2014 PCMH Program Performance Report

July 30, 2015

Contents

CareFirst

PCMH
Patient-Centered Medical Home

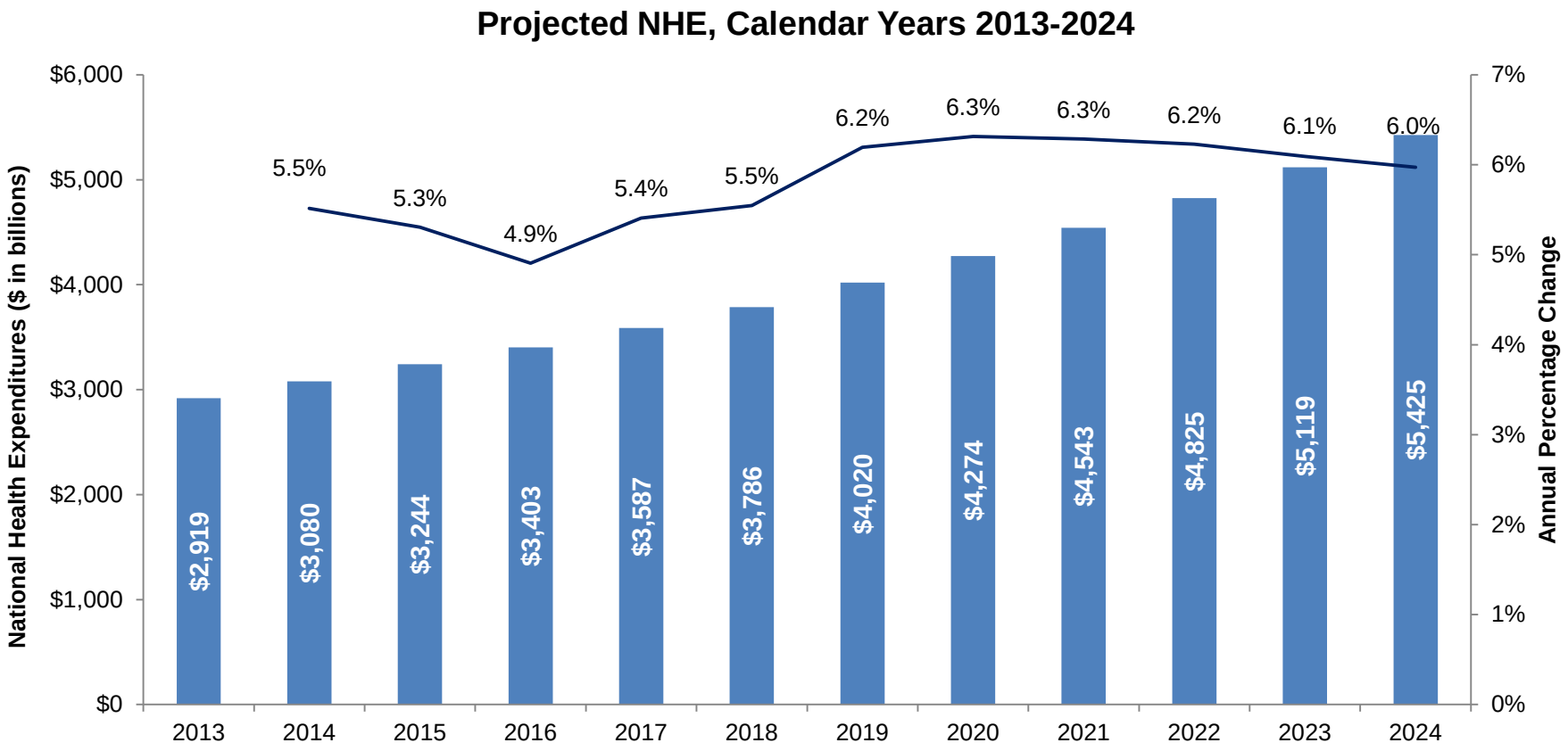
The Facts That Shape the Landscape

The Experience in the CareFirst Region

- CareFirst has 45% of the non-government insured population in its service area and is therefore highly representative of the region
- The region has some of the highest hospital admission and readmission rates in the Nation
- CareFirst accounts (often in the services sector) generally have generous benefit designs, further contributing to high use rates
- Prior to the start of the PCMH program in 2011, CareFirst's Overall Medical Trend was regularly between 6% and 9%, averaging 7.5%

Projected 6 Percent CAGR Between 2013 and 2024

- Steady growth rate in the 5% to 6% range is projected for the next 20 years
- Slowing the rate of growth to something closer to general inflation is critical for individual, corporate and government budgets

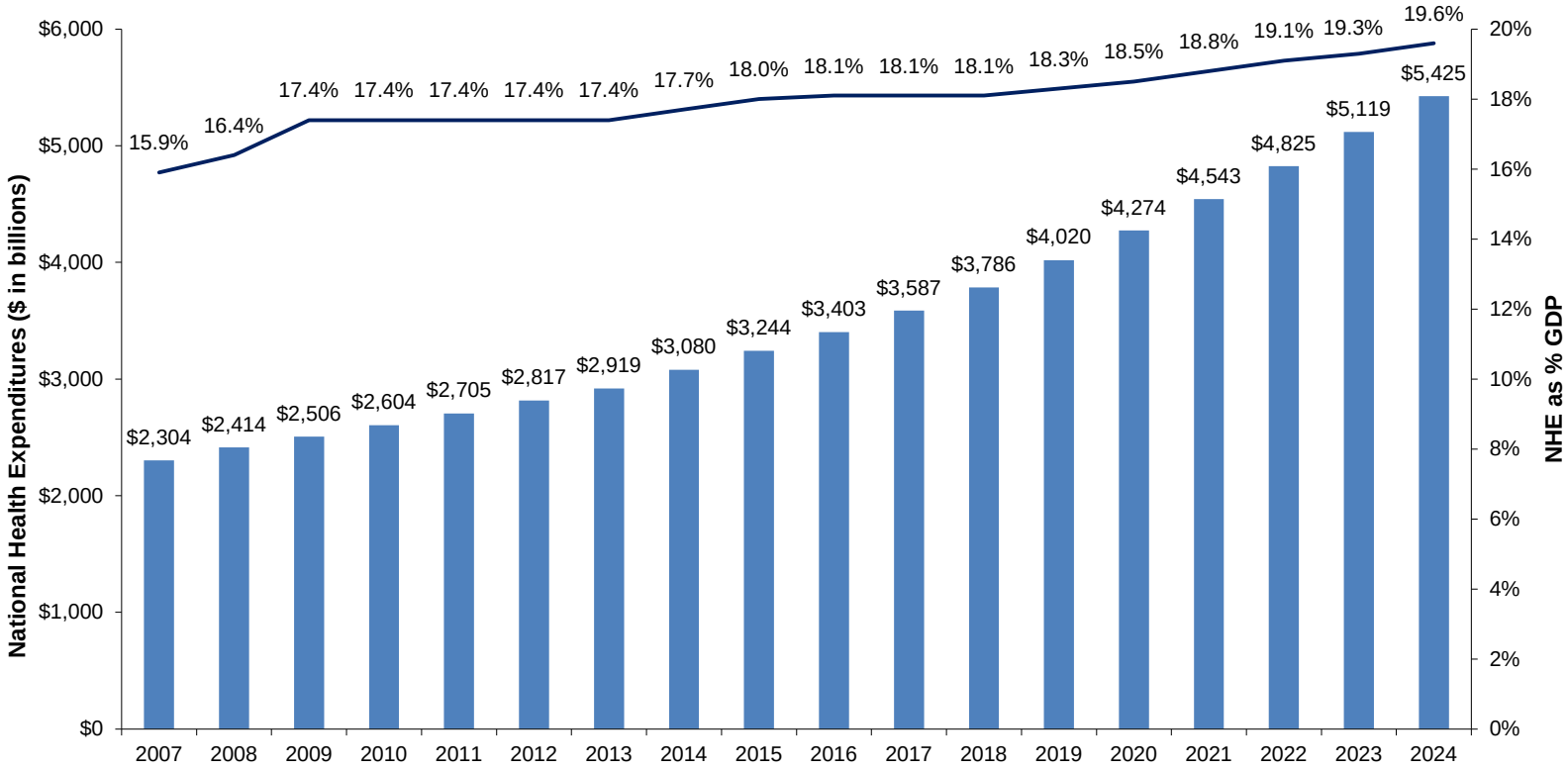


Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, July 2015.

National Health Expenditure Rising Toward 20 Percent of GDP

- The United States remains under a substantially greater financial burden for health care when compared to the rest of the world
- Other developed countries spend less than 10% of their GDP on health care

National Health Expenditure (NHE) Total Cost and Share of GDP, 2007-2023

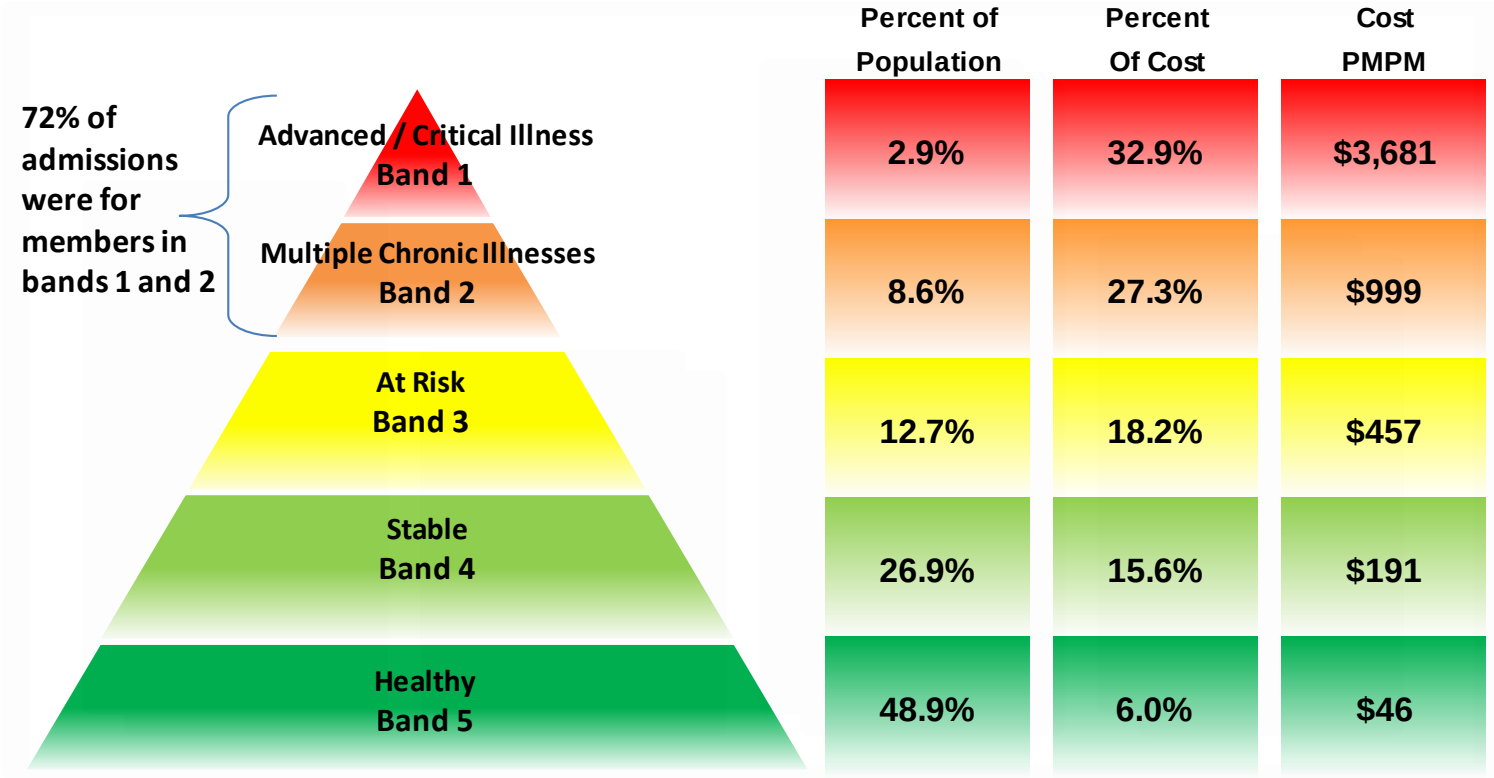


*Years 2013 forward are CMS projections.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, July 2015.

Illness Pyramid – The Rosetta Stone
Commercial, Under 65 Population – "Population Health"

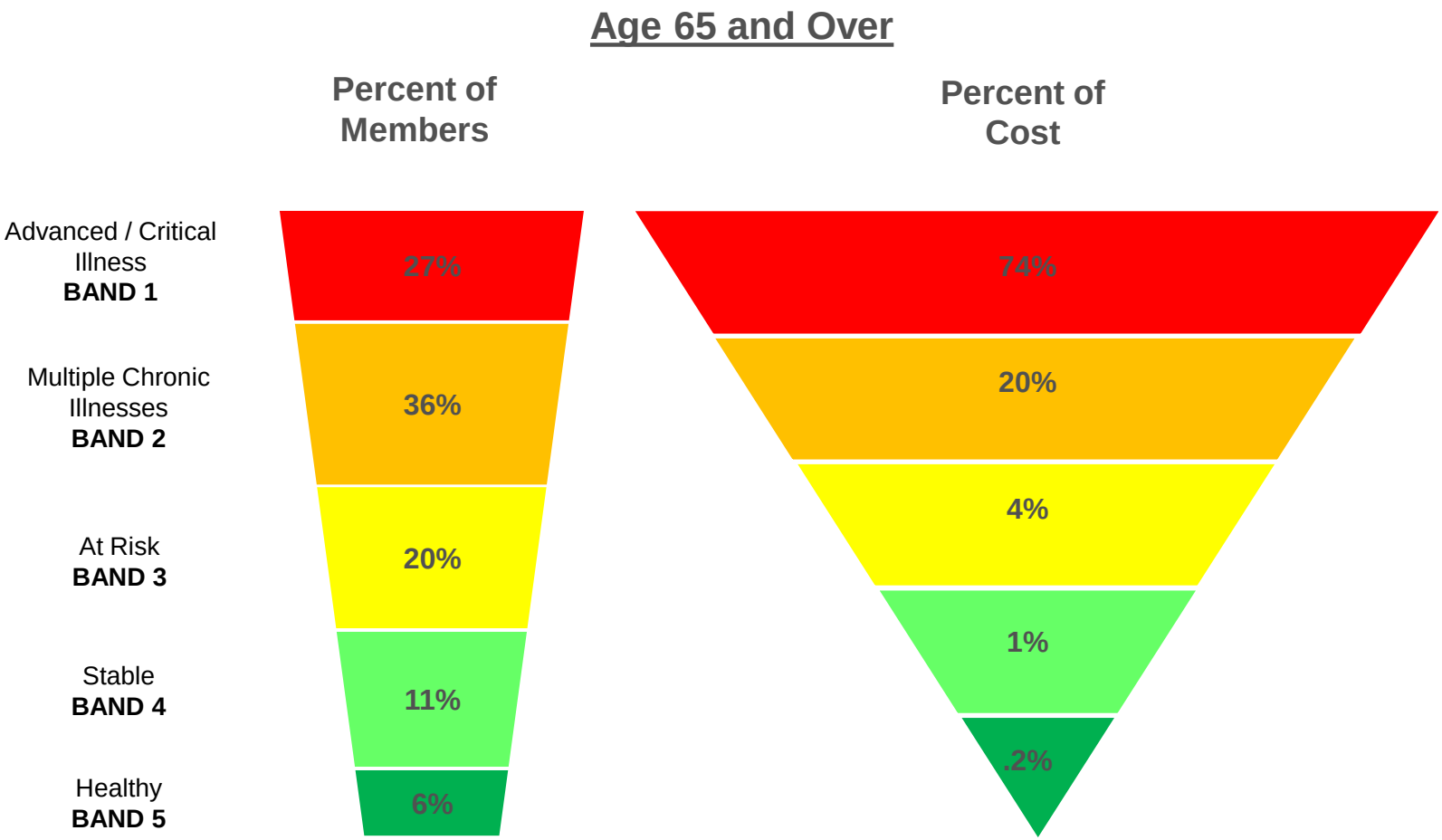
- Health care costs are concentrated at the top of the illness burden pyramid – the top two bands account for less than 12% of the population but more than 60% of total costs
- Members with (or at risk of) multiple chronic illnesses account for a disproportionate share of all costs



Source: CareFirst HealthCare Analytics – Incurred in 2014 and paid through March 2015 – CareFirst Book of Business, excluding Medicare Primary Members

Illness Pyramid – The Rosetta Stone
Medicare Population

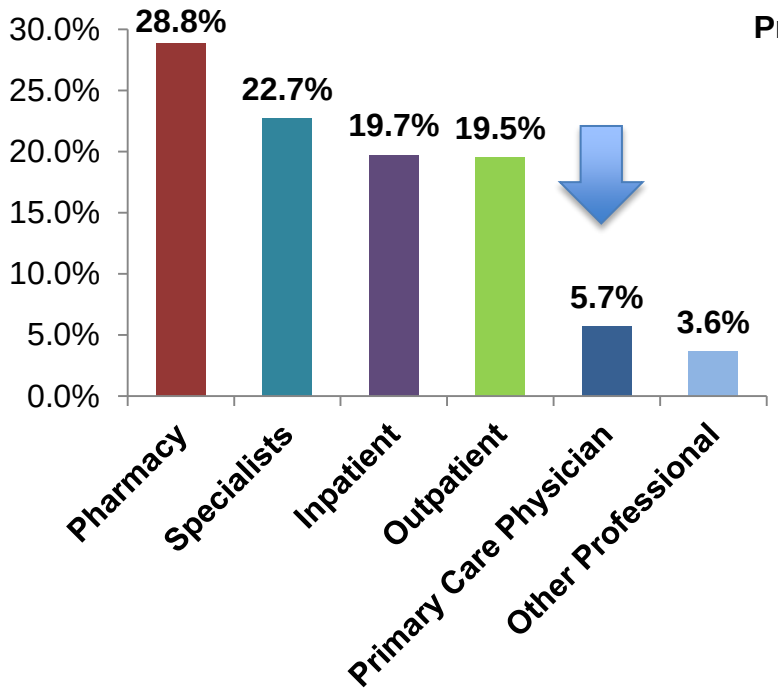
- Over 60% of the beneficiaries and nearly 95% of the cost for the Medicare program are contained in the top two bands

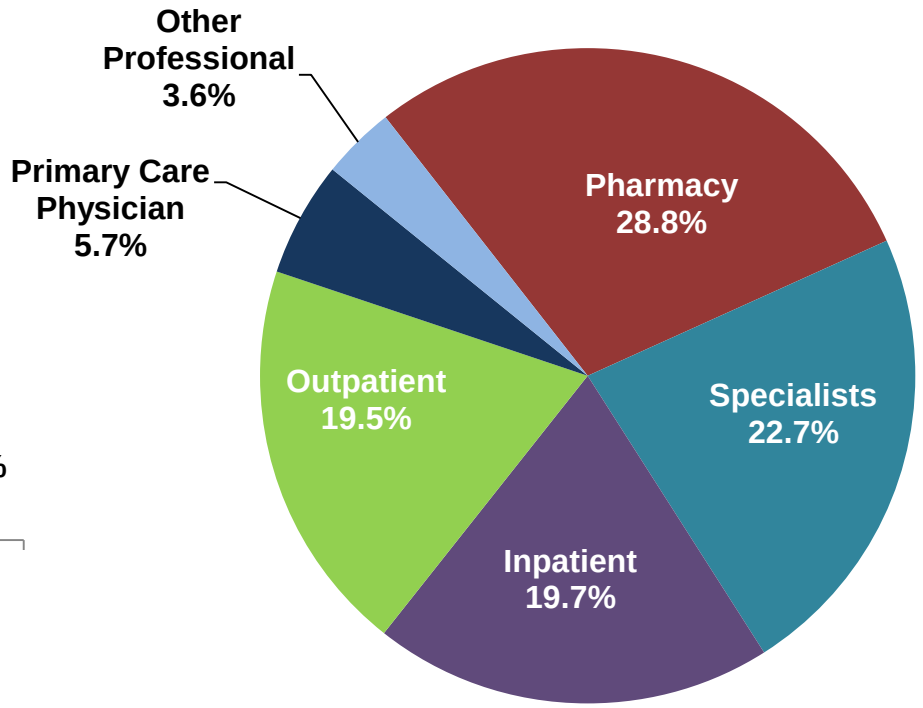


Source: CareFirst HealthCare Analytics – incurred in 2014 and paid through March 2015 – CMMI Grant Data for Medicare Beneficiaries

Total Distribution of CareFirst Medical Payments

- Spending on prescription drugs has become the largest share of the medical dollar (including spending in the Pharmacy and Medical benefits)
- This key change causes increased focus on pharmacy care coordination





Medical spending is based on 2014 CareFirst Book of Business. The Pharmacy % is adjusted to represent typical spend for members with CareFirst's pharmacy benefit.

Program Growth – 2011 to Present

- The PCMH program continues to grow, primarily through the addition of smaller practices since 2013
- As the number of PCPs has increased, so has the number of Attributed Members and the Global Cost of Care under management
- Over 80% of eligible* PCPs in CareFirst's service area participate in the PCMH Program

Year	Panels	PCPs**	Attributed Members	GlobalCost of Care
2011	180	2,152	489,623	$1.7B
2012	283	3,387	969,998	$2.5B
2013	402	3,703	1,040,028	$3.6B
2014	424	4,047	1,059,955	$4.0B
2015	438	4,052	1,079,190	$4.2B

* Non-eligible PCPs include those in the Maryland program, Concierge Practices, Providers not Participating in all networks and the Veterans Administration.

** PCPs include Physicians and Nurse Practitioners

Current and Projected State of Panels, Providers & Members

- CareFirst categorizes Panels into four types
- 75% of PCPs practice outside of a large health system
- The number of PCPs, Panels and Attributed Members has grown steadily

Panel Type	Panels	Practices	Providers*	Providers / Panel	Members	Members/ Panel	Members/ Provider
Single Panel Virtual	166	968	1,424	8.6	421,280	2,538	321
Single Panel Independent	70	70	586	8.4	185,212	2,646	314
Multi Panel Independent	97	106	968	10.0	280,425	2,891	210
Multi Panel Health System	105	75	1,074	10.2	192,273	1,831	218
Total January 2015	**438**	**1,219**	**4,052**	**9.3**	**1,079,190**	**2,464**	**266**
Total January 2016 (Projected)	**445**	**1,300**	**4,359**	**9.8**	**1,160,000**	**2,607**	**266**

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

Extent of Care Coordination in 2015

- Care Coordination is a team-based activity
- By the end of 2015, CareFirst will have provided nurse-led care coordination to well over 100,000 Members with Complex Cases, Chronic Diseases and Behavioral Health or Substance Abuse Diagnoses
- While this seems like a lot of care coordination, it only represents 3% of CareFirst's population – there is much more to be done
- Given the importance of prescription drug spending, the role of the pharmacist is critical in reviewing the medications of Members in Care Coordination programs

Program Name	2015 Member Engagement
Hospital Transition of Care (HTC)	99,000
Complex Case Management (CCM)	30,000
Chronic Care Coordination (CCC)	13,000
Behavioral Health/Substance Abuse Case Management (BSA)	6,000
Enhanced Monitoring Program (EMP)	2,000
Expert Consult Program (ECP)	1,000
Comprehensive Medication Review (CMR)	10,000

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CareFirst's Unique PCMH Model

Central Idea

- PCP is the core player
- Total care of patients is to be provided, organized, coordinated and arranged through small Panels of PCPs
- Panels as a team are accountable for aggregate quality and cost outcomes of their pooled population
- Savings against the Panel's pooled global budget target are shared with the Panel Providers
- This creates a powerful incentive for PCPs as a team to control costs for their pooled patient population and reward savings
- All supports in TCCI are designed to assist Panels to get better results
- Overall Outcome – both on quality and overall cost is the goal
- Lower cost trends cannot be achieved or maintained without improved overall quality

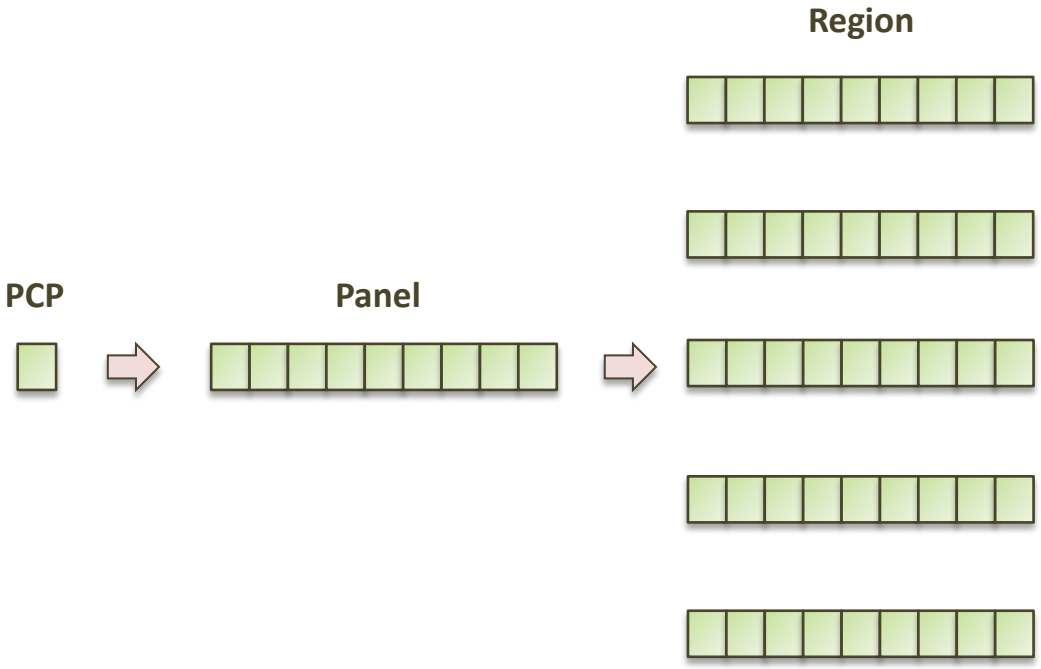
PCP Panels – Small Teams – Performance Units

Characteristics of Panels

- Average Panel Size: 9.3 PCPs
- The more independent the better
- The “buyers” and arrangers of services

Roles of Panels

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



Minimal Administrative Burden and Little Cost to PCPs in the Program

- No requirement to purchase software or upgrade system – all CareFirst tools are web based
- No requirement to overhaul practice workflow
- No requirement to hire additional staff
- CareFirst provides all supports
- Practice need only partner with CareFirst to identify and manage risks in the population

Yet,

- The program has a profound impact on behavior leading to far greater attentiveness to cost and quality outcomes
- We know that PCPs are using OIA wins to reinvest in their practices

Financial Model – Blend of Fee For Service and Global Capitation

Goal: Beat your own experience trended

- **Global budget 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
  - Illness Burden Scores embedded in attributed population are identified
  - Expected care costs are trended forward from base year
- PMPM Global Budget Target = Trended care costs ÷ Member months
- Quality scores ratchet gain share up or down; low overall engagement and quality scores disqualify Panel from an OIA
- Panels share the savings achieved against their budget targets through an Outcome Incentive Award (OIA) paid on each claim for CareFirst Members

OIA is the ultimate value measure

Patient Care Account – Illustration of A Scorekeeping System for Panels

- An Account for each Panel is setup – called the Patient Care Account
- 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)	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 1.25	Projected Overall Medical Trend over 4 years at 7.5%, 6.5%, 5.5%, and 3.5%
x 1.079	Illness Burden Adjustment 2014 vs. 2010 (1.36/1.26)
$12.1M	Performance Year Budget Target (2014)
÷ 33,600	Member months for 3,000 members
$361	Target PMPM care costs become “Credits” in Patient Care Account, posted monthly

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

Mary Smith – One Member

Debits			Credits	
1/4/2014	Primary Care Visit	$50		
1/4/2014	Vaccination	$10		
1/7/2014	Pharmacy Fill	$120	January	$361
2/4/2014	ER Visit	$700	February	$361
2/4/2014	ER Treatment	$300	March	$361
3/6/2014	Ophthalmologist Visit	$127	April	$361
4/22/2014	Orthopedic Visit	$257	May	$361
4/25/2014	Pharmacy Fill	$120	June	$361
4/25/2014	Physical Therapy	$22	July	$361
5/5/2014	Physical Therapy	$22	August	$361
7/10/2014	Pharmacy Fill	$120	September	$361
8/22/2014	Dermatologist Visit	$300	October	$361
8/23/2014	Pathology Test	$50	November	$361
10/15/2014	Outpatient Hospital Visit	$1,448	December	$361

$12,100,000 per year in global cost, divided by 33,600 member months = $361 PMPM

Total Debits: $3,646

Total Credits: $4,332

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 during and at the end of the performance year after claims run-out
- The Panel is either within the global expected budget or has exceeded it
- Panels are partially protected from catastrophic cases by a “stop loss” program

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: $716,000

Total Debits: $12,901,000 **Total Credits: $13,500,000**

Claims in excess of $75,000: ($117,000)

Net Debits: $12,784,000

Note: Insured stop loss protection will only reflect the first $75,000 plus 20% of claims dollars above that, per member, per year.

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

Quality – Five Categories

- Improvements or maintenance of quality is critical to Panel success
- The higher the quality score of a Panel, the greater the reward
- Engagement and Quality scores below a certain level disqualify a Panel from an OIA even if it produces savings

PCP Engagement*	35 points
Appropriate Use of Services	20 points
Effectiveness of Care	20 points
Patient Access	15 points
Structural Capabilities	10 points
Total 100 Points	

**At least 22 of 35 points are needed for Outcome Incentive Award (OIA) in 2015*

Quality Scores Hinge Heavily on Physician Engagement

- 35% of a Panel's quality score is based on the degree of their Engagement

PCP Engagement	35 points
PCP Engagement with the PCMH Program	7.5 points
PCP Engagement with Care Plans	7.5 points
Member Satisfaction Survey	7.5 points
Program Consultant Assessment	10 points
Program Representative Assessment	2.5 points
Appropriate Use of Services	**20 points**
Admissions	8 points
Potentially Preventable Emergency Room Use	4 points
Ambulatory Services, Diagnostic Imaging and Antibiotics	8 points
Effectiveness of Care	**20 points**
Chronic Care Maintenance	10 points
Population Health Maintenance	10 points

Patient Access	15 points
Online Appointment Scheduling	3 points
Unified Communication Visits / Telemedicine	3 points
Office Hours Before 9:00am and After 5:00pm on Weeknights	3 points
Office Hours on Weekends	3 points
Overall Patient Experience	3 points
Structural Capabilities	**10 points**
Use of E-Prescribing	2 points
Use of Electronic Medical Record (EMR)	2 points
Meaningful Use Attestation	2 points
Medical Home Certification	2 points
Effective Use of Electronic Communication	2 points

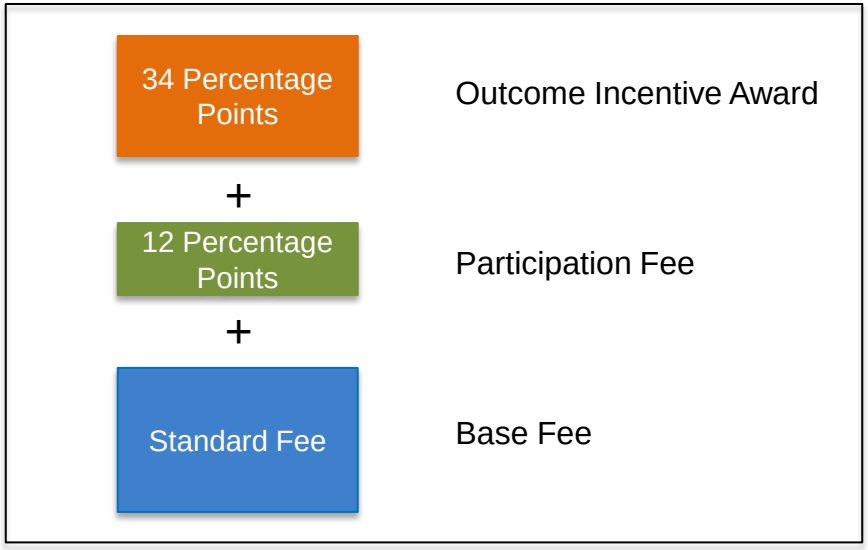
- By 2017, 50% of the Panel's quality score will be based on Engagement, with the other 50% based on CMS ACO quality measures – 2016 will be a transition year

Calculate Award as Intersection of Savings and Quality

- The intersection of savings level and quality score reveals the fee schedule increase percentage

OIA Awards: Degree of Savings

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



* Example for panels with greater than 3,000 members

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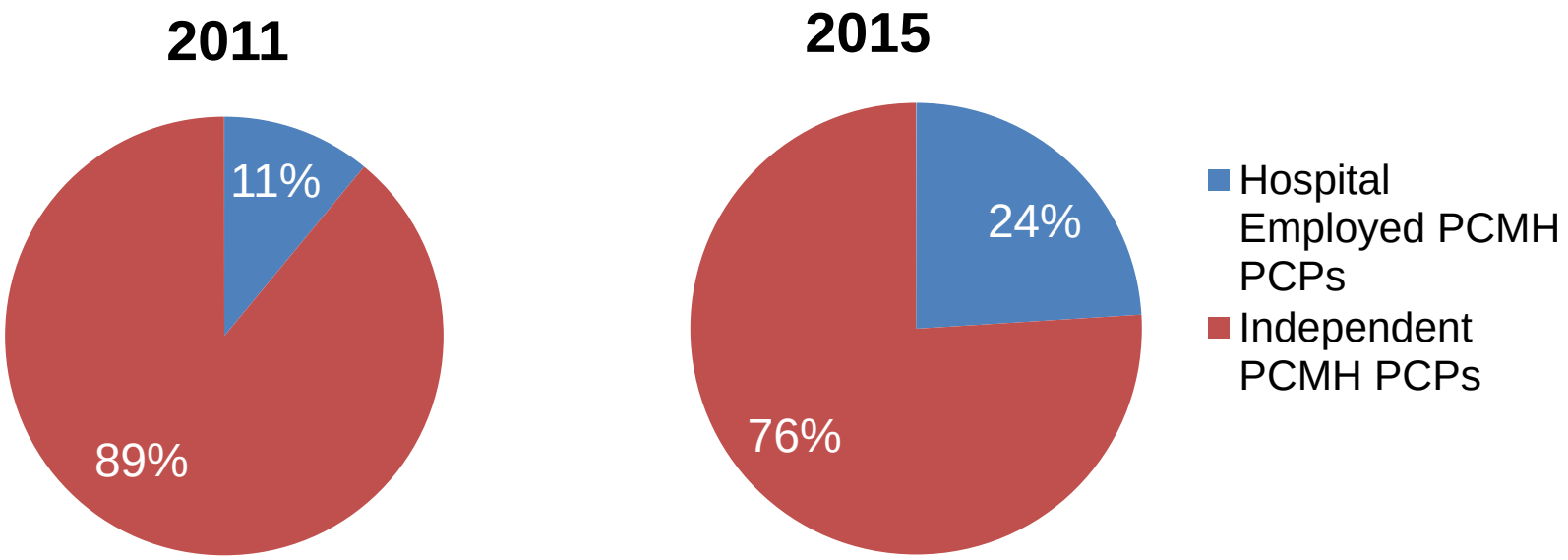
Panel Types, Make-up of Panels

Employed vs. Independent PCPs – Goal: Maintain Independence

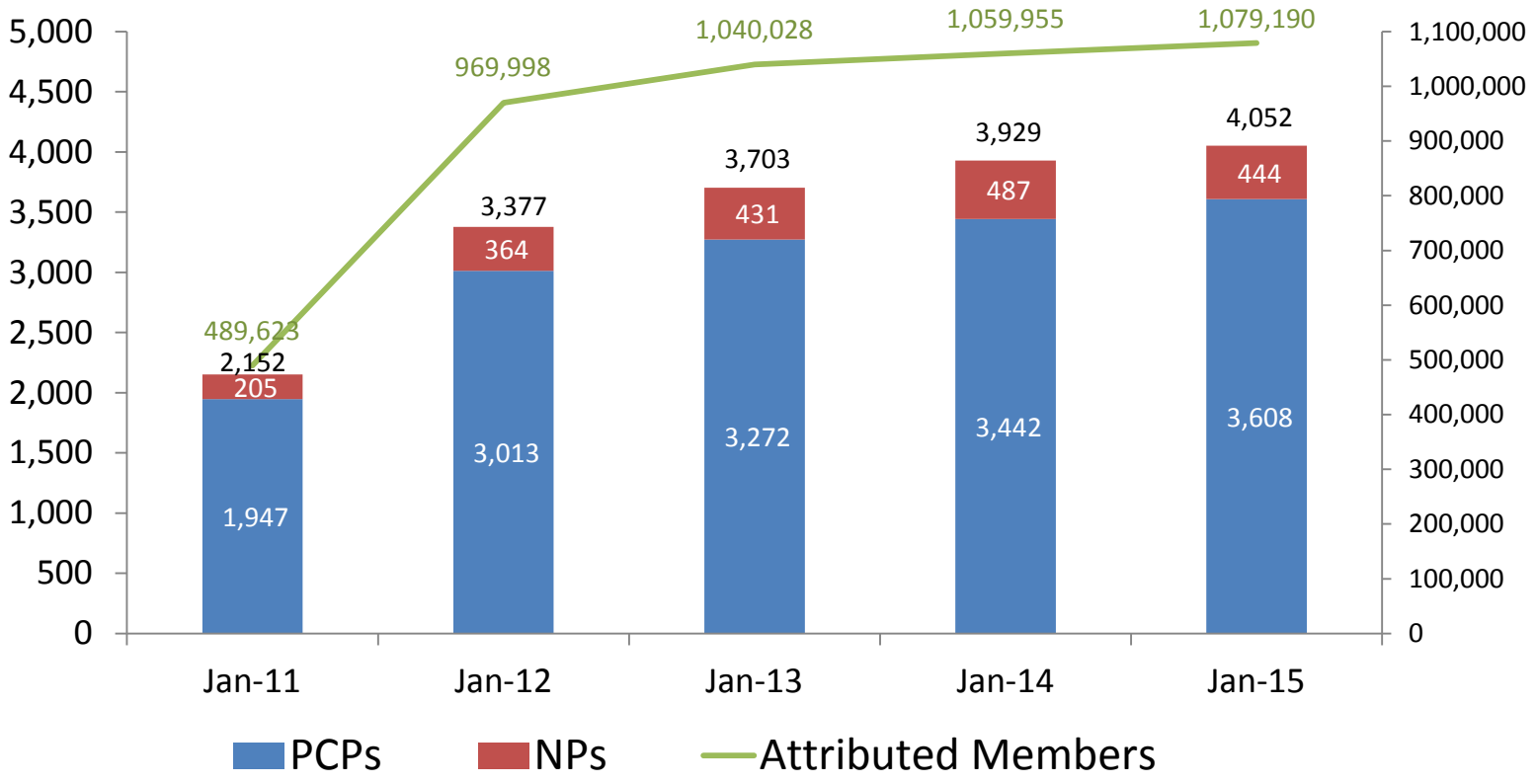
- Within the CareFirst service area, PCPs (as well as Specialists) are joining larger group practices (i.e., Privia) or hospital-owned practices (i.e., MedStar, Johns Hopkins, LifeBridge, Inova, etc)
- Recent national reports suggest 53% of physicians are employed by a hospital-owned practice
- Consolidation is often due to the economics of operating smaller practices, the promise of better security and a better financial position
- Hospital-owned PCP practices normally 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 24% in 2015 – still a small percentage by national standards



Source: CareFirst Networks Management Data as of 2014

Provider and Member Growth in the Program

- Participating PCPs have steadily increased and, with them, enrollment
- The number of NPs credentialed in the program has doubled since program inception
- There are many NPs who are working in practices that work under a physician's credentialing



Consistency in Program Design is Key to Behavior Change

- Program model has been consistent since program inception
- Stability in Panel participation and performance has been remarkable
  - Over three quarters of all Panels (327) that have been in the program for 4 years:
    - 124 (38%) had savings all 4 years
    - 103 Panels (32%) had savings 3 of the 4 years
    - Only 8 Panels (2%) have never had savings after 4 years

Stability in Panel Structure

- Very little change in the mix of panel types
  - The mix of Adult, Pediatric and Mixed Panels was 62% / 28% / 10% at the end of 2011
  - The mix was 67% / 22% / 11% as of June 2015
- “Few” Panels (29 or 7%) have undergone “Substantial Change” in the history of the program
- 46 (10.5%) Panels are classified as Non-Viable today

Stability in PCP Participation – Low Drop-Out Rate

- The Program has been attractive and as a result has grown
- Termination rates are unremarkable and reflect a typical amount of physician turn over
- Since 2011, 13% of PCPs left the Program
- Of those that left, 82% retired, left practice, or moved out of the area
- 18% were terminated due to lack of Program engagement
  - 7% of these later returned to the program

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Five Strategies for Panel Success

5 Focus Areas for Panels

- We have found 5 focal points of action – things a Panel can do as a practical matter to positively impact cost and quality outcomes
- These are weighted to show their relative importance
- The weight of the Referral Pattern area reflects the importance of the most value laden decision made by a PCP: when and where to refer
- The extent of engagement with the Program drives all behavior change, causing it to be heavily weighted as well

HealthCheck Profile:
5 Focus Areas for Panels that Most Influence Cost and Quality

5 Key Areas	Weight
Cost Effectiveness of Referral Patterns	35%
Extent of Engagement in Care Coordination Programs and with various TCCI programs	20%
Effectiveness of Medication Management	20%
Reduction in Gaps in Care and Quality Deficits	10%
Consistency of PCP Engagement and Performance within the Panel	15%

PCPs Are Increasingly Directing Referrals to Cost Effective Providers

- CareFirst ranks Specialists and Hospitals as High, Medium or Low cost
- This information is shared with PCPs in the PCMH program
- No judgement is made on CareFirst's part as to quality – that is left up to the PCP
- Since providing this cost information, we have seen evidence of changes in referral patterns
- PCPs develop a "favorites list" of preferred specialists
- Until now, PCPs were unaware (and economically disinterested) in the impact of their referral decisions – the PCMH has changed this
- PCPs employed by large health systems lose freedom to refer where they want – "sealing" referrals into only those specialists within the system

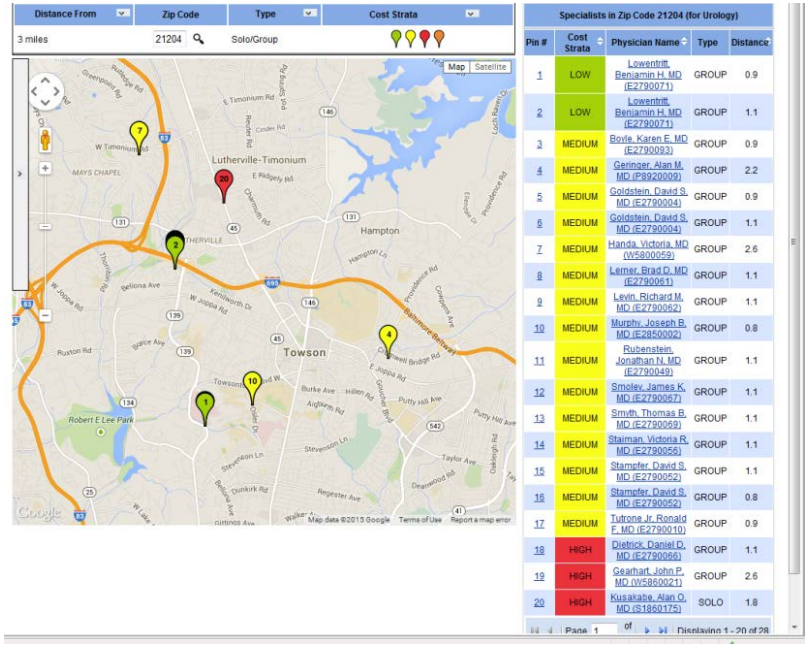
Variation in Cost Among Hospitals

- High cost tier hospitals are larger, with 25% of the total area hospitals and 36% of the admissions
- Expected costs are set by DRG for all hospitals in the CareFirst service area
- The average cost of admission at a High cost Hospital is double that of a Low cost Hospital

Cost Tier	Cost Per Admission
High	$26,111
Mid	$13,935
Low	$12,846

Variation in Cost Among Specialists

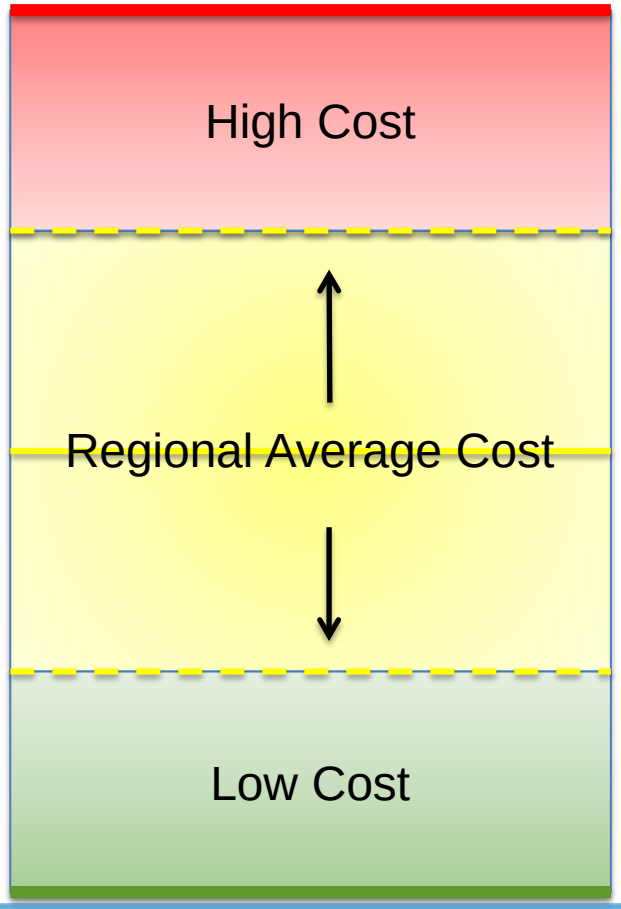
- Over 8,800 Specialists were assigned cost tiers, spanning 40 specialty categories
- The top 10 categories account for the majority of all expenditures
- Expected costs are set by episode and condition / procedure for all Specialists in the CareFirst service area
- The average spread between High and Low cost specialists is 71%
- In some common specialties, like General Surgery, the spread is 130% with no discernable difference in quality
- CareFirst provides tools to PCPs to help identify cost effective Specialists near them



Episodes Used to Determine Specialist Performance Relative to Regional Average

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

Specialists Stratified Relative to Regional Average Episode Cost



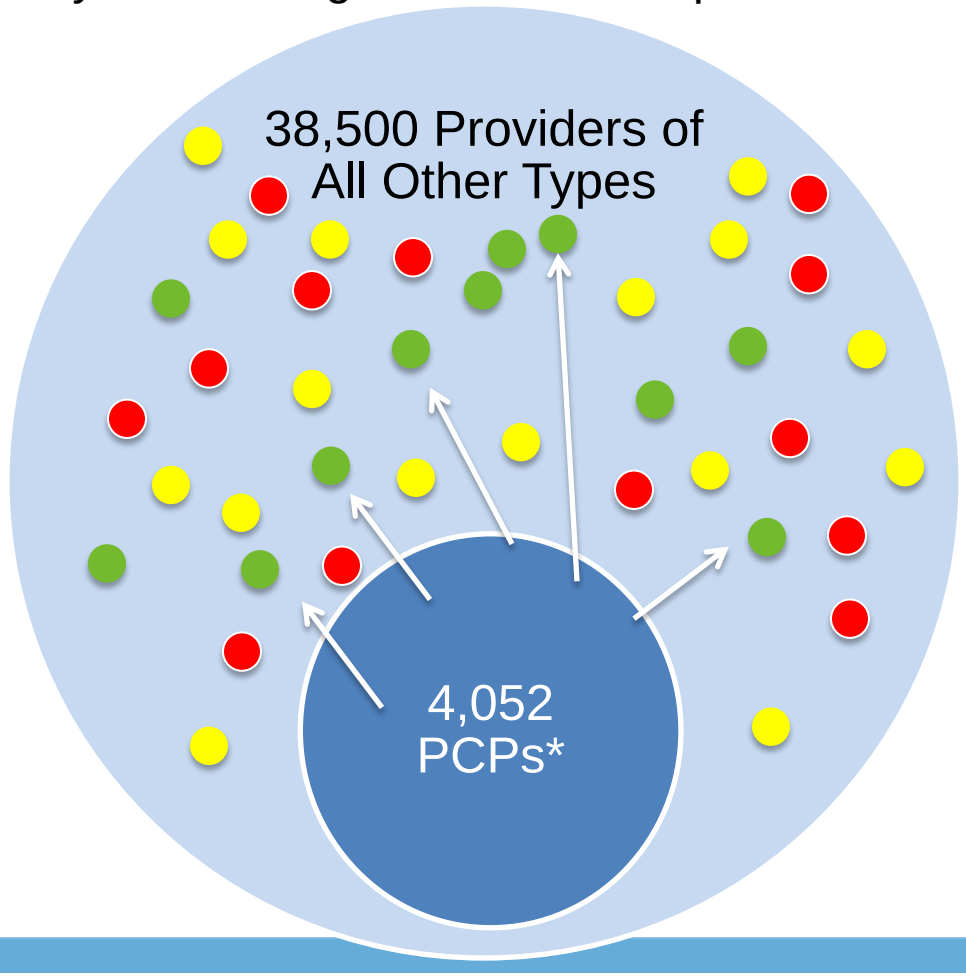
Panels Make "Buying" and Arranging Decisions Specialists and Hospitals Referrals

- No narrow networks are used
- PCPs refer where they believe they will get the best result
- Given the high percentage of admissions for common illnesses, many have become convinced of the efficacy of referring to lower cost Specialists and Hospitals

High Cost Providers

Medium Cost Providers

Low Cost Providers



* Includes Nurse Practitioners

Variation in Cost Among PCMH Panels

- The difference in total PMPM cost between the top third and the bottom two-thirds is 11%
- Variation in cost is attributable to the Panel's referral patterns and level of engagement
- CareFirst will begin providing incentives to Members to select PCPs in higher performing Panels

Cost Tercile	Illness Burden Adjusted PMPM		
	Adult	Mixed	Pediatric
Low	$308.59	$270.98	$143.45
Mid	$338.62	$280.00	$158.61
High	$356.14	--	$167.83
Total	$337.06	$259.61	$151.97
Mid/High	$345.88	$280.00	$161.51
Low vs. Mid/High	10.8%	3.2%	11.2%

Source: CareFirst HealthCare Analytics – 2012 thru 2014 Data for Panels Participating in PCMH for 3 Consecutive Years

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PCMH is Supported by TCCI

Total Care and Cost Improvement Program (TCCI)

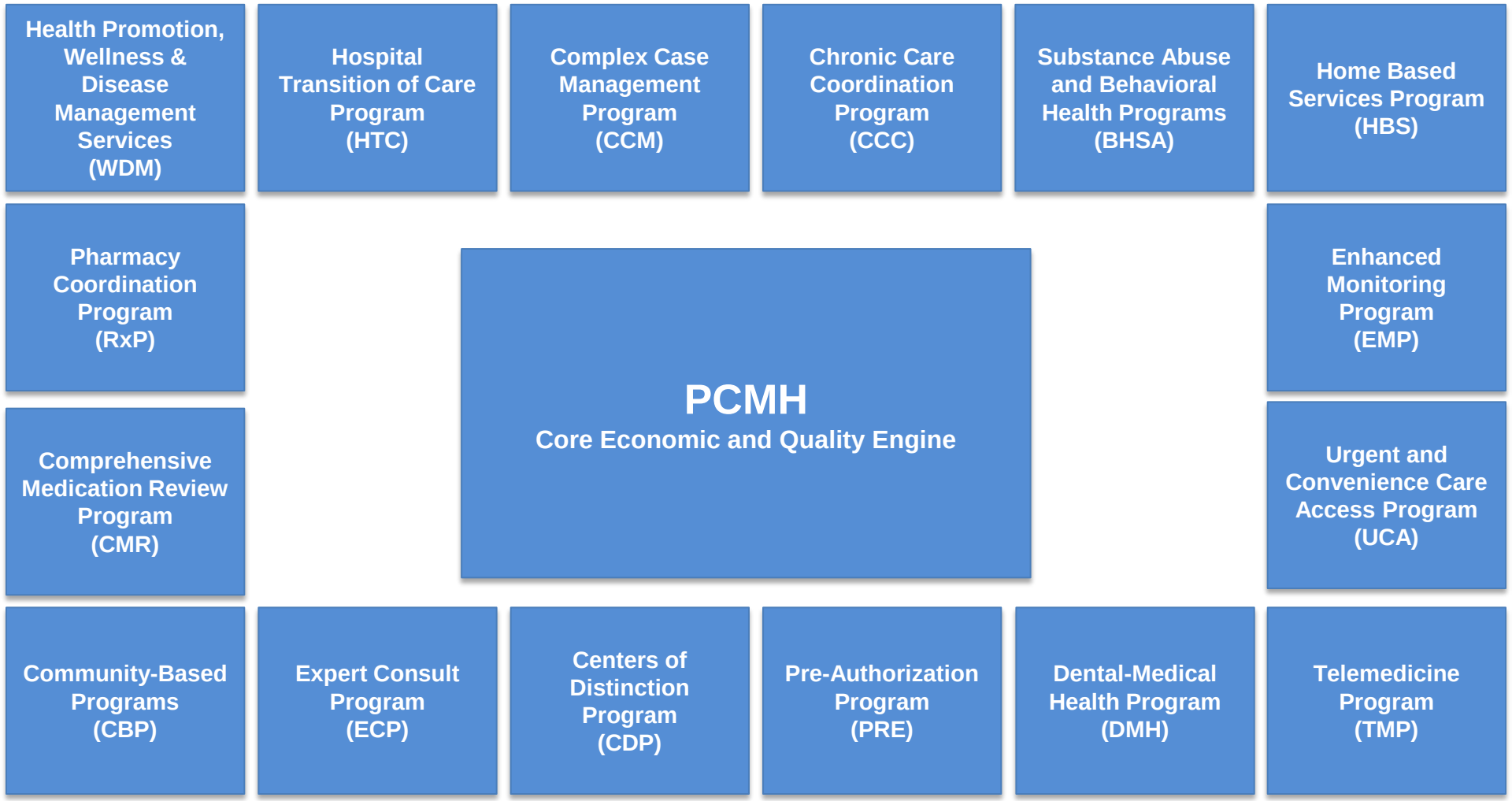
- Experience has shown that ***financial incentives alone are not enough*** to result in a long term bend in the care cost trend curve
- Extensive additional ***supports*** are needed that address the ***entire continuum of care***
- ***These essential capabilities and supports are well beyond the means of Panels – especially independent ones***

Total Care and Cost Improvement Program (TCCI)

embodies these supports

- 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***

PCMH Program At the Core of TCCI – 16 Supporting Programs



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Providing PCPs with Actionable Data To Identify Key Patterns

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
- SearchLight is the reporting system responsible for organizing and presenting the data
- Panels are provided with Key Indices and Top 50 Lists

10 Key Indices Used to Profile Member Populations in Panels

- Illness Burden Score
- LACE Index
- Charlson Comorbidity Index
- Consumer Health Inventory / PHQ-2
- Patient Activation Measure
- Framingham Heart Disease Score
- Well-Being Score
- Drug Instability Index
- Pharmacy Risk Groups
- Metabolic Index Score

Top 50 Lists Provided to PCPs to Identify Members in Need

- High Cost / High Risk Members with Multiple Indicators
- Overall PMPM in Dollars
- Pharmacy PMPM in Dollars
- Drug Volatility Score
- Specialty Drug PMPM in Dollars
- High Rx Utilization
- Hospital Use
- Multiple Comorbidities
- Gaps in Care
- Disease Instability
- Members with Adverse / High Risk Health Assessment Results

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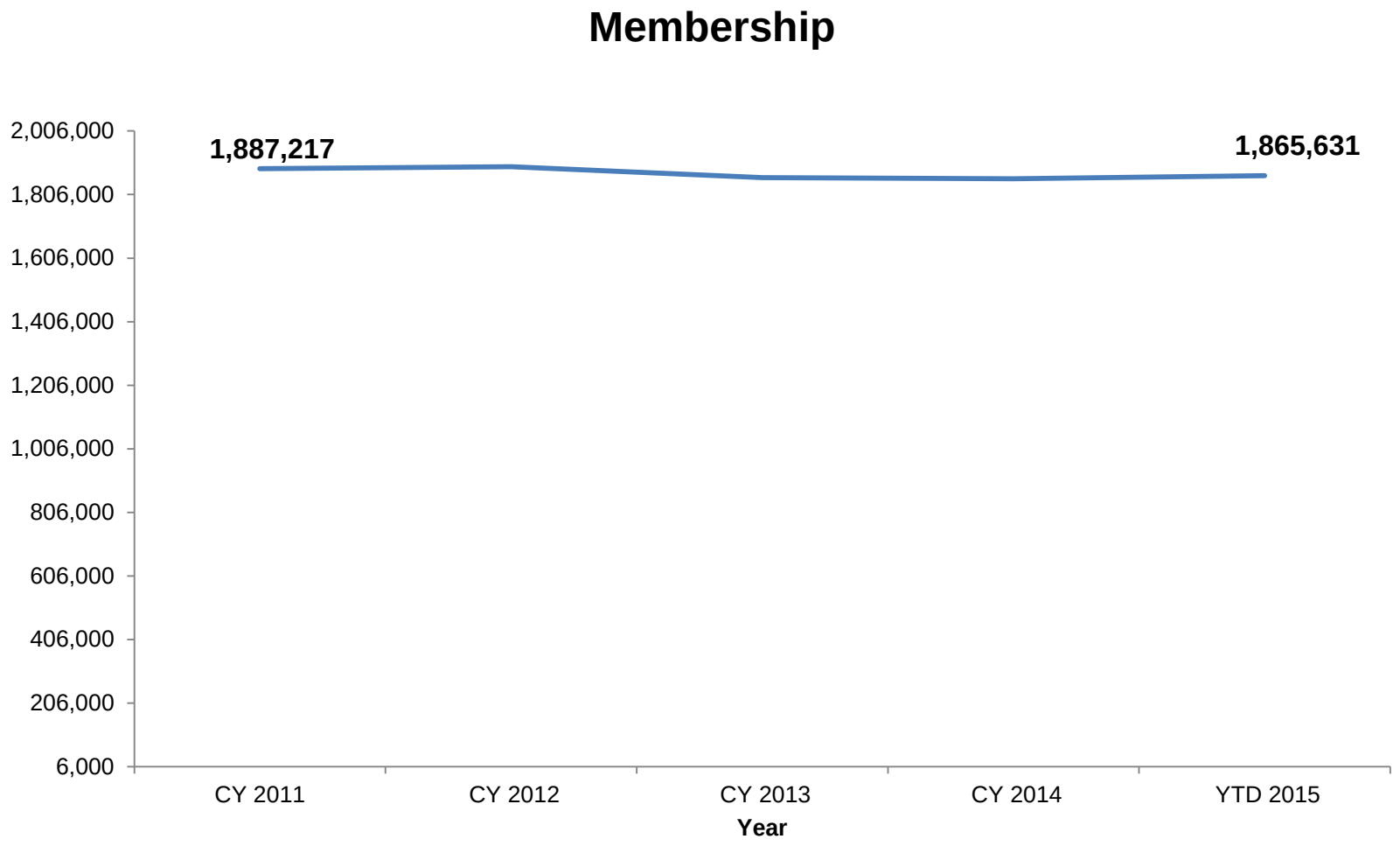
Major Sources of Savings / Cost Avoidance

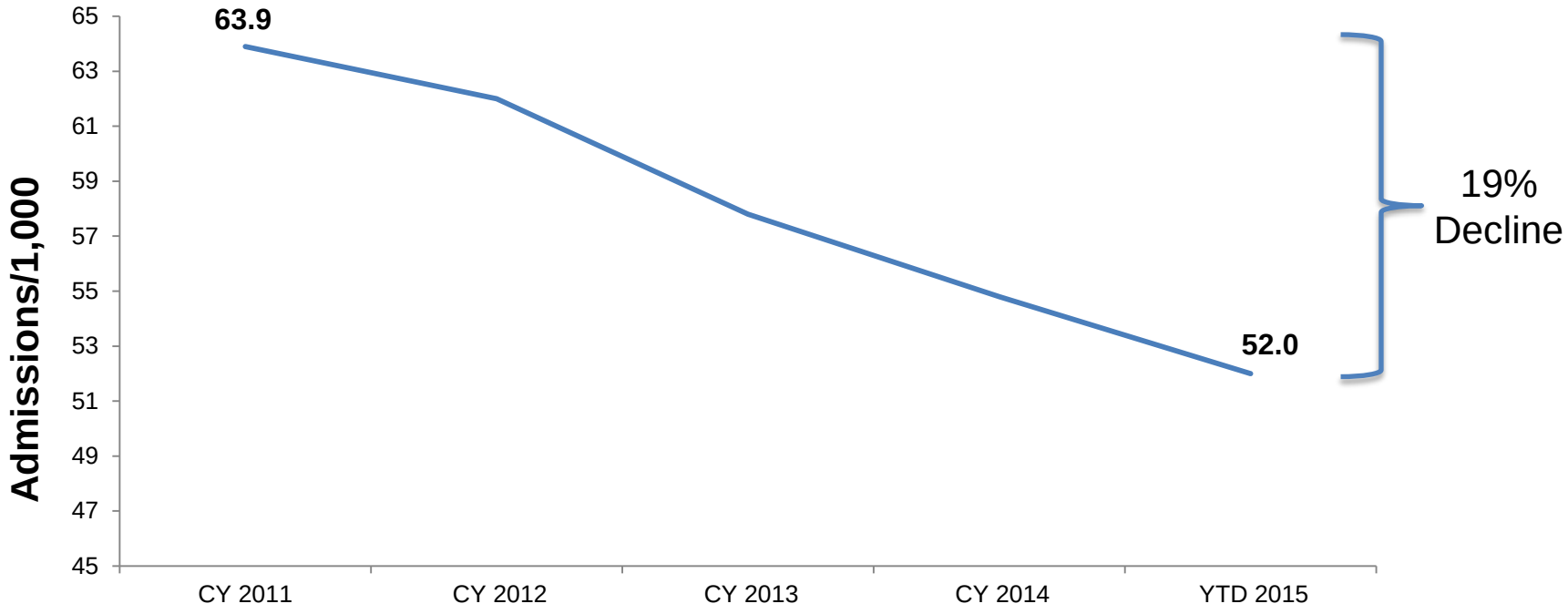
CareFirst Membership Has Been Very Stable (2011 – 2015)



Source: CareFirst Health Care Analytics. CareFirst Book of Business. Members residing in the CareFirst service area.

But Admission Rates are Dropping Sharply

- Despite stability in Membership:
  - The admission rate per 1,000 Members dropped 9.5% from 2011 to 2013 vs. a National decline (all payer) of 4.9%
  - The admission rate per 1,000 Members is down 19% from 2011 thru 2015 YTD

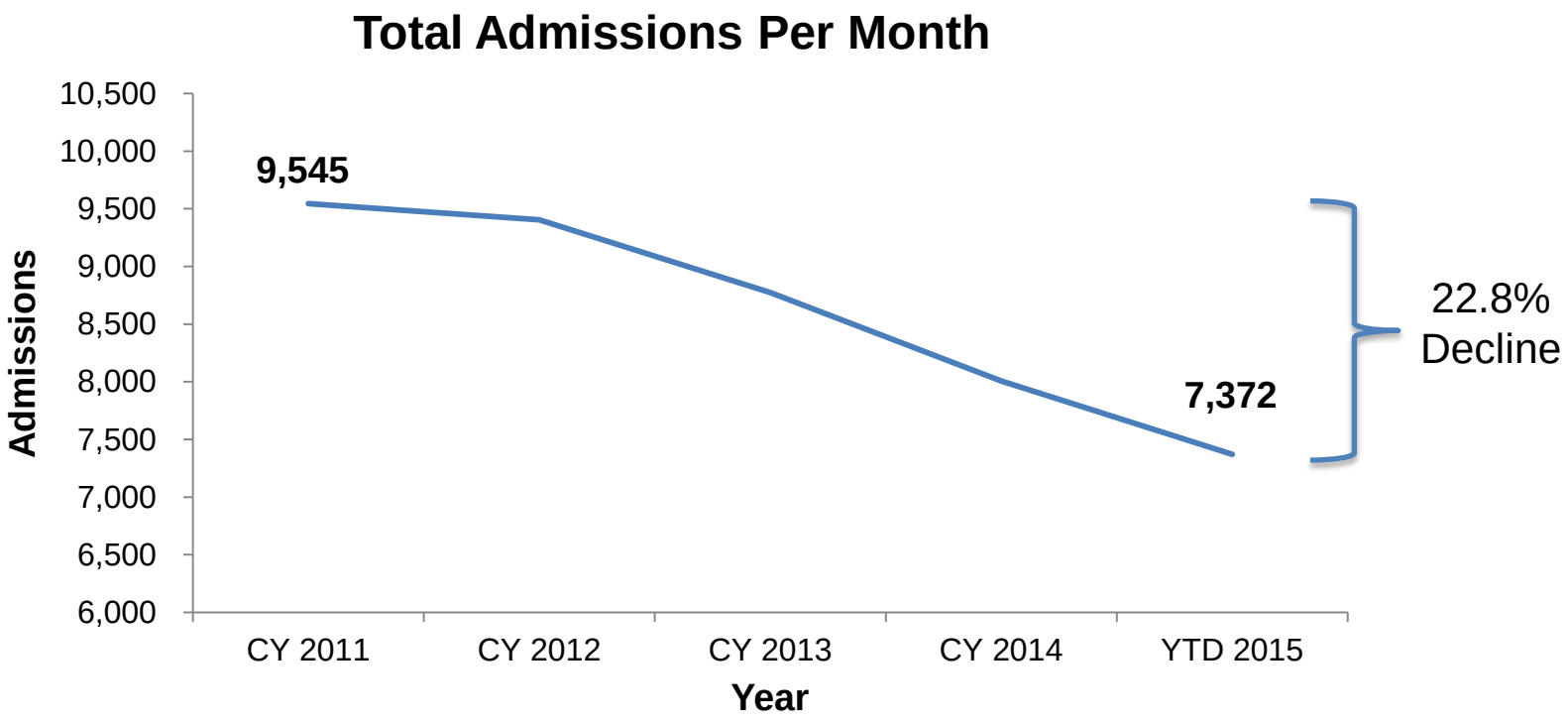


Source: CareFirst Health Care Analytics. CareFirst Book of Business for hospitals in the CareFirst service area. Claims paid through March 2015.

Source: National Decline in admission rate from American Hospital Association annual statistics, 2015 Statistical Guide.

Total Admissions Per Month – Steeper Decline in the CareFirst Service Area

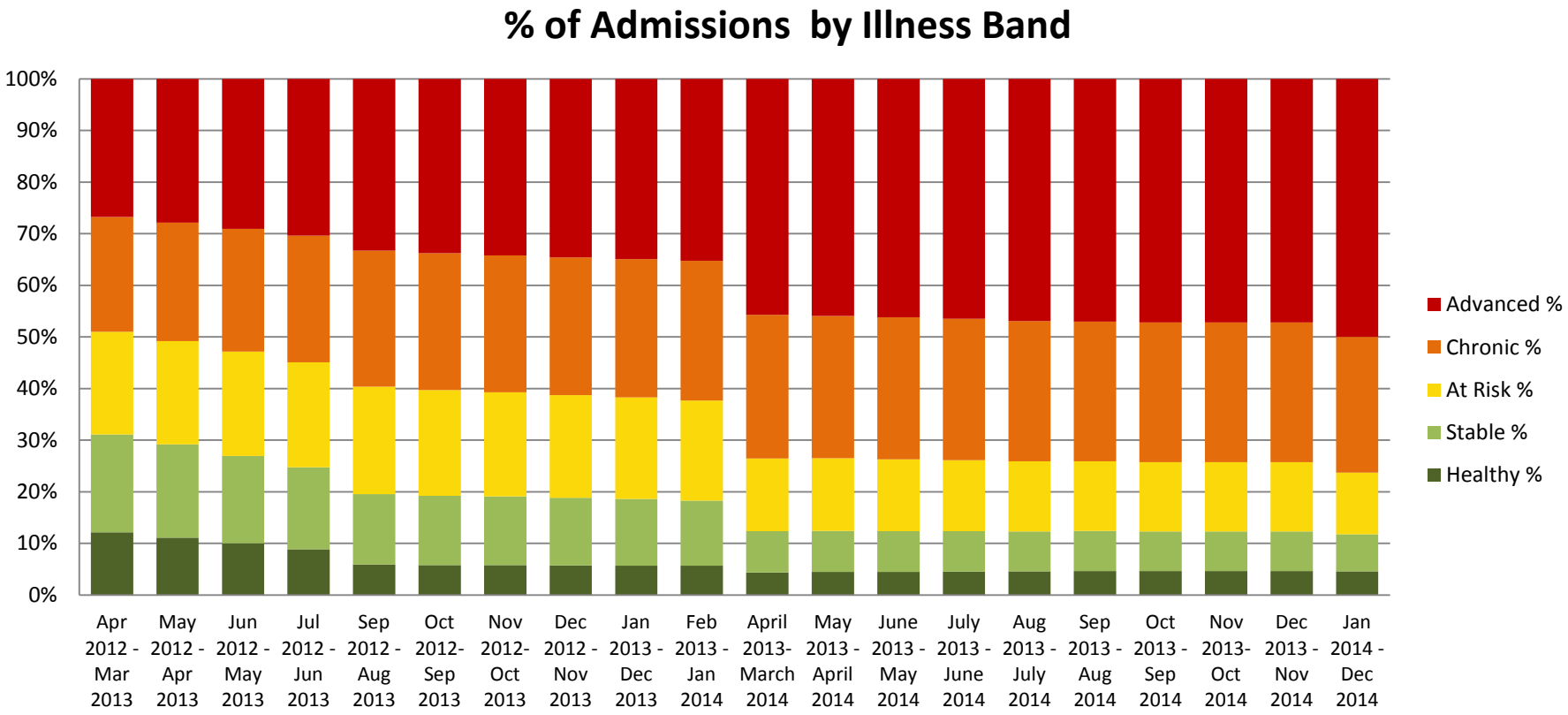
- Total admissions in the CareFirst service region (where the PCMH program applies) have declined 22.8% from 2011 to 2015 YTD
- Admissions to low cost Hospitals have declined less (19.0%) than high cost Hospitals (24.6%) over the same period
- Had admissions continued at the 2011 volume, CareFirst would have spent $480 Million more in 2014 on Inpatient care in the service area



Source: CareFirst Health Care Analytics. CareFirst Book of Business for hospitals in the CareFirst service area. Claims paid through March 2015.

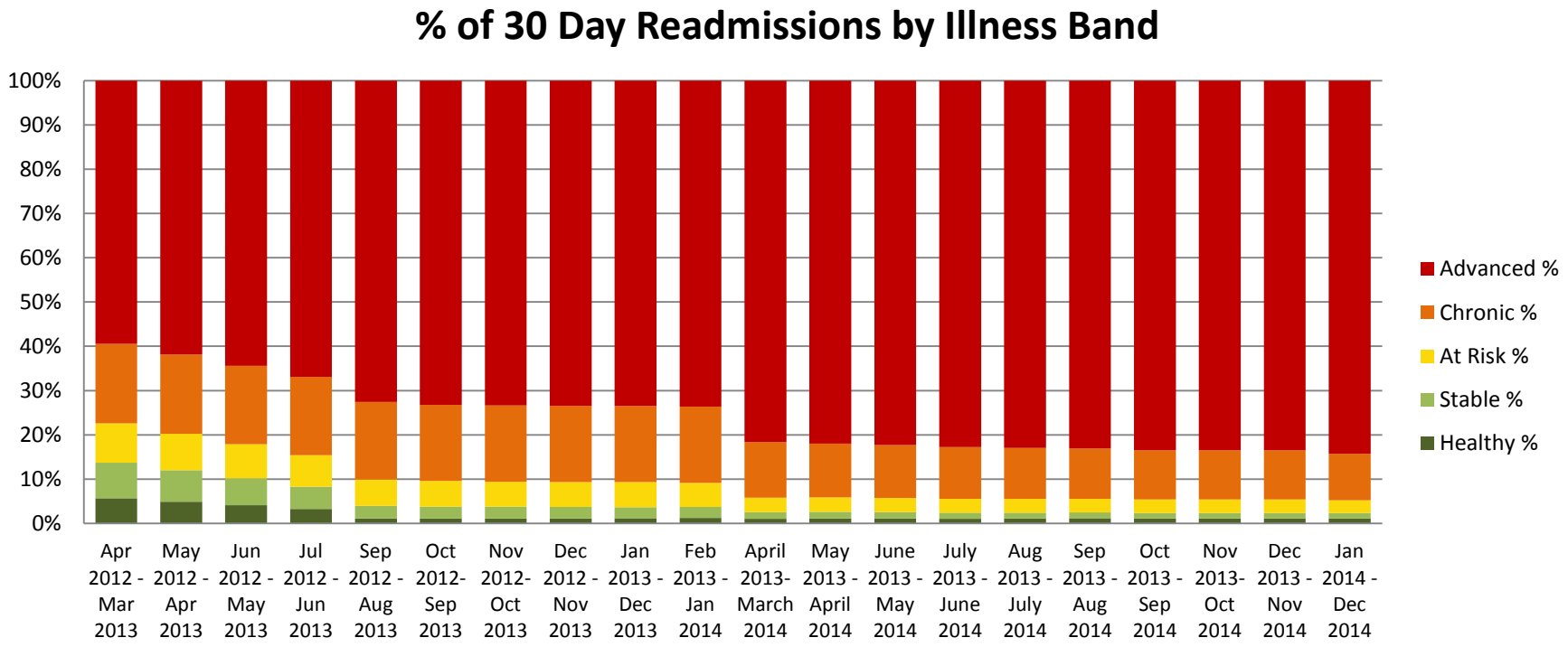
Admissions are More Acute

- The decline in Hospital admissions has resulted in greater acuity in those that are admitted



Readmissions are More Acute

- The same is true for readmissions
- Progression toward greater acuity driven by decrease in admissions for multi-chronic patients
- This is occurring at a pace greater than the national average



Top 20 Causes of Admission – Book of Business

- The top 20 episode categories for admission account for over 70% of all admissions
- Community Hospitals generally deal effectively with these episodes at a far lower cost

Admission Type	Book of Business			
Top 20 Episodes	Admits	% of Total #	Actual Total $	Actual Avg $
1. Pregnancy w Vaginal Delivery	14,516	19.3%	$161,765,597	$11,144
2. Pregnancy w Cesarean Section	8,393	11.2%	$126,181,798	$15,034
3. Osteoarthritis	5,480	7.3%	$163,797,430	$29,890
4. Condition Rel to Tx - Med/Surg	2,547	3.4%	$63,149,576	$24,794
5. Newborns, w/wo Complication	1,715	2.3%	$62,496,125	$36,441
6. Coronary Artery Disease	2,098	2.8%	$61,053,119	$29,101
7. Pneumonia, Bacterial	1,900	2.5%	$39,646,303	$20,866
8. Cerebrovascular Disease	1,755	2.3%	$46,715,068	$26,618
9. Diabetes	1,701	2.3%	$24,184,504	$14,218
10. Infec/Inflam - Skin/Subcu Tiss	1,561	2.1%	$17,379,170	$11,133
11. Overweight and Obesity	1,516	2.0%	$29,950,538	$19,756
12. Gastroint Disord, NEC	1,039	1.4%	$14,799,082	$14,244
13. Mental Hlth - Depression	1,342	1.8%	$11,600,577	$8,644
14. Mental Hlth - Substance Abuse	992	1.3%	$10,954,053	$11,042
15. Hypertension, Essential	1,135	1.5%	$17,281,594	$15,226
16. Tumors - Gynecological, Benign	1,074	1.4%	$14,593,645	$13,588
17. Diverticular Disease	1,113	1.5%	$16,584,311	$14,901
18. Cholecystitis/Cholelithiasis	1,095	1.5%	$17,072,029	$15,591
19. Cardiac Arrhythmias	989	1.3%	$14,141,523	$14,299
20. Asthma	897	1.2%	$8,492,088	$9,467
Total	**52,858**	**70.4%**	**$921,838,129**	**$17,440**

Source: CareFirst HealthCare Analytics – 2014 Data

Top 20 Causes of Admission – Academic Medical Center vs. Community Hospital

- The top 20 causes (episodes) for admission account for less than half of the total admissions for Academic Medical Centers, while they account for over 80% of the admissions in a Community Hospital
- The average cost of a common admission in these categories at an Academic Medical Center is approximately double that of a Community Hospital

Admission Type	Book of Business			Academic Medical Center			Community Hospital		
Top 20 Episodes	Admits	% of Total #	Actual Avg $	Admits	% of Total #	Actual Avg $	Admits	% of Total #	Actual Avg $
1. Pregnancy w Vaginal Delivery	14,516	19.3%	$11,144	176	3.7%	$17,066	1,124	25.8%	$9,658
2. Pregnancy w Cesarean Section	8,393	11.2%	$15,034	112	2.3%	$19,868	673	15.4%	$11,909
3. Osteoarthritis	5,480	7.3%	$29,890	87	1.8%	$30,721	454	10.4%	$25,167
4. Condition Rel to Tx - Med/Surg	2,547	3.4%	$24,794	266	5.5%	$27,628	104	2.4%	$15,393
5. Newborns, w/wo Complication	1,715	2.3%	$36,441	67	1.4%	$80,141	136	3.1%	$27,518
6. Coronary Artery Disease	2,098	2.8%	$29,101	127	2.6%	$35,404	82	1.9%	$20,100
7. Pneumonia, Bacterial	1,900	2.5%	$20,866	94	2.0%	$26,244	76	1.7%	$13,262
8. Cerebrovascular Disease	1,755	2.3%	$26,618	123	2.6%	$30,956	64	1.5%	$16,454
9. Diabetes	1,701	2.3%	$14,218	93	1.9%	$22,371	51	1.2%	$14,783
10. Infec/Inflam - Skin/Subcu Tiss	1,561	2.1%	$11,133	48	1.0%	$13,514	60	1.4%	$6,875
11. Overweight and Obesity	1,516	2.0%	$19,756	0	0.0%	$0	184	4.2%	$17,029
12. Gastroint Disord, NEC	1,039	1.4%	$14,244	76	1.6%	$19,550	48	1.1%	$8,940
13. Mental Hlth - Depression	1,342	1.8%	$8,644	55	1.1%	$20,058	0	0.0%	$0
14. Mental Hlth - Substance Abuse	992	1.3%	$11,042	22	0.5%	$21,569	37	0.8%	$11,312
15. Hypertension, Essential	1,135	1.5%	$15,226	52	1.1%	$40,307	31	0.7%	$7,792
16. Tumors - Gynecological, Benign	1,074	1.4%	$13,588	45	0.9%	$16,336	69	1.6%	$9,723
17. Diverticular Disease	1,113	1.5%	$14,901	29	0.6%	$22,020	68	1.6%	$15,206
18. Cholecystitis/Cholelithiasis	1,095	1.5%	$15,591	53	1.1%	$19,822	51	1.2%	$10,288
19. Cardiac Arrhythmias	989	1.3%	$14,299	104	2.2%	$21,372	46	1.1%	$8,194
20. Asthma	897	1.2%	$9,467	44	0.9%	$9,533	30	0.7%	$6,897
Total	**52,858**	**70.4%**	**$17,440**	**1,673**	**34.8%**	**$26,507**	**3,388**	**77.7%**	**$14,035**

Source: CareFirst HealthCare Analytics – 2014 Data

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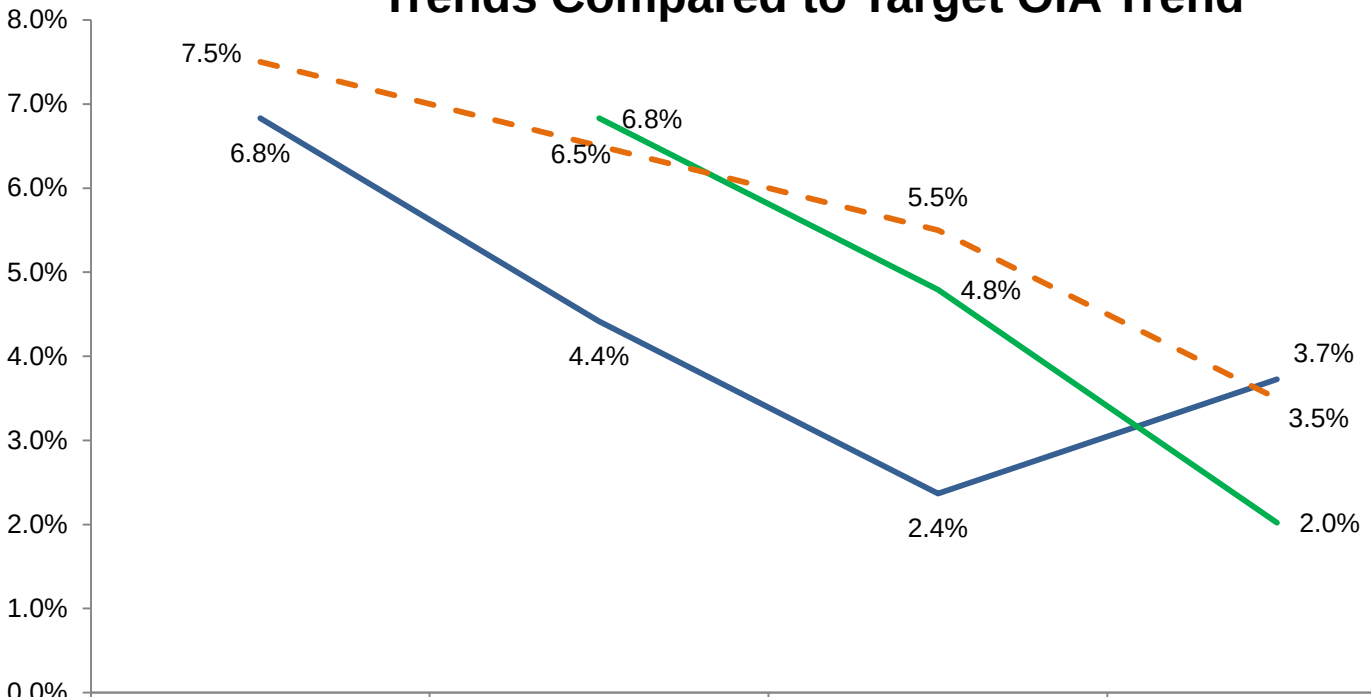
Outcome Award Patterns

Cost Avoided by "Bending the Curve"

- PCMH trend has continued to sharply decline while there is early evidence of a modest rebound in trend in the overall book

CareFirst Book of Business and PCMH Trends Compared to Target OIA Trend

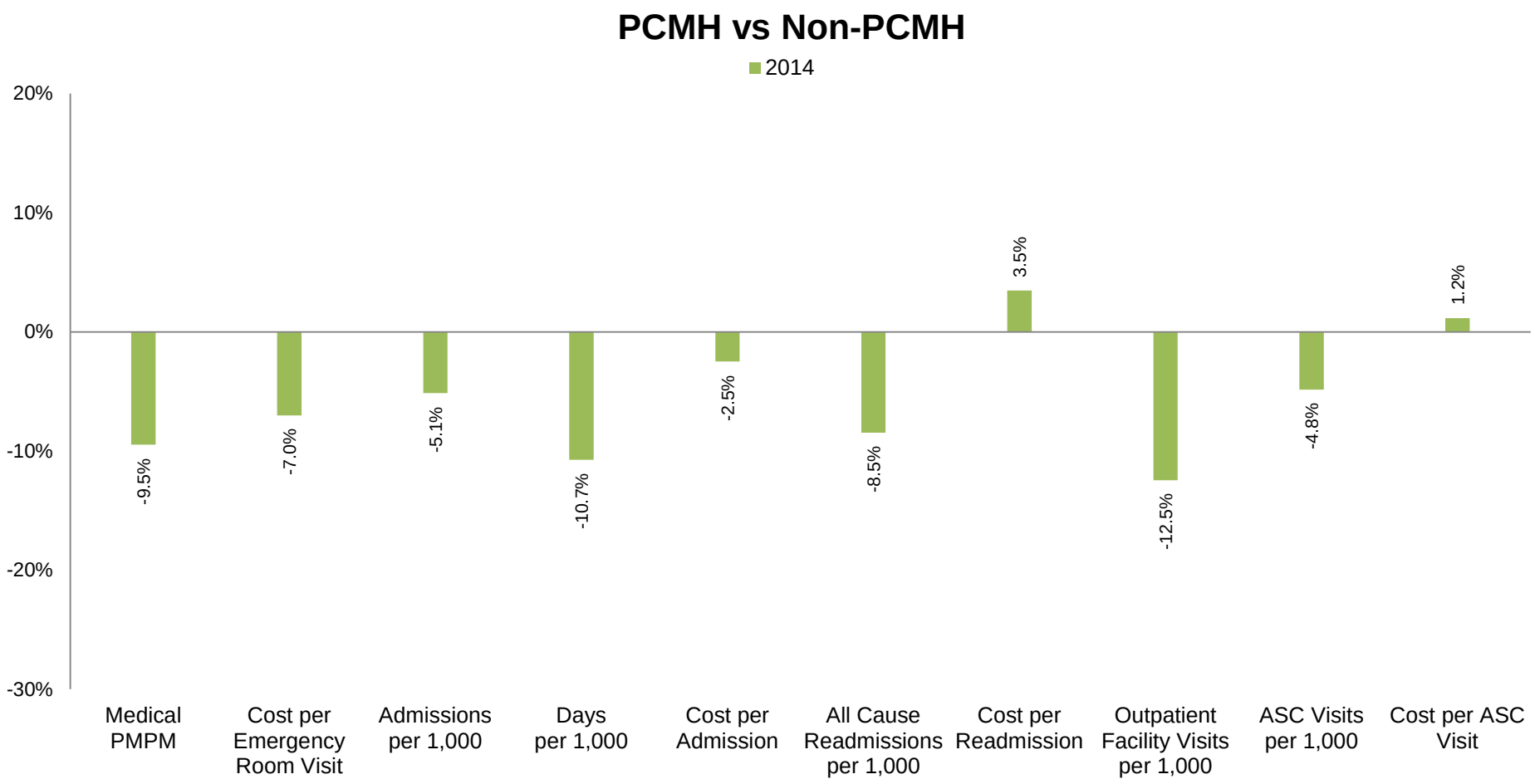


	2010/2011	2011/2012	2012/2013	2013/2014
CareFirst Book of Business Trend	6.8%	4.4%	2.4%	3.7%
PCMH Trend		6.8%	4.8%	2.0%
PCMH OIA Targeted Trend	7.5%	6.5%	5.5%	3.5%

Source: CareFirst HealthCare Analytics - Updated May 2014 – 2014 Projected based on claims run out through December 2015

Measures that Matter – 2014 Results

- Ten measures are tracked
- All are favorable – even the cost of readmission given the greater acuity

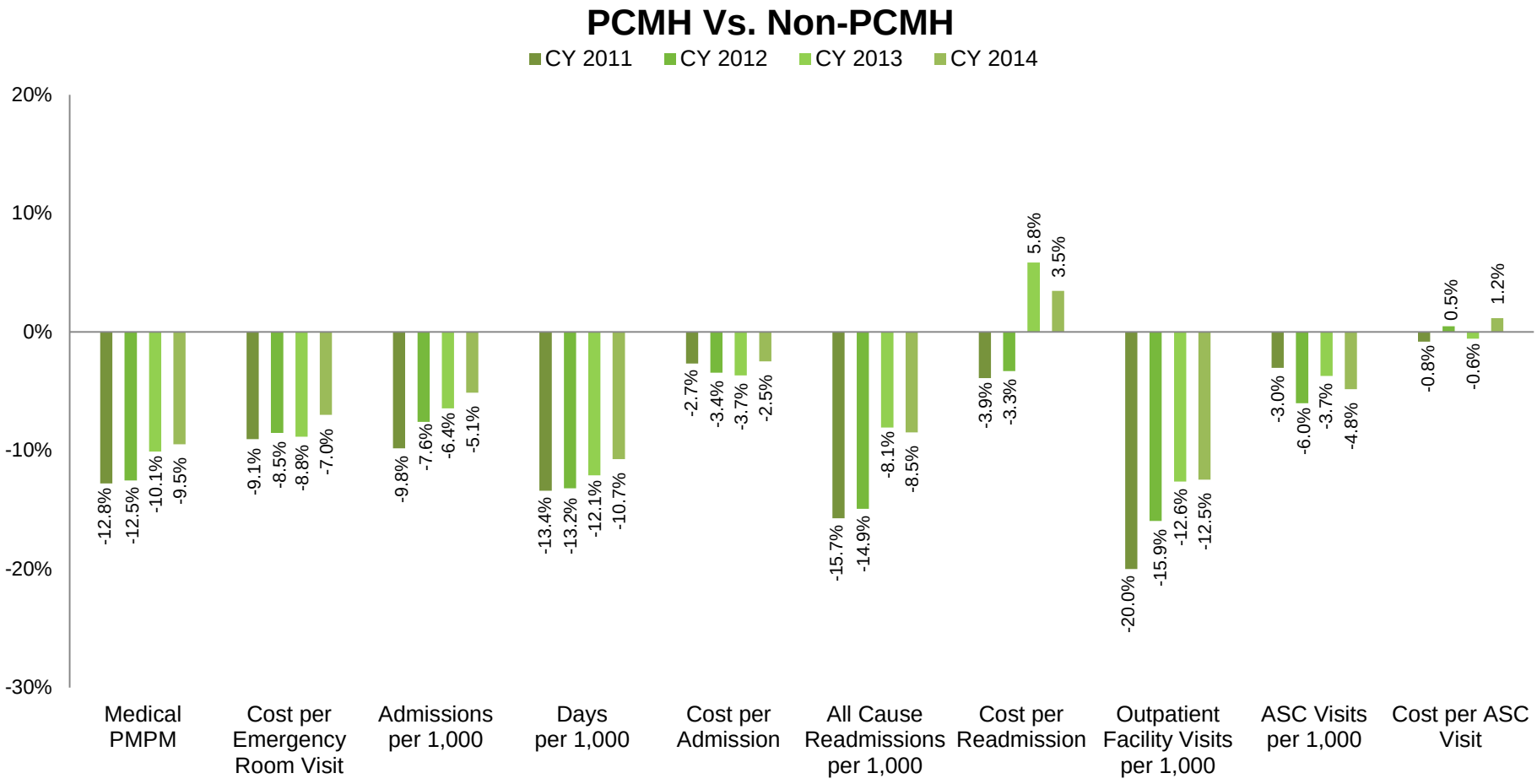


Source: CareFirst HealthCare Analytics - Attributed PCMH PCP population compared to attributed Non-PCMH PCP population

Includes data through December 2014, paid through March 2015. Exclusions: Medicare Primary, Catastrophic and TPA

Measures that Matter – Inception to Date

- The pattern in 2014 has held over a 4 year period even as it has become progressively harder to beat on declining volumes



Source: CareFirst HealthCare Analytics - Attributed PCMH PCP population compared to attributed Non-PCMH PCP population.

Includes data through December 2014, paid through March 2015. Exclusions: Medicare Primary, Catastrophic and TPA

PCMH – 2014 Outcome Incentive Award Results

- Of the 417 PCMH Panels participating in 2014, 349 (84%) achieved savings
  - Of the 327 panels participating in 2011-2014, 124 (38%) earned an OIA all four years
- The “winning” panels in 2014 managed their populations’ costs to 8.6% below target
- The net of “winning” and “non-winning” Panels was 7.6%
- The projected Overall Medical Tend in 2015 is 3.6%

Performance Year	% of Panels Receiving OIA	Average Award As a % of Increased Fee Schedules
2011	60%	25%
2012	66%	33%
2013	69%	36%
2014*	48%	59%

* Engagement criteria was strengthened in 2014 resulting in fewer panels receiving OIA.

Wins More Impressive on Slower Growing Global Budget

- Despite slowing / lower trend, savings have increased
  - The number of panels achieving savings has continued to grow
  - The size of the savings achieved has increased
- Panels who achieved savings in 2014, but were not sufficiently engaged to receive an OIA, have shown advancements in engagement in 2015

Performance Year	% of Panels with Savings	Net Savings % (all Panels)*
2011	60%	1.5%
2012	66%	2.7%
2013	69%	3.1%
2014	84%	7.6%

* Net Savings is the amount Panels were over budget subtracted from the amount other panels were under their targets.

Impact on Primary Care Practice Income

- The chart below shows the estimated annual value of the Outcome Incentive Awards for PCPs in Panels earning OIAs (does not include the 12% participation fee or fees for Care Plan development and maintenance)

Performance Year	Estimated Revenue Increase per PCP
2011	$11,500
2012	$17,000
2013	$21,900
2014	$41,600

- In addition to OIA increases above, the 12% participation fee represents $11,000 - $14,000 in additional revenue annually

Level of Patient Satisfaction is High

- Overall satisfaction is a very high 4.3 out of 5
- Based on a very high response rate of over 80%
- Some examples of Member feedback are included in the chart below

Member Feedback
"I believe I have not been hospitalized or needed emergency room visits due to her (LCC) interventions. I feel wonderful. I am in good hands. And I am glad BlueCross has this program. I think it is great."
"I call her (LCC) every week. Sometimes I call her twice a week and she is always there. She understands what I am talking about. She is right there and sends me data and it is a great program. So I am strongly for the program. I am happy. It is good communication between her and I, and her and the doctor. It is an excellent program."
"I would like to go on record to say that the program is a significant enhancement [to my health] and that my LCC and I are in communication once a week. I'm very, very impressed by the program although I had initial hesitation (prior to signing up) about it. I think it has benefits for ALL patients. It's an absolutely wonderful program; my LCC is TERRIFIC!!"

Savings to CareFirst

- For the program as a whole, CareFirst has saved $609M to date

Performance Year	Panels Beating Budget		Panels Exceeding Budget		Net
	Savings $	Savings %	Cost $	Cost %	
2011	$72M	4.2%	-$33M	-4.0%	$39M
2012	$130M	4.7%	-$32M	-3.6%	$98M
2013	$164M	5.1%	-$37M	-4.1%	$127M
2014	$370M	8.9%	-$25M	-6.3%	$345M
Total	$736M	6.2%	-$127M	-4.2%	$609M

All Costs Included in Savings Numbers

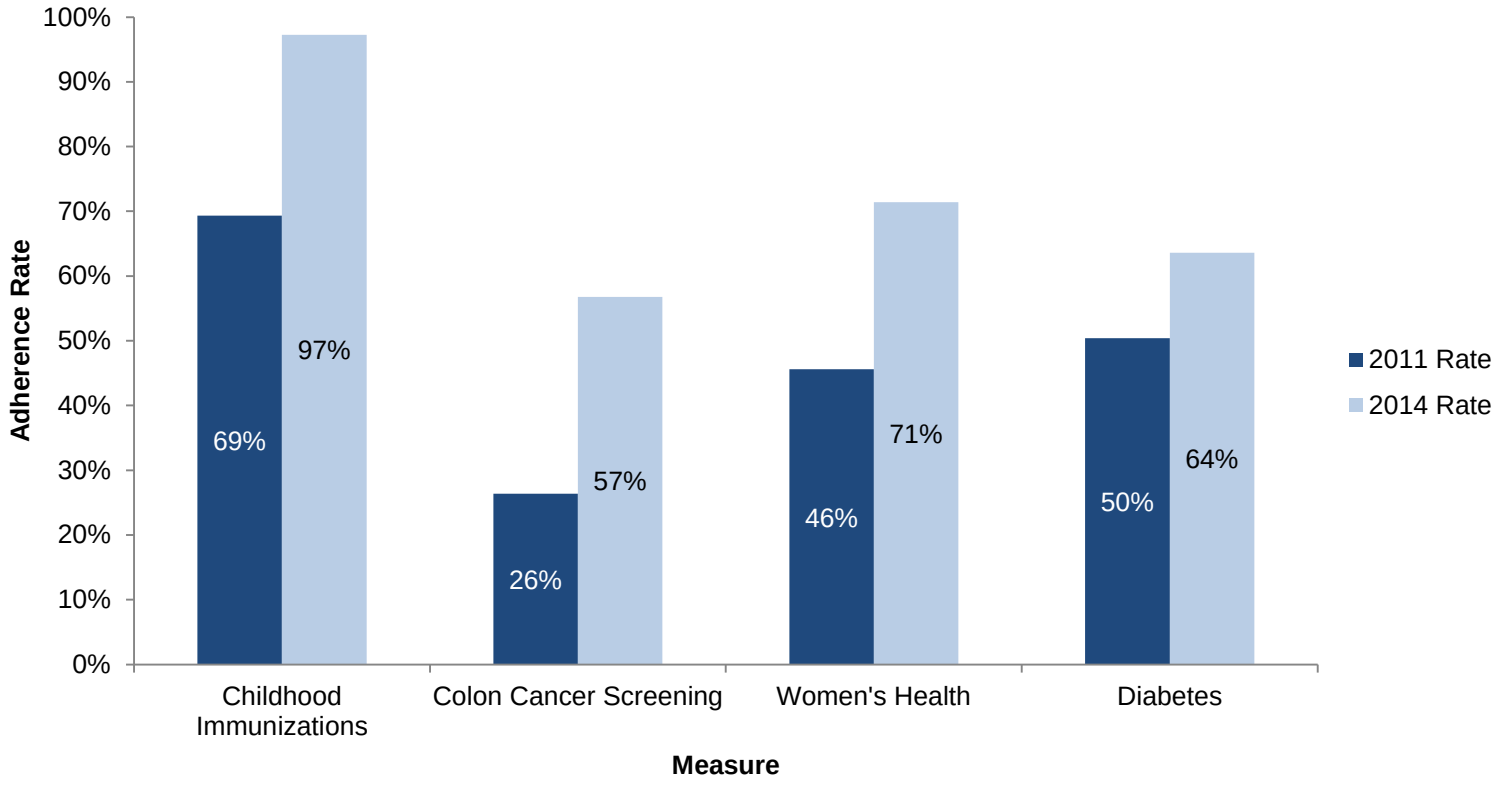
- Panels are beating budget targets with all costs loaded in, including their prior year OIA where applicable and the costs of all Care Coordination activities which are estimated at 2% - 3% of global cost

- The administration of the program has been accomplished primarily through a reallocation of resources – CareFirst's total G&A as a percentage of revenue has remained flat and is consistent with other Blue Plan benchmarks

Quality Scores Improve in Key Measures for PCMH Panels

- Overall quality sores have been stable across the panel types over the years
- Some key quality measures have shown dramatic improvement
- Efforts to close gaps in care are paying off without sacrificing savings

Key Quality Measures 2011 to 2014



Note: Women's health combines results on Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening measures.
Diabetes combines results on HbA1c Testing, Retinal Eye Exam, and Medical Attention for Nephropathy measures.

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Observations about Panels

Care Coordination is Overwhelmingly Carried Out by Nurses Provided by CareFirst

- At the outset in 2011, some Panels expressed a desire to hire their own nurses to create and maintain Care Plans – they became “Delegated” for this purpose
  - This is entirely consistent with Federal policy
- Four Entities selected this option – mostly large health systems with many Panels
- Two of these entities have since decided to use the CareFirst arranged Nurses
- One large system remains Delegated and has performed poorly
  - Only 33% of their PCPs have care plans compared to 56% of the non-delegated PCPs
- Delegated panels represent only 6% of Nurses, PCPs and Members in the program

Characteristics of the Best Performing Panels

The highest performing Panels have key characteristics – they are:

- Community-based and independent
- Not delegated
- Perform more care coordination – have higher number of Care Plans / PCP
- Careful in their referral decisions
- Have higher Engagement scores

The best performing Panels:

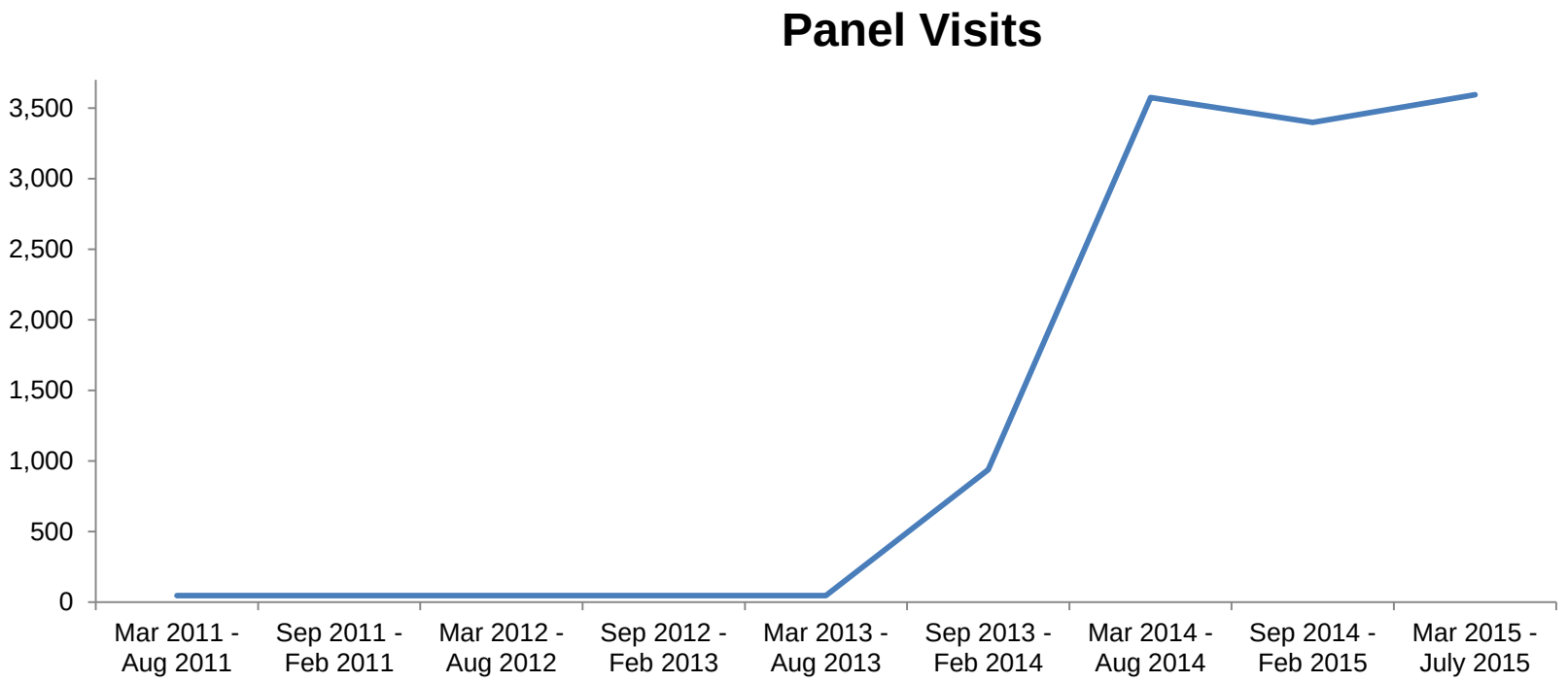
- Demonstrate that Care Coordination is catalytic in producing results and fosters engagement with TCCI Program elements
- Prove that when Engagement increases, results improve as well

Variances in Panel Performance by Type

- Adoption: Virtual Panels understand and adopt the program more quickly while the physicians in Health System Panels are insulated from the incentives and features of the program by large health systems
- Quality: Virtual Panels and Health System Panels earn similar quality scores
- Efficiency: Virtual Panels have a higher illness burden score in their population but cost less than Health System Panels
- Cost: Virtual Panels have a lower risk-adjusted cost of care for their population

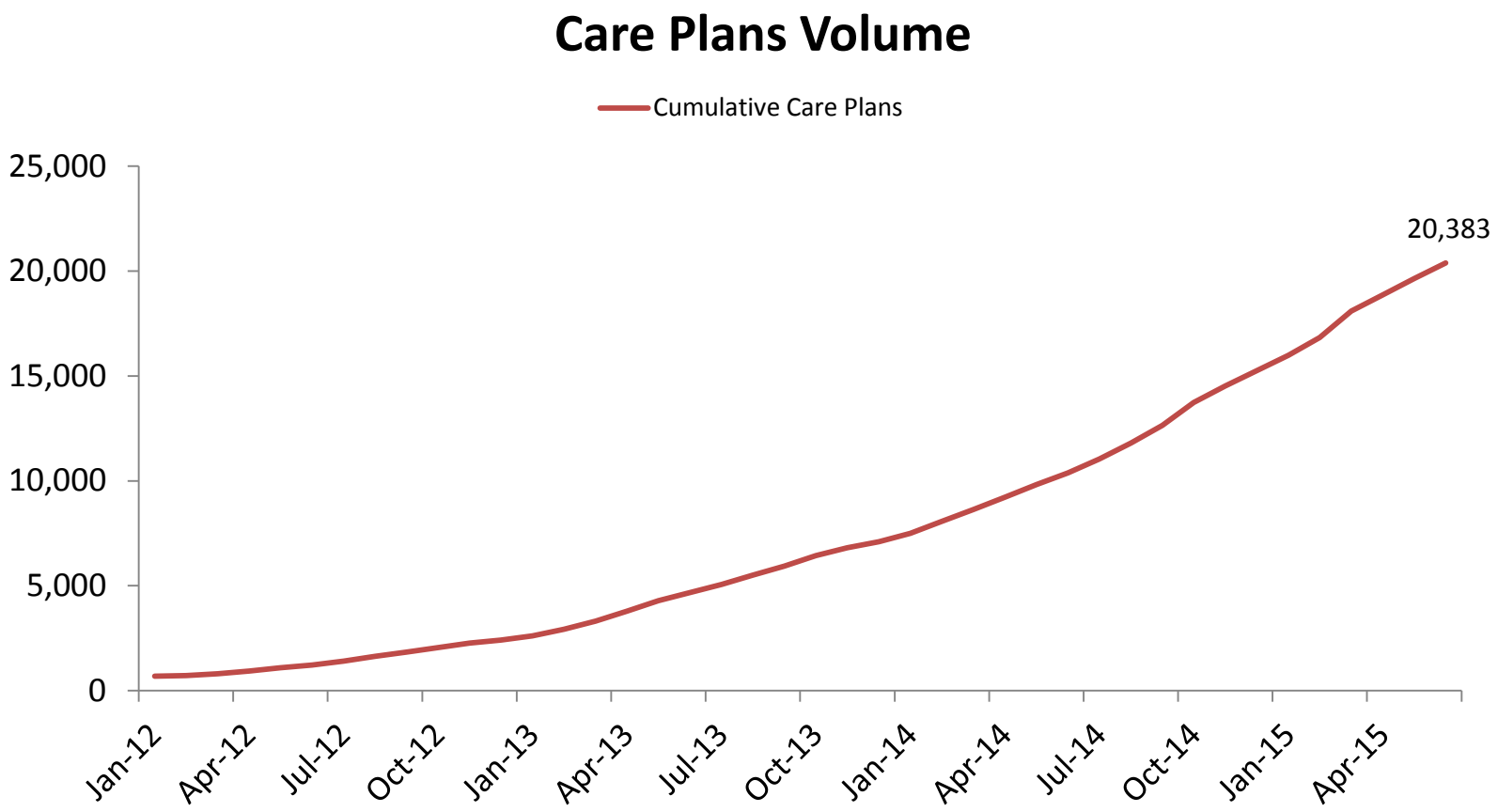
Panel Visit Impact

- Early in the Program, Panels meeting participation was sporadic and focused on “data errors”
- Panels now schedule to ensure all can attend and support one another’s success through engaged dialogue
- Data and the CareFirst Program Consultants are engaged to tailor strategies for programmatic success
- Panels collectively review results and collaboratively identify opportunities to reduce health care expense and/or improve quality



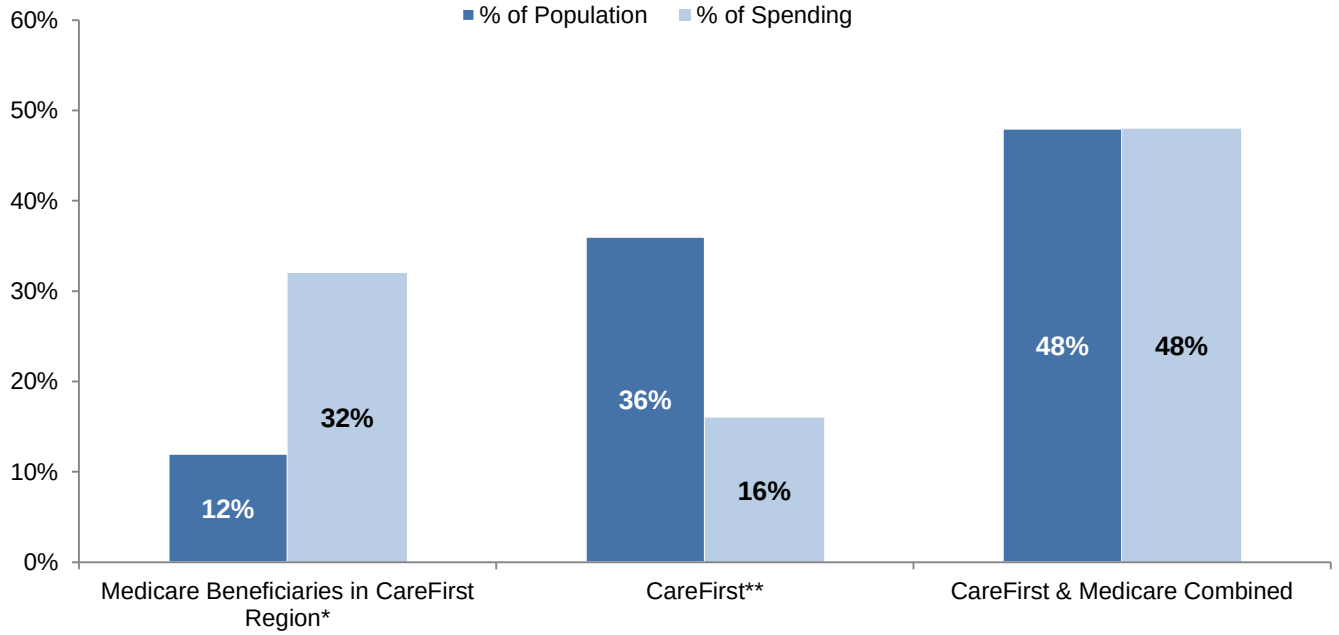
Care Plan Volume

- The volume of active Care Plans has significantly increased over the life of the Program
- This reflects growing engagement by Panels and is a proxy for behavior change as well as a leading indicator for improvements in outcomes



CareFirst & Medicare Together – Establishing a New "Common Model" of Care for the Region

Taken together, CareFirst and Medicare account for nearly half of the insured population and health care spend in the region



- 14 Panels
- 135 PCPs
- 38,000 beneficiaries

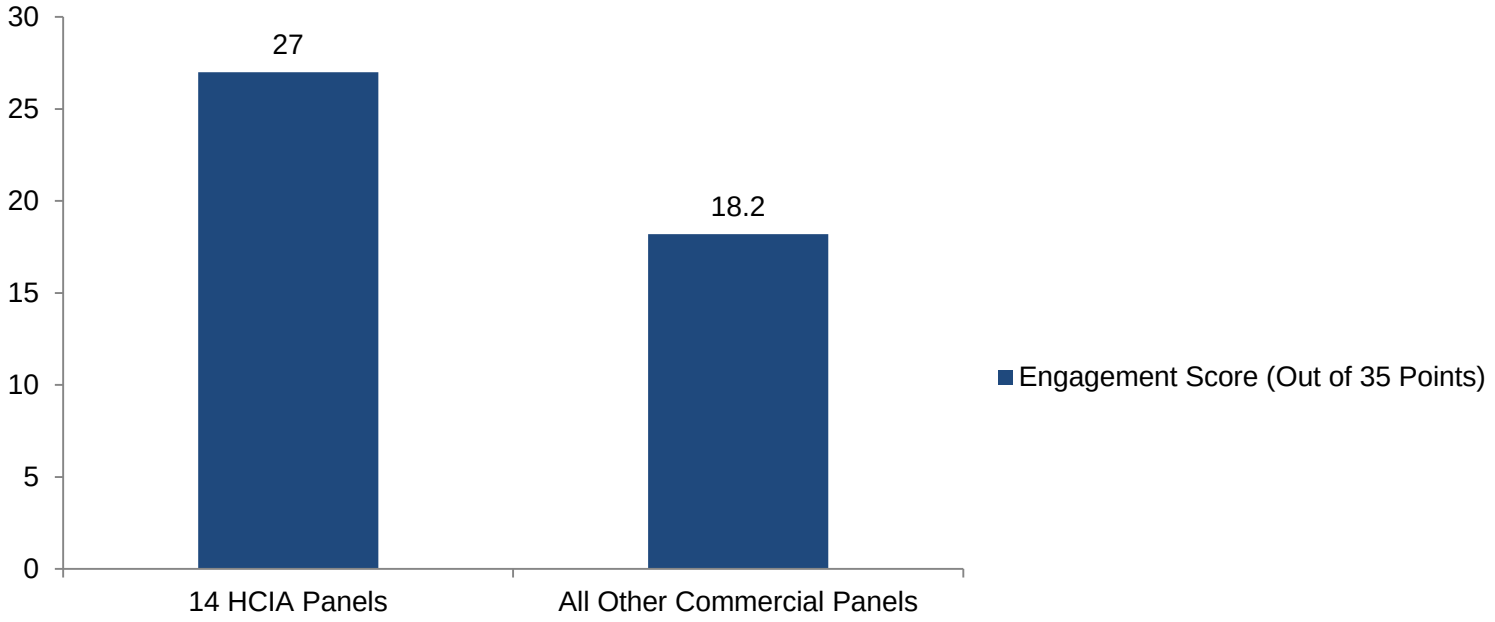
} Constitute the Pilot Program

Medicare beneficiaries include managed care and FFS beneficiaries. CareFirst total population excludes members outside of CareFirst Service Area

Impact of a Common Model on Panel Engagement Scores

- A Common Model between the region's largest private and public payer is creating a powerful effect on the approach taken by PCPs in caring for their patients.
- All rules, incentives, supports and infrastructure work the same way for Medicare FFS and CareFirst
- Panels in the Pilot are far more engaged in all aspects of the PCMH / TCCI Program than all other commercial Panels

2014 Average Commercial PCP Engagement Scores



Impact of a Common Model on Commercial Success

- Panels operating under a Common Model are outperforming the average of all other commercial Panels' in overall quality and cost savings for the commercial population

Measure	HCIA Participating Panels	Commercial Program (All Panels)	Difference
# of Panels	14 (100% winners)	417 (48 % winners)	N/A
Savings	9.23%	7.6%	1.63%
Average Quality Score	71.5	61.2	10.3
Average OIA	66	25	41

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Key Takeaways, Insights and Future Plans

The Top 10 Key Takeaways

1. There has been a dramatic slowing in the rise of overall costs driven by improved quality. This 'bend of trend' (down to 2%) exceeds expectations and is most pronounced in the PCMH population.
2. A key reason for the decline has been an unprecedented drop in Hospital Inpatient use (20%) beyond national trends and tightened control over drug costs – both of which have been achieved through Care Coordination.
3. 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.
4. Panels have found ways to continue to "win" even as the decline in trend has occurred – making projected budgets tougher to beat. The "winning" percentage of Panels has consistently increased as trend has declined. The best performing Panels are double digit lower on overall costs.
5. The best performing Panels are those that are independent and community based, while the highest cost Panels are generally those employed in large health systems.

The Top 10 Key Takeaways

6. The Illness Burden managed by and the quality performance achieved by independent Panels equals or exceeds the large health system Panels.
7. The Panels that are operating in a Common Model with Medicare are outperforming on all key measures – a lesson in the power of common rules and incentives.
8. The degree of Engagement in the Program is rising as understanding increases and results emerge. This is the key to future strong results.
9. The efficacy of an incentive only (no risk) model is being proven as is the power of incenting only the central player – the PCP – to drive full delivery system reform.
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 outcomes.

Top 10 Insights

1. Supports such as those within TCCI must span the whole Program. One off, idiosyncratic approaches within individual practices or health systems don't work across large populations.
2. Consistency of the Model and in the presentation of data – much of it based on claims data – is the key to seeing and understanding performance and making comparative judgments.
3. The costs of Care Coordination must be included before calculating savings in order to realistically measure results. Care Coordination and all needed supports are not cheap, so careful selection of Members for Care Coordination is essential.
4. "Wins" are – and will continue to be – invested by PCPs into their practices in what has become a virtuous, continuous improvement loop
5. Willingness to engage in the Program is highly related to letting a nurse in the door of the practice and inside its "ecosystem" as well as to the credibility of the data used in the Program.

6. The certifications on your wall and the internal systems you have as a practice are nowhere near as important as understanding data you typically don't see and becoming engaged beyond your own four walls.
7. Accountability for all costs and outcomes in all settings is essential in achieving favorable outcomes.
8. A shift of risk is not only not essential to change – the lack of risk is critical to fostering the participation of independent PCPs which, in turn, is critical to effective results.
9. The leverage inherent in sharing from first dollar of global cost is the essential economic power behind the whole Program (nearly 20 to 1 leverage).
10. Choice in referrals combined with the incentive to make wise referrals eliminates the need for narrow networks, yet creates a new form of them.

The Future

1. Refine the Model and hone the supports while differentially rewarding the best Panels and incenting Members to choose them.
2. Provide ever more targeted/focused data on patterns.
3. Expand the Common Model with Medicare to whole region.
4. Move to include Dual Eligibles in the Model.
5. Partner with Hospitals on key role of hospitalists.