

Patient-Centered Medical Home (PCMH) 2019 Program Description & Guidelines – Adult Medicine

Key Terms and Definitions

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

Panel Size

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

To form a Panel, PCPs must organize into a group of five to 15 PCPs. A Panel may be formed by an existing group practice, small independent group practices, and/or solo practitioners that agree to work together to achieve Program goals. When a Panel is between five and 15 PCPs, it is large enough to reasonably pool member experience for the purpose of pattern recognition and the generation of financial incentives, yet small enough for each PCP's contribution to be perceived as meaningful. The idea is to tie rewards as directly as possible to individual PCP performance while providing enough experience to support sound conclusions about overall performance for each Panel.

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

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

Panel Viability

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

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

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

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

Panel Composition

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

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

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

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

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

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

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

Panel Types

There are five types of Panels participating in the PCMH Program

Virtual Panel: A Virtual Panel is a voluntary association of small, independent group and/or solo practices formed by contract with CareFirst. The PCPs in the Panel agree to work together to provide services to CareFirst Members, use each other for coverage and work as a team in improving outcomes for their combined CareFirst population. CareFirst reviews and approves the formation of all Virtual Panels. PCPs in these Panels should practice within a reasonably proximate geographic distance from each other to ensure meaningful interactions among PCP Panel members.

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

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

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

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

Panel Peer Types

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

PCP Access

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

Concierge Practices

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

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

1. The Panel PCPs must make it clear that no fee, charge or payment of any kind is required of a CareFirst Member in order to become and/or remain a Member attributed to the PCP or medical practice (other than the payment of ordinary deductibles, co-pays and co-insurance under the member's CareFirst benefit contract);
2. There must be no differences in the treatment, care, access, responsiveness, engagement, communications, etc., provided to CareFirst Members who do not pay the fee compared to those who pay the fee;
3. The Panel PCPs must set up office procedures and processes in such a way that a Member could not misconstrue a voluntary fee for supplemental services as a requirement to receive covered services; and
4. The Panel PCPs must recognize and agree that CareFirst maintains the right to audit compliance with these assurances, which may include a survey of the PCPs and medical practices' members who are CareFirst Members.

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

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

Online Connectivity and Systems Requirements for PCPs

The PCMH Program is designed to empower PCPs and/or their Local Care Coordinator (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 via CareFirst's provider website.

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

Eligibility for PCMH Participation Incentive

A Panel becomes effective in the PCMH Program on the first day of the second month following CareFirst's receipt of a complete PCMH application and signed network contract addendum from the whole new Panel. Enrollment with a retroactive date is not allowed.

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

outcomes and value in the Program. If Panels do not invest in a way that achieves outcomes and value, the Participation Incentive is at risk of reduction or elimination.

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

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

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

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

Base Period

The Base Period for Panels in 2019 will be an average of Per Member Per Month (PMPM) Medical and Pharmacy Costs from 2016 and 2017. The two-year Base Period reduces volatility and reflects the realities of changes in the local health market. At the start of each Performance Year, the Base Period will shift forward one year and will be restated using the Panel's current PCP composition, lessening the impact of market shifts and adjusting for provider movement across Panels.

Risk Adjustment

With the availability of three years of historical data, CareFirst will transition to ICD-10 diagnosis codes for the 2019 Performance Year. Risk adjustment is calculated with ICD-10 applied to both the Base Period and the Performance Year, assuring the most accurate risk adjustment possible. Risk adjustment will use industry standard DxCG in 2019 as it has in the past to calculate Medical Illness Burden Scores (IBS) for Medical Budget calculation. Pharmacy budgets will be risk adjusted independently for Pharmacy Benefit Members based on the industry standard Pharmacy Risk Grouper which calculates Pharmacy Burden Scores (PBS). Panels' Performance Year budgets are adjusted based on changes in the risk of these two populations from Base Period to Performance Year.

Member Attribution

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

Setting Budget Targets

Budgets for the 2019 Performance Year will be calculated using the Base Period (2016 and 2017) PMPM Medical and Pharmacy costs. Those PMPMs are then risk adjusted and trended forward to create the budget for the 2019 Performance Year population. In 2019, CareFirst will use actual Medical and Pharmacy trends specific to CareFirst's adult population. At the start of the Performance Year, a trend target will be established to set the Panel's budget and will be adjusted to match the actual trend at the end of the Performance Year. Trends will be set based on the portion of health care spending controlled by the owner of the Panels, as described below. Trend targets will adjust each year to bring growth in health care costs in line with wage inflation.

- Independent Panels
 - Medical: CareFirst Medical trend minus 1 percentage point
 - Pharmacy: CareFirst Rx trend minus 1 percentage point
- Health System Panels
 - Medical: CareFirst Medical trend minus 2 percentage points
 - Pharmacy: CareFirst Rx trend minus 2 percentage points

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

Quality Measurement Program Requirements

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

CareFirst Core 10 Measures

Clinical Quality Scores will be a composite of 10 measures based on NCQA and HEDIS recommendations. Measures will now include process-based and outcomes-based measures collected through claims, and may require attestation, clinical data sharing, and survey responses in order for a Panel to achieve all Quality Scorecard points. Details of the inclusion and exclusion criteria for each measure can be found in the CareFirst Core10 Playbook, located in the appendix of this document. The 2019 CareFirst Core10 Measures for Adult Panels are shown below.

Adult Panel Clinical Measures	Points
Population Health Measures	
Optimal Care for Diabetic Population* <ul style="list-style-type: none"> HbA1c Control (<8%) Blood Pressure Control (<140/90) Retinal Eye Exam Chronic Kidney Disease Screening (ACR and eGFR annually) Statin Therapy (adherence) 	10
Management of Hypertension Population* <ul style="list-style-type: none"> Blood Pressure Control (<140/90) 	10
Colorectal Cancer Screening	10
Event-Based Measures	
Use of Imaging Studied for Low Back Pain	10
Follow-up After Emergency Department Visits for Behavioral Health* <ul style="list-style-type: none"> Follow-up after ED Visit for Mental Illness (7 days) Follow-up after ED Visit for Alcohol /Drug Dependence (7 days) 	10
Follow-up After Hospitalization for Mental Illness (7 days) (with mental health practitioner)	10
Risk-Adjusted Measures	
Hospitalization for Potentially Preventable Complications	10
All-Cause Readmission	10
Emergency Department Utilization	10
Survey Measures	
Member Experience Composite <ul style="list-style-type: none"> Getting Care Quickly Getting Needed Care Coordination of Care Rating of Personal Doctor 	10

*composite measure

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

MEASURES	Points Available	BENCHMARKS				
		Not Tiered (0 Points)	Tier 4 (50% Points)	Tier 3 (65% Points)	Tier 2 (80% Points)	Tier 1 (100% Points)
POPULATION HEALTH MEASURES		% COMPLIANCE TO ACHIEVE EACH TIER				
1. Optimal Care for Diabetic Population**	10	<12.06	12.06	19.41	28.53	42.98
▪ HbA1c Control (<8%)		<49.48	49.48	56.93	62.04	68.04
▪ Blood Pressure Control (<140/90)		<52.01	52.01	62.16	69.83	79.08
▪ Eye Exam		<43.07	43.07	50.36	60.17	73.02
▪ Chronic Kidney Disease Screening (ACR and eGFR annually)**		<45.62	45.62	53.47	61.77	68.25
▪ Statin Therapy (adherence)		<62.67	62.67	67.59	71.99	83.39
2. Controlling High Blood Pressure	10	<51.09	51.09	57.77	66.39	78.83
3. Colorectal Cancer Screening	10	<55.23	55.23	61.07	67.19	76.35
EVENT-BASED MEASURES		% COMPLIANCE TO ACHIEVE EACH TIER				
4. Use of Imaging Studies for Low Back Pain	10	<72.23	72.23	76.14	80.30	85.68
5. Follow Up After Emergency Department Composite - with any Practitioner	10					
▪ Follow Up After ED Visit for Mental Illness (7 days)	5	<37.75	37.75	44.42	51.82	68.87
▪ Follow Up After ED Visit for Alcohol/Drug Dependence (7 days)	5	<7.19	7.19	9.97	13.33	19.24
6. Follow Up After Hospitalization for Mental Illness (7 days) - with Behavioral Health Practitioner	10	<38.33	38.33	46.28	54.25	65.42
RISK-ADJUSTED MEASURES		OBSERVED TO EXPECTED RATIO TO ACHIEVE EACH TIER (Lower ratio is better)				
7. Hospitalization for Potentially Preventable Complications	10	NS*	NS*	NS*	NS*	NS*
8. All-Cause Readmissions	10	>0.78	0.78	0.73	0.66	0.54
9. Emergency Department Utilization	10	>1.17	1.17	1.05	0.93	0.73
SURVEY MEASURES		RATE TO ACHIEVE EACH TIER				
10. Consumer Assessment of Healthcare Providers (CAHPS) Composite	10	NS*	NS*	NS*	NS*	NS*
▪ Getting Care Quickly		<83.05	83.05	85.8	87.93	89.91
▪ Getting Needed Care		<85.11	85.11	87.39	89.40	91.01
▪ Coordination of Care		<79.58	79.58	82.68	85.12	87.81
▪ Rating of Personal Doctor		<82.43	82.43	84.94	87.13	89.67
Overall Clinical Score	100					

* Benchmarks not set (NS) and will be determined when 2019 data becomes available

** Indicates a non-HEDIS measure for which the benchmarks were set using actual PCMH scores

Panels must achieve at least 50 out of the 100 total clinical quality points to receive the full Participation Incentive and to be eligible for an OIA.

Engagement Program Requirements

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

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

2019 Engagement Scorecard	Points
I. Engagement with Care Coordination (PCP Level Score by Local Care Coordinator)	25
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
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 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 needs for all other TCCI Program Elements, including Home-Based, Enhanced Monitoring and Expert Consult services.	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 clearly and effectively explains to eligible Members the benefits of care coordination and TCCI Programs, assists in obtaining the Member's "Election to Participate," and works with the Member to set clear goals.	2.5
PCP is collaborative with the LCC, ensuring that the LCC has access to needed clinical information, completes Care Plans on a timely basis, provides consultation about Member status changes as needed, and works actively with Members to encourage compliance.	5.0
Overall, PCP is an active, willing, constructive, partner in achieving PCMH Program goals, helps create an environment in practice that is conducive to conducting the PCMH Program and instructs staff to this end.	5.0
II. Engagement with Practice Consultant (PCP Level Score by Practice Consultant)	30
PCP attends and actively participates in PCMH Panel meetings.	8
PCP provides active, unique email address in iCentric.	2
PCP demonstrates overall comprehension of the PCMH Program through actions, behaviors and words. PCP reviews Panel and PCP level data throughout the quarter with the CareFirst Practice Consultant and understands the relative performance of PCPs within the Panel to implement practice transformation recommendations.	10
PCP effectively manages Members' transition from the hospital or emergency department, including timely post-discharge follow up and co-management with specialists. PCP identifies and communicates with frequently used hospitals, getting notifications of IP admissions and discharges as well as ED visits and discharges.	10
III. Practice Transformation (Practice Level Score by Practice Consultant)	45
Practice identifies cost-efficient specialists in the top specialty categories and has an effective workflow in place to refer Members to cost-efficient specialists in the top specialty categories.	15
Practice participates in clinical data sharing with CareFirst through our preferred data sharing platform or preferred alternative method.	20
Practice has an effective plan for after-hours care to avoid unnecessary ER visits or breakdowns, such as after-hours appointments, the opportunity to speak with a clinician after hours, and telemedicine.	10
Total Points	100

*New measures highlighted in yellow

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

Eligibility for Outcome Incentive Awards

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

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

1. The Panel must have joined the Program on or before July 1st of the Performance Year. If the Panel joins after this date, it will not be eligible for an OIA until the following Performance Year.
2. The Panel must have a cost savings to budget in their Patient Care Account (i.e., Credits must exceed Debits).
3. The Panel must achieve 70 out of 100 points on the Engagement Scorecard and 50 out of 100 on the Clinical Quality Scorecard.
4. Each PCP must complete a clinical status review each month of all Members in their Core Target Population and document all results as an Assessment Outcome.

5. The Panel must be viable by having at least 15,000 Member Months for the Performance Year.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2020 for **Performance Year #9 - 2019**) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2021.). In order to be paid an OIA, the practice must participate in the PCMH Program throughout the incentive pay out period (August 1st - July 31st) following each Performance Year.

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

OIAs are always calculated at the Panel level. Panels that are part of a larger entity may be paid their OIA at the entity level. The entity may elect to be paid this aggregated OIA amount based on combined, weighted results for all Panels (including non-viable and ineligible Panels) or be paid separate OIAs for each winning Panel.

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

Proration of Outcome Incentive Award (OIA)

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

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

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

OIA Formulas Based on Panel Size and Win Years

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

CareFirst Offering Option for Upfront PCMH OIA Payment to Settle 2019 Performance Year: updated April 15, 2020

Due to the COVID-19 Pandemic, CareFirst will be offering eligible Panels an option to accept a one-time, lump sum OIA payment in lieu of the usual fee schedule adjustment effective August 1, 2020 through July 31, 2021. This lump-sum OIA payment (“Lump Sum OIA”) will be based on 25% of the Panel’s shared savings and will be increased or decreased based on the Panel’s performance on quality measures and persistency (the number of consecutive years a Panel has achieved an OIA).

If a practice accepts the Lump Sum OIA, it will not receive the standard OIA, which is based on an adjustment to the provider’s fee schedules. Accordingly, the fee schedules for practices that accept the Lump Sum OIA will return to the normal contracted fee schedule on August 1, 2020, when OIA adjustments for the 2019 Performance Year would normally have gone into effect. Eligible practices will, however, continue to receive the 12 percent Participation Incentive on top of their normal contracted fee schedule through the duration of their participation in the PCMH Program.

Consistent with the Centers for Medicare and Medicaid (CMS) and the National Committee for Quality Assurance (NCQA) actions, CareFirst is removing the Clinical Quality minimum score requirement of 50/100 for the 2019 Performance Year. The PCP Engagement minimum of 70/100 remains, and practices in Panels not meeting this minimum will not be eligible for shared savings in lump sum or standard OIA payout.

Practices, defined by the same Tax-Identification Number, that are interested in opting-in to receive the Lump Sum OIA should look for communication from CareFirst with detailed instructions and deadlines for applying. Practices that opt-in can expect to receive their Lump Sum OIA in May 2020. Panels with multiple Tax Identification Numbers will have their OIA lump sums allocated based on their percentage of the Panel’s 2019 Performance Year Credits.

Practices who decide not to opt-in to the one-time lump sum OIA payment will receive their OIA as defined in the 2019 PCMH Program Description and Guidelines starting on August 1, 2020 for the 2019 Performance Year.

Eligibility for Participation Incentive

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

Practices can earn their 12 point Participation Incentive by engaging in practice transformation and by sharing all PCMH utilization, budget, Quality Scorecard and OIA data with PCPs. Panels who do not meet at least 70/100 on the PCP Engagement Scorecard and 50/100 on the Clinical Quality Scorecard may lose all or portions of their Participation Incentive based on market size category as shown below. Adjustments for Panels losing all or part of the 12 Points will go into effect in August of 2020 based on 2019 Performance.

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

Determining market size category

- Entrepreneurial (3pts): All virtual Panels, single site independent Panels, multi-site independent Panels in a primary care only practice or multi-specialty practice with less than 50 PCPs
- Corporate (6pts): Multi-site independent Panels in a multi-specialty practice or practices with greater than 50 PCPs
- Health System (12pts): Multi-Hospital health systems and/or hospitals that employ a comprehensive range of specialties.

Changes in Participation Incentive will be effective on August 1st of the year following the Performance Year (e.g., August 1, 2020 for **Performance Year #9 - 2019**) and remain in place for a full year until July 31 of the following year (e.g., July 2019 PCMH Program for Adult Medicine

Changes in Panel Composition

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

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

The following rules govern these Panel changes:

1. If a Panel's participation falls below five PCPs it must, within one year, increase its membership to five or more or the Panel will lose OIA eligibility for the Performance Year. If the Panel participation falls below five PCPs for a full year, the Panel will be terminated from the Program. Exceptions may be granted with written request through Panel Governance.
2. A Panel may request an exception to the upper limit of 15 PCPs in writing. For an exception to be granted, the Panel must demonstrate that the Panel practices as a cohesive unit and must provide compelling justification as to why such larger size would not unduly diminish the contribution of each PCP to overall Panel performance.
3. Multi-Panel Independent Group Practices and Multi-Panel Health Systems may choose to have an OIA paid at the entity wide tax identification number (TIN) level, notwithstanding the fact that all OIAs are determined at the Panel level as a Program requirement. In the situation, all Panels under the same TIN will receive a single OIA, determined by the weighted average of each Panel, weighted on size of Panel Debits.
4. If a new PCP or practice joins an existing practice, the reimbursement level of the existing practice will be assumed by the new PCP or practice, including the Participation and OIA Incentive fees (if any), once the new PCP has signed on to the PCMH Program. A new PCP joining an existing practice will only be considered to be a member of the Panel on a prospective basis. No retroactive enrollment is allowed.
5. If a PCP leaves a Panel but remains in the CareFirst HMO and RPN networks without participating in another Panel, the PCP will lose the Participation Incentive and OIA incentive fees at the point they terminate from the Panel.
6. If a Panel changes ownership or Tax ID, but the actual PCPs making up the Panel remain the same, the Panel will be treated as having continuous participation in the PCMH Program for the purposes of OIA and persistency awards.
7. Any practice that joins a Panel is required to be an active PCMH participant of that Panel during the last two complete calendar quarters of the current Performance Year to be eligible for an OIA. That is, only practices that actively participate in the Program by July 1 of the Performance Year are eligible for an OIA for that Performance Year. If a practice joins a Panel after July 1, that practice is excluded from the OIA for that Performance Year. A practice will be considered active in the PCMH Program once the practice has signed both a Panel contract and the PCMH Addendum to their network agreement with CareFirst. A retroactive enrollment date is not allowed for practices that are new to PCMH.
8. Acceptance of a practice into an existing Panel requires unanimous agreement by the Panel, communicated in writing to CareFirst by the Panel's Designated Provider Representative (DPR).
9. If a practice leaves a Panel after the end of a Performance Year, joins another Panel and remains in good standing with the Program, the practice will keep the OIA earned in the previous Panel.

Appeals

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

will notify the appealing PCP and/or Panel of its response in writing within 90 days of the receipt of complete information from the PCP and/or Panel.

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

Signing on with PCMH

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

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

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

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

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

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

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

Termination from PCMH

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

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

A Virtual Panel may change its self-selected team of PCPs at any time, if it continues to meet the minimum size requirements of the Program and notifies CareFirst. The consent of at least three-fifths (3/5) of the PCPs in the Virtual Panel is required to forcibly remove a practice from the Panel.

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

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

2. The practice, PCP and/or Panel has substantial uncorrected quality of care issues.
3. Termination of either the Master Group Participation Agreement, or the Primary Care Physician Participation Agreement which terminates the Group's, PCP's and/or Panel's participation in CareFirst's RPN or HMO networks.
4. Any other termination reason set forth in the termination provisions of the underlying Participation Agreements within the applicable notice periods set forth therein.

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

Termination for Failure to Engage in Care Coordination

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

A PCP or practice that persistently fails to engage with the care coordination components of the Program will be terminated from the Program. The Regional Care Director (RCD), who is the PCMH Program lead for Care Coordination, will have oversight of the termination process as it relates to lack of engagement. When the RCD determines that a PCP or practice, despite multiple in person visits to the PCP's office, fails to engage, the RCD will begin the process of terminating the PCP from the Program.

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

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

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

Disqualification of Participants

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

Appendix A. 2019 Core10 Measure Guide and Playbook

2019 Core 10 Measure Guide

Introduction

The CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) Core 10 is a targeted list of metrics selected to help ensure best-in-class care for our members. This guide provides a high-level overview of each measure. More detailed information can be found in the specifications of the relevant measure steward. If this document is at any time in conflict with the specifications of the measure steward, then the measure steward's rules and specifications apply.

The Value of These Measures for Providers

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

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

Part I. Optimal Diabetes Care

Who is in the Measure?

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

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

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

Exclusions: Members who had gestational diabetes or steroid-induced diabetes during the calendar year or prior year or who are 66 years of age and older with frailty and advanced illness during the year are excluded. The statin sub-measure has additional exclusions, which can be found in the Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications.

Who is Compliant?

Members must meet all five of the sub-measures below to be compliant:

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

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

Criteria for Code	Code	Definition	Code System
HbA1c Level Less Than 7.0%	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	CPT®-CAT-II

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

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

Chronic Kidney Disease Screening: Members who receive screening for chronic kidney disease (CKD) using both albumin-to-creatinine ratio (ACR) and estimated glomerular filtration rate (estimated GFR, eGFR) tests during the year.

Criteria for Code	Code	Code System
eGFR (Serum Creatinine)	80048, 80050, 80053, 80069, 82565	CPT
ACR (Microalbumin)	82043, 82044	CPT
eGFR (Serum Creatinine)	33914-3, 48642-3, 48643-1, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 76633-7, 77147-7	LOINC®
ACR (Microalbumin)	13705-9, 14958-3, 14959-1, 32294-1, 9318-7	LOINC

Retinal Eye Exam: Members who receive a retinal or dilated eye exam by an eye care professional during the year or who had a negative retinal or dilated eye exam by an eye care professional during the prior year.

Statin Therapy Adherence: Members who achieved adherence, defined as a proportion of days covered of at least 80%, after being dispensed a statin medication during the year.

Part II. Optimal Hypertension Care

Who is in the Measure?

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

Exclusions: Members with any of the following:

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

Who is Compliant?

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

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

Part III. Colorectal Cancer Screening

Who is in the Measure?

Members aged 50-75.

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

Who is Compliant?

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

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

Part IV. Use of Imaging Studies for Low Back Pain

Who is in the Measure?

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

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

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

Who is Compliant?

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

Part V. Follow-up After Hospitalization for Mental Illness

Who is in the Measure?

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

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

Who is Compliant?

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

Part VI. Follow-up After Emergency Department (ED) Visit for Behavioral Health

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

Who is in the Measure?

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

Mental Illness: Members aged six and older who were in the ED for mental illness or intentional self-harm.

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

Who is Compliant?

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

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

Part VII. Hospitalization for Potentially Preventable Complications

Who is in the Measure?

Members aged 18 and older.

Who is Compliant?

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

Chronic ACSC

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

Acute ACSC

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

Part VIII. All-Cause Readmission

Who is in the Measure?

Members aged 18-64 with an acute inpatient stay.

Exclusions: Members who experience any of the following scenarios:

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

Who is Compliant?

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

Part IX. Emergency Department (ED) Utilization

Who is in the Measure?

Members aged 18 and older.

Exclusions: ED visits for psychiatry or electroconvulsive therapy, or ED visits with a principal diagnosis of mental health or chemical dependency.

Who is Compliant?

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

Part X. Member Experience Composite

Who is in the Measure?

Members aged 18 and older who are continuously enrolled in health coverage with CareFirst throughout the calendar year.

Who is Compliant?

Members who are randomly selected to participate in a CareFirst panel-level member experience survey and respond with either a nine or ten or Usually/Always as outlined in the question. Possible examples of questions are listed in the four sub-measures below:

Getting Care Quickly

In the last 12 months, how often did you get urgent care as soon as you needed it? (Response options: Never, Sometimes, Usually, Always)

In the last 12 months, how often did you get routine care as soon as you needed it? (Response options: Never, Sometimes, Usually, Always)

Getting Needed Care

In the last 12 months, how often was it easy to get the care, tests or treatment you needed? (Response options: Never, Sometimes, Usually, Always)

In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed it? (Response options: Never, Sometimes, Usually, Always)

Coordination of Care

In the last 12 months, how often did your personal doctor seem informed and up to date about the care you received from these doctors or other health providers? (Response options: Never, Sometimes, Usually, Always)

Personal Doctor

Using any number from 0 to 10, where 0 is the worst possible and 10 is the best possible, what number would you use to rate your personal doctor? (Response options: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10)

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