Patient-Centered Medical Home
2016 Program Performance Report

September 19, 2017

Contents

Overview and Scope of the Model

Overview of the Commercial PCMH/TCCI Program

The CareFirst PCMH/TCCI Program is in its seventh year of commercial region-wide operation

- Includes over 4,300 participating Primary Care Providers managing care for over 1 million CareFirst Members
- Provides financial incentives, clinical supports, and data analytics to PCPs to achieve high levels of quality care and lower total cost of care
- Manages nearly $5 billion a year in total hospital, non-hospital and drug spending for Members
- Generates 50,000-60,000 nurse-prepared care plans per year for high risk/high cost members.
- Has curbed CareFirst's overall medical trend to historic lows over the life of the Program
- Has decreased costly hospital admissions substantially over the life of the Program
- Has led to high levels of sustained member satisfaction that continue to rise as the Program matures

Without Healthcare Cost Control, Not Much Else Matters – CareFirst's PCMH Program

PCMH Five Key Characteristics

- Accountability for total cost of care
- Incentive only
- Information rich
- Behavior change based
- Uniform model

Five Elements of Changed Behavior

1. Effectiveness of referral patterns
2. Extent of engagement in care coordination
3. Effectiveness of medication management
4. Consistency of performance within each Panel of PCPs
5. Gaps in care and quality deficits

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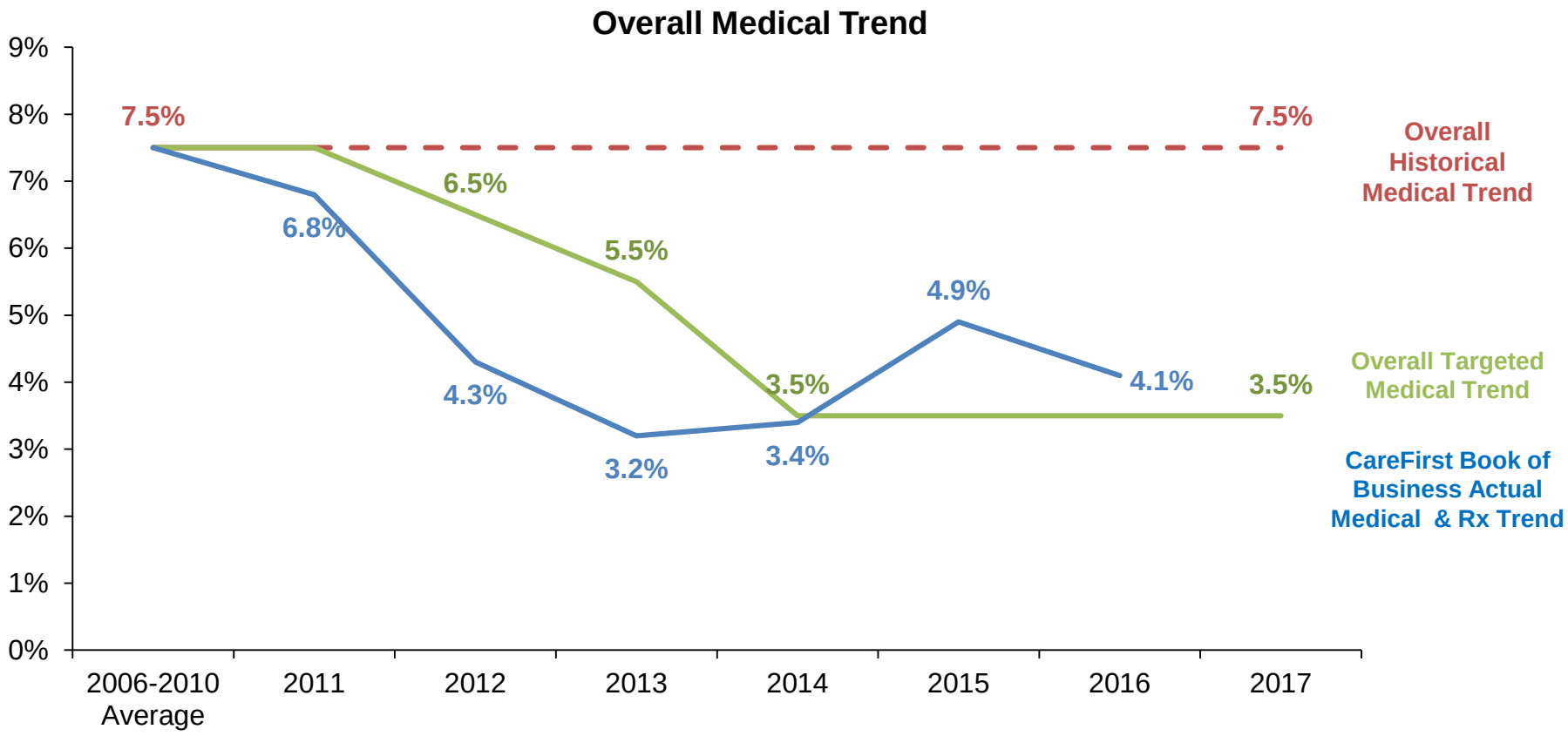
Sustained Favorable Results (2011 – 2016)

Driving and Maintaining Low Overall Medical Trend (OMT)

- Overall medical trend (including pharmacy and adjusted for rebates) in 2016 was 3.2%, excluding the volatility from Individual ACA market segment.
- OMT includes all costs for care coordination activities (1.9%).

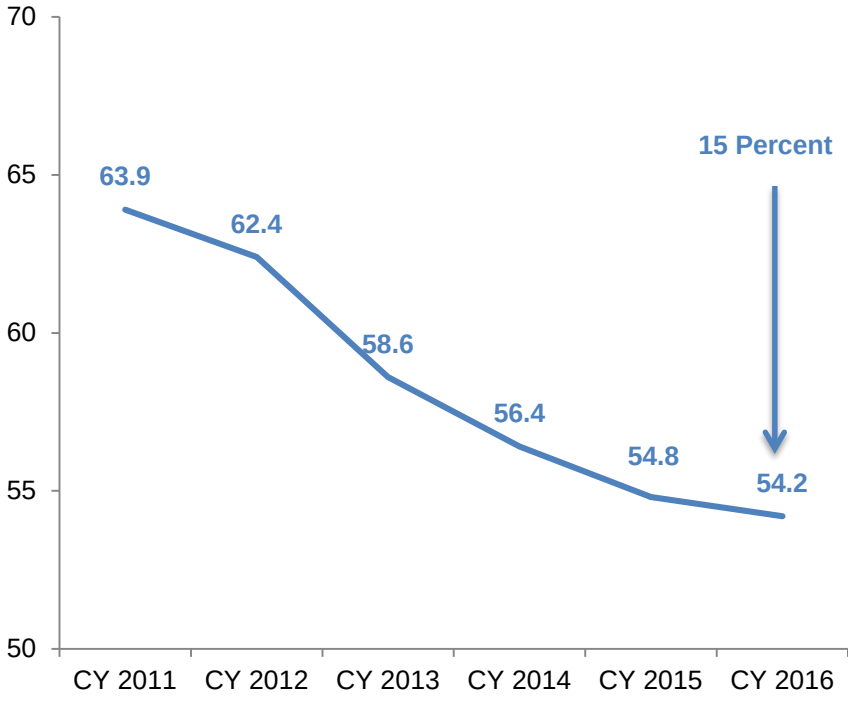


Source: HealthCare Analytics – Includes data through December 2016, paid thru March 2017. CareFirst Book of business, excluding Medicare Primary, Catastrophic and TPA members

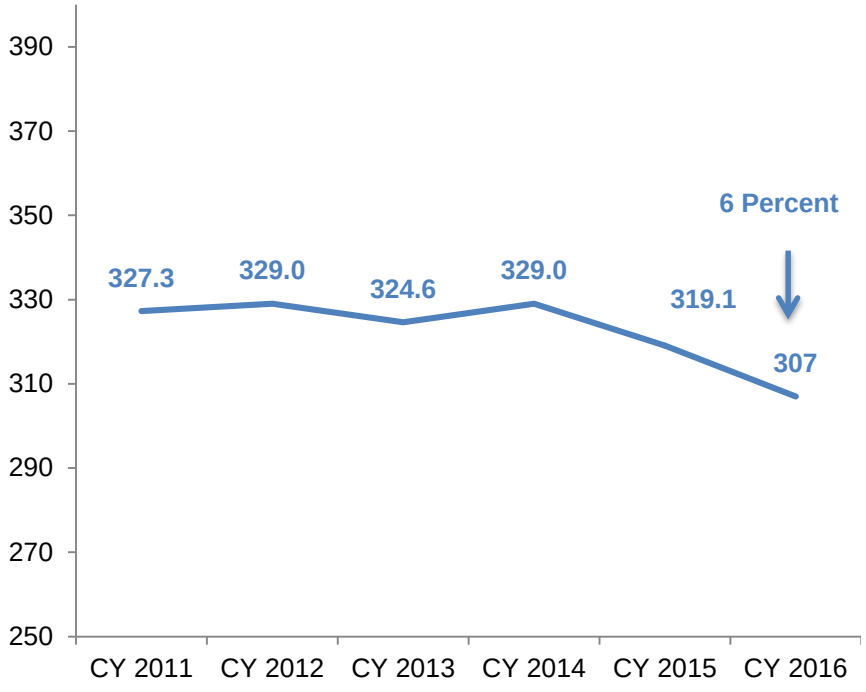
CareFirst In-Service Area Book of Business – Admissions Measures

- The number of Inpatient Admissions per 1,000 and Days per 1,000 continued to decline in 2016 for CareFirst Members

CareFirst Members
Admissions per 1,000



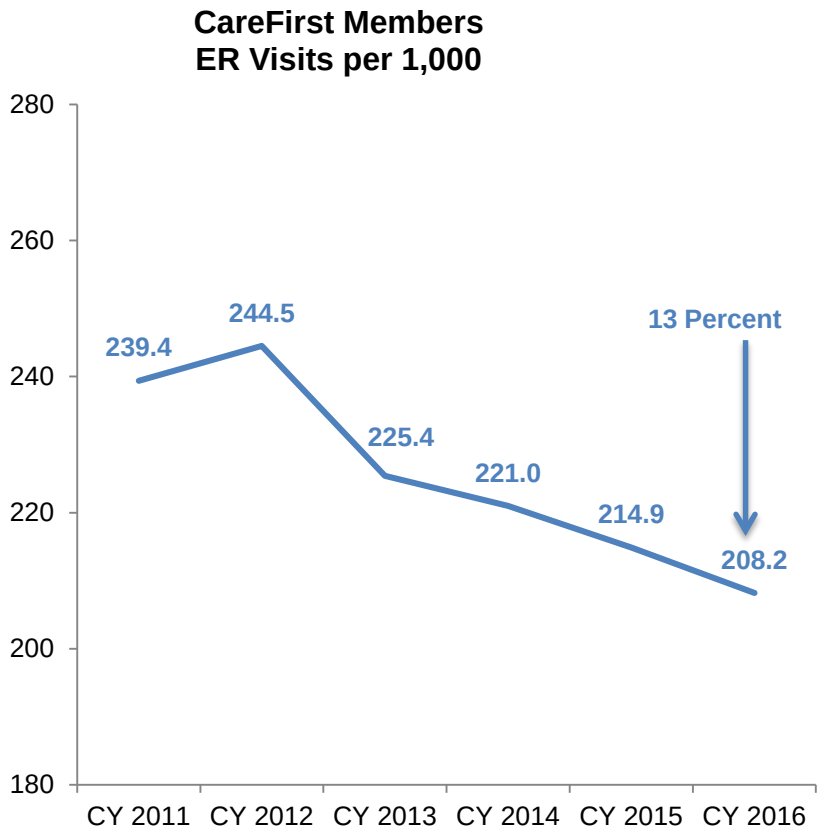
CareFirst Members
Days per 1,000



Source: HealthCare Analytics – Includes data through December 2016, paid thru March 2017. CareFirst Book of business, excluding Medicare Primary, Catastrophic and TPA members

CareFirst In-Service Area Book of Business – Emergency Room Measures

- CareFirst members saw a decrease in ER utilization in 2016, but a steep rise in cost per visit continued, likely due to increased acuity and increased cost as a result of the Maryland All-Payer Hospital Model

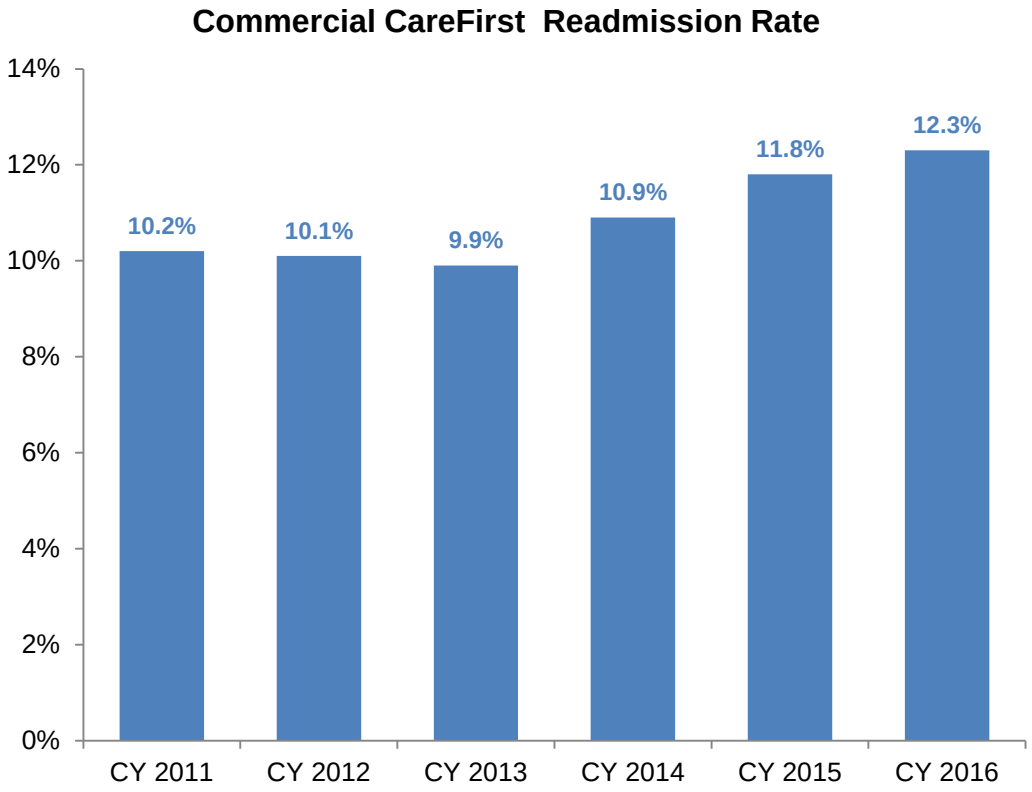


Source: HealthCare Analytics – Includes data through December 2016, paid thru March 2017. CareFirst Book of business, excluding Medicare Primary, Catastrophic and TPA members

CareFirst Commercial and Medicare Readmissions Measures

- Readmissions for the commercial population continued to rise in 2016, due to an increase in the acuity of patients being admitted.

- CareFirst categorizes each admission. Category 1 admissions (More Intensive – Needing Follow Up Care) represent over 70% of all admissions – up from 45% in 2012.

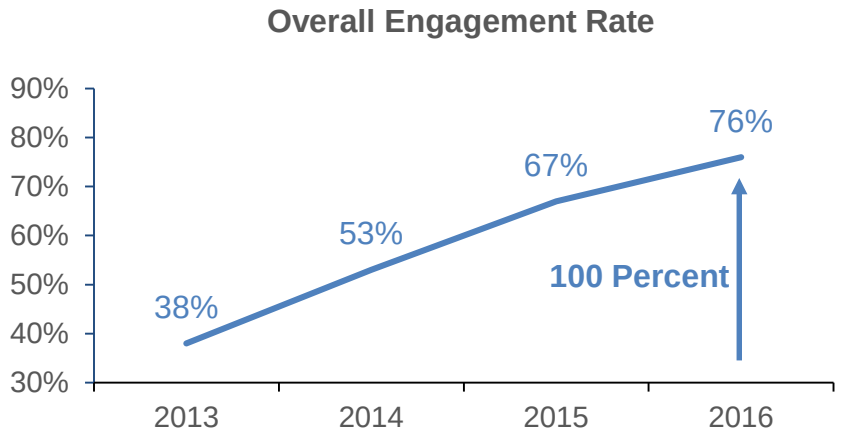


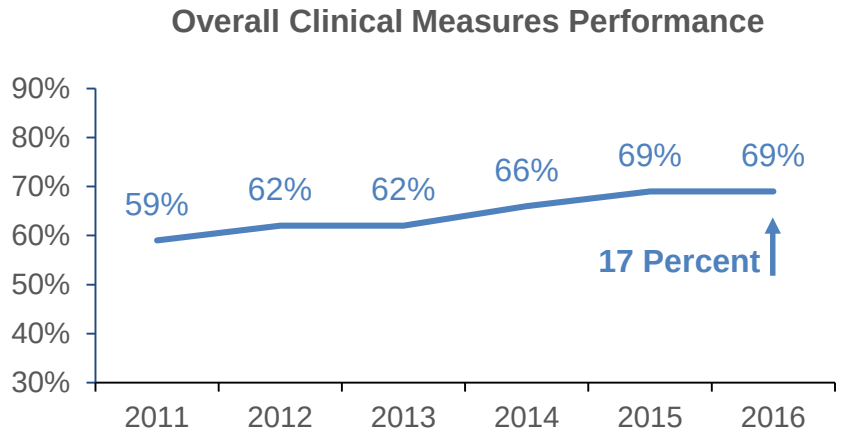
Source: HealthCare Analytics – Includes data through December2016, paid thru March 2017. CareFirst Book of business, excluding Medicare Primary, Catastrophic and TPA members

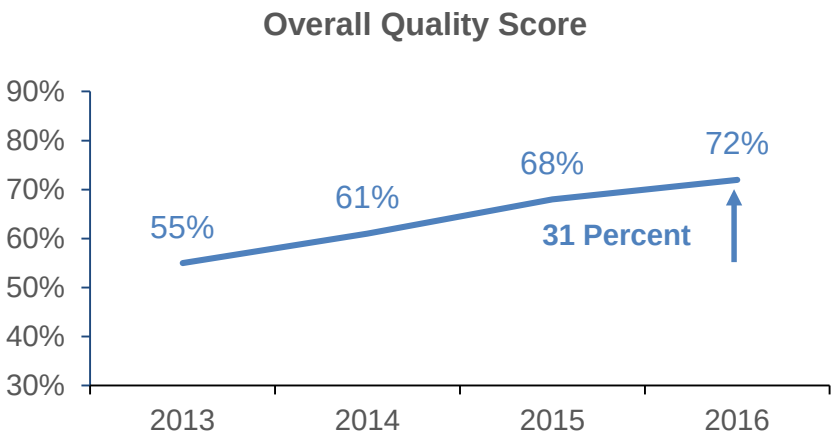
PCMH Quality Scores Steadily Improved

- The Overall Quality Score is an equally weighted average based on the value of the Engagement and Clinical Quality scores. Overall Quality has increase by 31% over 3 years.

- Beginning in 2013, Engagement Score rates across all panels have continued to improve by 12.5% each year .

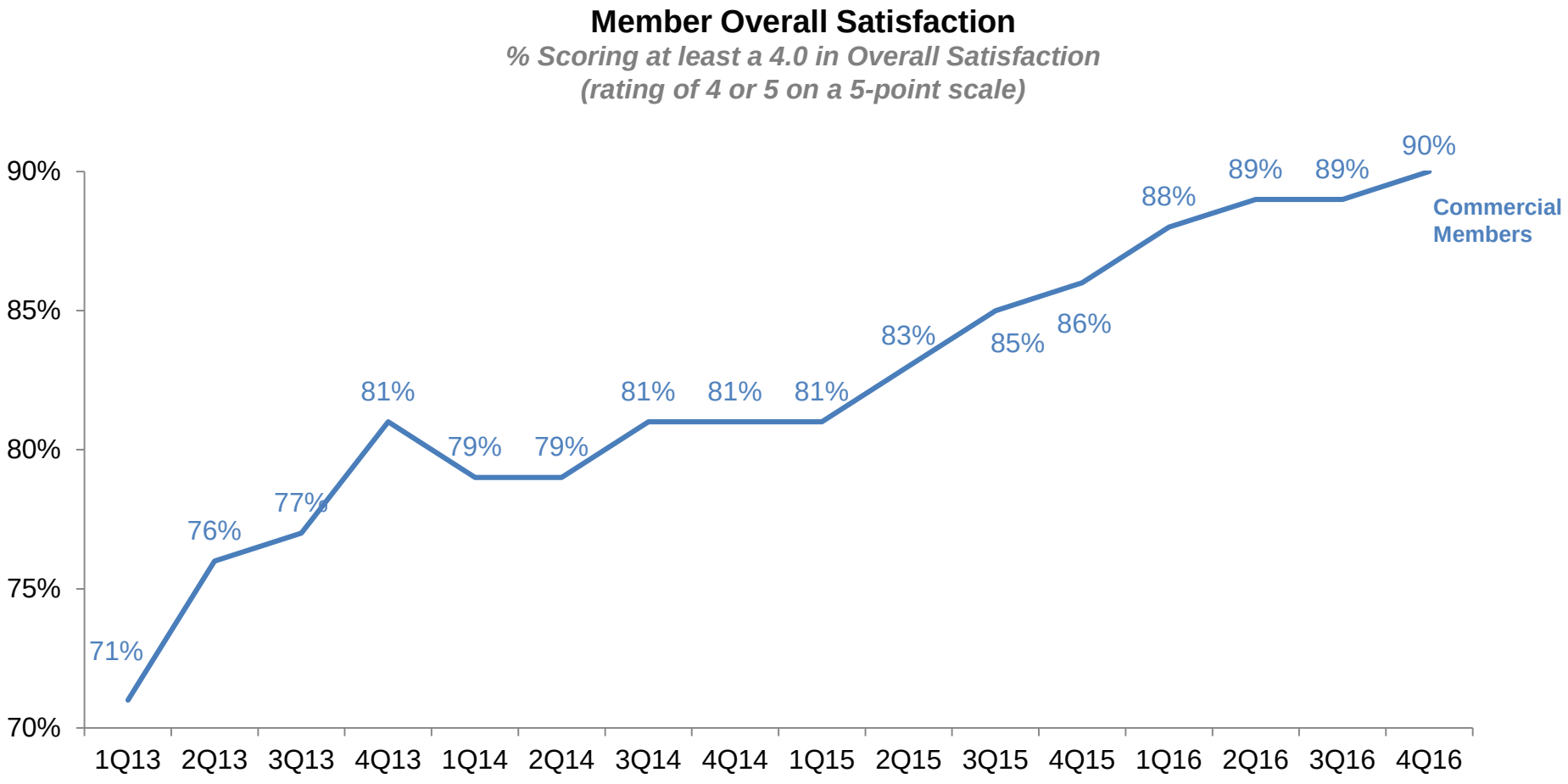






High Overall Satisfaction for Patients in Care Plans

- Ratings from commercial members in care plans have been very high and have risen as the Program matures



Source: CareFirst PCMH Care Plan Survey

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The Facts That Shape the Landscape

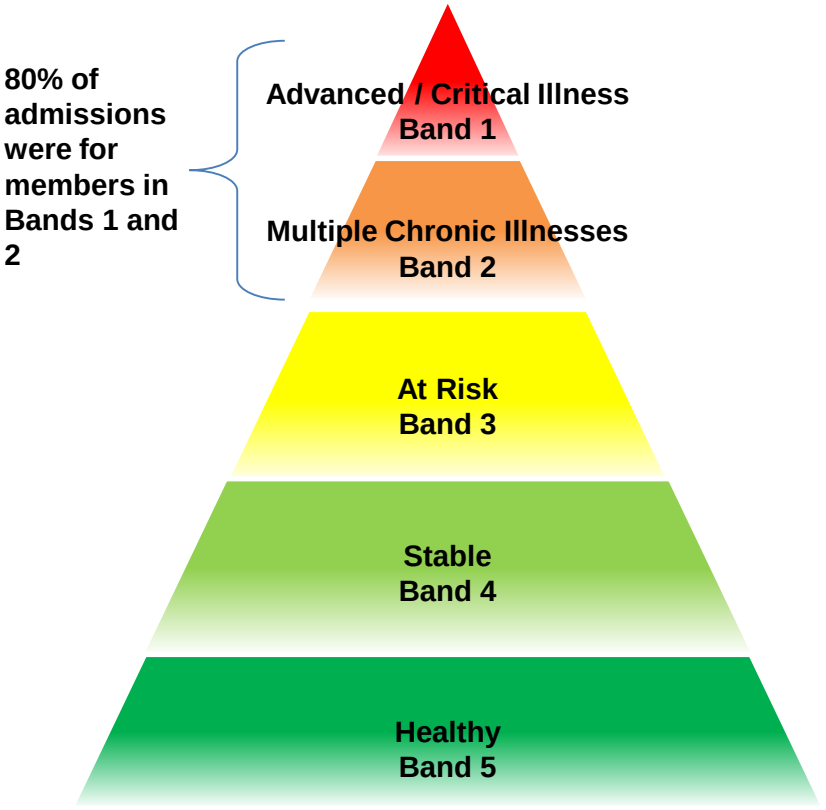
The Experience in the CareFirst Region

- CareFirst Members account for 58% of the non-government commercially covered population in CareFirst's service area
- The region has had some of the highest hospital admission and readmission rates in the nation – that are now declining
- CareFirst customer accounts (often in the services sector) generally have generous benefit designs in the Large Group and FEP (Federal Employee Program) segments and far less generous benefits in the Individual and Small Group segments
- Prior to the start of the PCMH program in 2011, CareFirst's Overall Medical Trend (i.e. rise per Member per month) was regularly between 6% and 9% annually, averaging 7.5% in the 5 – 10 year period preceding the launch of the Program on January 1, 2011

Illness Pyramid – The Rosetta Stone
2016 CareFirst, non-Medicare Primary Population – "Population Health"

- Health care costs are concentrated at the top of the illness burden pyramid – the top two bands account for less than 11% of the population but nearly 60% of total costs

- PMPM cost for the sickest members (Band 1 – Advanced/Critical Illness) is more than 100 times that of the healthiest members (Band 5)

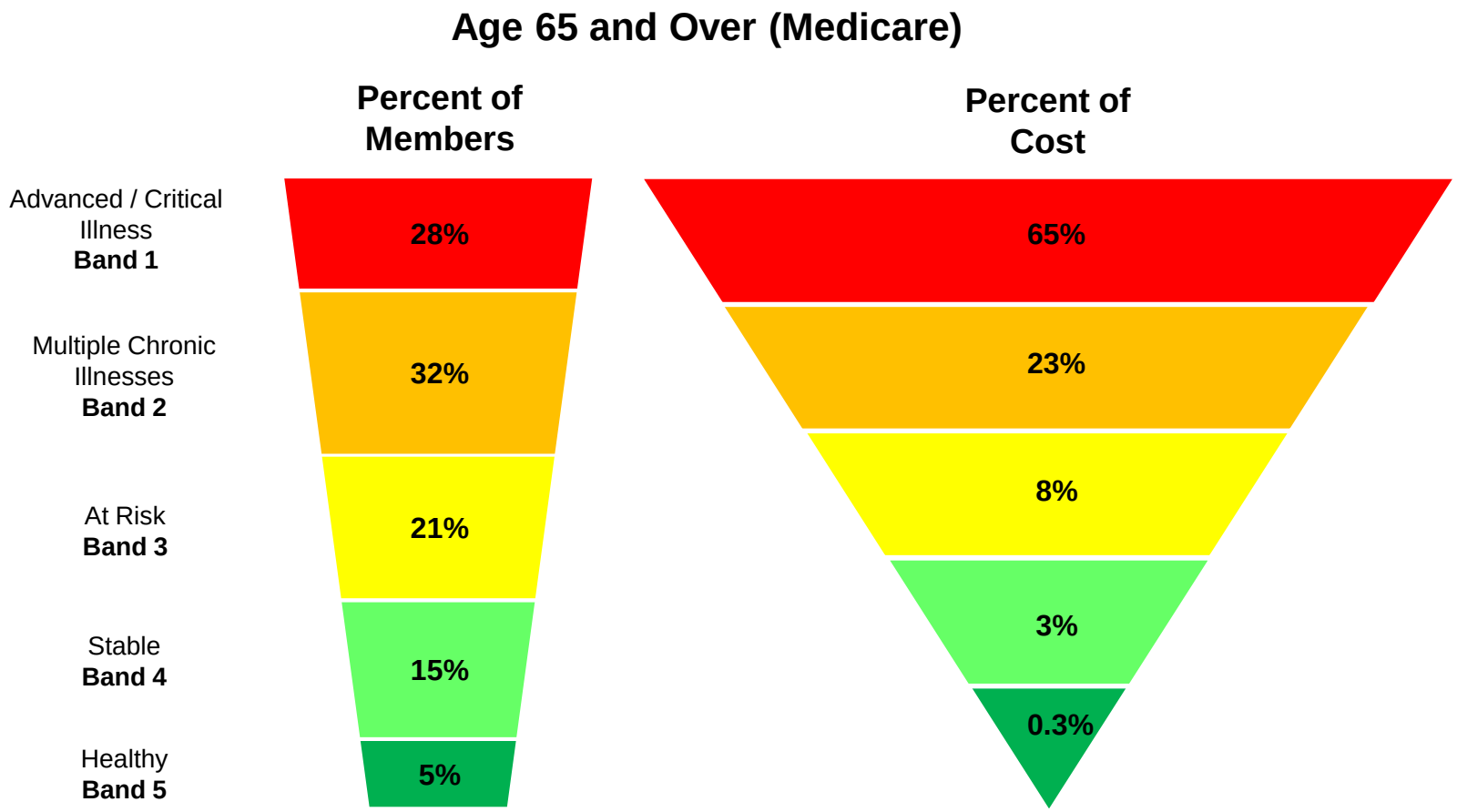


	Percent of Population	Percent Of Cost	Cost PMPM	Admits Per 1,000	Readmits Per 1,000	ER Visits Per 1,000
Band 1	2.6%	32.5%	$4,659	868	167	1,074
Band 2	8.9%	27.8%	$1,151	194	12	569
Band 3	13.2%	18.3%	$512	59	4	325
Band 4	32.6%	16.9%	$195	6	0	176
Band 5	42.6%	4.4%	$44	1	0	39

Source: HealthCare Analytics - incurred in 2016 and paid thru April 2017 – CareFirst Book of Business, excluding Medicare Primary and Catastrophic members

Illness Pyramid – The Rosetta Stone
2016 Medicare Population – The Inverted Pyramid

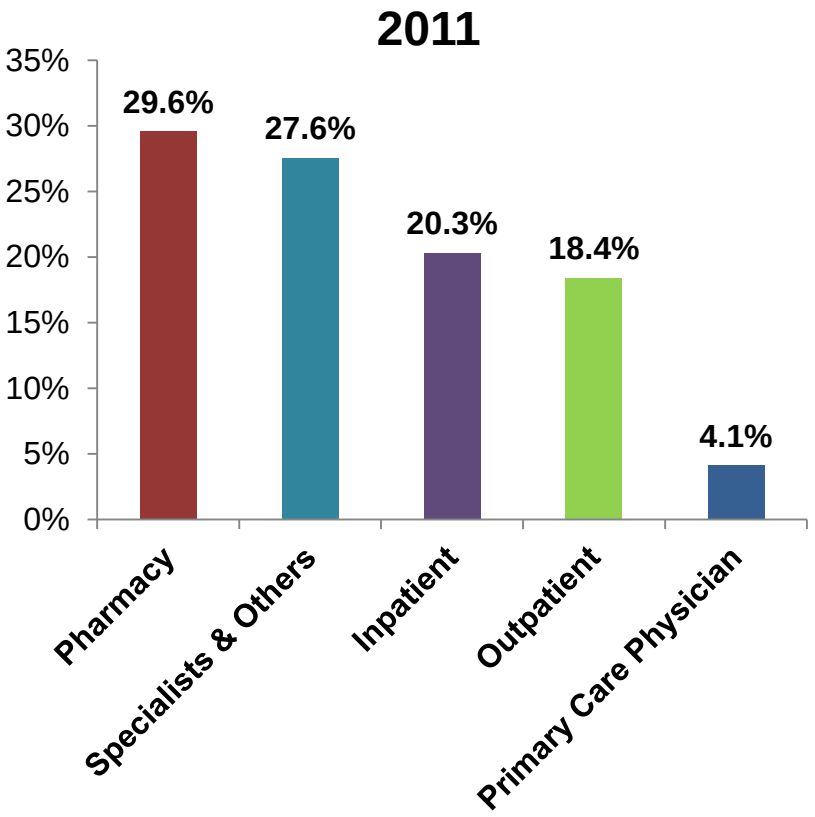
- 60% of Medicare beneficiaries and nearly 90% of the cost for the Medicare program are contained in the top two bands

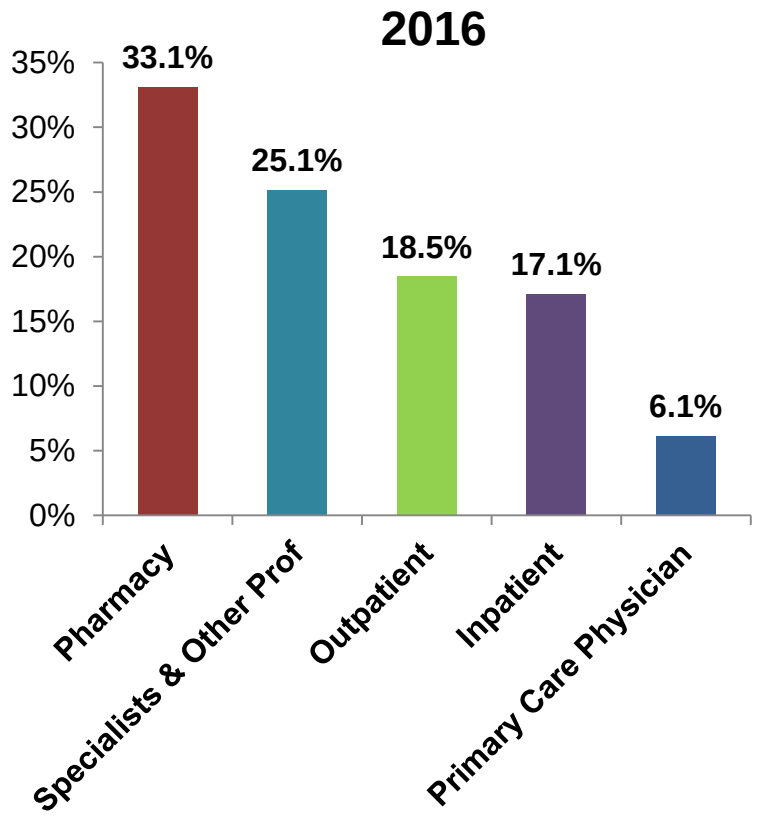


Source: HealthCare Analytics - incurred in 2016 and paid thru Apr-2017

Total Distribution of CareFirst Medical Payments for Commercial Population

- Spending on prescription drugs is the largest share of the CareFirst medical dollar (including spending in both the Pharmacy and Medical portions of CareFirst benefit plans)
- This places increased focus on pharmacy care coordination and on the use of drugs in treatment





Medical spending is based on 2011 and 2016 CareFirst Book of Business. Pharmacy % is adjusted to represent typical spend for members with CareFirst's pharmacy benefit.

Continuing Growth of the Program

- The number of PCPs and Panels has grown steadily along with the global cost of care they coordinate and manage
- Nearly 90% of eligible PCPs in the region now participate

Year	Panels	GlobalCost of Care
2011	180	$1.7B
2012	283	$2.5B
2013	402	$3.6B
2014	424	$4.0B
2015	438	$4.2B
2016	445	$4.4B
2017 (Est.)	**455**	**$4.8B**

Current and Projected State of Panels, Providers & Members

- CareFirst categorizes Panels into four types as shown below
- 70% of PCPs practice outside of a large health system

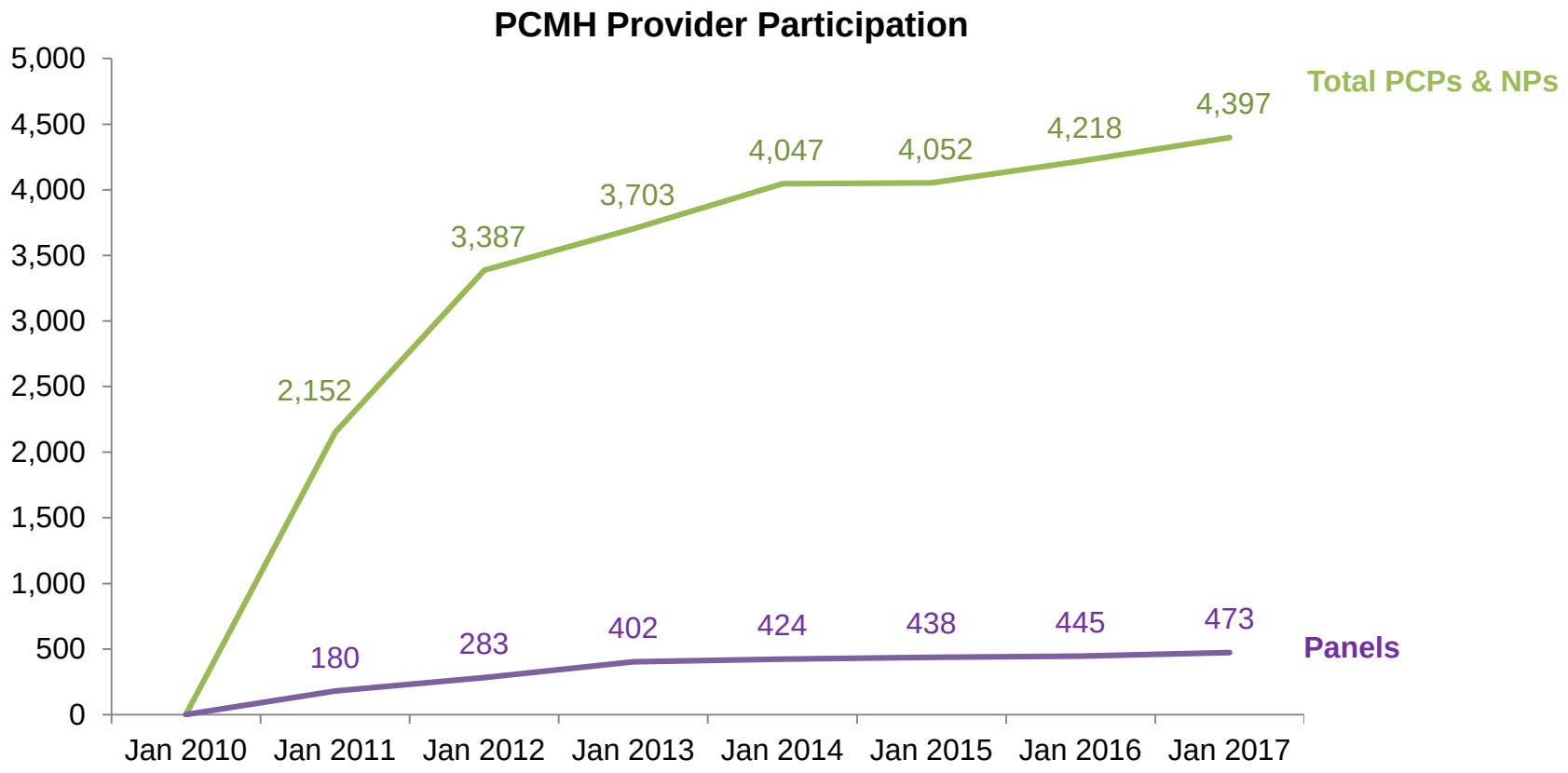
Panel Types

Panel Type	Panels	Providers*	Providers / Panel	Members	Members/ Panel
Single Panel Virtual	154	1,385	9.0	363,089	2,358
Single Panel Independent	70	641	9.2	175,392	2,506
Multi Panel Independent	115	1,148	10.0	275,098	2,392
Multi Panel Health System	113	1,193	10.6	275,395	2,437
January 2016	**452**	**4,367**	**9.7**	**1,088,974**	**2,409**
January 2017	**447**	**4,397**	**9.8**	**1,140,892**	**2,552**

* Primary Care Physicians and Nurse Practitioners are included in the Provider counts above.

Provider Growth in the Program

- Provider's participation in CareFirst's TCCI/PCMH program continued to grow in 2016
  - 4,397 providers in 447 Panels participate as of January 2017
  - Now reaching saturation point
  - Largest network and member enrollment in a single uniform program model in the United States



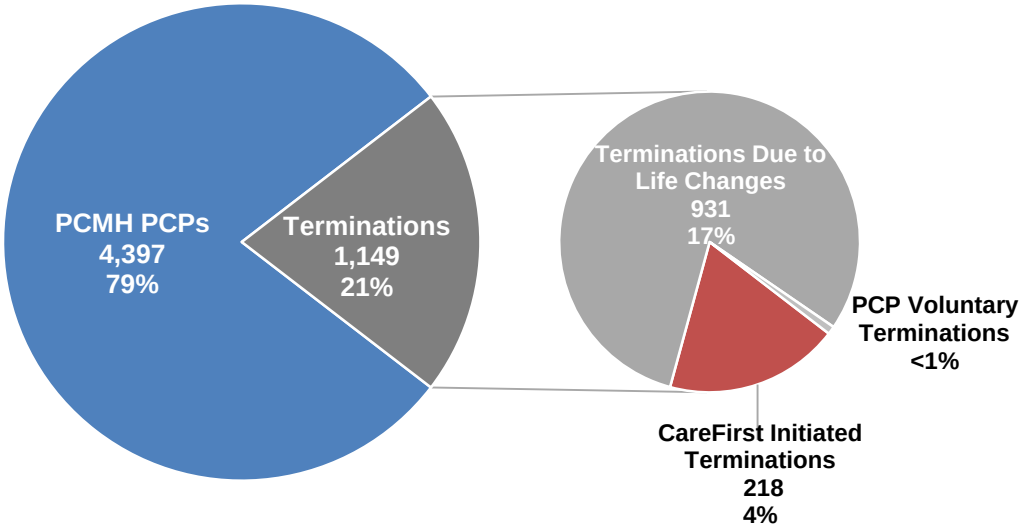
PCMH Program Has Been Remarkably Stable – Despite "Swirl" of Activity from Hospitals, Government

Two measures of stability:

1. Program-wide Stability: PCPs that came into the PCMH Program and stayed
2. Panel Stability: PCPs participating in a Panel that remained largely unchanged

Program Stability

- PCMH program has been remarkably stable
- Virtually no PCPs have left the Program due to dissatisfaction
- The vast majority of terminations (80%) reflect life changes: retirement, stopped practicing as a PCP, moved out of area
  - Remainder were initiated by CareFirst due to a lack of engagement by the PCP/Panel
  - Of PCP terminations for lack of engagement, 5% later returned to the Program.



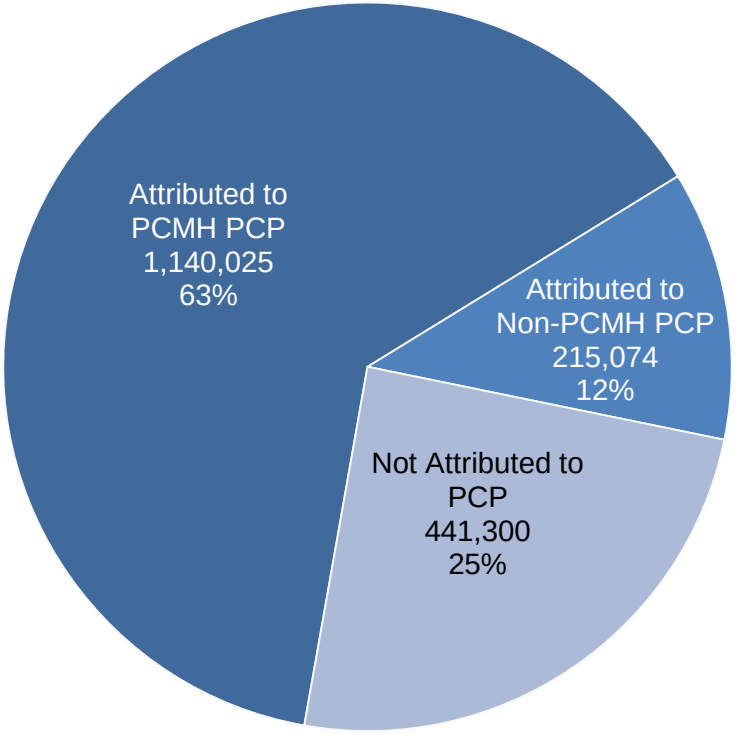
Panel Stability

- Panels have also remained remarkably stable over six years with few undergoing a "substantial change" [defined as 50% change in PCPs and 5% change in base PMPM].
  - Of approximately 450 Panels, only 52 Panels (12%) have met the threshold for substantial change:
    - 2013: 6 Panels
    - 2014: 16 Panels
    - 2015: 30 Panels

PCP is the Central Player – Holistic Home Base for the Member

- Those members not attributed to a PCP are, in general, healthier than those members with a PCP. Non-attributed members have an average Illness Burden Score 50% lower than attributed members.

Member Attribution to PCP
January 2017



Members in Service Area = 1,796,399

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The Framework of the Patient-Centered Medical Home Model

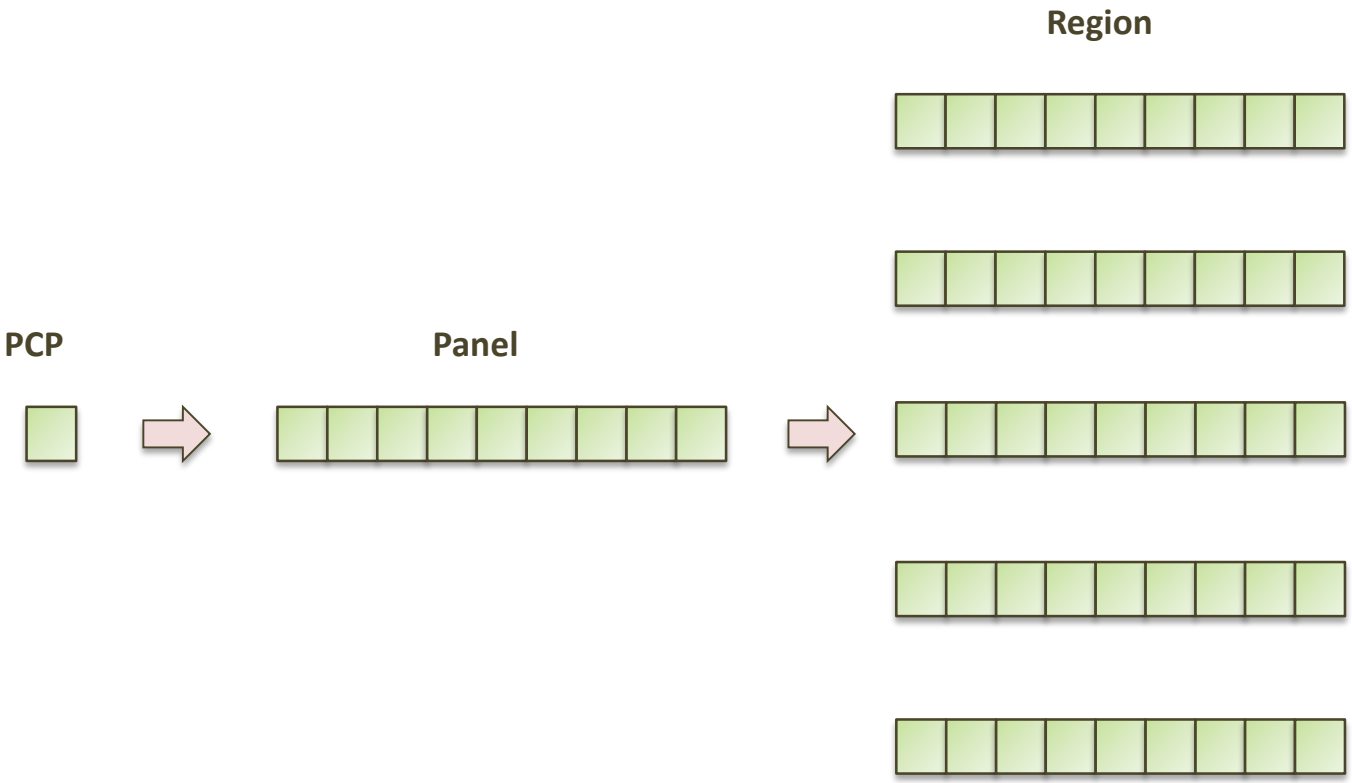
PCP Panels – Small Teams – Performance Units

Characteristics of Panels

- Average Panel Size: 10 PCPs
- The more independent the better
- The “buyers” and arrangers of all services

Roles of Panels

- Backup and coverage
- Peer review – shared data
- Pooled experience



Financial Model – Blend of Fee For Service and Global Capitation

- The goal for each Panel is to **beat its risk-adjusted experience** trended
- **Global cost target** is set for each Panel at the beginning of a performance year
  - Members are attributed to each PCP and then rolled up to the Panel level
  - Historical claims data is gathered for each attributed member for a base year (2010 for most Panels)
  - Illness Burden Score (IBS) in attributed population is measured and updated monthly
  - Expected care costs are trended forward from base year [by Overall Medical Trend (OMT)]
- PMPM Global Budget Target =

OMT trended base year care costs
Adjusted monthly for IBS changes in attributed population
÷
Member months

Patient Care Account – Illustration of A Scorekeeping System for Panels

- An Patient Care Account for each Panel is set up
- All expected costs (Credits) and all actual costs (Debits) are recorded in this account

Patient Care Account

Debits (PMPM)	Credits (PMPM)
All services paid (Allowed Amount) for every line in every claim	Global projected care costs expressed as a PMPM

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 5 years at 7.5%, 6.5%, 5.5%, 3.5%, 3.5, and 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

Note: In any panel, month to month fluctuations in Membership occur. Member month counts shown reflect this.

Patient Care Account – Illustration of One Patient for One Year

- Debits are based on actual claims paid at CareFirst's allowed amounts – shows every service ever rendered to any attributed Member by any provider at any time in any setting

Mary Smith – One Member

Debits			Credits	
1/4/2015	Primary Care Visit	$50		
1/4/2015	Vaccination	$10		
1/7/2015	Pharmacy Fill	$120	January	$361
2/4/2015	ER Visit	$700	February	$361
2/4/2015	ER Treatment	$300	March	$361
3/6/2015	Ophthalmologist Visit	$127	April	$361
4/22/2015	Orthopedic Visit	$257	May	$361
4/25/2015	Pharmacy Fill	$120	June	$361
4/25/2015	Physical Therapy	$22	July	$361
5/5/2015	Physical Therapy	$22	August	$361
7/10/2015	Pharmacy Fill	$120	September	$361
8/22/2015	Dermatologist Visit	$300	October	$361
8/23/2015	Pathology Test	$50	November	$361
10/15/2015	Outpatient Hospital Visit	$1,448	December	$361

$13,000,000 per year in global cost, divided by 36,000 member months = $361 PMPM

Total Debits: $3,646

Total Credits: $4,322

Note: In any panel, month to month fluctuations in Membership occur. Member month counts shown reflect this.

Patient Care Account – Illustration of One Panel for One Year

- All Debits and Credits are compared monthly and at the end of each Performance Year after 3 months claims run-out
- Savings are converted to bonuses/incentives that are paid as fee increases
- Panels are partially protected from catastrophic cases by a $85,000 “stop loss” point

XYZ Family Practice Group (10 PCPs)

Debits		Credits	
Primary Care	$774,060	Mary Smith	$4,332
Inpatient Care	$2,967,230	John Doe	$4,332
Outpatient Care	$3,354,260	Jane Richards	$4,332
Specialist Care	$2,451,190	Bob Jones	$4,332
Ancillary Care	$1,290,100	Steve Patel	$4,332
Prescription Drugs	$2,064,160		

List of Members continues to a total of 3,000 attributed to this panel.

Savings From Expected Cost: $216,000

Total Debits: $12,901,000 **Total Credits: $13,000,000**

* 80% of Claims in excess of $85,000: ($117,000)

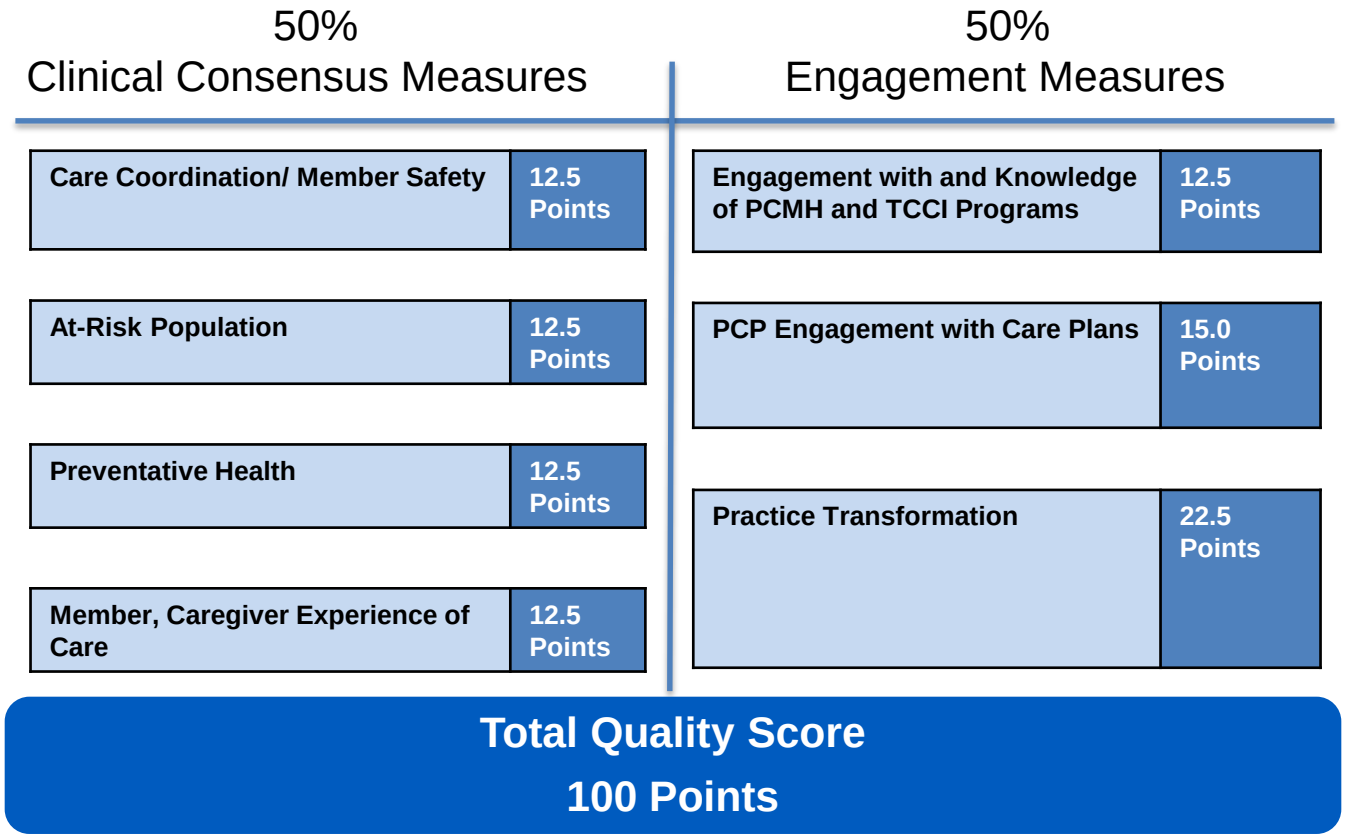
Net Debits: $12,784,000

* Stop loss protection: 20% of claims dollars above $85,000 per member in 2016 debited. Prior to 2016, stop loss protection was limited to 20% of claims dollars above $75,000 per member per year.

Note: In any panel, month to month fluctuations in Membership occur - Member month counts above reflect this.

Quality Scorecard - 2016

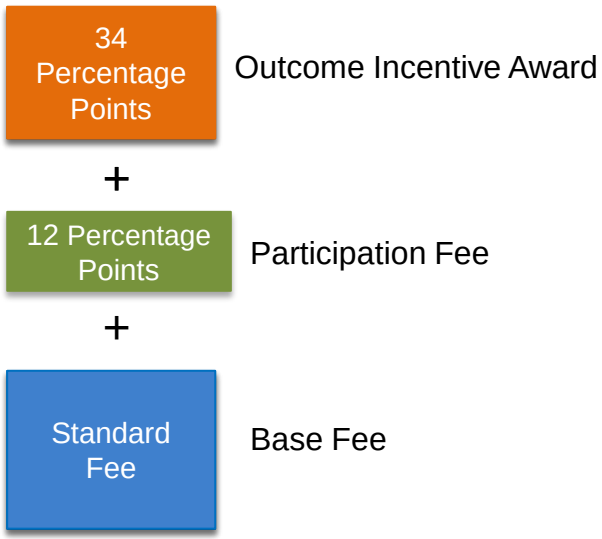
- Quality is measured in two components: Clinical Measures and Engagement – Both have equal weight on an 100 point scale
- An equal weight is placed on Panel Engagement/Practice Transformation as on Clinical Measures
- Panels must score a minimum 35 of 50 Engagement points to earn an OIA
- Clinical Measures are those established by CMS as “consensus measures” with commercial payers



OIA Awards are at the Intersection of Savings and Quality

OIA Awards: Degree of Savings

EXAMPLE: PCP PERCENTAGE POINT FEE INCREASE: YEAR 1					
QUALITY SCORE	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



Persistency Increases In OIAs

Program rewards *consistent* strong performance

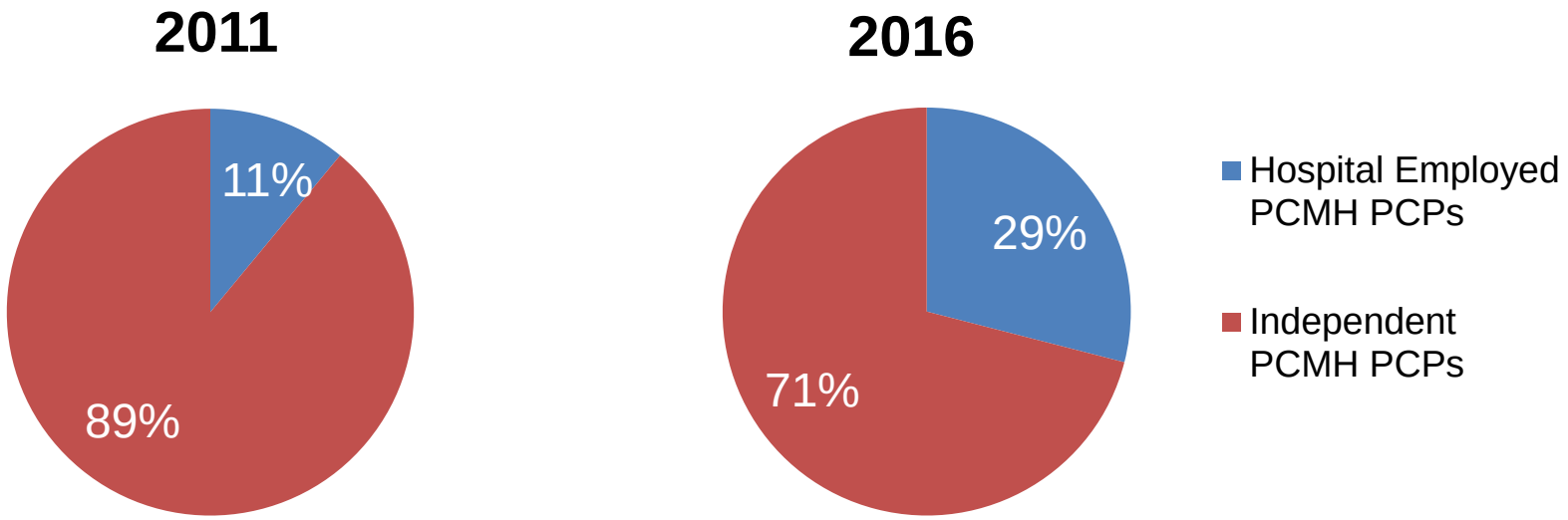
Panels who earn an OIA for

- 2 Consecutive Years = OIA increased by 10%
- 3 Consecutive Years = OIA increased by 20%

Persistency Awards recognize sustained results and incentivizes Panels not to under serve their patients in seeking results

Employed vs. Independent PCPs – Goal: Maintain Independence

- Within the CareFirst service area, PCPs (as well as Specialists) are joining larger group practices (i.e., Privia) or hospital-owned practices (i.e., MedStar, Johns Hopkins, LifeBridge, Inova, etc)
- Recent national reports suggest 53% of physicians are employed by a health system
- Consolidation is often due to the lack of attractive economics in operating smaller practices and the promise of better security and a better financial position in a large system
- Hospital-owned PCP practices typically require referral within the hospital's system
- Since the launch of the CareFirst PCMH Program, hospital employed PCMH PCPs have increased from 11% in 2011 to 29% in 2015 – still a small percentage by national standards



Source: CareFirst Networks Management Data as of July 2016

Stability in Program Structure

Consistency in Program Design is Key to Behavior Change

- PCMH Program model has been consistent since program inception – this has mattered greatly and this stability fosters physician behavior change
- Model, data, and incentive infrastructure is uniform across all Panel types – permits valid comparisons on performance
- Stability in Panel participation and performance has been remarkable
  - Almost three quarters of all viable Panels (274 out of 374) have been in the program for 6 years:
    - 94 (34%) had savings all 6 years
    - 62 (23%) had savings 5 of the 6 years
    - 48 (18%) had savings 4 of the 6 years
    - 36 (13%) had savings 3 of the 6 years
    - 17 (6%) had savings 2 of the 6 years
    - 9 (3%) had savings 1 of the 6 years
    - Only 8 (3%) have never had savings after 6 years

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Five Strategies for PCMH Success

5 Focus Areas for Panels

- We have found 5 focal points for action – things a Panel can do as a practical matter – to positively impact cost and quality outcomes
- The higher weight of the Referral Pattern focal point reflects the importance of the most value laden decisions made by a PCP: when and where to refer for specialty care

PCMH HealthCheck
Five Focus Areas for Panels that Most Influence Cost and Quality

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%

Direction of Referral to High Value Specialists is Key

PCPs are Increasingly Directing Referrals to Cost-Effective Providers

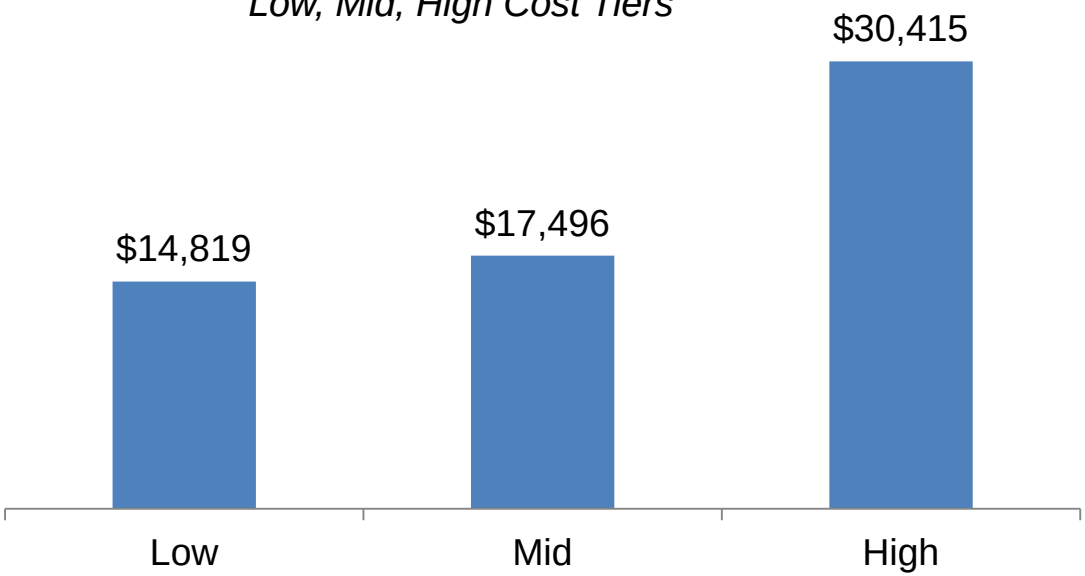
- CareFirst ranks specialists and hospitals as High, Medium or Low cost based on comprehensive episode profiling over a 3-year period
- This information is shared with PCPs in the PCMH program
- CareFirst does not make judgments as to the quality of specialists – this is left up to the PCP
- PCPs react to cost data and increasingly change referral patterns toward cost effective specialists
- PCPs develop a “favorites list” of preferred specialists based on cost data and their perception of a specialist’s quality
- PCPs become increasingly and acutely aware of the cost of their referral decisions
- PCPs employed by large health systems have little freedom to refer where they want – “sealing” referrals into only those specialists within the system

Huge Variability in Costs Among Hospitals

- Inpatient admission costs are 105% higher among high cost tier hospitals compared to low tier hospitals.
- High cost tier hospitals are generally larger, and account for 26% of the total area hospitals, but 32% of all CareFirst's admissions.
- Higher rate of referral to low cost hospitals is a major cost-saving opportunity for Panels.

Average Cost per Inpatient Admission

Low, Mid, High Cost Tiers

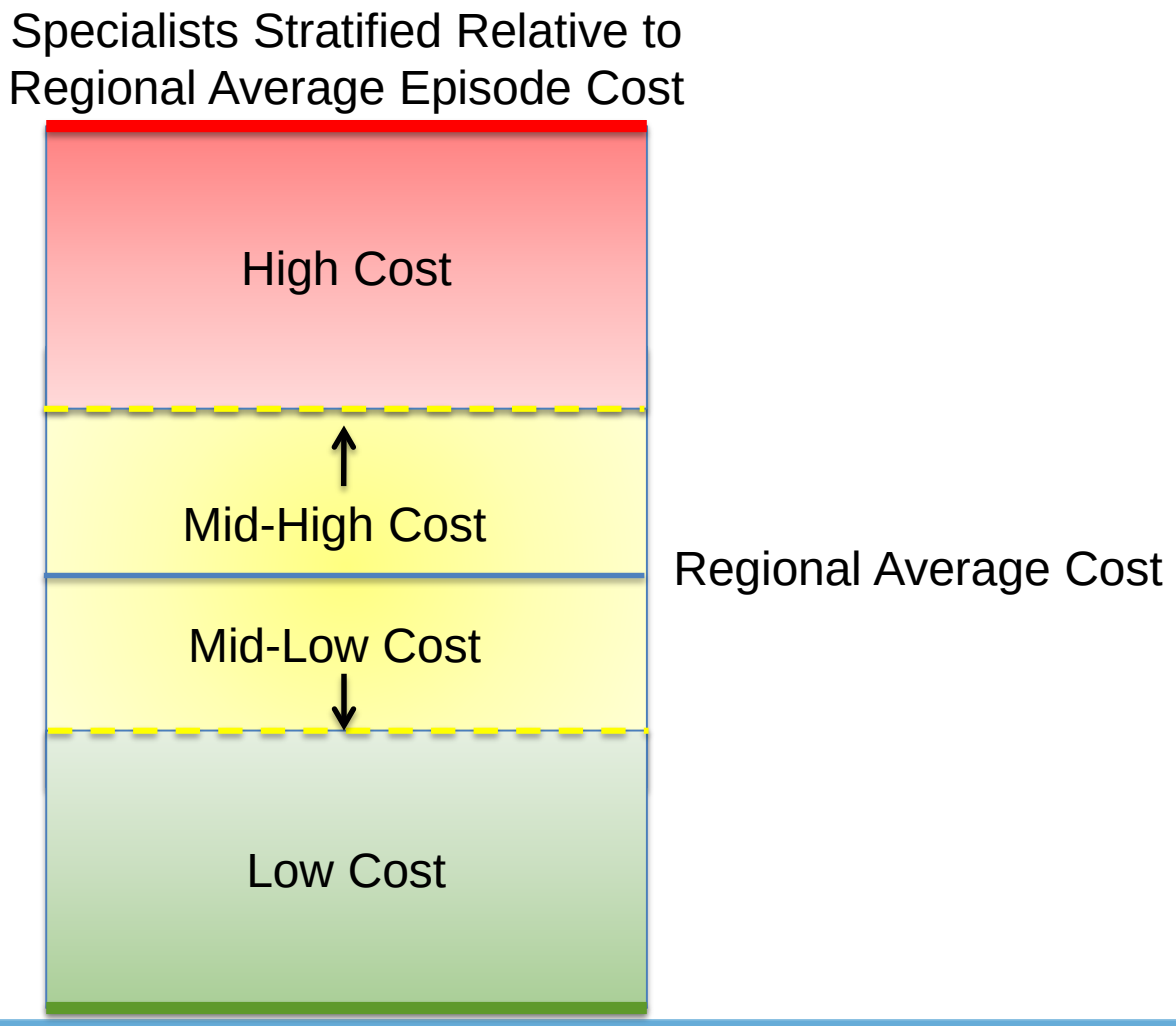


	Low	Mid	High
No. Hospitals	16	32	17
% Admissions	28%	40%	32%

Source: CareFirst HealthCare Analytics – 2016 Data

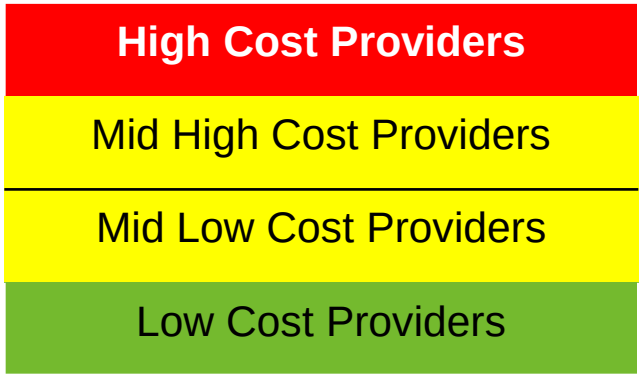
Episodes Used to Determine Specialist Performance Relative to Regional Average

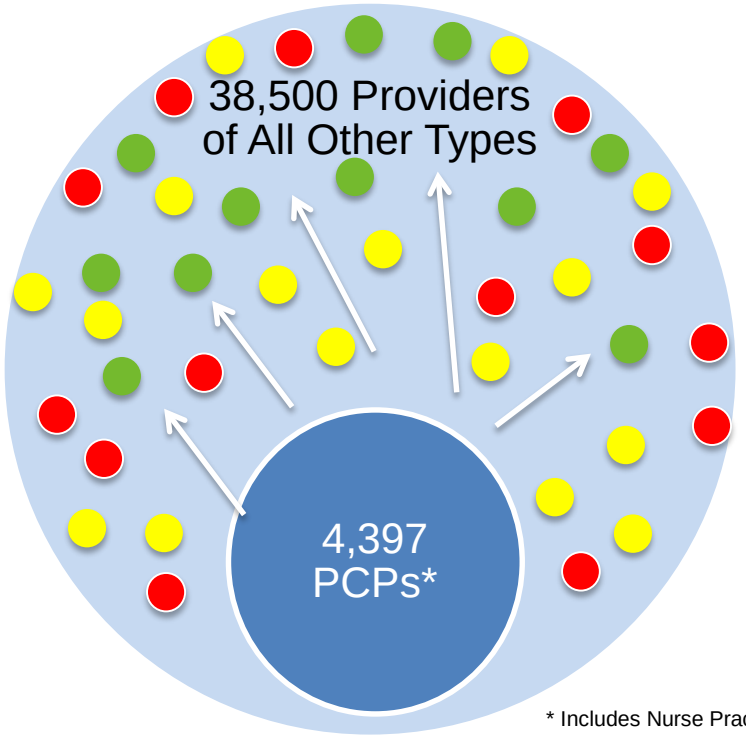
- All Hospitals and Specialists are stratified based on their profile of episode specific costs over a rolling 3-year period



Panels Make Core "Buying" and Arranging Decisions – Increasingly Directing Referrals to Cost Effective Providers

- High, Mid-High, Mid-Low, and Low Cost Specialist rankings are shared with PCMH PCPs.
  - Quality judgment is left to PCPs – PCPs refer where they believe they will get the best result.
  - PCPs develop a list of **preferred specialists**; free to make exceptions.
  - Since providing this cost information, CareFirst has seen evidence of changes in referral patterns from independent PCPs – many have become convinced of the efficacy of referring to lower cost Specialists and Hospitals for common, routine illnesses.
  - In contrast, PCPs employed by large health systems have lost freedom to refer where they want – only referring to specialists within their high cost system.





* Includes Nurse Practitioners

Variation in Cost Among PCMH Panels

- The difference in total PMPM cost between the top quartile and the bottom quartile of adult Panels is 25.0% and 33.6% for pediatric Panels
- The greatest reasons for variation in cost are Panel specialty referral patterns
- CareFirst offers incentives to Members to select PCPs in higher performing Panels (PCMH Plus)

Adult Panels

Cost Quartile	Risk Adjusted PMPM
Low	$348.65
Mid-Low	$376.53
Mid-High	$401.01
High	$435.94
Total	$390.03

25.0%

Pediatric Panels

Cost Quartile	Risk Adjusted PMPM
Low	$145.79
Mid-Low	$160.85
Mid-High	$176.26
High	$194.76
Total	$168.97

33.6%

Source: CareFirst HealthCare Analytics – 2016 Data through December

Variation in Cost Among PCMH Panels in 2016

- 34% of large Health System Panels are high-cost, while 39% of all Virtual Panels are low-cost
- Large Health System Panels typically cause PCPs to refer only to specialists in their own system, usually at high cost

Cost Tercile	Health System Panels	Virtual Panels	Single Panel Independent	Multi-Panel Independent
Low	13%	39%	25%	7%
Mid-Low	23%	28%	27%	19%
Mid-High	30%	18%	27%	31%
High	34%	14%	20%	44%
Total	100%	100%	100%	100%

Source: CareFirst HealthCare Analytics – 2016 Data through December

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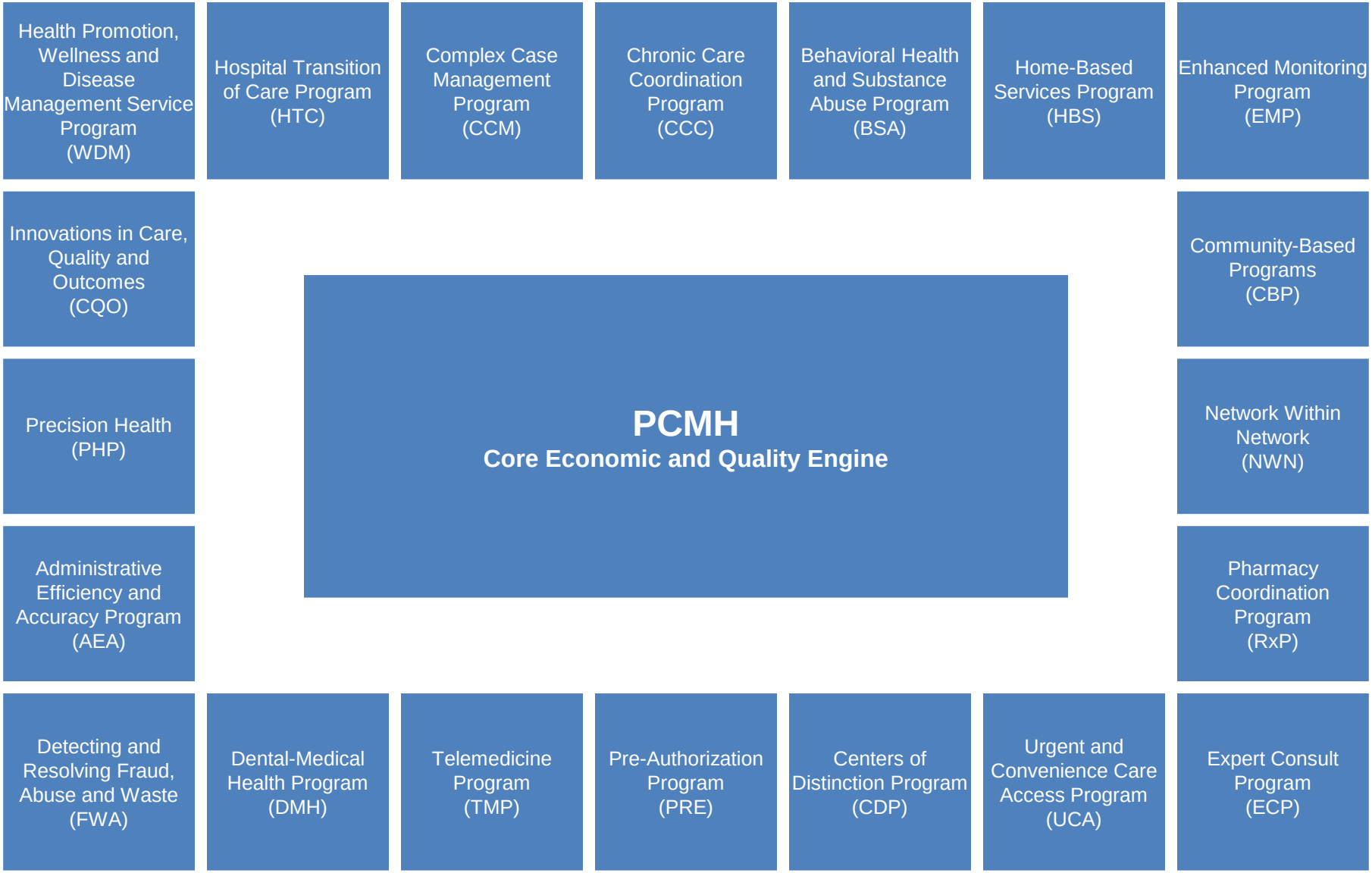
Total Care and Cost Improvement Program (TCCI) – Key Supports

Total Care and Cost Improvement Program (TCCI)

The Total Care and Cost Improvement (TCCI) Program Provides a Full Range of Supports

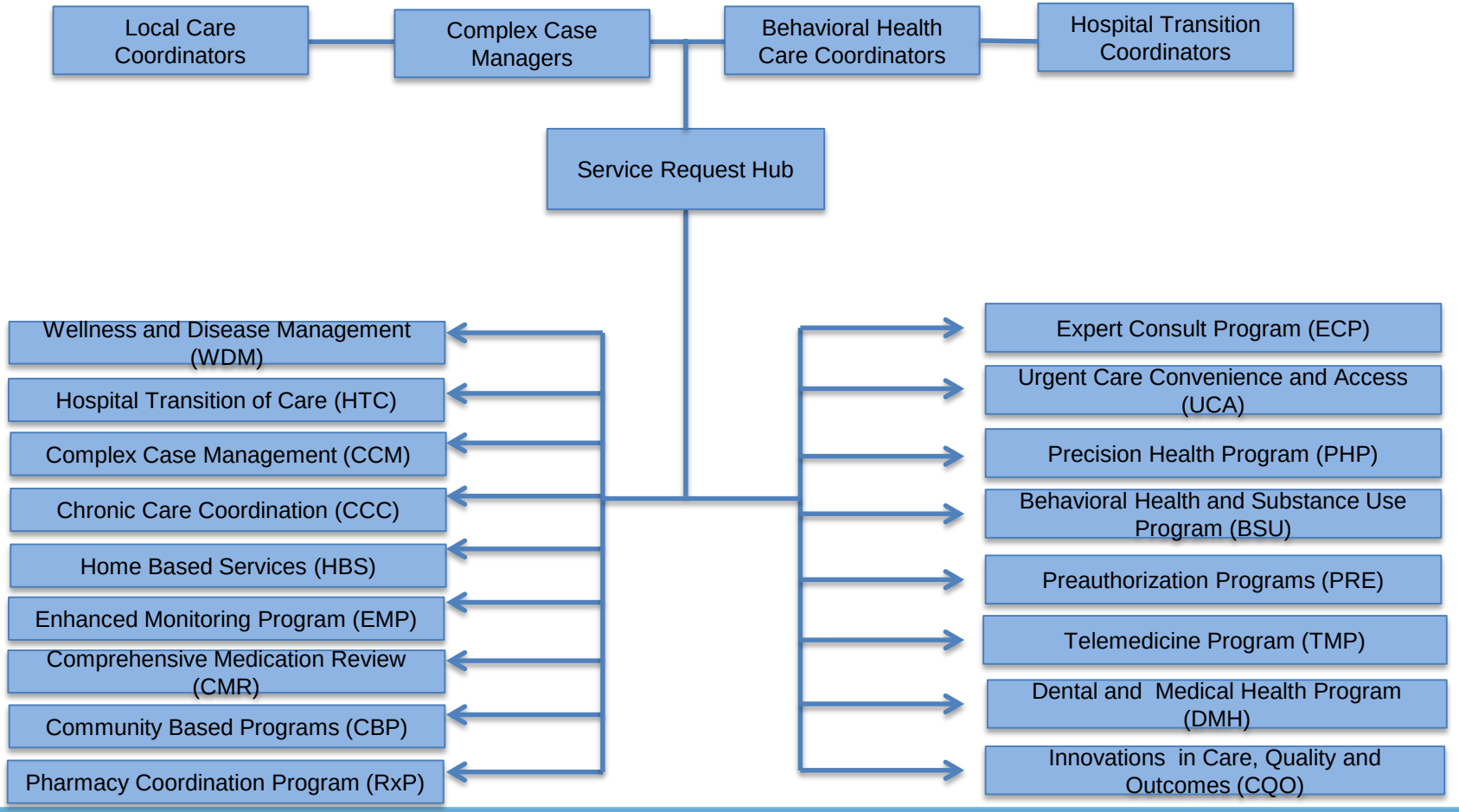
- Experience has shown that *financial incentives alone are not enough* to result in a long term bend in the care cost trend curve
- Extensive additional *supports* are needed that address the *entire continuum of care*
- *These essential capabilities and supports are well beyond the means of Panels – especially independent ones in the community*
- All are aimed at coordinating care, the “efficiency” of referrals to specialty care, or providing key ancillary services
- Supports must span settings, provider types and multiple geographic areas
- It is not any one thing that is needed – it is a cluster of things all aimed at the same results: *higher quality + lower costs*

TCCI Program Elements Surround and Support PCMH



iCentric Service Request Hub – Directing Traffic to the Right Services and Tracking Results

- All requests for TCCI Program Services are made through the Service Request Hub – which directs, connects and tracks requests to preferred ancillary service providers
- The Service Request Hub directs all requests to preferred providers and assures connects are made as well as tracks and monitors completion of requests



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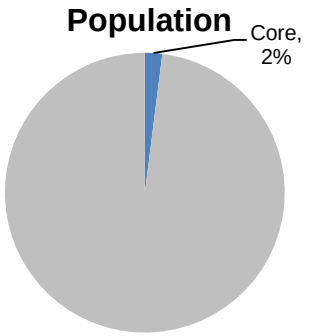
Providing PCPs with Actionable Data

Substantial Data & Analytic Capability Underlie Program

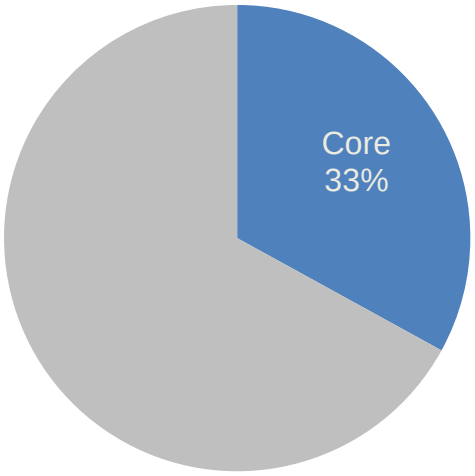
- CareFirst processes 36 million Medical claims annually – every line of every claim is stored
- CareFirst Business Intelligence database houses information equivalent to 300 Libraries of Congress
- The system includes all clinical notes for those in care plans as well as collected data from all care coordination partners
- All data is totally secure / encrypted
- Multiple years of data, all online and available 24 x 7 with a few clicks – organized, summarized and drillable
- SearchLight is the reporting system responsible for organizing and presenting the data
- Panels are provided with Key Indices and Top 50 Lists

“Core Target List” Used to Select Members for Care Plans

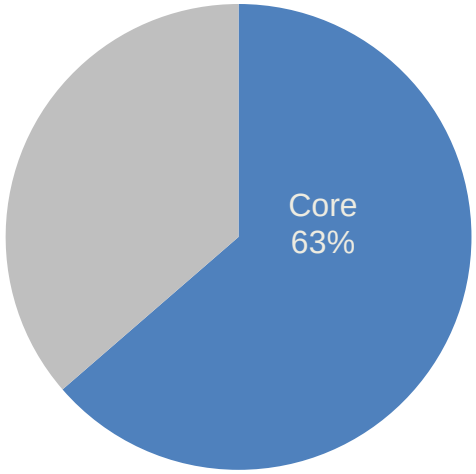
- Core list contains top 50,000 members out of 3.2 million Members identified by:
  1. Predictive High-Cost Flag and LACE Score
  2. Readmission Utilization
  3. Consistent High Cost Spend (6 months or more of >$5,000 medical spend)
  4. Band 1: Acute – Return to Chronic
  5. Multiple High Risk Indicators



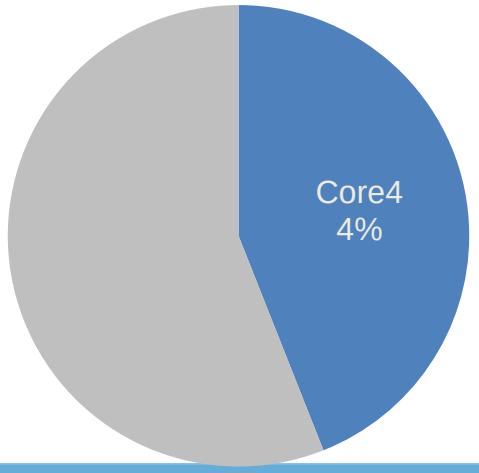
Total Spend



Inpatient Spend



ER Spend



Core Target Population – Five Core Target Subpopulations

- The “Core Target” population is composed of members who are sickest and the highest users of costly hospital-based services.

	Members	Average IB Score	Average Overall PMPM	Admissions per 1,000	Readmissions per 1,000	ER Visits per 1,000
HTC High Cost Flagged and High LACE Members	13,263	15.62	$7,548.31	$7,164.82	$760.78	1,897
Readmission Utilization	5,170	18.04	$9,641.98	$9,283.51	$717.03	3,701
Consistent High Cost Spend	5,138	15.45	$13,421.49	$10,406.29	$4,326.39	1,182
Band 1: Acute - Return to Chronic	13,042	15.25	$5,985.32	$5,479.28	$1,040.55	1,109
Multiple High Risk Indicators	33,778	9.26	$5,343.61	$3,933.23	$1,871.50	745
Unique Members	**48,896**	**9.89**	**$5,250.66**	**$4,201.18**	**$1,615.66**	**914**

Source: Health Informatics

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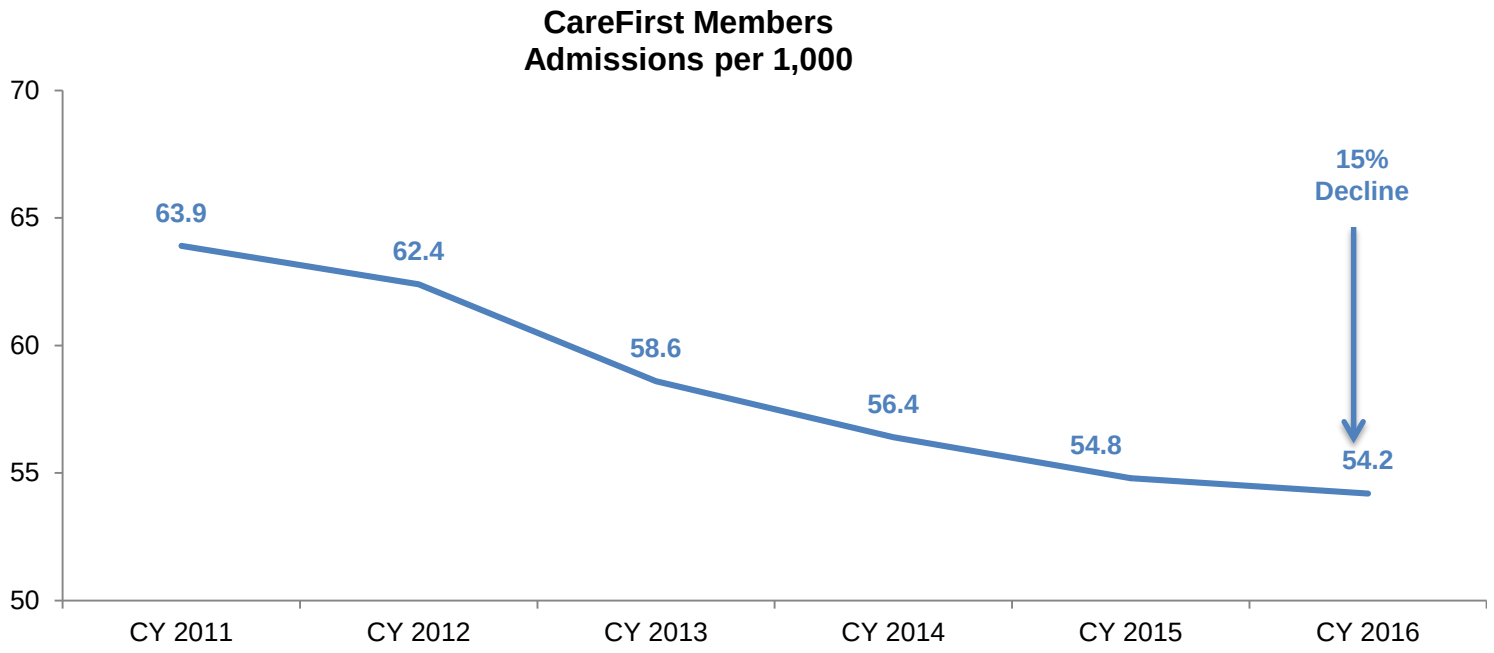
Major Sources of Savings / Cost Avoidance

CareFirst's Admission Rates are Dropping Sharply

- The admission rate per 1,000 Members in the CareFirst service region (where the PCMH program applies) has declined 15% from 2011 to 2016 YTD
- Had admissions continued at the 2011 volume, CareFirst would have spent nearly $550 Million more in 2016 on inpatient care in the service area



Source: CareFirst Health Care Analytics for Hospitals in the CareFirst Service area. 2016 claims paid through March 2017.

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Outcome Incentive Award Patterns

Outcome Incentive Award

- PCMH Program rewards Panels, as strongly as possible, for the results they achieve on cost savings and quality improvements on their entire attributed population
- Net overall (Total Cost of Care) savings at a Panel level is a requirement to receive any OIA
- Minimum quality and engagement thresholds are gates to an OIA, even if savings are produced
- OIAs are not strictly a “shared savings” payment, but relate to the intersection of cost control and improved quality – adjusting upward for higher quality and cost savings and downward for lower quality and cost savings
- OIAs are also adjusted depending on the population size of the Panel – due to the enhanced credibility that accompanies a larger size Member population
- To reward consistent performance, OIAs are adjusted upward for Panels that earn incentives for consecutive years

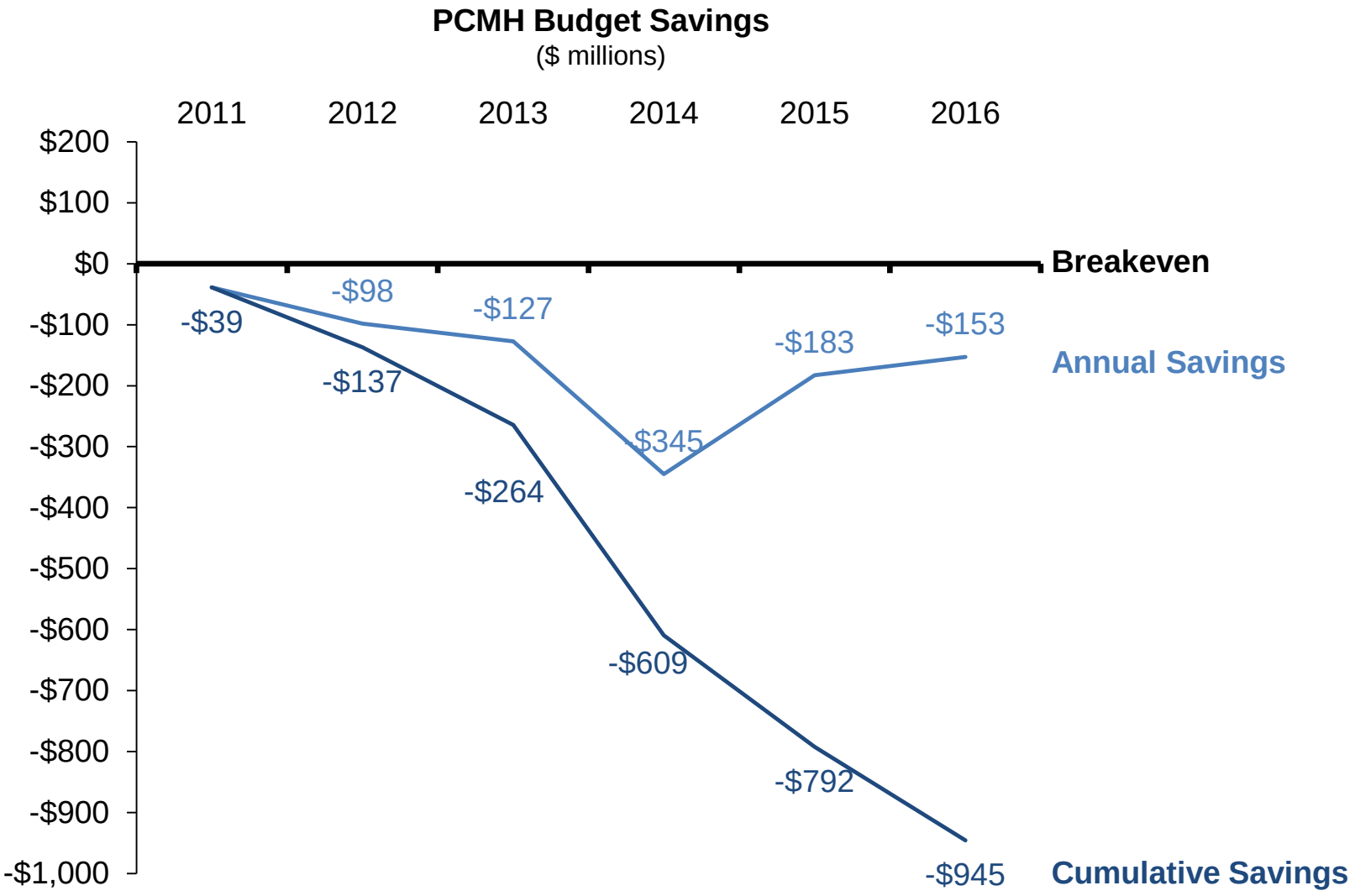
PCMH – 2016 Outcome Incentive Award Results

- Of the 365 viable PCMH Panels participating in 2016, 67% achieved savings.
- The savings of “winning” Panels has continually exceeded the losses of “non-winning” Panels.
- A net savings of $153M was produced in 2016 and $945M since the Program’s inception.
- The average OIA earned in 2016 was a 49 percentage point increase in fee schedule.

Performance Year	Panels Achieving Savings	Panels Receiving OIA	Average Award as % of Increased Fee Schedules	Net Savings % (all Panels)*
2011	60%	60%	25%	1.5%
2012	66%	66%	33%	2.7%
2013	69%	68%	36%	3.1%
2014	84%	48%	59%	7.6%
2015	74%	57%	42%	3.9%
2016	67%	59%	49%	3.0%

Note: 2014 was the first year Panels had to meet quality standards to earn an OIA. Quality standard criteria were raised in 2015 and 2016 Not all Panels achieving savings received an OIA.
*Net Savings is the amount Panels were over budget subtracted from the amount other panels were under their targets.

PCMH – 2016 Outcome Incentive Awards

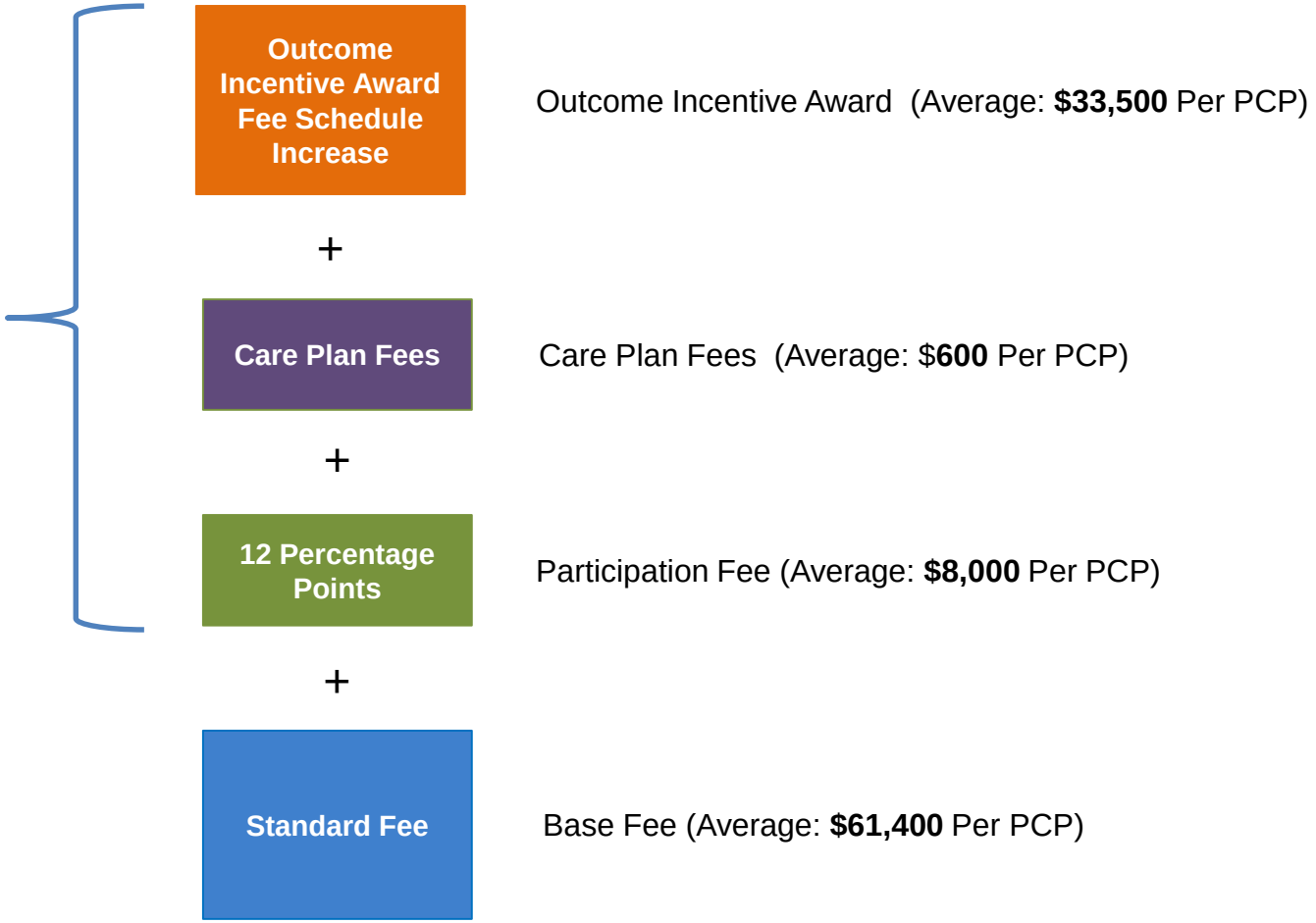


*2014 was the first year when panels has to meet quality standards to earn an OIA. The quality standard criteria were raised in 2015 and 2016.

The Average PCP in the Program Who Achieves a Savings Earns $42,100 in Additional Annual Income

- CareFirst's fee schedule (including provider specific arrangements or PSPs) for primary care is 92% of the Medicare fee schedule
- PCPs have a material incentive to produce a cost savings and to maintain that level of savings over time

Pay for Value has averaged 68% since Program inception



Data above is based on average PCP performance in 2016

Material Increase in Payments to Primary Care Providers

- Over the first six years of the PCMH Program, CareFirst has paid $360M directly to PCP Panels for participating in the Program over and above standard fees.

Year	PCP Base Claims ($M)	12% PCMH Fee ($M)	OIA ($M)	Care Plan Fees ($M)	Total PCMH Payments ($M)
2011	$179.7	$21.6	$0.0	$0.3	$21.9
2012	$210.4	$25.3	$9.7	$0.6	$35.5
2013	$206.8	$24.8	$28.8	$1.2	$54.9
2014	$216.9	$26.0	$39.7	$1.9	$67.6
2015	$255.6	$30.7	$49.1	$2.3	$82.1
2016	$269.8	$32.4	$63.6	$1.7	$97.8
6-Year Totals	**$1,339.3**	**$160.7**	**$191.0**	**$8.0**	**$359.7**

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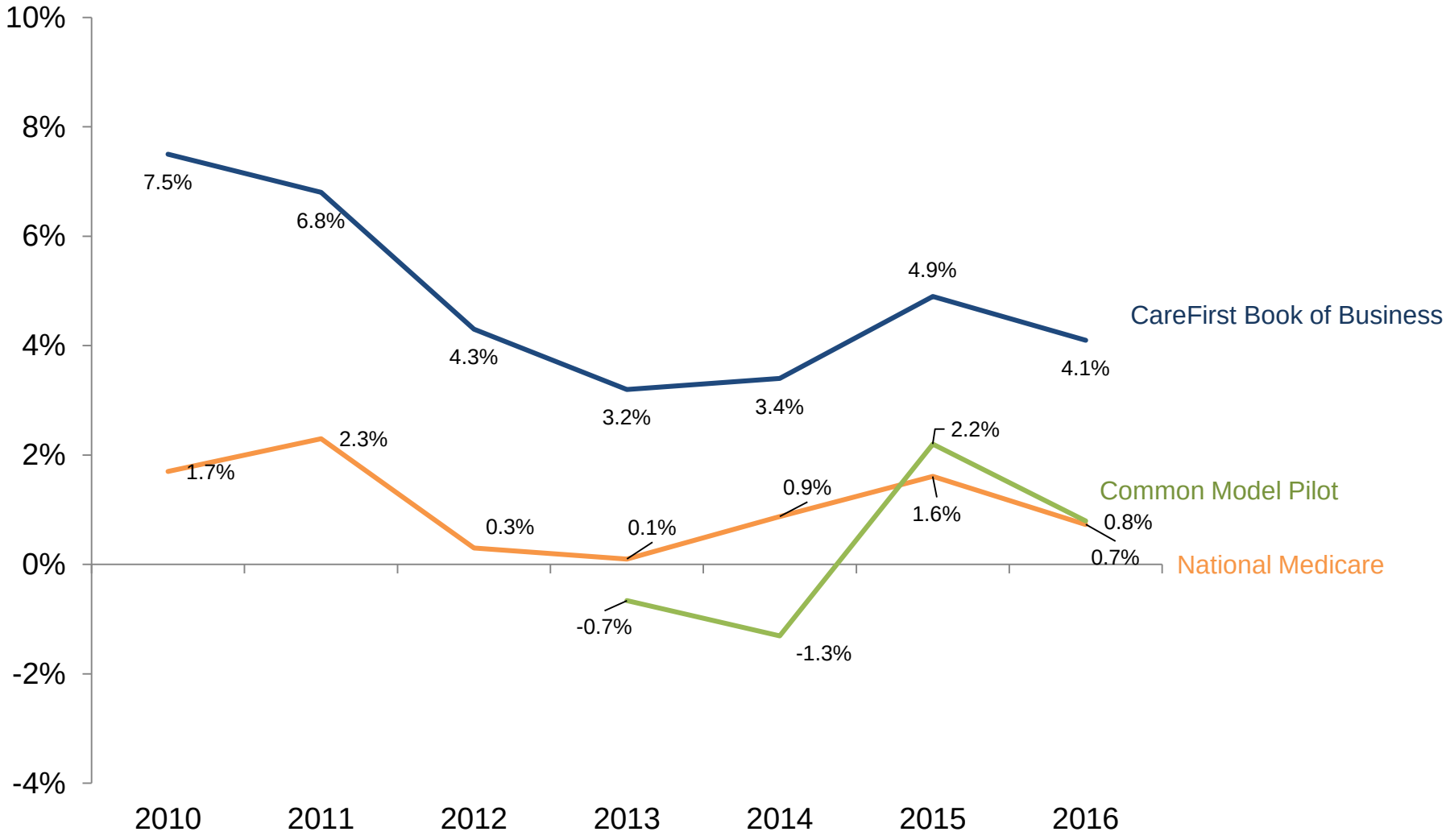
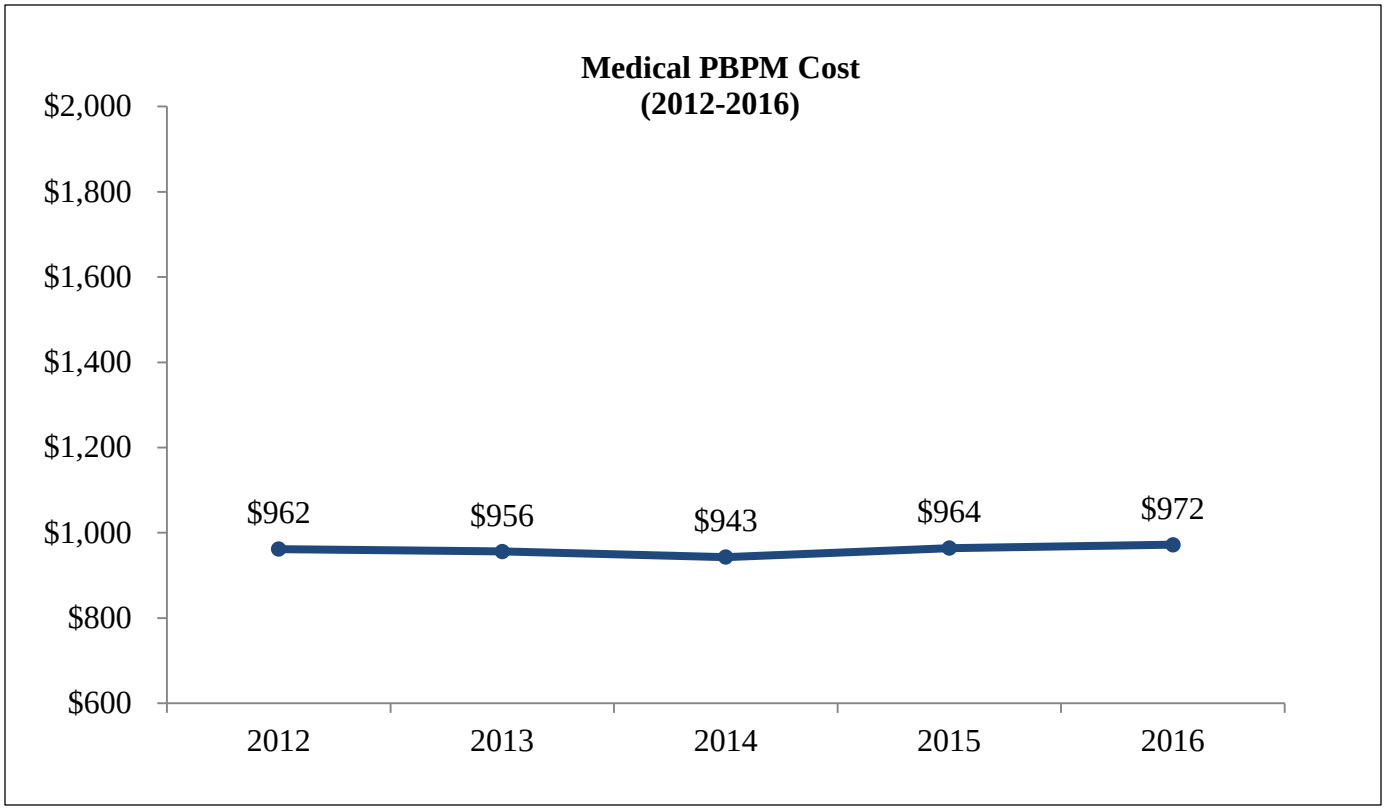
Common Model Pilot Results -

CareFirst and Medicare Trends 2010-2016



Source: HealthCare Analytics – Includes data through December 2016, paid thru June 2017. CareFirst Book of business, excluding Medicare Primary, Catastrophic and TPA members

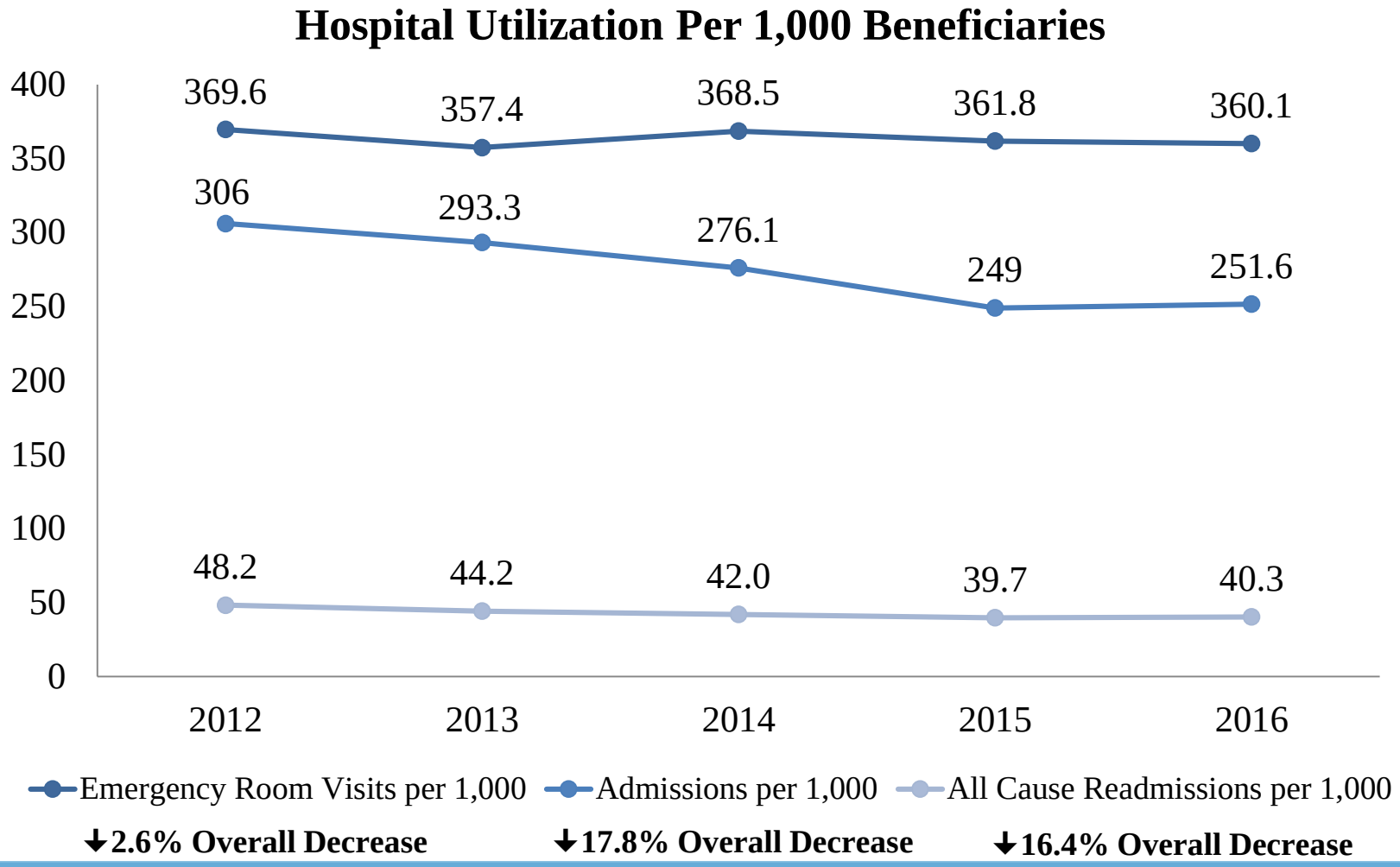
Common Model PBPM Costs 2012-2016



Source: HealthCare Analytics – Includes data through December 2016, paid thru June 2017. CareFirst Book of business, excluding Medicare Primary, Catastrophic and TPA members

Common Model Admissions Measures

- The number of Inpatient Admissions per 1,000 and Days per 1,000 continued to decline in 2015 for Medicare beneficiaries in the Common Model



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Key Takeaways and Insights

Key Takeaways and Insights

1. There has been a dramatic slowing in the rise of overall costs driven by improved quality. This decline of trend for CareFirst Members exceeds expectations.
2. The principle reason for the decline has been an unprecedented drop in hospital inpatient use (15%).
3. The ACA brought with it a cohort of members that are sicker and more costly than the rest of the population which distorts trend analysis (appears to make Overall Medical Trend 1% higher).
4. In order to achieve sustainable returns, an intense focus must be placed on identifying and selecting members for care coordination who are not only chronically ill, but unstable and vulnerable.
5. The principal building block of the Program – the Medical Care Panel – has remained remarkably stable and effective. This has been accompanied by steady growth in the number of Panels. Few PCP terminations have occurred. The Program now blankets the region.
6. Panels have found ways to continue to "win" even as the decline in trend has occurred – making projected budgets tougher to beat – as quality requirements have been heightened.
7. The best performing Panels are those that are independent, virtual, and community based, while the highest cost Panels are generally those employed in large health systems.
8. The Panels that are operating in a Common Model with Medicare outperform on all key measures – a lesson in the power of common rules and incentives.
9. The degree of Engagement in the Program is rising dramatically as understanding increases and results emerge. This is the key to future strong results.
10. It takes years of consistency in model and incentive design together with careful education and substantial support to make progress and change behavior toward improved quality and cost outcomes.