a face-to-face or telemedicine meeting between the Member and the PCP to update the information. The service date included on the claim is the date that the updated Care Plan was reviewed by the PCP. The date of service should be within 90 days of the Care Plan reactivation date.

Sharecare will use the Care Coordination T-Code (T2022) to submit a claim for Care Coordination. This claim can be submitted every month that the Member is in an active Care Plan and receiving Care Coordination.

### *Care Coordination Activities*

The activities associated with carrying out Care Plans are outlined below. The LCC is expected to:

- Facilitate activities, such as coordinating and scheduling referrals to specialists, laboratory testing centers, imaging centers, and ancillary services. Referrals will be initiated through a discussion with the PCP to determine the need for these services. If the PCP's office staff does not assist Members in making referrals for other TCCI Programs, the LCC can assist the Member in completing the task, but this should be noted in the record and discussed with the PCP so that it is not an ongoing practice.

- Ensure that appointments to referred consulting providers are scheduled in a time sensitive fashion. The severity of the diagnosis and stability of the Member's condition requiring the referral should guide the LCC in determining appropriate turnaround time for referral appointments. The LCC should assist the Member in preparing for appointments with consulting providers by identifying any laboratory and/or diagnostic results needed beforehand that would be required in the consultant's decision-making and lead to a more efficient appointment by having needed information at hand; assist the PCP and Member in identifying in-network CareFirst providers, laboratory, imaging and other diagnostic testing centers and act as a liaison between consulting providers and the PCP to assist in effectively sharing consultation findings and/or diagnostic results.

- Assist the PCP in reviewing the cost information available on referral specialists in the referral tab in iCentric.

- Track scheduled appointments to ensure they take place. The LCC will track scheduled appointments that have been documented in the "Assessment and Plan" section of the Care Plan to ensure that the Member goes to the appointment. A reminder call or email to the Member within 48 hours of the scheduled appointment can serve to remind the Member and avoid missed appointments. The results and outcomes of the appointment should be ascertained by the LCC and documented in the appropriate section of the Care Plan.

- Retrieve consultation findings or diagnostic testing results. The LCC should be in continual contact with specialists/consultants that the Member uses in managing their clinical conditions. Relevant notes, findings, recommendations, testing results and secondary referral information should be obtained from the consultant and communicated back to the PCP. These pieces of information should be documented in a concise fashion in the appropriate section of the Care Plan (see Section VI: *Concise and Actionable Care Plan Documentation and Care Coordination*) and discussed with the PCP to ascertain if modifications are necessary for the Member's plan of care. The same should be performed for various diagnostic testing results.

- Assist the Member in obtaining the various types of equipment needed in the course of managing the Member's care. For example, glucometers and blood pressure monitoring devices are sold over the counter in most pharmacies and the PCP should be consulted to see if they have a preference for any particular type. Some PCPs provide these devices to their Members directly. For equipment, such as Durable Medical Equipment (DME), a determination should be made as to coverage for the particular device through contact with the Customer Service Advocate associated with the Member's plan. Ordering equipment under the direction of the PCP should be done through the Service Request Hub.

- Assist in improving the Member's compliance by assessing barriers and offering/implementing solutions such as providing information, education, and support. The LCC should be in continual contact with the Member through brief calls, emails, or in-person visits at the PCP's or specialist's office. During these encounters, the LCC should make assessments based on a conversation with the Member and direct questioning about compliance with the recommended plan of care. If the Member is not sharing relevant information, more direct probing should be performed to understand if the Member is carrying out the self-management plans defined in the Care Plan, and if not, why not. If barriers are voiced or suspected, the LCC should use his or her own judgment to determine what interventions are needed to overcome the barriers and, where appropriate, discuss these with the PCP. Member education may be required, as well as assistance with items such as medications, finances, or home situations. These areas may need to be addressed in order for the Member to remain or achieve stabilization in their home or community.

- Consistently communicate the status of the Care Plan and Care Coordination activities with the PCP.

### *Day to Day Care Coordination Methods*

Care Coordination may be carried out via in-person meetings, phone conversations, email exchanges, or online video conferencing. The LCC must make assessments as to the most desirable and efficient means to communicate with the other party. Protected Health Information (PHI) must be safeguarded during these exchanges.

The LCC should develop a schedule to communicate with the Member based on the activities needed to carry out Care Coordination – at a minimum of once every week. The frequency of contacts with the Member will be determined by the Member's needs. Phone conversations (not emails) are essential so that a relationship can develop and information can be discovered during the dialog that might not otherwise be shared. In the event that the Member is aphasic, cognitively impaired or unconscious, the LCC speaks with the Member's caregiver for the weekly phone conversations. For a pediatric Member, the LCC speaks with the Member's parent. Excluding caregivers and parents as defined, the LCC refrains from discussing the Member's health or Care Plan with the Member's spouse, family, or friends.

A successful contact is defined as a two-way interactive exchange of information between the LCC and Member, either by an in-person visit or voice-to-voice communication by phone. Leaving a phone message or sending an email does not qualify as a successful contact. For Members with complete hearing impairment, the LCC may use e-mail and text to conduct weekly information exchanges with the Member. For most calls, the conversation can be expected to last five to 15 minutes, but will vary based upon the Member's needs.

In order to properly establish the expectation of effective communication, a discussion should take place between the LCC and Member to determine an acceptable day and time for the LCC to routinely contact the Member. Experience has shown that:

- Having the same day of the week and time to communicate is most effective so that the Member can make plans to be available, just as they would any other healthcare appointment. If the Member is not available during the pre-determined timeframe, calls can be tried on alternative days and times.

- If the Member does not answer the phone or email, calls should be made on successive days instead of waiting longer between attempts. The efforts to contact the Member should demonstrate urgency to coordinate their care and assist with the Member's healthcare needs.

- If there are repeated attempts to contact the Member without success, the LCC should reach out to the PCPs office to see if they can contact the Member to stress to the Member the importance of engaging with the LCC, per Section VI: *Concise and Actionable Care Plan Documentation and Care Coordination*. Calls made from the PCPs office may also be successful in contacting the Member.

Online video conferencing using an online system such as Skype can be a very effective form of communication. This communication method allows sharing needed information without having to physically be present with the other person. The LCC should encourage the PCP to download the Skype web application.

However, it is essential to have an in-person component for the process. The LCC meets the Member in person at least once in the first three months of the Program. The in-person meeting promotes more detailed and personal exchange of information. LCCs should arrange to meet at the PCPs office for the initial Care Plan development, as well as for maintenance visits to gather the necessary information to update and complete the Care Plan.

Some PCPs welcome the LCC into the examination room during the visit, while others prohibit this level of interaction. A discussion should take place with the PCP about their preferences in this regard. If they do not allow access to the examination room, time should be scheduled after the Member's visit for a discussion with the PCP and Member to capture relevant information to document and carry out the Care Plan. If they do allow access to the examination room, the LCC should make sure the Member is agreeable as well. Some Members also request that the LCC meet them at their specialist's offices to more clearly understand what the specialist is recommending, to share information about the Care Coordination process with the specialist, and to integrate the specialists' recommendations into the Care Plan.

In the case of phone initiated Care Plans, the LCC should arrange a time to review the plans with the PCP at the next LCC visit to the practice or during monthly clinical status review meetings.

The LCC should set some evening time each week to contact Members that cannot be reached during the day. This can be best managed by staggering the hours of these calls.

When Members have many complicated clinical issues, the LCC should focus on one or two things to address initially, then add others gradually. Addressing too many items at one time may overwhelm the Member and can lead to an excessive number of issues for the LCC to work on at one time.

### *Patient Activation Measure (PAM)*

To assess how to best support the Member and gauge the Member's progress toward the envisioned State of Being and effective self-management, the LCC uses the PAM to determine a score and level of activation.

The PAM is administered as part of the initial interview with the Member. The LCC reads each statement to the Member and the Member provides a response indicating the extent to which he or she agrees or disagrees with the statement. Based on the Member responses, a score and level are calculated in iCentric. The initial PAM level and score are documented in the Narrative. The PAM is administered every 10 to 12 weeks. A final PAM is administered during the last week of the Care Plan if more than four weeks have elapsed since the previous PAM administration. The PAM responses and results are documented in the Progress Notes section the same day the PAM was administered.

In general, a Member begins their Care Plan with a low level of activation (PAM level 1 or 2), indicating the Member does not have confidence or skill to self-manage his or her chronic conditions. As the LCC helps the Member start to self-manage, the PAM score generally increases, indicating a higher level of confidence that the Member effectively can manage his or her chronic conditions.

### *Graduating from a Care Plan*

Graduation from a Care Plan signifies that the Member has obtained the targeted State of Being. Graduation occurs when the Member has met the goals of the Care Plan and no longer needs the support of the LCC. The PCP, Member, and LCC discuss the Member's progress to determine whether the Member is ready for Care Plan closure.

The LCC prepares the Member for graduation by performing a medication reconciliation and PAM (if not completed within the previous two weeks). The LCC updates the Clinical Guidelines to reflect the current status of the goals and verifies that all Service Requests excluding Expert Consultation, Behavioral Health and Substance Use Disorder Services, and Wellness and Disease Management have been completed/closed. In the Assessment and Plan section, all completed interventions must be marked as complete, while any remaining interventions have been updated prior to Plan inactivation. The LCC then inactivates the plan for all conditions. Finally, the LCC informs the Member that he or she will receive a call to complete a final Member Survey and will receive PAM texts beginning three months after graduation.

The final phone conversation with the Member includes a summary of the goals the Member has achieved through the course of the Care Plan, barriers that the Member was able to overcome, and a review of the steps to maintaining their graduate status. The LCC documents the conversation in the Progress Notes section, selecting the Closure Note drop-down option to indicate that the note was the final contact with the Member up through graduation.

The final note highlights the progress the Member made throughout the course of the Care Plan as well as what the Member must do to maintain their health status. The final phone conversation typically occurs during the last week of the month. The last week means the Monday and Tuesday of the month. In some months, this may be a partial week. The LCC considers a partial week consisting of a Monday and Tuesday to be the final week of the month.

After entering the Closure Note, the LCC selects the Closure Reason from the Member Row Expansion in iCentric. The Care Plan is then placed in the RCD closure queue for RCD review and closure.

## Care Plan Quality Reviews

## Purpose

**To establish the process and standards through which Care Plans are evaluated for all LCCs.**

The purpose of the Care Plan review process is to assure that Care Plans and the Care Coordination that flows from them are maintained at a high-quality level as well as to promote consistency in Care Plan standards across the PCMH Program. Beginning in **Performance Year #7 (2017)** a new component will be added to the review -- the post-graduation Member status review. This will be in addition to the Care Plan reviews during the active phase of the Care Plan.

### *Initial Care Plan Review*

To accomplish this purpose, small rotating teams of RCDs are established to review every Care Plan after it has been developed by an LCC. This gives the opportunity for continuous learning from peers with different experiences, as well as avoidance of possible "group think" in judging plans. It also assures that new perspectives and learnings are shared in an iterative manner, steadily improving the judgment brought to bear in evaluating Care Plans. This is intended to make RCDs more effective mentors and leaders of the extensive field force of LCCs. It also assures that the same review process and standards and are brought to bear on all Care Plans — a key to uniform performance, which is so important to purchasers of the PCMH Program.

At its core, this process of iterative scoring and feedback from a team of RCD reviewers is intended to help LCCs become highly proficient in the Care Plan development and Care Coordination processes.

### *RCD Review Teams*

- The 20 RCDs in the PCMH Program are divided into five Care Plan review teams of four RCDs each.
- Each RCD team has a captain who serves as the facilitator of the team. The captains rotate every six months.
- Teams rotate two Members every month. The goal is to reduce "group think" in team reviews.

### *Review Standards and Process*

Teams are required to meet every week and completely review a random sample of newly activated Care Plans.

- All review teams are required to use the same standards that are contained in this Section of the PCMH SOPs. Each week, newly activated Care Plans are divided among the teams. This includes a percentage of new Care Plans for high performers and all Care Plans for all other LCCs. Workload is balanced across the teams. Care is taken to assure that no RCD may review their own LCCs' Care Plans.
- Each Care Plan review is completed by no less than three RCDs on a review team. Each RCD will be responsible for communicating with the team captain one week in advance of any scheduled absence in order to assure sufficient team coverage of review sessions.
- Each Care Plan is reviewed (not scored) by each RCD team member prior to the team meeting, so the team is prepared to discuss each Care Plan. The team then reviews the Care Plan together and collectively determines a score for the Care Plan. Each element is either met or not met, meaning that the LCC receives all or none of the points associated with the standard in question. Partial scoring or granting a pro-rated number of points is not used.
- Prior to scoring, the team ensures that the Member selected for a Care Plan developed by an LCC was from the Core Target, Emerging Core Target or Potential Core Target lists. The team also ensures that the Care Plan meets the appropriate Member selection criteria, including instability. This is a threshold matter. If this threshold is not met, the LCC will be instructed to close the Care Plan.

- There are three categories to Care Plan scoring: Care Plan quality (55 point), Care Coordination effectiveness (35 points) and Care Plan completeness (10 points).

    - Care Plan quality refers to the thorough and clear documentation of the Member's future target "State of Being" enabling graduation from their Care Plan, as well as clear, concise and compelling narrative, actionable steps, and identification of barriers to care.

    - Care Coordination effectiveness is demonstrated through documentation of timely progress notes, completed medication reconciliation, and assessment of Member's engagement.

    - Care Plan completeness refers to the completion of all required portions of the Care Plan, including an assessment of the Member's need for TCCI referrals.

- The LCC must achieve at least 80 out of 100 in order to pass the review successfully.

- The maximum raw score is 100 points. The raw score is converted to a percentage and then converted to a five-point scale. The final score will be used as a Care Plan score.

- Team scores for each Care Plan must be entered into the "Quality Measures" section in the PCMH Provider Portal by a designated team member. All team scores must be by consensus; no averaging of individual team member scores may occur.

### *Review Based on Sampling*

The Care Plan review process outlined above may be conducted on a sampling basis for experienced, high performing LCCs. All activated Care Plans will be reviewed and graded according to the processes and standards described above. However, if an experienced LCC that has more than 25 written Care Plans and has attained an average Quality Score equal to or greater than 4.0, a sampling of his/her Care Plans may be undertaken. For all such LCCs, one in three Plans will be selected randomly for review.

Once an LCC reaches 35 Care Plans on which he/she has attained an overall average score of 4.0, the sampling may rise to one in five Care Plans randomly chosen for review. If an LCC has not yet met either of these thresholds, all Care Plans written by the LCC will be reviewed. If the scores of an LCC for whom sampling has been initiated fall below the thresholds for one in three or one in five sampling (for 25 or 50 Care Plans consecutively) the Care Plans for the LCC will revert to a higher sampling or be removed from sampling altogether until these thresholds are attained and sustained.

### *Feedback to and Correction by LCC*

An RCD designee from each review team will give direct feedback to the LCC for each Care Plan that was developed by that LCC and will share this review with the RCD to whom the LCC is assigned. Feedback will be objective and direct – with as positive a tone as possible.

The LCC is required to make revisions to the Care Plan within one week of the review, based on the feedback from the RCD review team. By making the necessary revisions, the LCC understands the importance of Care Plan quality and learns to incorporate the feedback of the RCD review team into Care Plans written in the future.

The week after the review, the Clinical Quality Specialists review Care Plans that received a score less than 80. The focus of the Clinical Quality Specialists review is to ensure the LCC has made the necessary revisions. Once the necessary revisions have been made and the Clinical Quality Specialists have confirmed this, the LCC's score may be modified to reflect the revisions. The expectation is that the final version of the Care Plan achieves a standard consistent with a score of 100. If the LCC neglects to make the necessary revisions as required by the RCD review team, the LCC's RCDs addresses this as a performance issue. The expectation is that the LCC delivers the highest possible quality of work the first time the Care Plan is submitted for review after understanding what is expected.

If the LCC has submitted a partial plan for review and the plan is missing significant portions of information (One or more of the following: blank or only one word in the narrative, blank plan section, blank medication section, blank clinical guidelines, blank progress notes) the LCC must revise the plan but will receive a score of zero. The LCC's RCD will address this as a performance issue.

A summary of scores will be provided by each review team every week to the Senior Directors of the PCMH Program by the end of the week. The score determined by the RCD review team is used to calculating the LCC's average quality score for performance purposes. The purpose behind using the initial score assigned by the RCD review team is to ensure that the LCC exerts every effort to submit an excellent document initially. Even though the score remains unchanged, the LCC is expected to produce a top-quality Care Plan for every Member. Hence, the revisions are required, even without a change in score.

## *Consequences of Review*

LCCs who persistently score lower than standard will receive increased mentoring by the RCD to whom they are assigned until they consistently achieve program standards or until a conclusion is reached that they cannot achieve these standard. This, then, becomes a performance issue that will be addressed by the supervising RCD.

Information from the review process will be used to harvest multiple insights to: identify common items missing, common strengths, common deficiencies, and training opportunities. Documentation of these discussions will be maintained by each review team as well as the Operations team to promote sharing across all RCDs and LCCs and to enhance training of new LCCs or refresher training for more experienced LCCs.

## *Care Plan Quality Scoring Guidelines*

The table below contains the Care Plan quality measures.

| Category | Elements | Points |
|---|---|---|
| **Care Plan Quality** | The narrative is clear, concise, and compelling. The target State-of-Being is well described and evidences collaborative articulation between the PCP, LCC, and the Member. | 30 |
| | The care plan is actionable and shows a clear path for the Member to achieve the targeted State-of-Being. | 20 |
| | The barriers are assessed and the Plan addresses the barriers. | 5 |
| **Care Coordination Effectiveness** | Timely, weekly progress notes show evidence of progress toward the target State-of-Being. | 25 |
| | Medication reconciliation complete. | 5 |
| | Patient Activation Measure complete. | 5 |
| **Care Plan Completeness** | All elements of the Care Plan are complete. | 5 |
| | Assessment for appropriate TCCI referrals complete. Service Requests entered for appropriate services. | 5 |
| **Total Points Possible** | | **100** |
| ***Note: Weekly Care Coordination calls with the Member are mandatory and LCCs must achieve a score of 80 or higher to successfully pass the review process.*** | | |

### Tracking and Assessing Post Graduation Member Performance

Throughout the course of the Care Plan, the LCC educates the Member on the principles of clinical stabilization and supports the Member as these principles are used in daily life. Once the Member has demonstrated successful and sustained clinical stability, the Member is ready for graduation from the Care Plan. To assess whether the Member maintains the stability achieved during the course of the Care Plan, the PAM is used to track the Member's progress and risk for breakdown over time.

At three, six, nine, and twelve months after graduation, the Member receives the PAM assessment via text message. After the final PAM statement response is provided, the Member can request an LCC to call him or her regarding their health status. If the LCC determines that the Member has regressed toward instability, the LCC contacts the PCP to discuss Care Plan reactivation or other appropriate steps/actions.

The PAM scores and levels are reviewed monthly to assess for Members who may be at risk for breakdown as evidenced by lower PAM scores from prior assessments. The decrease in PAM scores signals a possible breakdown in the Member's health status and warrants further investigation. Members with scores that decrease10 points or more are reviewed by the PCMH Leadership Team. If the Member does not respond to text from the LCC, the LCC must call to discuss with the Member the reasons of decline and steps necessary to restore the Member to their graduation level.

## Using the CareFirst Service Request Hub

## Purpose

**To outline the process that LCCs are to use when connecting Members to the TCCI Program through the Service Request Hub.**

The LCC is required to understand how to use the Service Request Hub in fulfilling the needs of Members in Care Plans as well as meeting the needs of Members who may not be in a Care Plan but who could benefit from one or more services provided by the TCCI Program. The LCC should be knowledgeable about all available TCCI Elements, as described in the *PCMH and TCCI Program Description.*

All TCCI Services are available to Members. These include Complex Case Management, Comprehensive Medication Review; Pharmacy Coordination Program; Home-Based Services (only available to Members with an active Care Plan); Community-Based Programs; Expert Consult Program and Enhanced Monitoring Program. When an LCC identifies a Member, who may benefit from referral to one of these programs, the LCC must follow the process below and then check to ensure services are rendered. Benefit eligibility for all Programs is required.

To enable the PCP and the Panel to access TCCI Program Elements, the LCC should first review the data in Member Health Record for the Member and:

1. Consult with the PCP for approval. The PCP must be aware and supportive of the services that could be offered to their Members.

2. Make an online request to the Hub. All pertinent information that is applicable to the Member's condition and illness as well as to the effective application of the TCCI services sought must be provided to the Hub upon making the Service Request. The LCC must provide necessary clinical data, demographic data and reason for the request(s). The LCC will conduct a three-way call with the Member and their dedicated CSA to determine the Member's applicable insurance coverage. No Service Request will be processed for without confirming insurance coverage.

3. Check on actions taken and results achieved as a result of the referral and enter these into the appropriate sections of the Care Plan on a continuous, updated basis.

## Evaluating Primary Care Provider (PCP) Engagement With The PCMH Program And Assessing Practice Access And Structural Capabilities

### Purpose

**To clarify what is expected of all LCCs and Practice Consultants in fairly judging PCP Engagement each month and quarterly as well as to describe the process by which each RCD is to review the scores entered each month and makes an assessment of the fairness, accuracy and appropriateness of these scores.**

**This section also describes how Engagement Scores are calculated as well as the survey measures that contribute to the Clinical Scorecard. It also explains how an overall Engagement Assessment Composite Score is calculated that is used in the Engagement portion of a Panel's overall Quality Score.**

### *Engagement Scores for the PCMH Quality Scorecard*

The CareFirst PCMH Program rests on the belief that PCPs must "engage" in efforts to improve outcomes on cost and quality in an active way – especially for those of their Members with multiple chronic diseases. To do this requires a behavioral change on their part. This is seen as the most essential ingredient in changing long established patterns of practice in a fragmented health care system that will not "heal" itself were it not for the proactive drive of PCPs toward better overall results for their Panel's population of Members.

This "Engagement" on the part of PCPs manifests itself in different ways. Accordingly, to assess the degree of PCP Engagement, different measures of PCP Engagement are used that count toward a Composite Panel Engagement Score in the Quality Scorecard. As described in **Part III, Design Element #8**, Engagement is a critical category of quality assessment in the PCMH Program carrying a 50-point weight in the overall Quality Profile Score for each Panel.

The combined experience, observation and assessments of PCP behavior by LCCs, RCDs, and Practice Consultants (PCs) offers a holistic view of "Engagement" in its different facets that is expressed as a composite score for each PCP that is then summed for each Panel as a whole. The PCP Engagement category includes the following:

**Components of Engagement**

- Engagement with and knowledge of PCMH and TCCI Programs;
- PCP Engagement with Care Plans; and
- Practice Transformation.

The LCC and PC are responsible for documenting individual components of Engagement in the first and third categories above, while Engagement with Care Plans is documented by only the LCC alone. The LCC enters Engagement Scores for each PCP in the Measures module of iCentric each month, while the Practice Consultant enters scores every quarter. Both the LCC and the PC support the PCP in an effort to obtain favorable scores.

The RCD reviews all Engagement Score documented in iCentric by each LCC and verifies the integrity of the Quality Measures through discussion with the LCC and first-hand observation and experience. The RCD may modify the Quality Measures if the scores are inconsistent with the RCD's own assessment of the PCP. Therefore, final scores recorded reflect the review and conclusions of the RCD, not solely the LCC.

Below is the process to be followed for determining scores in each component above:

#### A. PCP Engagement with the PCMH Program

There are six required sub-measures for this Engagement component based on judgments reached by LCCs, PCs and RCDs, regarding the degree to which a PCP is engaged with the PCMH Program. These five sub-measures are expressed as statements that the LCC or PC uses in scoring each and every PCP on their degree of Engagement with the PCMH Program. The LCC or PC scores the PCP for each statement as a 5 (Strongly Agree), 4 (Agree), 3 (Agree Somewhat), 2

(Disagree), 1 (Strongly Disagree), or U (Unassessed). A score of U will not be counted in the Panel Quality Profile Score on this measure. Unassessed scores will be limited to instances when the PCP is not known to the LCC or PC, such as when a PCP is new to the practice.

The six specific sub-measures used for Engagement with the PCMH Program are:

1. **Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in his/her practice that is conducive to conducting the PCMH Program and instructs his/her staff to this end.**

   In scoring, the LCC should consider whether the:

   - PCP frequently meets with the RCD and LCC and responds to their requests, comments, and suggestions.
   - PCP encourages staff to work closely with the LCC and supports the facilitation of meetings with PCMH representatives.
   - PCP is available and attends regularly scheduled office meetings to discuss PCMH.
   - PCP takes an active role in finding solutions to overcome barriers and engage other PCPs to implement approaches that better enable the Program to be implemented through a unified team effort.

2. **PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words.**

   In scoring, the PC should consider whether the:

   - PCP understands global budget targets and understands that managing his/her attributed population creates the opportunity for gain share against these budget targets.
   - PCP understands the drivers of cost; how to bring global costs down and bring quality up.
   - PCP realizes that the OIA is a reflection of their work in bringing costs down and improving the quality of care.
   - PCP understands the HealthCheck Assessment categories and how to interpret their performance on these.

3. **PCP attends and actively/constructively participates in PCMH Panel meetings.**

   In scoring, the PC should consider whether the:

   - PCP encourages staff to work closely with the PC and supports the facilitation of setting up Panel meetings each quarter.
   - PCP attends Panel meeting and engages in thoughtful dialogue.
   - PCP encourages other PCPs within the Panel to attend Panel meetings and to participate in the dialogue.
   - PCP agrees to take specific action items to improve Panel performance based on discussion at Panel meeting.

4. **PCP reviews Panel and PCP level data, understands relative performance of PCPs within the Panel.**

   In scoring, the PC should consider the:

   - PCP seeks to compare the relative performance of other PCPs in the Panel.
   - PCP points out the differences in how Panel Members are performing, relative to each other, and seeks to influence all Panel Members to improve.

5. **PCP takes due care to review a Member's need for CMRs and Drug Therapy Recommendations and responds as needed.**

   In scoring, the LCC should consider whether the:

   - PCP reviews Member medications at activation of the Care Plan and on an ongoing basis to avoid medication interactions and the possibility of adverse consequences of polypharmacy.
   - PCP responds to the pharmacist in a timely manner to discuss a Comprehensive Medication Review.
   - PCP fully assesses the medications the Member is taking and consults as necessary with specialists who have prescribed medications to assure appropriateness.

6. **PCP takes due care to review a Member's need for all other TCCI Program elements, including Home-Based Services, Enhanced Monitoring and Expert Consult.**

   In scoring, the LCC should consider whether the:

   - PCP is aware of the TCCI Program Elements and actively works with LCCs to refer Member to the appropriate TCCI Program, both those in active Care Plans and those who do not require Care Coordination.

## B. PCP Engagement with Care Plans

The degree of PCP Engagement with the Care Plan process is based on judgments reached by LCCs after review by the RCD, regarding the extent to which a PCP actively carries out the intent of the PCMH Program to be attentive and responsive to the Care Plan development and maintenance process. In answering each of the five sub-measures in this Component of Engagement, the LCC will score the PCP as a 5 (Strongly Agree), 4 (Agree), 3 (Agree Somewhat), 2 (Disagree), or, 1 (Strongly Disagree).

A PCP who does not have an active Care Plan and, therefore, cannot be graded on Care Plan Engagement, will receive a score of zero, which will count towards the Panel score.

The LCC submits the scores in the iCentric Portal each quarter for each and every PCP to which they are assigned and the RCD reviews and verifies all scores. The RCDs may change the score if they disagree with them.

The six specific sub-measures used for Engagement with the Care Plan Process are:

1. **PCP timely and constructively completes a Clinical Status Review of all Members on the Core Target (CT1) list on a monthly basis to identify appropriate Care Plan Eligible Members.**

   In scoring, the LCC should consider whether the:

- PCP designates time with the LCC on a regular basis to review Core Target lists to identify Members in need of a Care Plan based on appropriate Member selection criteria.

- PCP is helpful in selecting high value Members for Care Plans (i.e., those that are sickest, most vulnerable and most volatile and likely to break down).

**2. PCP timely identifies Members who may have emerging needs (CT2) and reviews those Members on the Potential Core Target (CT3) list who may be appropriate for Care Coordination.**

In scoring, the LCC should consider whether the:

- PCP designates time with the LCC on a regular basis to review SearchLight and other data to identify Members in need of a Care Plan based on appropriate Member selection criteria.

- PCP is helpful in selecting high value Members for Care Plans (i.e., those that are sickest, most vulnerable and most volatile and likely to break down).

**3. PCP clearly and effectively explains to Care Plan Eligible Members the benefits of Care Plans, effectively obtains the Member's "Election to Participate" and sets clear goals and a targeted "State of Being" for Care Plan Members.**

In scoring, the LCC should consider whether the:

- PCP demonstrates a clear understanding of the PCMH Program in order to communicate the benefits to eligible Members.

- PCP answers all Member questions and effectively directs their care.

- PCP describes potential benefits of Care Plan by using clear examples that are unique to each Member based on their medical problems (for example, adequate pain control, weight loss, improved diet, personalized coordination of care, decrease in the frequency of ER visits).

- PCP or office staff is able to obtain "Election to Participate" for a Care Plan from a Member when the LCC is not present.

**4. PCP reaches an appropriate and timely Assessment Outcome for each Member on the Core Target list on a monthly basis.**

In scoring, the LCC should consider whether the:

- PCP designates time with the LCC on a regular basis to review Core Target lists and other data to initiate Care Plans, refer Members to TCCI Programs or document why the Member doesn't require any additional services.

**5. PCP is collaborative with the LCC, ensuring that the LCC has access to needed clinical information, completing the Care Plans on a timely basis, providing consultation about Member status changes as needed, and works actively with Members to better ensure Care Plan compliance.**

In scoring, the LCC should consider whether the:

- PCP facilitates timely open access to the EMR or other clinical record keeping system of the practice.

- PCP timely schedules and completes initial visits with Care Plan Eligible Members as determined by the LCC or RCD.

- PCP actively consults with LCC on progress of Members in Care Plans to improve their likelihood of attainment of the targeted "State of Being" necessary for Member graduation from their Care Plan.

- PCP differentially outreaches to noncompliant Care Plan Members to encourage continued participation and progress.

## C. Practice Transformation

The degree of PCP Engagement with Practice Transformation is based on judgments reached by LCCs and PCs after review by the RCD. In answering each of the three sub-measures in this Component of Engagement, both the LCC and PC will score the PCP as a 5 (Strongly Agree), 4 (Agree), 3 (Agree Somewhat), 2 (Disagree), 1 (Strongly Disagree), or U (Unassessed). A score of U will not be counted in the Panel Quality Profile Score on this measure. Unassessed scores will be limited to instances when the PCP is not known to the PC, such as when a PCP is new to the practice.

Each does this independently and then the PC submits the scores in the iCentric Portal each month for each and every PCP to which they are assigned. The PC's manager then reviews and verifies all scores. The manager may change the score if they disagree with them after consultation with the PC who submitted them.

The key categories that are used to measure Practice Transformation are as follows:

1. **PCP identifies and refers to cost-efficient specialists in the top specialty categories.**

   In scoring, the PC should consider whether the:

   - PCP has established a target list of specialists and instructed office staff to support use of targeted specialists.

   - PCP makes appropriate exceptions to use of targeted specialists when needed.

   - PCP uses data in SearchLight and HealthCheck to support their use of high value targeted specialists to the maximum extent feasible.

2. **PCP has an effective plan for after-hours care, including offering Members the opportunity to speak with a clinician after hours, to avoid unnecessary emergency room visits or breakdowns.**

   In scoring, the PC should consider whether the:

   - The PCP provides access to Members to make an appointment, speak with the PCP, make same day appointments when necessary, provide reasonable wait times and offer back up or cross coverage with other providers when unavailable.

   - The PCP makes a clinician available after hours for triage or use CareFirst provided resources for this purpose.

3. **PCP (or designated practice staff for all Panel providers) is meaningfully engaged with the CareFirst Practice Consultant between quarterly Panel meetings to implement practice transformation recommendations as indicated by the HealthCheck data.**

   In scoring, the PC should consider whether the:

- PCP meets regularly with the PC and RCD to develop and implement plans for Practice Transformation with identified outcome measures.

4. **PCP offers and uses video visits to improve convenience and access for CareFirst Members after hours or when follow-up visits are not required to be in-person.**

   In scoring, the PC should consider whether the:

   - The PCP offers interactive, two-way video visits to Members for the purposes of diagnosis, consultation or maintenance treatment. The PCP may use their own videoconferencing technology or CareFirst technology available through iCentric.

### Member Satisfaction Survey

The Member Survey is intended to gauge the degree to which the Member is aware of, engaged in and receiving benefit from their Care Plan. An independent third-party vendor conducts a quarterly telephonic Member Survey of each Member with an active Care Plan. The LCC is responsible for obtaining the preferred telephone number for all Members in the portal and encouraging each Member they have responsibility for to participate in the Survey. Thus, the LCC is held accountable for the completion rate of the Survey of Members assigned to them with the active support of the Member's PCP.

Six statements are read to the Member as follows:

1. You understand your Care Coordination plan, including the actions you are supposed to take.

2. Your Care Coordination nurse and Care Coordination Team are helpful in coordinating your care.

3. Your doctor or NP spends enough time with you.

4. After starting your Care Coordination plan, you have had access to information that you need to understand and manage your health better.

5. Finally, overall, your health is more stable and better managed as a result of the Care Coordination plan.

After each statement, the interviewer asks the Member, "Do you:"

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

6. When you first started the Care Coordination Program, you participated in a call with your Care Coordination nurse and a dedicated CareFirst CSR. (This question is only asked of Members in a newly activated Care Plan.

   Please tell me how much you agree or disagree with the following statement:

   - Strongly disagree 1
   - Disagree 2
   - Neither agree nor disagree 3
   - Agree 4
   - Strongly agree 5
   - Do not know 0
   - Did not participate in a call like this -1

The Member may also volunteer that he or she does not know the answer to a statement and the interviewer will record this response.

After the Member rates his or her degree of agreement with each of the above statements, he or she is asked one open-ended question:

What suggestions or comments do you have that could improve your Care Coordination experience?

Each of the first five questions is scored on a scale of 1 to 5, with a score of 1 for a response of "Strongly Disagree" and a score of 5 for "Strongly Agree." All scores for all Members are averaged to create a Panel Score. Each Member who has an active Care Plan and does not answer the survey is counted in the average as a zero score. The Panel average is converted to a rate and applied to the 2.5 points available each quarter, with sample scores shown below. Each quarter's score is summed to a total of 10 possible points in the Performance Year.

| Panel Average | QSC Points |
|---|---|
| 5.0 | 2.5 |
| 4.0 | 2.0 |
| 3.0 | 1.5 |
| 2.0 | 1.0 |

## Appendix F: Method For Calculating Overall Medical Trend (OMT)

The methodology by which Panel credits are updated annually to reflect expected changes in the upcoming year's healthcare costs is explained in this Appendix. Overall Medical Trend (OMT) is expressed as year over year movement in aggregate PMPM total health care costs. The components impacting these costs are aggregate changes in Members' utilization of care and the cost per unit of care. Utilization of care varies for a variety of reasons ranging from the development of new medical technologies to the state of the economy and the health status of Members. Factors influencing the cost for each unit include changes in provider fees, changes in the mix of services, treatment location and a wide range of other factors.

Various methodologies are used to measure the large scale, macro changes in healthcare costs, including Medical Consumer Price Index (CPI), increases in Medicare spending and the percent of GDP spent on medical care. Macroeconomic metrics such as these are generally informative, but do not address the factors that more directly impact the expected annual changes to the PCMH Program's health care costs. More specific approaches are needed to project changes in such costs for specific populations. The measurement sought is best understood as the change in cost PMPM from one-time period to another, within a region of the country – in this case, the CareFirst Service Area.

Therefore, the combined impact of all unit price changes and changes in use of services in the CareFirst Service Area is called OMT and is typically expressed as a percentage change year-over-year in total/global PMPM healthcare costs of CareFirst Members. Other types of changes, such as changes in the Illness Burden Scores of attributed Members, the percentage of Members with certain types of benefits, and changes in Panel's membership are factors that are separately dealt with in the Program apart from OMT.

OMT for all PCMH Panels is calculated as a blend of historical "actual" trends (i.e., those that are known and observed) as well as a "projected" going forward assumed trend as explained more fully below.

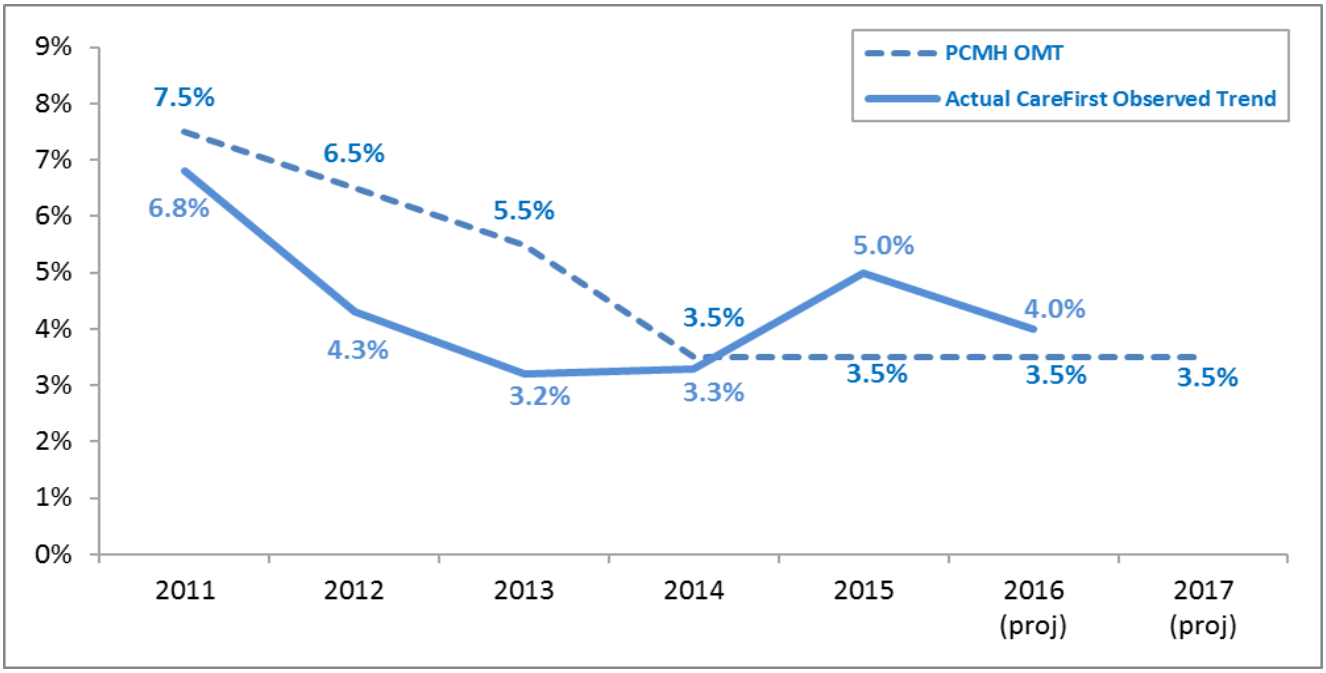
It should be noted that, while projecting trend is based upon actuarial principles, it is not an exact science as anyone with experience in the field knows. It is very difficult to predict with accuracy what will happen in a future period with regard to the movement in healthcare costs. This is why the approach used by CareFirst to develop the OMT involves both historical and projected experience.

Future trend estimates are based upon the most recent observations of current changes in healthcare costs and on future trend estimates used in CareFirst premium rate filings that must be approved by state insurance regulators - a process that has recently been intensified under the Affordable Care Act. CareFirst must not only justify its projected trends to regulators, but needs to maintain competitiveness in a price sensitive market place. The goal is to assure that rates cannot be too high to be competitive nor too low so that they fail to cover costs. This is a check against over-estimation of trend. Trend projections are benchmarked to regional and national competitors to provide additional confidence in CareFirst estimates.

Thought of another way, the projections used to develop CareFirst trend forecasts are foundational to the Company's long term financial health and ability to fulfill its mission to the community. If over or under estimation of future changes in healthcare trend were to miss the mark on an ongoing basis, it could have a devastating impact to competitiveness and/or financial solvency. The care and diligence used in this process by the Company is validated through external actuarial expert review and provides assurance that a best practice approach is being implemented. In effect, the need for premium price competitiveness in the marketplace acts as a check against trend being systemically wrong on the upside while the demand for financial solvency prevents it from being systemically low on the downside. And, regulators stand guard over the entire process.

With this said, it must be observed that the majority of CareFirst products cover similar benefits. However, in recent years, employers have shifted more responsibility to their employees through deductibles, coinsurance and other cost shifting approaches. These employees, as well as individuals who enroll directly with CareFirst, have caused CareFirst membership to have a greater direct financial responsibility to providers than at any time in CareFirst history. This phenomenon is pervasive throughout the health insurance industry. The long-term impact of employer cost shifting to employees is watched very closely to determine if it impacts Member behavior.

CareFirst OMT, which tracks with the overall industry, is highlighted in the graph below.




The annual trend used for the PCMH Program is calculated based on the trends observed for the 1.8 million CareFirst Members who live in the CareFirst service area, excluding those who are Medicare primary.

The projected trend for each upcoming Performance Year is an estimate that reflects the best considered judgment of CareFirst's HealthCare Analytics Team and Executive Leadership as to what future PMPM global cost movements will be.

The OMT that was used to project 2011 costs in **Performance Year #1 (from 2010)** Base Year costs was 7.5 percent. In retrospect, observed experience came in lower at 6.8 percent.

For **Performance Year #2 (2012)**, OMT was projected at 6.5 percent for movement from 2011 to 2012, while the actual result was significantly lower at 4.2 percent.

For **Performance Year # 3 (2013)** OMT was projected at 5.5 percent for movement from 2012 to 2013 compared to an observed result of 3.2 percent.

For **Performance Year #4 (2014)**, OMT was projected at 3.5 percent compared to the actual observed trends were lower on average than the projected trends.

For **Performance Year #5 (2015),** OMT was separately projected for medical and pharmacy costs. This was done to recognize the much higher pharmacy trend that was seen in the industry. In that year, the medical trend was projected at 3.5 percent and the pharmacy trend was projected at 10 percent. Further, this excluded the cost of two emerging Hepatitis C drugs (Harvoni and Sovaldi) due to their severe impacts.

For **Performance Year #6 (2016)**, OMT was set at 3.5 percent for medical costs and 7.5 percent for pharmacy costs.

For **Performance Year #7 (2017)**, OMT is set at 3.5 percent for medical costs and 7.5 percent for pharmacy costs.

In no case are trends set to reflect Panel specific trends since these are at too micro a level to be representative of the broader regional trend CareFirst experiences.

## Appendix G: Method For Determining Member Attribution To Primary Care Providers (PCPs) And Panels

Members are attributed to PCPs using a rules-based algorithm based on the Member's current enrollment status and claims history. The majority of CareFirst membership is in PPO product designs that do not have a requirement for the Member to select a PCP. While HMO Members have typically selected PCPs, they often see other PCPs who are actually managing and coordinating their care.

Therefore, it is more accurate to attribute Members to PCPs based on their actual patterns of use – that is, reflecting those PCPs they are actually seeing for primary care services. However, HMO Members are attributed to their self-selected PCPs if they have made the selection within the last six months or in the absence of claims information.

CareFirst uses a standard attribution methodology (endorsed by NCQA), involving a 12 month look back period (repeated for an additional 12 month look back, if needed). Attribution is based on the following:

- Member has self-selected a PCP within the last six months.
- PCP most often seen by Member in the most recent 12-month period.
- In case of a tie between two PCPs, Member is attributed to the PCP seen most recently.
- If no PCP is found in the last 12 months, process is extended to previous 24 months.
- Members not seen by a PCP are attributed to their self-selected PCP upon enrollment, if this is known.

If no claims for primary care services are found and no selection of a PCP has been made by the Member, no attribution is made.

In making attribution, CareFirst uses only:

- Non-rejected claims.
- Professional claims.
- Claims from practitioners in Family Practice, General Practice, Family Practice and Geriatric Medicine, Pediatric, and Internal Medicine.
- Evaluation and Management Procedure Codes (i.e., 99201 through 99499) on claims.

CareFirst also:

- Excludes all pediatric claims when the Member is over 21 years old.
- Excludes claims where the place of service is assisted living or skilled nursing facility, urgent care facility, hospice, hospital (inpatient and outpatient), ER, ambulatory surgical center, psychiatric or substance use treatment facility, military facility, pharmacy, or school.

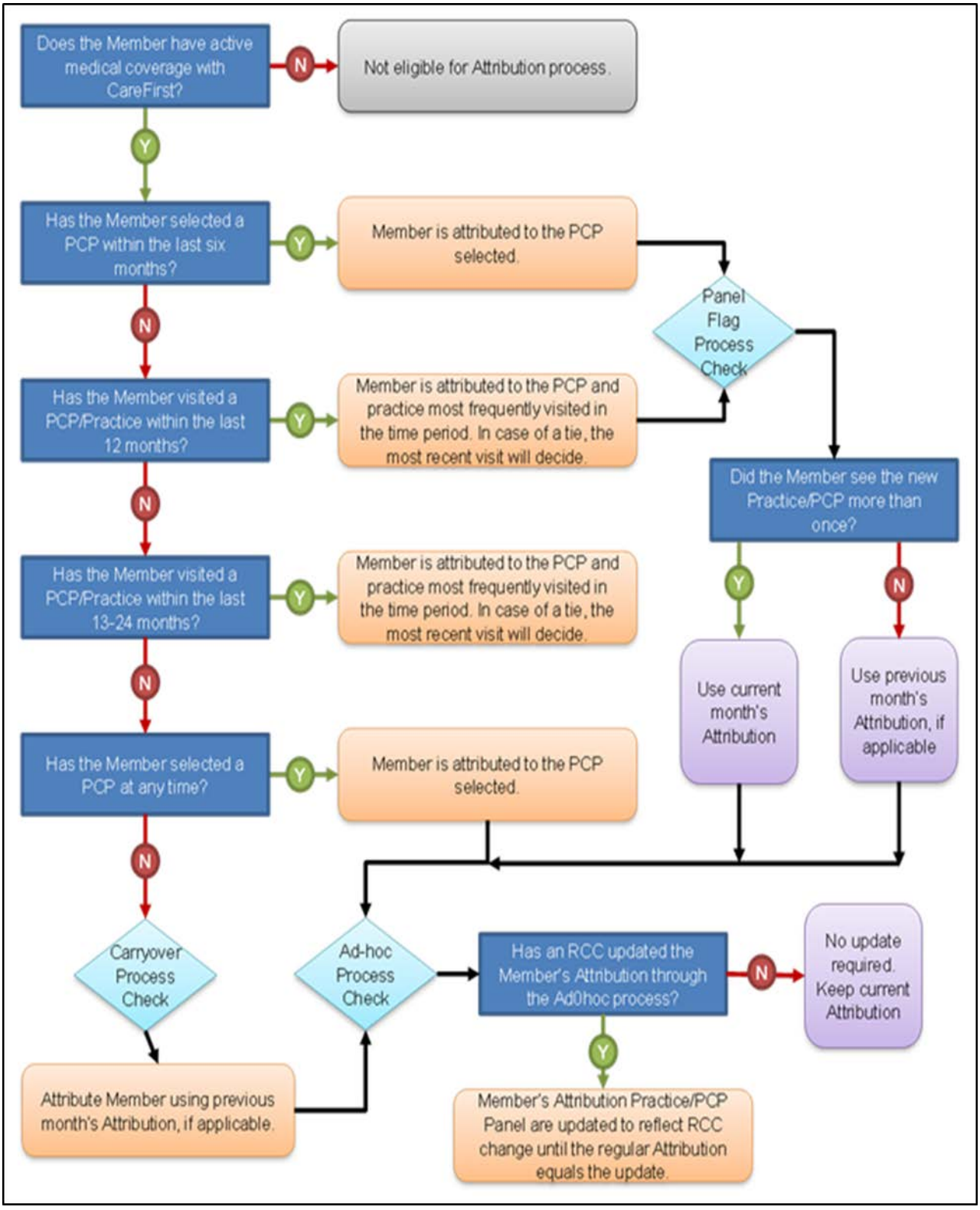
Currently, Panel attribution is based on the Member attributing at the Practice level since not all Members are attributed to a specific PCP based on claims data. This is because a small percentage of claims (less than 1 in 10) come in from practices with more than one PCP but do not contain an NPI for the PCP in the practice who actually rendered service.

At the end of each month, the attribution process compares the Member's attribution from the previous month. If the Member is attributed to the same practice in both months, the attribution stands. If not, then the attribution from the previous month will be carried over unless the Member has seen the new practice more than once.

In the event that an RCD and PCP agrees that a Member's attribution should change or be corrected, a manual override may take place and the monthly attribution process will be updated by the attribution made by the RCD. The update will take place each month until the normal monthly attribution has caught up with the new RCD attribution.

The logic flow in the attribution process is shown in the chart on the next page.

**Attribution Logic Flow**



## Appendix H: Method For Calculating Changes In Panel Credits Due To Panel PCP Membership Changes

If a Panel undergoes a "substantial change" in Panel PCP membership as described in **Part III, Design Element #4**, a number of steps are followed to calculate a new Base Year PMPM. As a further explanation of how the process would work, the following steps are illustrative and meant to clarify the mechanics that are employed to calculate a new Base Year PMPM.

**Calculating the Panel's Change in Composition**

As of December, of each Performance Year, a Panel's composition is reviewed to determine if it has undergone substantial change over the past two years. This determination is made if more than 50 percent of the PCPs from two years prior have left the Panel or if more than 50 percent of the current PCPs are new to the Panel. This is illustrated with the following four scenarios for sample Panels being evaluated at the end of the 2016 Performance Year:

| | | | | |
|---|---|---|---|---|
| A. PCPs as of December, 2014 | 10 | 10 | 6 | 6 |
| C. Number Joining the Panel | 1 | 1 | 2 | 6 |
| E. Percent PCPs Leaving (B/A) | 20% | **60%** | 17% | 17% |
| Substantial Change (E or F > 50%) | No | **Yes** | No | **Yes** |

In these examples, Panels B and D are determined to have undergone substantial change, with Panel B having lost 60 percent of its PCPs over two years and Panel D having acquired 55 percent of its current PCPs within the last two years.

**Recalculation of PMPMs**

Let us assume that Panel D originally had its Base Year costs determined using its 2010 claims and membership experience for five PCPs who were with the Panel when it formed. Below is an illustration of the Panel's original Base Year calculations broken down by PCP:

| PCP | Panel Status | Net Debits 2010 | Member Months 2010 | Debits PMPM 2010 |
|---|---|---|---|---|
| PCP #1 | Continuously Active | $1,865,590 | 6,491 | $287.41 |
| PCP #2 | Continuously Active | $1,044,627 | 4,707 | $221.94 |
| PCP #3 | Continuously Active | $1,704,953 | 5,607 | $304.06 |
| PCP #4 | Continuously Active | $1,205,427 | 4,535 | $265.82 |
| PCP #5 | Left in February-15 | $1,078,434 | 3,863 | $279.16 |
| **Total** | | **$6,899,031** | **25,203** | **$273.74** |

As outlined in **Part III, Design Element #4**, the new Base Year for Panels with substantial change will become the Performance Year prior to the Performance Year in which the change is identified. For smaller Panels (less 2,000 attributed Members), the new Base Year will consist of the two prior Performance Years. Looking at our sample Panel D, the Panel ended Performance Year 2016 with 11 PCPs. To set the new 2015 Base Year, the full experience for those PCPs in 2015 will be used, regardless of where the PCPs were practicing.

For example:

| PCP | Panel Status | Net Debits 2015 | Member Months 2015 | Debits PMPM 2015 |
|---|---|---|---|---|
| PCP #1 | Continuously Active | $2,336,450 | 6,556 | $356.39 |
| PCP #2 | Continuously Active | $1,425,977 | 4,942 | $288.52 |
| PCP #3 | Continuously Active | $2,448,867 | 6,056 | $404.40 |
| PCP #4 | Continuously Active | $1,607,526 | 4,762 | $337.59 |
| PCP #5 | New in March-12 | $1,735,193 | 5,728 | $302.95 |
| PCP #6 | New in January-15 | $1,363,231 | 3,778 | $360.81 |
| PCP #7 | New in January-15 | $1,187,237 | 3,404 | $348.81 |
| PCP #8 | New in January-15 | $1,397,544 | 3,181 | $439.28 |
| PCP #9 | New in January-15 | $1,023,644 | 2,232 | $458.59 |
| PCP #10 | New in January-16 | $1,067,674 | 2,251 | $474.25 |
| PCP #11 | New in January-16 | $1,195,919 | 2,568 | $465.77 |
| **Total** | | **$16,789,262** | **45,458** | **$390.60** |

The recalculated Base Year PMPM is then compared to the original Base Year PMPM to determine if the resulting change is greater than five percent. To ensure a meaningful comparison, the original PMPM is first trended forward to 2015 and adjusted for Illness Burden changes from 2010 to 2015. This is shown below

| | |
|---|---|
| Original Base Year PMPM using 2010 data | $273.74 |
| Original PMPM trended by 29.4% (cumulative OMT from 2010 to 2015) | $354.22 |
| Original PMPM Illness Burden adjusted (0.993 change from 2010 to 2015) | $351.74 |
| New 2015 Base Year PMPM | $390.60 |
| **Change in Base Year PMPM** | **11.0%** |

Since the change in Base Year PMPMs (11.0 percent) exceeds five percent, the Panel meets both criteria and the new PMPM of $390.60, based on 2015 experience, would be applied prospectively starting with the **2017 Performance Year** (with an additional two years of trending). In this example, the Panel's 2017 Credits would be increased in conjunction with the higher PMPMs associated with the newer PCPs joining the Panel.

## Appendix I: Method For Calculating Illness Burden Scores Of Members

Since the degree of Member health or illness is the most powerful direct contributor to the healthcare costs of each Panel, CareFirst measures the overall health of each and every Member in every PCMH Panel each month by calculating an Illness Burden Score for each Member and then summarizing this by Illness Burden Band for the Panel's Member membership as a whole. This is the "ultimate" Panel population view based on build up from the individual Member level.

The Illness Burden Score is calculated using a methodology that considers combinations of factors such as: demographic information (age and gender) and data on all Member medical claims, including inpatient, outpatient, and pharmacy claims. A higher Illness Burden Score generally equates to a greater use and cost of health care services.

The average Illness Burden Score for the entire CareFirst Member population is set to 1.00 in order to establish a normalization rate. Thus, a Member having an Illness Burden Score of 1.75 means that the Member's illness level is 1.75 times (75 percent) "sicker" than the average CareFirst Member.

The DxCG methodology is used to calculate all Illness Burden Scores. The DxCG methodology was originally created for use by the Federal Government and continues to be recognized by leading independent researchers as the most proven model available for the purpose of understanding illness levels. It is based on over twenty years of scientific research. One of the model's strengths is that it is updated annually to account for changes in ICD-9-CM diagnosis codes. Additionally, major clinical revisions are performed periodically to adjust for changes in disease patterns, treatment methods, and coding practices.

The Illness Burden calculation methodology uses data from CareFirst's population of over three million Members. The model gathers ICD-9-CM diagnosis codes from both inpatient and outpatient claims for each Member and categorizes all diagnosis codes into an appropriate diagnostic group. Each diagnostic group has an impact on the Illness Burden Score. The model also considers elements such as whether or not a diagnosis code, is a principal diagnosis on a claim, the timeliness of the service rendered on the claim, and the severity of the diagnosis code, thus allowing the model to group diagnosis codes into the most accurate diagnostic group.

The severity of a diagnosis code and the presence of co-morbidities are also considered and may elevate the Illness Burden Score. When creating a diagnostic profile for a Member, hierarchies are considered by the model in relation to the severity of a diagnosis. Thus, the diagnosis of diabetes with renal failure represents a more severe manifestation of diabetes than a diagnosis code for diabetes mellitus without mention of complication. Accordingly, the hierarchical diagnosis group takes precedence in the diagnosis group category.

As noted, Illness Burden Scores are calculated monthly for each Member in every Panel and a cumulative average score is calculated for the Panel as a whole. By doing this identically for each Panel, valid Panel comparisons can be made.

The Illness Burden Bands used in the PCMH Program are derived by picking significant "break points" and ranges of Illness Burden Scores that are available within the DxCG methodology which has hundreds of categories available. This reduces the number to Illness Burden Bands to five bands showing what a Panel's overall Member population looks like with regard to illness. This, in turn, is shown in the Illness Burden Pyramid calculation for each Panel and the Program as a whole. Changes are tracked and shown over time. Each Panel can then see how the level and extent of illness in their Panel Member population compares with the illness and sickness patterns in other Panels.

The Illness Burden calculation model includes only those diagnosis codes appearing on claims that are face-to-face encounters. The coding of claims for laboratory tests and X-rays is not always reliable since the diagnosis codes often indicate what the test is looking for and not necessarily what the Member's actual diagnosis is. Additionally, in the practice of medicine, a physician may order a test prior to seeing a Member. The diagnosis codes on these claims may serve as an evidentiary aid in the Illness Burden calculation model but are not included in the primary methodology for determining a diagnostic group. Similarly, as pharmacy claims do not include diagnosis codes, the information obtained from pharmacy claims is used only for support for diagnosis groups assigned by the model.

The model uses a system of Hierarchical Condition Categories to classify over 14,000 diagnosis codes into approximately 800 diagnostic groups or DXGs. Each diagnosis code maps to exactly one DXG. DXGs are further aggregated into Condition Categories (CC). Although CCs are not as homogeneous as DXGs, diseases within a CC are related clinically. Over a 12-month period, a Member can have many encounters with the health system, resulting in multiple claims being submitted with the same diagnosis code or with various diagnosis codes related to the same condition.

The model uses only one instance of each diagnosis code encountered, and hierarchies are imposed among related CCs so that only the most severe manifestation of a condition is used. In the case of a Member identified with CCs of diabetes with Ophthalmologic Manifestation and diabetes with Acute Complications, the latter CC would trump the former in the severity hierarchy and only the latter would carry weight in the Member's Illness Burden calculation.

As noted earlier, the Illness Burden calculation for each Member and for each Panel as a whole is run monthly to consider up-to-date claims information as it becomes available. Thus, the one year of claims data used in determining the Illness Burden Score is a continuously trailing 12-month period. Since Illness Burden Scores are derived from available Member demographics and claims data, Members attributed to a Panel that have no prior claims history with CareFirst will only be assessed based on demographic factors. These Members may initially be attributed to the Panel as "healthy", but may be elevated to a higher Illness Burden Band once they use healthcare services. In this way, a higher number of new Members to a Panel hold the potential to artificially inflate the healthy band in the short term.

This is, among other reasons, why monthly adjustments in Illness Burden Scores are performed and why Member Panel size matters in obtaining credible results, since the randomness of illness or the sudden full expression of serious illness in a few Members that has been developing over a long period of time may distort Panel results. Panels with larger Member populations are less prone to the uncertainties and spikes in costs that smaller Member populations expose some Panels to. This is what actuaries refer to as the "credibility" of a population. Full credibility is achieved at 2,500 to 3,000 Members for a Panel (with the inclusion of an $85,000 Individual Stop Loss Level for high cost claims).

One final note: While Illness Burden Scores are calculated monthly, each month's addition reflects the trailing 12 months' experience for each Member. So, in calculating a score, a "full year" experience is always used, not just the increment of new experience that is added each month. A final Illness Burden Score is calculated for each Panel at the end of each Performance Year after allowing for three months of claims run-out following the completion of the Performance Year. This is compared to the Illness Burden Score calculated in the same manner at the start of the Performance Year to determine the degree of change (up or down) in each Panel's population of patients. This is used to adjust the credits of the Panel to fairly account for changes in the illness level of the Members of the Panel as a whole.

## Appendix J: Method For Determining Episodes Of Care

Claims submitted to CareFirst come in at different times for different services from different providers and may be processed on different systems for payment. All of these claims, which appear disparate and unrelated, are placed into a single database. It is only then that the relationship among them can be discerned. This is precisely what happens in finding a pattern or episode of care out of what may look like unrelated claims.

Episodes of care are defined as series of sequential health services that are related to the treatment of a given illness or in response to a Member request for healthcare. These series of related events, as seen in claims data, each have a beginning date and an end date which define the episode boundaries.

Since healthcare for a Member involves a variety of service providers and settings, it is imperative to incorporate all available claims data for all services to develop a comprehensive view of a Member's health through seeing their episodes of care. Thus, determining a Member's episodes of care involves the integration of institutional, professional, and pharmacy claims into logical treatment patterns. The classification period for assigning episodes of care occurs over a 12-month period.

Episodes of care are primarily defined in one of two ways: Medical (diagnosis-based) and surgical (procedure-based). Medical episodes of care encompass all aspects of care for a particular disease state. The current medical episode model used in the PCMH Program contains 195 Episode Summary Groups comprised of 575 Episode Groups which in turn are comprised of 4,826 Episode Sub-Groups.

Surgical episodes of care are based on specific surgical interventions and include all services associated with a procedure, including all professional and facility claims related to the procedure, as well as pre-operative workups, post-operative care, and follow up on complications. The current surgical episode model used in the PCMH Program contains 180 distinct procedures. The two-episode types (medical and procedural) are built independently of each other, providing the capability to view Member episodes from two different perspectives.

Both episode calculation methodologies involve a sophisticated approach to combining clinically-relevant, severity-scaled condition or procedure specific groups - while also considering time periods in which healthcare services are rendered. For example, the appearance of the diagnosis code 250.00 "diabetes mellitus without complication" on a physician claim having a service date of January 1, 2010 would open a medical episode of care for diabetes for this Member effective January 1, 2010. Similarly, the appearance of a claim for procedure code 27134 "revision of Total Hip Arthroplast" on a physician claim having a service date of April 1, 2010 would open a surgical episode of care for Hip Replacement for this Member effective April 1,2010.

Additional diagnostic evidentiary support incorporated in the episode of care calculation models includes the use of pharmacy claims, laboratory and X-ray claims, and non-specific diagnosis codes found on physician office visit or hospitalization claims. As diagnosis codes do not appear on pharmacy claims, such claims cannot be used to open an episode. However, the prescriptions filled by a Member can support the presence of an existing episode. For example, the presence of an insulin prescription is used by the model as evidentiary support for an episode of care for diabetes that is already established for a Member. Since diagnostic coding found on laboratory and X-ray claims is not always a reliable indicator for a Member diagnosis, such claims are not used to open an episode but can be used by the models as evidentiary support for diagnoses appearing on other claims.

Often diagnosis codes found on claims indicate the diagnosis for which a test is searching and are not necessarily indicative of a current diagnosis for a Member. For example, if an Hba1C lab test was ordered by a physician for a Member who was suspected of having diabetes and a later physician office visit claim included a diagnosis code for diabetes, the lab test claim will be used as evidentiary support for the episode of care for diabetes. With regard to laboratory and X-ray claims, the model will only consider such correlating evidentiary support if the diagnosis or procedure is from the same episode group and occurred up to 30 days before the beginning of the opened medical episode.

An important component of the Medical Episode Grouper is Disease Staging. Disease Staging allows for the differentiation of a single episode group by classifying the seriousness of the condition, incorporating information specific to the condition, as well as ranking complications and comorbidities. This, in essence, answers the question: "How serious" is this? When compared over time, changes in the disease stage indicate the progression of the condition.

Acute Flare Ups associated with chronic conditions are also captured. These occur when there is a relatively brief, but intense complication related to a condition. Acute flare ups generally involve ER services or hospital admissions. Acute flare ups are identified separately from the general chronic episode and may indicate a more progressive disease stage. The presence of multiple acute flare ups is an indicator that the chronic condition is not well managed.

Surgical episodes are based on a particular "anchor" surgical intervention or procedure such as a knee replacement. The identified procedure is the anchor for the episode. Claims incurred up to six weeks prior to the procedure and six months after the procedure are reviewed to determine an association with the anchor procedure. This allows for the inclusion of all related pre-operative testing, post-operative care, radiology, lab, and pharmacy costs to be included in the total cost of the knee replacement.

Non-specific diagnosis codes often occur in the billing of Member treatments. For instance, an initial physician visit sought by a Member for weakness (and coded as such on the claim) may indicate the presence of hemiparesis. The episode model incorporates logic to link the non-specific diagnoses and costs to the specific episode of care for hemiparesis.

As the progression of treatment abates, particularly for acute illnesses or specific surgical interventions, episodes of care end. If a clearly determined end to treatment is not found in claims, the ending point for an episode is deduced in the methodology through clinically-relevant pre-determined time periods associated with the recovery period for a particular medical or surgical episode. This time period represents the period of time estimated for a Member to recover from a disease, condition, or surgical intervention, and for the completion of any subsequent care. If a later visit for a disease occurs within this time period, it is assumed to be a part of the previously determined episode. If a visit for a disease occurs later than this time period, a new episode is established.

Both medical and procedural episodic methodologies include all allowed dollars that are the basis of payment by CareFirst. These appear on claims associated with an episode and the allowed amounts of CareFirst payments are assigned to each episode of care (i.e., all attributable claims dollars for diabetes will be associated with the episode of care "diabetes"). This allows for the calculation of episode costs and the identification of "dominant" medical episodes. Dominant episodes of care are those episodes within a Panel's population of Members that account for the highest dollar amounts per episode per Member. This information is then used for analysis pertaining to healthcare costs related to overall disease management, as well as those for specific surgical procedures.

Additionally, a secondary medical episode (or a medical episode having the second highest dollar value) can indicate comorbidity in a Member's health. Comorbidity, the presence of multiple medical episodes, can also be an indicator of the severity of illness for a Member. The dominant episode in combination with the presence of multiple comorbid episodes can serve as an indicator of a Member in need of a Care Plan or additional coordinated care.

Since all claims define or initiate an episode of care, and not all dollars are associated with an episode of care, the model groups all dollars not assigned to episodes of care as "unassigned." However, it is worth noting that over 90 percent of all claims can be grouped into medical episodes with only this small residual left that is unassigned.

## Appendix K: Method For Calculating Metabolic Index Score ("MIS")

**Importance of the Metabolic Index Score (MIS)**

Metabolic Health is the measurement of how well the cells in the body function. Proper cell function allows the body's physiology to operate at an optimal level. Early signs of break down in metabolic health are seen in common lab results such as abnormal kidney function test, glucose tests, and lipid tests. A Member's metabolic health is a very powerful indicator of current or future healthcare costs. CareFirst uses available lab and biometric results for key metabolic measures to calculate the Metabolic Index Score (MIS) of each Member.

In order to enhance the focus of Care Coordination efforts on Members who have a high potential for breakdown because of their metabolic health, a MIS is calculated for Members each month using available lab and biometric results. The MIS is a predictive scoring model that indicates risk of future metabolic-related breakdowns and poor health in a Member.

The MIS stratifies Members into different levels of potential metabolic instability on a 1 to10-point scale. A low score indicates little risk while a higher score, typically 8–10, presents great risk of instability and cost. Additional risk is present in a Member whose MIS is rapidly progressing over a span of several months. The MIS allows Care Coordinators to prioritize their efforts and focus on Members who appear to require intervention due to their potential for deteriorating health.

The MIS is derived from two sources of Member data: lab and biometric results. Certain lab tests provide four components of a Member's metabolic health. A fifth component considers a Member's biometric measurements. The five components, taken together, are used to formulate the MIS. They are explained below and listed in order of their weighting:

**Kidney Health –** Creatinine is the sole lab result measured for determining the Kidney Health component. This component focuses on targeting Members who have or are at risk of conditions like renal function failure and chronic kidney disease. This factor is weighted most heavily as abnormal kidney functions are associated with poor overall health and substantiated healthcare needs and spend.

**Impaired Glucose –** HbA1c and Fasting Glucose are the two lab results measured for the Impaired Glucose component. This component focuses on targeting Members who have or are at risk for diabetes. Members with abnormal lab results in this component can require an increased amount of management in their lifestyle and dietary needs.

**Liver Health –** SGOT, SGPT, and Bilirubin are the lab results measured for the Liver Health component. This component focuses on Members who have or are at risk of conditions like liver disease or failure. Determining the right diagnosis and treatment or change in health habits can catch problems when they are still in the treatable stage.

**Cardiac Health –** Total Cholesterol, LDL Cholesterol and Triglycerides are the lab results measured for the Cardiac Health component. This component focuses on targeting Members who have or are at risk of conditions like hypertension, cardiovascular disorders and coronary artery disease. Heart disease remains one of the leading causes of death in the U.S., making cardiac health a vital component of MIS that can help predict the need for lifestyle and dietary modifications and consequently reducing the risk of heart disease.

**Biometric Factor –** Blood Pressure (BP), Body Mass Index (BMI), and nicotine use are the three biometric measurements considered for the Biometric Factor component. This component focuses on targeting Members who have or are at risk of conditions like hypertension, obesity and heart disease. Like the cardiac health component, the biometric measurements give additional warning signs in order to make changes and protect the heart.

The five components above are given weightings based on the degree of abnormality in each of the listed lab and/or biometric results. The final calculation also takes Member age into consideration to account for the increased likelihood of greater instability present as one ages.

Certain statutory limitations restrict the amount of lab and biometric data available for formulating the MIS. Current law restricts the use of Member lab data in Washington D.C. and Virginia. Results from labs performed in Maryland are available from two laboratory networks at this time: Quest and LabCorp. Additionally, the biometric data currently available is

obtained from health screening programs, which are grossly underutilized by most large groups. CareFirst will continue to seek legislative change and promote the use of Health Risk Assessments.

A MIS is calculated for a Member when a Member has only lab results, when a Member has only biometric results, and when a Member has both lab and biometric results. Obviously, the desired situation is to have the MIS calculated where both lab and biometric data is available. We note that in a high percentage of cases both lab and biometric data are not available.

**Calculating Metabolic Index Score for Members with only Lab Results**

The lab-only MIS is the sum of the four lab-based health components (cardiac, kidney, liver and glucose) and the age factor. If a person has multiple abnormal lab results in a health component, the max value is used. Total scores over 10 are assigned a value of 10 and the range of valid total scores is one to 10.

| Lab Only Result Weightings | | | | |
|---|---|---|---|---|
| | | Abnormal Ranges | | |
| Health Category | Test | Minimal | Moderate | Severe |
| **Cardiac** | **Triglycerides** | - | 1 | 2 |
| | **Total Cholesterol** | - | 1 | 2 |
| | **LDL Cholesterol** | - | 1 | 2 |
| **Impaired Glucose** | **HbA1c** | 1 | 2 | 3 (4 if >= 10) |
| | **Glucose** | 1 | 2 | 3 |
| **Kidney** | **Creatinine** | 3 | 4 | 5 |
| **Liver** | **SGOT** | 1 | 2 | 4 |
| | **SGPT** | 1 | 2 | 4 |
| | **Bilirubin** | 1 | 2 | 4 |

| Age Range Weightings | |
|---|---|
| Age | Adjustment Factor |
| 18 - 39 | 1 |
| 40 - 49 | 2 |
| 50 - 59 | 3 |
| 60 - 69 | 4 |
| Greater than 69 | 5 |

**Calculating Metabolic Index Score for Members with only Biometric Results**

The biometric-only MIS is the sum of the three biometric factors (BMI, BP, and nicotine use) and the age factor. If a person has multiple abnormal biometric results for a given factor, the max value is used. Total scores over 10 are assigned a value of 10 and the range of valid total scores is 1-10. The age factor is the same one used in the lab test results.

| Biometric Result Weightings | | | |
|---|---|---|---|
| | Abnormal Ranges | | |
| Biometric Factors | Minimal | Moderate | Severe |
| **BMI** | 1 | 2 | 3 |
| **Blood Pressure** | 1 | 2 | 3 |
| **Nicotine Use** | 3 | 3 | 3 |

| Age Range Weightings | |
|---|---|
| Age | Adjustment Factor |
| **18 - 39** | 1 |
| **40 - 49** | 2 |
| **50 - 59** | 3 |
| **60 - 69** | 4 |
| **Greater than 69** | 5 |

**Calculating Metabolic Index Score for Members with Lab and Biometric Results**

The MIS begins in the same way as the MIS for Members with only lab results. Then, the sum of a Member's biometric factors is taken into account excluding any age factor. This biometric factor result is multiplied by 20 percent and creates a composite. MIS is equal to the sum of all measures, rounded to the nearest integer. Total scores over 10 are assigned a value of 10 and the range of valid total scores is 1-10.

*Example: 55-year-old Member has moderately abnormal glucose and severely abnormal BP. Age factor (3) + impaired glucose (2) + (abnormal BP (3) * .20) = 5.6 = MIS of 6.*

| Lab Result Weightings | | | | |
|---|---|---|---|---|
| | | Abnormal Ranges | | |
| Health Category | Test | Minimal | Moderate | Severe |
| **Cardiac** | **Triglycerides** | - | 1 | 2 |
| | **Total Cholesterol** | - | 1 | 2 |
| | **LDL Cholesterol** | - | 1 | 2 |
| **Impaired Glucose** | **HbA1c** | 1 | 2 | 3 (4 if >= 10) |
| | **Glucose** | 1 | 2 | 3 |
| **Kidney** | **Creatinine** | 3 | 4 | 5 |
| **Liver** | **SGOT** | 1 | 2 | 4 |
| | **SGPT** | 1 | 2 | 4 |
| | **Bilirubin** | 1 | 2 | 4 |

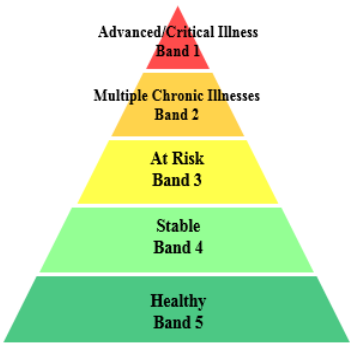
| 20 Percent Biometric Result Weightings | | | |
|---|---|---|---|
| Biometric Factors | Abnormal Ranges | | |
| | Minimal | Moderate | Severe |
| **BMI** | 0.2 | 0.4 | 0.6 |
| **Blood Pressure** | 0.2 | 0.4 | 0.6 |
| **Nicotine Use** | 0.6 | 0.6 | 0.6 |

| Age Range Weightings | |
|---|---|
| **Age** | **Adjustment Factor** |
| **18 – 39** | 1 |
| **40 – 49** | 2 |
| **50 – 59** | 3 |
| **60 – 69** | 4 |
| **Greater than 69** | 5 |

**The Metabolic Index Score (MIS) with Only Lab Results**

The following data consists of Members 18 and older with an MIS calculated using only lab tests performed in Maryland in 2014. The distribution of Members by band indicates that there is a strong correlation between Illness Burden Band and MIS. The number of Members in the Advanced/Critical Illness Burden Band increases significantly with 55.7 percent of Members in this band when MIS equal to 10. As expected, the average PMPM increases as the MIS increases consistent with what is observed within the Illness Burden pyramid. Below is the Member distribution of MIS by Illness Burden Band and a table with other key metrics for 2014.

**2016 Metabolic Index Score (MIS) And Illness Band Member Distribution (Lab-Only Results)**




| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| 1.8% | 3.0% | 4.9% | 6.9% | 9.1% | 12.1% | 16.2% | 19.4% | 28.0% | 45.1% |
| 2.1% | 3.7% | 4.6% | 5.9% | 7.0% | 7.7% | 8.8% | 8.1% | 10.2% | 11.4% |
| 22.5% | 22.3% | 24.2% | 27.1% | 29.5% | 32.1% | 32.0% | 30.8% | 30.8% | 24.1% |
| 31.3% | 35.5% | 38.4% | 39.2% | 38.1% | 36.3% | 33.0% | 33.8% | 24.9% | 16.8% |
| 42.2% | 35.5% | 27.9% | 21.0% | 16.3% | 11.9% | 10.0% | 7.8% | 6.1% | 2.7% |
| 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

**2016 Metabolic Index Score (MIS) And Illness Band Member Distribution (Lab-Only Results)**

| | 1 - 4 | | | 5 - 7 | | | 8 - 10 | | | All | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Illness Band** | **Members** | **Avg IB Score** | **Medical PMPM** | **Members** | **Avg IB Score** | **Medical PMPM** | **Members** | **Avg IB Score** | **Medical PMPM** | **Total Members** | **Avg IB Score** | **Medical PMPM** |
| **Advanced/Critical Illnesss** | 10,841 | 10.31 | $3,819.32 | 7,789 | 11.09 | $3,726.40 | 1,686 | 15.64 | $5,077.51 | **20,316** | **10.88** | **$3,887.74** |
| **Multiple Chronic Illnessses** | 46,145 | 2.93 | $936.37 | 18,755 | 3.08 | $758.09 | 1,797 | 3.17 | $685.74 | **66,697** | **2.99** | **$879.33** |
| **At Risk** | 61,286 | 1.44 | $385.05 | 21,164 | 1.44 | $308.81 | 1,505 | 1.47 | $287.82 | **83,955** | **1.44** | **$364.06** |
| **Stable** | 104,392 | 0.59 | $142.70 | 22,202 | 0.66 | $121.85 | 1,233 | 0.69 | $111.05 | **127,827** | **0.60** | **$138.76** |
| **Healthy** | 29,428 | 0.16 | $47.02 | 2,464 | 0.16 | $38.04 | 89 | 0.14 | $57.85 | **31,981** | **0.16** | **$46.36** |
| **Grand Total** | **252,092** | **1.59** | **$497.88** | **72,374** | **2.59** | **$730.04** | **6,310** | **5.54** | **$1,649.43** | **330,776** | **1.88** | **$571.02** |

**The Metabolic Index Score with Only Biometric Results**

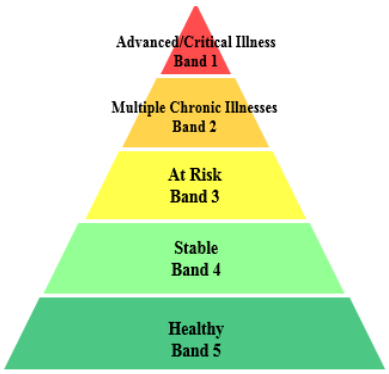
The following data consists of Members 18 and older with an MIS calculated using only biometric results in 2014. The biometric results are obtained through the TCCI Wellness and Disease Management (WDM) Program. Although a much smaller data set, it generally correlates to Members with Metabolic Index scores calculated using only lab results.

The average Medical PMPM increases as MIS increases, but to a lesser extent than Members with lab results only MIS. Unlike the lab-calculated MIS Members, biometric-calculated MIS Members have a lower Illness Burden Score on average

(1.53 vs 1.76). The difference between the overall average Illness Burden Scores in the populations is small; however, the scale on which a Member's Illness Burden Score increases as MIS increases is much more significant with the lab-calculated population than the biometric-calculated population.

While a Member with a biometric-calculated MIS between eight and 10 has an average Illness Burden Score of 2.61, a Member with a lab-calculated MIS between eight and 10 averages an Illness Burden Score of 5.37. This dramatic difference in correlation to Illness Burden Score and PMPM supports the lower weighting used for the MIS calculated based on both lab and biometric results. Below is the Member distribution of MIS by the Illness Burden Band and a table with other key metrics for 2014.

**2016 Metabolic Index Score (MIS) And Illness Band Member Distribution (Biometric-Only Results)**




| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| 0.6% | 1.2% | 2.3% | 4.3% | 6.8% | 7.7% | 6.4% | 6.4% | 5.9% | 0.0% |
| 0.8% | 1.5% | 2.7% | 4.6% | 7.0% | 5.9% | 8.7% | 6.4% | 5.9% | 6.7% |
| 14.0% | 14.6% | 17.8% | 24.5% | 28.0% | 28.7% | 32.6% | 39.1% | 20.6% | 40.0% |
| 20.7% | 28.0% | 34.0% | 34.6% | 35.2% | 33.6% | 30.3% | 30.9% | 41.2% | 33.3% |
| 64.0% | 54.8% | 43.3% | 32.0% | 23.0% | 24.1% | 21.8% | 17.3% | 26.5% | 20.0% |
| 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

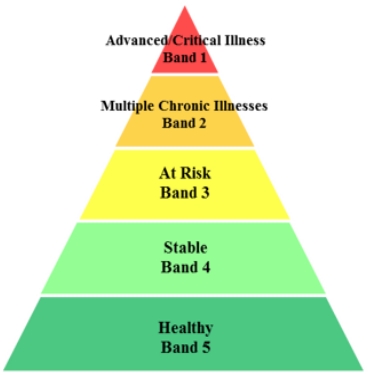
**2016 Metabolic Index Score (MIS) And Illness Band Member Distribution (Biometric-Only Results)**

| | 1 - 4 | | | 5 - 7 | | | 8 - 10 | | | All | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Illness Band | Members | Avg IB Score | Medical PMPM | Members | Avg IB Score | Medical PMPM | Members | Avg IB Score | Medical PMPM | Total Members | Avg IB Score | Medical PMPM |
| Advanced/Critical Illnesss | 394 | 10.62 | $4,046.33 | 230 | 10.02 | $4,238.05 | 9 | 8.97 | $3,415.69 | **633** | **10.41** | **$4,106.84** |
| Multiple Chronic Illnessses | 2,565 | 2.85 | $1,043.35 | 801 | 3.04 | $991.99 | 49 | 2.96 | $708.91 | **3,415** | **2.90** | **$1,026.45** |
| At Risk | 3,956 | 1.43 | $435.65 | 906 | 1.43 | $343.26 | 40 | 1.36 | $385.18 | **4,902** | **1.44** | **$417.93** |
| Stable | 8,756 | 0.56 | $156.65 | 967 | 0.62 | $131.10 | 49 | 0.63 | $154.07 | **9,772** | **0.56** | **$154.07** |
| Healthy | 6,893 | 0.12 | $45.09 | 373 | 0.13 | $37.83 | 12 | 0.16 | $7.91 | **7,278** | **0.12** | **$44.63** |
| **Grand Total** | **22,564** | **1.01** | **$355.24** | **3,277** | **2.05** | **$689.48** | **159** | **1.96** | **$569.04** | **26,000** | **1.15** | **$400.47** |

**The Metabolic Index Score with Both Lab Results and Biometric Results**

The following data consists of Members 18 and older who had an MIS calculated using both biometric and lab test results. As observed in the prior examples, abnormal lab results appear to indicate more immediate health concerns and consequently a larger increase in medical costs and Illness Burden Score as opposed to biometric results only. The following shows the Member distribution of MIS scores when both lab and biometric are used.

**2016 Metabolic Index Score (MIS) And Illness Band Member Distribution (Lab And Biometric Results)**




| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| 1.6% | 1.9% | 3.9% | 7.0% | 8.9% | 10.8% | 15.2% | 19.6% | 14.3% | 34.8% |
| 2.0% | 3.6% | 4.9% | 6.8% | 8.1% | 10.4% | 12.4% | 11.6% | 10.7% | 15.2% |
| 20.2% | 22.9% | 26.6% | 29.0% | 32.6% | 39.0% | 40.7% | 30.4% | 50.0% | 32.6% |
| 30.5% | 36.1% | 39.0% | 39.2% | 38.5% | 32.0% | 26.4% | 33.0% | 19.6% | 15.2% |
| 45.7% | 35.5% | 25.6% | 17.9% | 11.9% | 7.9% | 5.3% | 5.4% | 5.4% | 2.2% |
| 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

**2016 Metabolic Index Score (MIS) And Illness Band Member Distribution (Lab And Biometric Results)**

| | 1 - 4 | | | 5 - 7 | | | 8 - 10 | | | All | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Illnesss Band | Members | Avg IB Score | Medical PMPM | Members | Avg IB Score | Medical PMPM | Members | Avg IB Score | Medical PMPM | Total Members | Avg IB Score | Medical PMPM |
| Advanced/Critical Illnesss | 385 | 9.00 | $3,409.15 | 271 | 9.86 | $2,905.12 | 46 | 13.12 | $3,861.89 | **702** | **9.47** | **$3,245.12** |
| Multiple Chronic Illnessses | 2,037 | 2.93 | $977.65 | 818 | 3.13 | $855.84 | 84 | 3.19 | $842.02 | **2,939** | **3.00** | **$939.69** |
| At Risk | 2,675 | 1.44 | $411.16 | 835 | 1.47 | $298.28 | 52 | 1.48 | $327.25 | **3,562** | **1.44** | **$383.35** |
| Stable | 4,501 | 0.59 | $144.50 | 675 | 0.68 | $130.48 | 31 | 0.66 | $94.95 | **5,207** | **0.60** | **$142.37** |
| Healthy | 1,305 | 0.17 | $46.53 | 61 | 0.18 | $35.44 | 1 | 0.22 | $175.92 | **1,367** | **0.16** | **$46.13** |
| **Grand Total** | **10,903** | **1.49** | **$475.36** | **2,660** | **2.55** | **$690.18** | **214** | **4.43** | **$1,261.93** | 13,777 | **1.74** | **$529.67** |

**Metabolic Index Score When Using Lab Only vs. When Using Lab Results and Biometric Results**

The chart below compares MIS when calculated for a Member using only lab results to the MIS calculated using both lab and biometric results thus allowing us to better understand the impact of the biometric result weighting.

Of the 9,993 Members with both lab and biometric results, 1,376 or 14 percent of them saw an increase in MIS from their lab-only MIS once the biometric results were considered. The shift in MIS after applying the biometric results factor is displayed in the movement chart below. Over 99 percent of Members with an increase in MIS had their MIS increase by a factor of one; however, three Members with severely abnormal biometric results had their MIS increase by a factor of two.

| Members with Both Lab and Biometric Results: The Shift from Applying Biometric Results | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | MIS With Biometric and Lab Results | | | | | | | | | | |
| MIS Using only Lab Results | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Grand Total |
| **1** | 1,294 | 157 | | | | | | | | | 1,451 |
| **2** | | 1,411 | 217 | 2 | | | | | | | 1,630 |
| **3** | | | 2,027 | 296 | | | | | | | 2,323 |
| **4** | | | | 1,956 | 309 | | | | | | 2,265 |
| **5** | | | | | 1,162 | 196 | | | | | 1,358 |
| **6** | | | | | | 454 | 116 | | | | 570 |
| **7** | | | | | | | 175 | 60 | | | 235 |
| **8** | | | | | | | | 71 | 18 | 1 | 90 |
| **9** | | | | | | | | | 36 | 4 | 40 |
| **10** | | | | | | | | | | 31 | 31 |
| **Grand Total** | **1,294** | **1,568** | **2,244** | **2,254** | **1,471** | **650** | **291** | **131** | **54** | **36** | **9,993** |

**Conclusion**

The MIS is a valuable aid in the early identification of Members who are candidates for one or more TCCI Programs. Early intervention increases the ability to impact the Member's health as early as possible in their disease process in order to mitigate disease progression and/or exacerbation both improving the Member's health status and quality of life as well as reducing unnecessary spend.

## Appendix L: Method For Calculating High, Medium And Low-Cost Specialists And Hospitals

An important objective of the PCMH Program is to provide meaningful cost information to PCPs to assist them in making informed referral decisions for planned care provided by specialists. To this end, CareFirst provides data on the costs of all regional specialists and hospitals. Rankings are made annually. The data provided is based on costs only, with no judgment about quality or outcomes.

The rankings are completed at three levels:

**By Individual Specialist** based on cost per episode versus peers within the same specialty group, ranked by Low, Low-Mid, High-Mid, and High cost for individual physicians.

**By Practice Group** based on cost per episode versus peer practices with like specialties, ranked by Low, Low-Mid, High-Mid, and High cost at the group level.

**By Hospital** based on inpatient, outpatient, and ER costs for hospitals and the providers that provide services at those hospitals, ranked by Low, Low-Mid, High-Mid, and High cost for each hospital.

These rankings provide Panels with key insights into the cost impacts of their referral decisions. Data on these patterns is available through the Key Referral Patterns section of SearchLight.

**Individual Specialist Rankings by Cost per Episode**

A "dominant" physician responsible for an episode of care is determined for each episode identified by the Procedural Episode Grouper (PEG) and Medical Episode Grouper (MEG). For a PEG, the dominant physician is the specialist who performed the primary procedure. For a MEG the dominant physician is the PCP or Specialist with the largest share of costs over the course of the episode. The costs are CareFirst payments at allowed levels. Episodes for Members with Medicare or that have payments from other insurance plans are excluded, as the costs for these episodes may be incomplete. Physicians with ancillary specialties such as pathology, anesthesiology, or radiology are not eligible to be dominant physicians, as these specialties would not be responsible for managing an episode of care. However, the costs of their services are included in all episodes where they appear.

Each physician is assigned to a Peer Group based on their primary specialty, ensuring that physicians are compared to like physicians treating similar conditions. For example, since an Immunologist would likely treat more complicated asthma cases than would a PCP, asthma episodes with dominant physicians outside of the Immunology peer group are not considered in the Immunology ranking process. Like specialties may be combined. For example, Immunology, Allergy, and Allergy and Immunology are assigned to a homogeneous Peer Group of Allergy and Immunology.

In order to perform valid comparisons, physician costs are evaluated according to the specific types of episodes that they manage, at the condition/disease stage or procedure level. This is accomplished by comparing each physician's individual episode costs with the average or "expected" costs for like episodes managed by peers. For example, a physician may handle a large number of croup episodes, which typically are not very costly. If that physician's croup episode costs are higher than other croup episodes handled in the Peer Group, then the physician's efficiency ranking will be negatively impacted, even though his or her total costs across all episodes in his or her specialty may be relatively low.

Actual and expected costs are calculated at the procedure code level (with modifiers in some cases, as appropriate) for PEG episodes. Likewise, MEG costs are calculated at the condition and disease stage level within each episode group, in order to better compare episodes of similar complexity. For example, a chronic maintenance asthma episode with a disease stage of 1.01 would not be compared with an episode of asthma with complications and disease stage 3.02. For more information on episode conditions and disease staging, see **Appendix J: Method for Determining Episodes of Care**.

Expected costs for each MEG or PEG are the average cost for each episode procedure/modifier or condition/disease stage combination found within each Peer Group's experience in the CareFirst service region. Since the range of costs can be much more broad for some episodes than others, a 95 percent Confidence Interval (CI) is calculated and a range of expected costs is produced for each.

Actual episode costs are totaled for each physician, and these costs are then compared to the average costs for peer physicians performing like episodes. The result also includes the range of total costs experienced for each episode as well as the episode mix that makes up a physician's specific pattern of practice. Physician episode costs are then ranked based on their actual costs per episode for all their episodes compared to the expected average costs for their episodes as derived from the actual cost results achieved by all physicians performing these same episodes. In this way, actual versus expected costs are calculated for each physician for each of the last three complete calendar years, and these yearly results are combined using weightings of 20 percent, 30 percent, and 50 percent respectively from the oldest to the most recent year.

To ensure fair comparisons, the costs for each specialty are calculated only when there is a minimum of 10 specialists and 100 qualifying episodes included in the region wide average. Individual specialists need a minimum of 30 episodes overall and 10 episodes for any procedure or condition/disease stage combination in order to be measured and compared to the regional average. To avoid the negative impacts of isolated catastrophic cases, episodes costing more than five times the average cost for that episode type within the specialty Peer Group are considered outliers and are capped at five times that episode's average cost. Episodes costing less than one tenth of the average cost are excluded entirely.

Each physician is assigned a cost rating in one of four categories:

1. High (performing much worse than average)
2. High-Mid (slightly worse than average performance)
3. Low-Mid (slightly better than average performance)
4. Low (performing much better than average)

More precisely, physicians are placed into one of four quartiles based on their cost efficiency (in terms of actual vs. expected costs) compared to all other evaluated physicians in their Peer Group. Specialist cost tiers are updated annually and are released to iCentric and SearchLight at the beginning of the year following the analysis.

**Specialty Group Practice Cost Comparisons**

The methodology for ranking group practices follows essentially the same methodology used for ranking individual physicians. The episodes of care, dominant physician assignments, expected cost calculations, and specialty peer group designations are calculated at the individual level and rolled up to the group level. That is, for the group level, all actual and expected costs are aggregated for all physicians within each group practice for each specialty peer group. While individual physicians are assessed based on the totality of the episodes that they manage, their work can be divided up by practice for the group-level assessments. A multi-specialty practice may receive separate rankings for each specialty peer group associated with its physicians' members.

As with individual physicians, each specialty group is assigned a cost rating in one of four categories:

1. High (performing much worse than average)
2. High-Mid (slightly worse than average performance)
3. Low-Mid (slightly better than average performance)
4. Low (performing much better than average)

Actual vs. expected cost ratios are calculated for each group for each of the last 3 complete calendar years, and these yearly results are combined using weightings of 20 percent, 30 percent, and 50 percent respectively from the oldest to the most recent year. Since specialty groups can vary greatly in size, the 25 percent quartile divisions are assigned based on episode volumes to ensure an even distribution of episodes across the four cost tiers. In other words, groups are ranked from Low to High cost within each Peer Group, and the lowest cost practices with 25 percent of all managed episodes are assigned to the Low-cost tier, and so forth.

**Hospital Cost Comparisons**

Hospital cost rankings are calculated in a similar manner for the 65 acute care hospitals within the CareFirst service region. These cost rankings are based on the following three cost components and weightings:

1. Inpatient admissions (45 percent)
2. Outpatient visits (40 percent)
3. ER visits (15 percent)

The weightings are adjusted annually, if needed, to reflect the proportion of overall costs associated with these services throughout hospitals in the region.

"Inpatient" admissions are case-mix adjusted by the Diagnosis-Related Group (DRG) assigned for each admission. As with the specialist rankings, actual costs are compared to expected costs, with the latter determined by the average admission costs for each DRG for all hospitals in the CareFirst region. "Outpatient" visits are similarly case-mix adjusted based on the dominant (highest cost) procedure for each visit, while emergency room visits are case-mix adjusted by the five ambulatory payment classification levels (codes 99281-99285).

All costs are CareFirst payments at allowed levels, and exclude admissions or visits for Members with Medicare or with payments from other insurance plans, as the costs for these encounters may be incomplete. Both facility and professional costs are included. Actual vs. expected cost ratios are calculated by year for each service type (inpatient, outpatient, and ER) per the weightings above.

As with the specialty physician rankings, the analysis includes the last three complete calendar years, and these yearly results are combined using weightings of 20 percent, 30 percent and 50 percent respectively from the oldest to the most recent year.

Each hospital is assigned a cost rating in one of four categories:

1. High (performing much worse than average)
2. High-Mid (slightly worse than average performance)
3. Low-Mid (slightly better than average performance)
4. Low (performing much better than average)

As described above, hospitals are also placed into quartiles and are assigned cost tiers based on their cost efficiency (in terms of actual vs. expected costs) compared to all other hospitals in the CareFirst service area. Hospital cost tiers are updated annually, and updates appear in SearchLight at the beginning of the year following the analysis.

## Appendix M: Method For Calculating Drug Volatility Scores (DVS)

In order to enhance the focus of Care Coordination efforts on Members who have a high potential for breakdown because of the drugs they have been prescribed, a Drug Volatility Score (DVS) is calculated on every Member every month. The DVS model provides a means to stratify Members into different levels of potential instability, ranging from 0 to 10 on a ten-point scale. A low score indicates little risk of instability while a higher score (8-10) presents great risk of instability. This allows the pharmacist and physician to prioritize their efforts, focusing on those Members who appear to require intervention on a timelier basis because of their potential to rapidly decompensate into a lesser state of health.

For example, Members taking oral medications for the treatment of Hepatitis C must be in at least 95 percent compliance with their treatment regimen. These regimens have a cost of approximately $80,000 and represent a cure for the disease. The treatment is grueling with very significant side effects. This reduces the chance Members will comply with the regimen. If compliance drops below 95 percent, the entire regimen is no longer clinically effective and any previous treatment is wasted.

Another example where high compliance is required is in the treatment of HIV infection. Taken properly, Antiretrovirals are very effective in keeping HIV virus titers under control. Antiretroviral regimens represent a heavy "pill burden" where multiple pills/capsules must be taken multiple times daily. When compliance drops below 90 percent, the risk for viral resistance increases significantly, thus, making the Member more susceptible to complications. Close attention to these Members is needed to ensure that they stay on their regimens and control their viral titers.

Hence, the DVS creates a way to find Members who will feel ill from their drugs, could have serious side effects, or face complications leading to non-compliance. These Members are far more likely to break down and be admitted/readmitted or use ER services frequently. The DVS score is derived from prescription drug claims data and Member demographic information.

In general, the DVS takes the following into account:

**Medications that Require Tight Monitoring -** These classes of medications are known to require close monitoring and if not taken properly, even with the slightest deviation, will not produce the intended clinical benefit. Example: HIV medications requiring at least 90 percent compliance to remain effective.

**Medications with a likelihood of Non-compliance Due to Adverse Effects -** These medications possess a high prevalence and/or severity of adverse effects that increase the likelihood of Member non-compliance. Decreased compliance will lead to health instability (example: severe flu-like symptoms from "biologic" medications).

**Medication Regimen Complexity -** As the number of medications increases, particularly chronic medications, there is the greater potential for instability due to drug-drug and drug-disease interactions, confusion of the medication regimens, mis-identification of the medications, or inability to obtain the medications – all leading to breakdown or suboptimal effects.

**Overall Compliance/Adherence -** This includes medications that must be taken correctly to produce the intended clinical effect and outcome and where decreased compliance will lead to health instability (example: 30-day supply prescription that was last filled 60 days ago).

**Gaps in Care -** This includes Members who do not appear to be taking medications in accordance with accepted National Treatment Guidelines for control of a chronic disease (example: Identified diabetic Member not taking an ACE inhibitor (needed to protect the kidneys from damage).

**Member Age -** With age, there is usually an increase in the number of medications taken, an accentuation of the intended clinical effect, as well as a lower tolerance for adverse effects. All of this could lead to lower compliance and greater instability.

**Drug Interaction -** Drug interactions can result in adverse effects or a diminution of the intended clinical effect. The potential net result is not achieving the desired clinical benefit (example: Taking two different antidepressants together which interact and produce a severe adverse effect.

**Dose/Duration Concerns -** Members who often do not take the entire course of prescribed medications, or may be on a dosage regimen that is either not producing the intended clinical result, or is outside of the accepted indicated dose range. Examples:

- Taking only four days of a 14-day antibiotic regimen;
- Taking a diabetic medication and blood glucose is not in control; and
- Taking a high dose of a medication to control blood pressure, when the person gets dizzy each time upon rising from a sitting position.

**Improper Administrative/Technique -** This involves medications that must be administered properly in order to achieve the desired clinical effect. Example: Member not using their inhaler correctly.

Medications that require tight monitoring, have a relatively severe adverse effect profile, or have complex administration regimens are grouped together and are referred to as Volatile Medications. Volatile medications are those identified as most sensitive to proper administration with respect to dose, duration, and compliance. Classes of medications that are listed as volatile are:

**Antiretrovirals** – These medications are used for the treatment of HIV. In order to minimize the development of resistance, at least 90 percent compliance rate is required.

**Antipsychotics** – The antipsychotic class of medications has significant adverse effects that impact compliance. Reduced compliance leads to mental breakdowns.

**Basal-Insulins** – This specific type of insulin is administered as a constant infusion. In these Members, the steady infusion of insulin is required for adequate blood sugar control. Improper dosing as well as improper administration can lead to serious metabolic complications.

**Oral Hepatitis C** – These medications represent a cure to the Hepatitis C infection if taken properly. Compliance rates must be better than 95 percent for a cure to be achieved. Compliance rates of less than 95 percent will render the total treatment regimen ineffective, thus increasing the potential need for a liver transplant.

**Anti-Transplant Rejection** – Medications must be taken consistency and properly to prevent a rejection reaction.

**Antiplatelet** – Medications must be taken regularly, with a high regard to compliance to prevent clot formation. Inadequate compliance can lead to cardiovascular events, stroke, Transient Ischemic Attack (TIA), and other circulation complications.

**Anticoagulants** – Medications must be taken regularly, with a high regard to compliance to prevent clot formation. Inadequate compliance can lead to cardiovascular events, stroke, TIA, and other circulation complications.

Since the DVS is a 0-10 scale – with a higher score equating to an increased potential of developing complications or creating instability in the Member – Members with high Drug Volatility Scores are more likely to experience care breakdowns, leading to compromised disease control, unnecessary utilization of healthcare systems, and increased costs. It is these Members that the SearchLight process seeks to find in the data and bring to the attention of the PCP and local pharmacist through the Comprehensive Medication Review Service (CMR) that is part of the Pharmacy Coordination Program (RxP).

The DVS scale is categorized as follows:

**Very High Instability (DVS: 8-10)** – Members who have a very high potential to decompensate and become critical. Members require close monitoring. Profile would include taking a volatile medication, poor compliance (< 50 percent), or are on multiple chronic medications. Frequent follow-up is required (monthly).

Examples: Member being treated for Hepatitis C must take three drugs with near perfect adherence. These drugs include Incivek®, interferon and ribavirin. The interferon makes the Member very ill and if the regimen is not taken exactly as prescribed, all drug costs are wasted. Worse, stopping therapy before it ends is likely to lead to death or a costly liver transplant. Another example of Members with Very High Instability includes any Member on oral Oncology drugs. The side effects can be unbearable resulting in high instability and substantial risk of non-adherence.

**High Instability (DVS: 6-7)** – Members who have multiple conditions and multiple medications with low compliance (55-65 percent). Members will eventually decompensate in time. Quarterly follow-up may be required.

Examples: Member is taking medications for high blood pressure and high cholesterol. Blood pressure is border line high and compliance is 65 percent; Total cholesterol is 295 and compliance is 55 percent. Member is taking medication for diabetes and high cholesterol. A1C is 9.1 and compliance is 60 percent; Total cholesterol is 195 and compliance is 55 percent.

**Moderate Instability (DVS: 3-5)** – Members who have a few (one to two) chronic medications / chronic diseases with borderline compliance (65-75 percent). Member is relatively controlled. Member follow-up can occur every six months.

Examples: Member has borderline diabetes with an A1C of 7.5. Compliance to medications is 70 percent. Member has high blood pressure. Blood pressure is 140/95 and compliance is 75 percent.

**Low Instability (DVS: 1-2)** – Member is on one chronic medication for a single chronic disease, and is relatively stable. Disease is controlled with non-pharmacological interventions. Follow-up annually unless there is an event change.

Examples: Member has high blood pressure. Blood pressure is 125/80 and compliance is 85 percent. Member has high cholesterol. Total cholesterol is 160 and compliance is 88 percent.

**Minimal Instability (DVS: 0)** – Member is on minimal or no medications. Follow-up is on an "as needed basis." Examples include:

- In the past year, Member has filled a single prescription for an antibiotic for a respiratory infection.
- In the past year, Member has not filled any prescriptions.

Members with the highest DVS scores are listed each month for each Panel to assure focused attention on them in an attempt to prevent the inevitable breakdown. These Members are included in the top 10-50 lists presented each month to Panels (Section V) as well as in the HealthCheck Summary (Category A) provided at the front of the SearchLight Report.

The iCentric System automatically flags these cases for a CMR. This consult is typically performed by the local pharmacist who filled most or all of the prescriptions the Member is on. The pharmacist consults, as necessary, with the physicians who prescribed the medications as well as with the PCP of the Member. Results are returned via the iCentric System and made part of the updated Member Health Record that is available 24 x 7 to the PCP, LCC, or CM, and other treating providers of the Member.

## Appendix N: Method For Charging TCCI Care Coordination Fees As Debits To Patient Care Accounts (PCAs)

There are three main components to TCCI Care Coordination fees as applied to Panel debits in PCAs:

1. **PCP Fees** – These include PCMH PCP Participation Fees and Care Plan initiation and maintenance fees that are paid to PCPs as part of the FFS reimbursement to the provider.

2. **Care Coordination Fees** – These are the actual fees for Care Coordination activities that are carried out by licensed professionals, most commonly nurses. These fees are debited on a monthly PMPM basis for nursing-based Care Coordination, but other coordination activities may also be debited. For example, EMP services are rendered on a FFS basis, while CMRs are charged just one time for a review. These fees apply only to Members who actually receive Care Coordination services and only in months when the service is active and approved by the PCP with the Member's consent. This provides checks and balances as the Member receives Care Coordination services under the guidance and oversight of the PCP.

3. **Member Cost Share Waiver** - This component applies to waivers of Member cost sharing for specific professional services that may be applicable in carrying out a Care Plan, excluding drugs or services performed in or by a hospital. This is known as the "Cost Share Waiver" and is only made available to those Members who actively comply with the terms of a Care Plan. When not in compliance, the Cost Share Waiver is suspended until the Member returns to compliance. If a Member does not comply, the Care Plan and cost share waiver are terminated.

Hence, the costs for the three components of TCCI above are highly targeted for Members who understand and consent to Care Coordination (always under the direction of the guiding authority of the Member's PCP) and only for as long as the active period of Care Coordination lasts.

As a guiding rule of thumb, combined TCCI Care Coordination activities typically account for two to three percent of total debits. The activities described above that qualify to be debited to the PCA of the Panel are subject to claims runout and are treated as any other debits would be in this respect. This assures that all costs of care, as well as all the costs of coordinating care, are taken into account before savings are calculated against the budgeted credits of a Panel.

## Appendix O: Method For Calculating Panel HealthCheck Scores – Five Areas For Focused Action

**UPDATE PENDING**

## Appendix P: Method For Determining Panel Cost Efficiency For The PCMH Plus Program

In order for PCPs in a Panel to receive an invitation to participate in the PCMH Plus Program, the Panel must meet five qualifying conditions, the last of which relates to the overall cost efficiency of the Panel. Specifically, the Panel must have produced an Illness Burden adjusted aggregate medical cost PMPM over the prior three Performance Years that is in the upper third of all Panels in the same peer group (adult, pediatric and mixed) in its geographic sub-region.

Two different tests are used to determine if this condition has been met. An otherwise qualifying Panel must meet one of these tests.

### Test 1. Illness Burden Adjusted PMPM

The first test calculates the cumulative Illness Burden adjusted PMPM cost for each Panel over the most recent three years of its experience in the PCMH Program. This is expressed as a single weighted PMPM dollar amount for the full three-year period. Different weights are assigned to each of the three years in calculating this amount as shown below. This places greatest weight on the most recent experience of each Panel but does not ignore earlier experience since pattern results are best seen over a multi-year period.

| | |
|---|---|
| Most recent year | 50 percent |
| Next most recent year | 30 percent |
| Oldest year | 20 percent |

All costs used in this calculation are taken directly from the Panel's Patient Care Account data as shown in the Panel's SearchLight report. Costs are Net Medical Debits, after applying Individual Stop Loss protection and excluding pharmacy debits since the proportion of pharmacy to medical costs can vary widely depending on the proportion of a Panel's membership with pharmacy coverage through CareFirst.

The calculation of the Illness Burden adjusted PMPM performed for the three-year period 2012-2014 is illustrated below based on Net Medical Debits for a fictitious PCMH Panel.

| Metric | 2012 | 2013 | 2014 | Weighted PMPM |
|---|---|---|---|---|
| Net Medical Debits | $4,700,000 | $4,841,000 | $4,937,820 | |
| Member Months | 16,500 | 16,400 | 16,600 | |
| Raw PMPM | $284.85 | $295.18 | $297.46 | |
| Illness Burden Score | 1.25 | 1.23 | 1.21 | |
| **Illness Burden Adjusted PMPM** | $227.88 | $239.99 | $245.83 | **$240.49** |
| Weight | 20% | 30% | 50% | |

This calculation is completed for all Panels within each peer group (adult, pediatric and mixed) in each of the 20 sub-regions in the PCMH Program. Panels that have performed in the upper third of all their peer Panels in their sub-region meet the qualifying condition on cost effectiveness specified by Condition #4 of the PCMH Plus Program.

The chart on the next page shows a sample peer group and sub-region with six Panels, two of which qualify by being in the top third of their group:

| Region | Peer Group | Panel | Weighted IB Adjusted PMPM | Qualified |
|---|---|---|---|---|
| 1 | Adult | Panel 1 | $240.49 | Yes |
| 1 | Adult | Panel 2 | $257.12 | Yes |
| 1 | Adult | Panel 3 | $262.98 | No |
| 1 | Adult | Panel 4 | $263.55 | No |
| 1 | Adult | Panel 5 | $265.04 | No |
| 1 | Adult | Panel 6 | $273.36 | No |

**Test 2. Actual vs. Expected Costs by One Point Illness Burden Interval**

An alternative test calculates the average cost attained over the last three years by all Panels for each one point of Illness Burden Score (e.g., from 0 to 1 IBS, 1 to 2 IBS and so on, with an additional break at 0.25 to separate the Healthy and Stable Bands). Adult and pediatric Members are calculated separately in this step. The result becomes an "expected" or benchmark cost for each one-point level of illness for all adult and pediatric Members. This calculation is performed for each Panel peer type (adult, pediatric and mixed), without regard to geographic sub-region in order to determine a robust average built on a large enough volume of cases to create valid results within each one-point integer of Illness Burden Score.

To further enhance the creditability of results, only data for otherwise qualifying Panels is used in the expected cost calculations. (i.e., Panels that fail to meet basic Member size or Engagement Score qualifications are excluded).

Each Panel's actual Member Months are then determined for each of these one-point Illness Burden Score intervals and multiplied by the respective "expected" PMPM cost for each interval.

| Adult s (age 21 and older) | | | | Pediatric Members (under 21) | | |
|---|---|---|---|---|---|---|
| **Illness Burden Interval** | **Panel Member Months** | **Peer Group Expected PMPM** | **Total Expected Panel Cost** | **Panel Member Months** | **Peer Group Expected PMPM** | **Total Expected Panel Cost** |
| | 3 | $15,000 | $45,000 | 0 | $10,000 | $0 |
| > 50.00<br>45.00 – 49.99<br>40.00 – 44.99 | 1 | $10,000 | $10,000 | 0 | $9,000 | $0 |
| | 6 | $9,000 | $54,000 | 0 | $8,000 | $0 |
| 35.00 - 39.99 | 13 | $8,000 | $104,000 | 0 | $7,000 | $0 |
| | 17 | $7,600 | $129,200 | 1 | $6,500 | $6,500 |
| 30.00 – 34.99<br>25.00 – 29.99<br>20.00 – 24.99 | 16 | $6,600 | $105,600 | 0 | $6,000 | $0 |
| | 25 | $6,100 | $152,500 | 1 | $5,500 | $5,500 |
| 15.00 - 19.99 | 29 | $5,500 | $159,500 | 1 | $4,000 | $4,000 |
| | 32 | $4,500 | $144,000 | 0 | $3,500 | $0 |
| 14.00 – 14.99<br>13.00 – 13.99<br>12.00 – 12.99 | 48 | $4,000 | $192,000 | 2 | $3,000 | $6,000 |
| | 21 | $3,500 | $73,500 | 1 | $2,800 | $2,800 |
| 11.00 - 11.99 | 34 | $3,200 | $108,800 | 0 | $2,600 | $0 |
| | 31 | $2,900 | $89,900 | 0 | $2,400 | $0 |
| 10.00 – 10.99<br>9.00 – 9.99<br>8.00 – 8.99 | 19 | $2,700 | $51,300 | 0 | $2,200 | $0 |
| | 48 | $2,500 | $120,000 | 1 | $2,000 | $2,000 |
| 7.00 - 7.99 | 72 | $2,200 | $158,400 | 2 | $1,700 | $3,400 |
| 6.00 - 6.99 | 80 | $1,800 | $144,000 | 3 | $1,600 | $4,800 |
| 5.00 - 5.99 | 90 | $1,300 | $117,000 | 3 | $1,300 | $3,900 |
| 4.00 - 4.99 | 213 | $1,100 | $234,300 | 6 | $1,100 | $6,600 |
| 3.00 - 3.99 | 398 | $850 | $338,300 | 9 | $600 | $5,400 |
| 2.00 - 2.99 | 965 | $650 | $627,250 | 18 | $400 | $7,200 |
| 1.00 - 1.99 | 2,554 | $330 | $842,820 | 55 | $300 | $16,500 |
| 0.25 - 0.99 | 5,397 | $130 | $701,610 | 96 | $200 | $19,200 |
| 0.00 - 0.249 | 6,068 | $30 | $182,040 | 221 | $150 | $33,150 |
| **Total** | **16,180** | | **$4,885,020** | **420** | | **$126,950** |

The Panel's total actual costs are then compared to the aggregated "expected" costs for the Panel given its distribution of Members across all one-point Illness Burden Score intervals. This enables a determination of whether a Panel's actual costs are better or worse than expected. In the example above, the hypothetical Panel would have a total expected cost of $4,885,020 for its adult population and $126,950 for its pediatric population, or a combined expected value of $ $5,011,970 for the Performance Year. This process is repeated for each of the past three years, with a resulting Savings Percentage calculated for each year. These are weighted 20 percent/30 percent/50 percent as was done in Test 1 above.

This is illustrated for our sample Panel in the following chart:

| Metric | 2012 | 2013 | 2014 | Weighted Savings % |
|---|---|---|---|---|
| Total Actual Debits | $4,700,000 | $4,841,000 | $4,937,820 | |
| Total Expected Debits | $4,800,000 | $4,900,000 | $5,011,970 | |
| Savings Percent | 2.1% | 1.2% | 1.5% | **1.5%** |
| Weight | 20% | 30% | 50% | |

Panels that have performed in the best third of all their peer Panels in their sub-region in terms of their three-year weighted percent savings meet the alternative test for qualifying under Condition #4 of the PCMH Plus Program. Panels without comparable peer Panels within their sub-region must have a positive overall weighted cost savings percent in order to satisfy Condition #4.

Panels that meet one or both tests are deemed to have qualified under Condition #4. In the following example, Panel 3, shown at the top, failed to qualify under Test 1, but qualified under the alternative test by being in the top third of all its sub-region based on Savings Percent:

| Region | Peer Group | Panel | Weighted Illness Burden Adjusted PMPM | Savings Percent | Qualified |
|---|---|---|---|---|---|
| 1 | Adult | Panel 3 | $262.98 | 2.6% | Yes |
| 1 | Adult | Panel 1 | $240.49 | 1.5% | Yes |
| 1 | Adult | Panel 2 | $257.12 | 1.2% | Yes |
| 1 | Adult | Panel 4 | $263.55 | 0.4% | No |
| 1 | Adult | Panel 5 | $265.04 | -2.4% | No |
| 1 | Adult | Panel 6 | $273.36 | -4.8% | No |

Additional considerations will be made for Panels already included in the PCMH Plus program to remain - whether or not the Panel remains in the top third of all Panels in its geographic sub-region. The Panel may remain in PCMH Plus if one or more of the following conditions are met:

- The Panel's growth in Illness Burden adjusted global PMPM is less than or equal to 75 percent of the OMT applicable to the entire PCMH Program.
- The Panel is within 1.5 percent of the highest permissible three-year Illness Burden PMPM for the top third of all Panels in its geographic sub-Region.
- The Panel is within 0.5 percent of the lowest permissible savings rate for the top third of all Panels in its geographic sub-region, and the Panel has costs that are below expected.

## Appendix Q: Method For Calculating Completion Factors For Debits To Patient Care Accounts (PCAs)

Prior to 2017, monthly Patient Care Account (PCA) results in PCMH SearchLight have been shown on a three-month lag, so that January debits with claims paid through April are reported in May and so forth. This lag was implemented in order to account for the time delay from when a service occurs to when the claim for that service is received and paid by CareFirst.

Typically, only 50 percent of all medical and pharmacy claims are received and paid in the same month in which a service occurs, while approximately 97 percent of medical and pharmacy claims are paid within the three months following the month of the service. While waiting for this lag to complete has ensured that Panel debits are not significantly understated when they are reported in SearchLight, it has limited the ability of Panels to observe and respond to the most recent changes in the Panel's PCA.

Starting in 2017, the claims (debit) reporting lag will be reduced from three months to two months for monthly PCA results in SearchLight. While this allows Panels to see emerging budget trends earlier, the reported debits are less complete, especially earlier in the year when the impact of the most recent month weighs more heavily. As each year progresses, the older months' approach 100 percent completion of claims paid and the combined year to date debits become more representative of the Panel's overall performance.

From 2017 onward, PCMH Panel debits will be reported with a two-month lag until the final report for each Performance Year, which will include an additional month of paid claims (the March following the Performance Year). In order to allow complete run out of paid claims (as has always been the case since PCMH Program inception).

To compensate for the reduced claims runout period for reporting, completion factors will be included in the monthly PCA reports to provide an estimate of the Panel's YTD debit position versus its credits. Completion factors are set using historical PCMH debit payment patterns from prior years, taking into account seasonality and the "incurred to paid" timing for professional, facility, and pharmacy claims. Completion factors are calculated using the historical percentage of incurred claim dollars that were paid through each month compared to the total dollars that were ultimately paid through March of the following year.

The Completion factors for 2017 shown below are illustrative:

| YTD Service Dates Thru | Claims Paid Thru | Percentage Complete |
|---|---|---|
| Jan-15 | Mar-15 | 94.5% |
| Feb-15 | Apr-15 | 96.1% |
| Mar-15 | May-15 | 96.9% |
| Apr-15 | Jun-15 | 97.3% |
| May-15 | Jul-15 | 97.7% |
| Jun-15 | Aug-15 | 98.0% |
| Jul-15 | Sep-15 | 98.3% |
| Aug-15 | Oct-15 | 98.7% |
| Sep-15 | Nov-15 | 98.8% |
| Oct-15 | Dec-15 | 98.9% |
| Nov-15 | Jan-16 | 99.2% |
| Dec-15 | Feb-16 | 99.5% |
| Dec-15 (final) | Mar-16 | 100.0% |

PCMH SearchLight PCA reports will continue to show actual debits by month and in total for the Performance Year. But, for the first time, the reports will also include an estimated year-to-date completion factor, based on historical patterns, and a corresponding estimate of completed debits for the Panel. This will facilitate a more meaningful comparison with year-to-date credits so that the Panel can better track changes to its estimated savings rate over time.

It is important to note that while region wide completion rates are fairly stable from year-to-year, Panel specific completion can vary as much as five percent. This suggests caution in reviewing Panel results inclusive of depending on provider payment patterns, Member demographics, and geographic factors. This suggests caution in reviewing Panel results inclusive of completion factors, especially early in a Performance Year.

## Appendix R: Glossary Of Key Terms And Acronyms

**Acamprosate -** A medication for people in recovery who have already stopped drinking alcohol and want to avoid drinking. It works to prevent people from drinking alcohol, but it does not prevent withdrawal symptoms after people drink alcohol.

**Addiction -** A term used to indicate the most severe, chronic stage of substance-use disorder, in which there is a substantial loss of self-control, as indicated by compulsive drug taking despite the desire to stop taking the drug. In the DSM-5, the term *addiction* is synonymous with the classification of severe substance use.

**Applied Behavioral Analysis (ABA) -** The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree.

**Attribution –** The process used to associate Members with their treating PCP, based on a nationally accepted algorithm using claims history and, for HMO benefit Plans, Member enrollment selections of a PCP.

**Autism Spectrum Disorders (ASD) -** Complex neurodevelopmental disorders which are associated with mild to severe persistent impairments in social interaction and communication.

**Base Year –** The one year or two years prior to a Panel's entry into the PCMH Program depending on panel enrollment size that is used to establish the underlying costs and illness patterns of each Panel's population of attributed Members.

**Base Year Rate Per Member Per Month ("PMPM") –** The aggregate costs PMPM for each Panel in the Base Year.

**Behavioral Health And Substance Use Disorder Program (BSD) -** This TCCI Program uses specially trained behavior health and substance use professionals who provide coordination of care and services, including community support services; as well as administer specialized outcome assessments. Services are designed to care for Members who have disorders such as depression or psychosis, whether they are stand alone or accompany a physical illness. There is a focus on the integration of medical and behavioral health disorders.

**Behavioral Health Care Coordinator (BHCC) -** Specialty trained behavioral staff, with clinical experience in the areas of behavioral health and substance use, support the coordination of care by providing assessment and coordination of Member needs. Members who meet criteria will be referred for Behavioral Health Substance Use Disorder Care Coordination services.

**Behavioral Health Hospital Transition Coordinator (BHTC**) - Specialty trained, licensed behavioral health or substance use professionals who monitor admissions to behavioral health and substance use hospitals or institutions anywhere in the country. Upon admission and throughout the hospital stay, these professionals identify and assess Members' clinical and other needs with a specific focus on coordination of post discharge services. The majority of these Members will be referred to BHCM services. Members will also be referred to other TCCI Programs, as appropriate.

**Buprenorphine -** Used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. It can come in a pill form or sublingual tablet that is placed under the tongue.

**Care Coordination Debits –** Fees associated with TCCI Care Coordination Programs. These fees appear as Debits against a Panel's PCA and are usually expressed as monthly or case fees.

**Care Plan** – A plan directed by the PCP and coordinated by an LCC, with Engagement by the eligible Member.

**CareFirst Business Intelligence (CBI) -** All data - both claims-based and non-claims data – that is stored in CareFirst's data warehouse.

**Centers of Distinction Program (CDP) –** This is a TCCI Program focused on highly specialized, high cost categories of hospital care. Hospitals that demonstrate expertise in delivering quality specialty care in these high volume/impact specialty areas are designated by the Blue Cross Blue Shield Association as Blue Distinction Centers.

**Chronic Care Coordination (CCC) –** This TCCI Program provides coordination of care for Members with multiple chronic illnesses. While Care Plans often result from a case management episode, they also originate from a review of the trailing 12 months of healthcare use by an attributed Member who is identified as likely to benefit from a Care Plan. Care Coordination for these Members is carried out through the Local Care Coordinator (LCC) who is assigned to each PCP within a Panel. The LCC assists the PCP in coordinating all Elements of the Member's healthcare and ensures all action steps in the plan are followed up and carried out.

**Common Model –** This refers to the incorporation of Medicare FFS Beneficiaries into PCMH and TCCI Programs in which all PCMH Program elements are applied to Medicare FFS Beneficiaries just as they are to CareFirst Members. The "Common Model" has been enabled by the CMMI Innovation Award Pilot Program so that CareFirst Members and Medicare FFS Beneficiaries are governed by the same rules and incentives. This creates a single incentive, accountability and population health Program "model" that is referred to as the "Common Model."

**Community-Based Programs (CBP) -** This TCCI Program is a compendium of local Programs that have been reviewed and selected in advance by CareFirst to be made available to Members with identified needs who could benefit from such Programs. The Service Request Hub connects Members to specific services such as diabetes, congestive heart failure and palliative are/hospice programs.

**Complex Case Management (CCM) –** This TCCI Program uses specially trained nurses who provide complex and specialty case management, coordination of care and services, assistance with medical benefits, and access to Community-Based Services. Complex Case Managers have extensive experience in certain diseases and conditions common to Members at the top of the Illness Burden Pyramid (Band 1 and upper Band 2 in the Illness Burden Pyramid).

**Complex Case Manager –** This is a registered nurse who works with a treating physician who is a specialist in order to coordinate the care needs of certain Members with complex medical conditions in accordance with the guiding principles of case management for complex specialty care including, but not limited to, oncology, hospice, rehabilitation, trauma, and high-risk pregnancy. These nurses carry out of the CCM Program.

**Comprehensive Medication Review Service (CMR) –** This service is part of the Pharmacy Coordination Program and is offered to Members where there are indications of high potential for drug interaction, overdosing, side effects, etc. The review is performed by a local pharmacist who consults with prescribers. High Rx use, high cost and high Drug Volatility Score (DVS) Members are flagged for a comprehensive Rx review by a local pharmacist or specialty pharmacist to assure a Member's drug profile is optimal and to resolve any issues with it. In addition, other cases are identified from data mining for review to reduce problems resulting from dosage or drug interactions, etc.

**Credits –** This is the total expected cost for each attributed Member in a Performance Year. Credits for each Member are calculated using the PMPM adjusted for the Illness Burden Score of the Panel. Credits are posted into the PCA of a Panel each month as a PMPM. When summed, they constitute the target global budget of each Panel.

**Debits –** This is the total medical claims cost (inpatient, outpatient, physician, other providers and pharmacy claims) for each attributed Member in a Performance Year, as well as fees associated with TCCI Care Coordination Programs ("Care Coordination Debits") used by each Member attributed to a PCP in a Panel.

**Disulfiram -** A medication that treats chronic alcoholism. It is most effective in people who have already gone through detoxification or are in the initial stage of abstinence. This drug is offered in a tablet form and is taken once a day. Disulfiram should never be taken while intoxicated and it should not be taken for at least 12 hours after drinking alcohol. Unpleasant side effects (nausea, headache, vomiting, chest pains, difficulty breathing) can occur as soon as 10 minutes after drinking even a small amount of alcohol and can last for an hour or more.

**Engagement Score –** A compilation of five separate components measuring the Engagement of a Panel and its PCPs with the PCMH/TCCI Programs and with Care Coordination activities. The Engagement Composition Score represents 35 of the 100 points on the Quality Scorecard.

**Expert Consult Program (ECP) –** This TCCI Program allows network physicians, Members or CareFirst to seek an outside expert opinion from leading, recognized experts when needed for highly complex treatment situations. CareFirst maintains a consultant Panel and has connections to the top physicians in the country in each specialty and sub-specialty, organized by disease state, which can be quickly accessed for consultations.

**HealthCheck Score –** A numeric score that provides a Panel with an overview of its performance in the current Performance Year. An emphasis is placed on actionable information that is pulled from the detailed data views found within the SearchLight Report.

**Home-Based Services Program (HBS) -** This TCCI Program serves Members in CCM or CCC who often need considerable support at home, sometimes on a prolonged basis. These services can include home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following an assessment of the home situation by an RN Home Care Coordinator (HCC) and become part of the overall plan of care maintained by the LCC or Complex Case Manager responsible for the Member. HBS are often critical to avoiding the cycle of breakdown (admission, readmission) that commonly occurs with Members who have multiple chronic diseases. Only Members specifically referred to the Home-Based Care Coordination Program by a Case Manager or an LCC are eligible for full assessment and integrated home-based services pursuant to a plan of care. Preferred home care agencies are used in the provision of home care services.

**Home Care Coordinator (HCC**) – This is a registered nurse in a specially designated and qualified Home Health Agency who performs an assessment of a Member's home situation and makes recommendations to LCCs or Complex Case Manager about whether HBS are necessary and to what extent.

**Hospital Transition of Care Program (HTC)** – This TCCI Program monitors admissions of CareFirst Members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC Program assesses Member need upon admission and during a hospital stay with a focus on post discharge needs. It begins the Care Plan process for Members who will be placed in the CCM or CCC Programs. The HTC process also categorizes Members based on the level of their severity of need and the nature of their illness or condition so that they can be placed in the best possible "track" for follow-up Care Coordination services and flags cases that will likely result in high cost to ensure they receive the attention they need.

**iCentric System –** This is CareFirst's web-based system that is available 24/7 via the Internet through the CareFirst Provider Portal. It includes Member rosters, Member health records, online referrals, Election to Participate forms and PCAs.

**iCentric Service Request Hub** – This is an online capability that receives, tracks and monitors fulfillment of TCCI Program services that are requested by LCCs and Complex Case Managers.

**Illness Burden Pyramid –** This is a stratification of Members into five bands based on Illness Burden Score. The five bands are:

- Band 1 - Advanced/Critical Illness
- Band 2 - Multiple Chronic Illnesses
- Band 3 - At Risk for Serious Illness
- Band 4 - Stable
- Band 5 - Healthy

**Illness Burden Score** – This is a score for each Member that is based on the Member's unique claims history using the trailing 12 months of claims experience for each Member. This score shows not only the relative current illness level of the Member, but is useful in determining which cohorts of Members are most likely to have high future costs.

**Individual Stop-Loss Protection (ISL) –** This insurance feature offers protection by CareFirst against extremely high cost cases that could distort Debits and Credits. The ISL limits the total amount of actual claims that can be debited against the Panel's PCA for any one Member with annual claims that exceed $75,000. Only twenty percent of any costs above the $75,000 limit are debited against the PCA of a Panel.

**Local Care Coordinator (LCC)** – This is a registered nurse based in a local community who develops and implements Care Plans for certain Members with chronic medical conditions in coordination with the Member's PCP and other treating providers.

**Medical Care Panel or Panel** – This is a small performance team of PCPs formed by an existing group practice or by a number of solo practitioners and/or small independent group practices that agree to voluntarily work together to achieve Program goals. Panels must contain no fewer than five PCPs and no greater than 15.

**Medication Assisted Therapy (MAT) -** The FDA has approved several different medications to treat opioid addiction and alcohol dependence. Because some of the medications used in MAT are controlled substances due to their potential for misuse, a common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused opioid or alcohol. There is no universal agreement on the length of time to prescribe these medications. While many providers attempt to discontinue them after one year, others believe that the rate of relapse can be reduced by longer term treatment.

**MAT Medications and Child Safety -** It's important to remember that if medications are allowed to be kept at home, they must be locked in a safe place away from children. Methadone in its liquid form is colored and is sometimes mistaken for a soft drink. Children who take medications used in MAT may overdose and die.

**Membe**r – This is an individual covered under any health benefit plan issued by CareFirst as well as participants in other Blue Cross and Blue Shield Plans, who may, on occasion, require services while in CareFirst's service area.

**Member Months –** Each month that a Member is attributed to a PCP in a Panel is considered a "Member Month". For Members who are attributed to a Panel PCP continuously over the course of a year, a total of 12 Member Months are counted for that year. For those that are attributable for less than a year, only the months of attribution are counted.

**Member Health Record** – This is a record in the iCentric System of all health services provided to a Member that includes, but is not limited to, Member demographic and claims information and related supplementary information gathered through the various TCCI Programs.

**Methadone -** Used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. Methadone tricks the brain into thinking it's still getting the abused drug. In fact, the person is not getting high from it and feels normal, so withdrawal doesn't occur. Pregnant or breastfeeding women must inform their treatment provider before taking methadone. It is the only drug used in MAT approved for women who are pregnant or breastfeeding.

**Naltrexone -** Used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. This is a short acting opiate/alcohol blocking agent has been used for the last 30 years. Naltrexone works differently than methadone and buprenorphine in the treatment of opioid dependency. If a person using naltrexone relapses and uses the abused drug, naltrexone blocks the euphoric and sedative effects of the abused drug and prevents feelings of euphoria. Naltrexone allows people with alcohol addiction to reduce their drinking behaviors enough to remain motivated to stay in treatment, avoid relapses, and take medication.

**Nurse Practitioner (NP) –** This is a registered nurse certified by a national certification body as an adult nurse practitioner, family nurse practitioner, geriatric nurse practitioner, acute care nurse practitioner or pediatric nurse practitioner providing primary care services in the BlueChoice and Regional Provider networks. The nurse practitioner must have an agreement for collaborating and consulting with a physician of the same specialty participating in the same networks.

**Opioid Overdose Prevention Medication -** FDA approved naloxone, an injectable drug used to prevent an opioid overdose. According to the World Health Organization (WHO), Naloxone is one of a number of medications considered essential to a functioning health care system. This medication is now also available to use in an easier nasal spray form.

**Outcome Incentive Award (OIA) –** This is the award distributed to a Panel based on the Panel's degree of attainment of savings against its total global budget as well as its attainment of quality as measured by an overall Quality Score composed of numerous discrete measures.

**Overall Medical Trend (OMT) –** This is the overall change in year over year aggregate PMPM total health care costs. This change is driven by an increase or change in the utilization of health care services and changes in the cost per unit of care.

**Participation Fee –** A twelve percentage point fee increase applied to CareFirst's Standard Fee Schedules for primary care professional services (excluding supplies and drugs) for all PCPs in a Panel who contract to participate to remain in good standing with the PCMH Program.

**Patient Care Account (PCA) –** This is a non-cash based tabular accounting of a Panel's Debits and Credits. The balance of a Panel's PCA at the end of each Performance Year largely determines whether a Panel will earn an OIA.

**Performance Year –** This is a calendar year period used as the timeframe to assess savings and quality standards in a Panel's attributed population**.**

**Pharmacy Coordination Program (RxP)** –This TCCI Program is available for Members with pharmacy benefits as part of their coverage plan. This includes management of retail and wholesale pharmacy benefits, including formulary management as well as specialty pharmacy benefits for certain disease states (such as hepatitis C, rheumatoid arthritis, and multiple sclerosis) that require high cost pharmaceuticals that must be administered according to rigorous treatment plans. The SPC Program not only delivers cost savings, but also optimizes Member treatment outcomes through a compliance Program that includes refill reminders and side effect management. Management of drugs associated with transplants is included in this category.

**Primary Care Provider (PCP)** – This is a full-time, duly licensed participating medical doctor, doctor of osteopathic medicine or nurse practitioner contracted to render primary care services, in both the CareFirst BlueChoice Participating Provider Network and the CareFirst Regional Participating Preferred Network (RPN) and who has a primary specialty in internal medicine, family practice, general practice, pediatrics, geriatrics, family practice/geriatric medicine and osteopathy.

**Practice Consultant** – This is a CareFirst employee who is a Masters prepared analyst who is trained and assigned to a specific sub-region for the purpose of enabling Panels to see and understand the patterns in their SearchLight data that is critical to their success.

**Quality Score –** A measurement of Panel performance based on various measures of quality most of which are based on standards set by National Standards bodies. This score is a critical component of each Panel's OIA.

**Regional Care Director (RCD)** – This is a registered nurse who is an employee of CareFirst and who is assigned to over-see all Care Plan and data consulting activities in a CareFirst sub-region. There are twenty sub-regions in the CareFirst Service Area.

**Run Out Period –** This is a three-month period following the conclusion of the Performance Year, which allows for the processing of claims data that is used to calculate Debits to be posted to PCAs. The Run Out Period is needed for accurate and complete calculations of the OIA based upon the adjudication of all claims received for services rendered during the Performance Year.

**SearchLight Reports –** These are online views of all cost, demographic and clinical patterns for Panels that are available 24/7. These are used in support of a specific Member or to see patterns for all Members in a particular Panel. They also track, on a pre- and post- Engagement basis, every Member's claims experience in order to assess the degree to which the TCCI and PCMH Program elements are working to improve care to the Member and reduce breakdowns that may involve expensive hospital-based services.

**Standard Fee Schedules –** These schedules include CareFirst fees for professional services rendered by treating providers who are in CareFirst RPN or HMO networks.

**Substance-Use Disorder -** A diagnostic term in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) referring to recurrent use of alcohol or other drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Depending on the level of severity, this disorder is classified as mild, moderate, or severe.

**Target Global Budget –** The aggregate Credits of each Panel's attributed Members in a Performance Year.

**Vivitrol** - Is an extended release form of Naltrexone. The extended release properties of Vivitrol help to maintain patient compliance as it does not have to be used every day.