Arkansas
BlueCross BlueShield
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Patient-Centered Medical Home (PCMH) Program Manual

2021 Program Year

This document is a manual to the 2021 Arkansas Blue Cross and Blue Shield Patient-Centered Medical Home program (PCMH). This document does not guarantee clinic participation in the Arkansas Blue Cross and Blue Shield PCMH Program. This document is subject to change without notice.

Contents

Definitions

Aligned Members: The Arkansas Blue Cross and Blue Shield members for whom primary care providers and participating practices have accountability under the PCMH program. A primary care provider's aligned members have been determined by claims, member selection, or auto-assignment.

Alignment: The methodology by which Arkansas Blue Cross and Blue Shield determines members for whom a participating practice may receive practice support.

Attest: Verify that the information provided is truthful and can be supported.

BlueMedicare: A Medicare Advantage plan offered by Arkansas Blue Cross and Blue Shield.

Care Coordination: The ongoing work of engaging members and organizing their care needs across providers and care settings.

Care Management Fees: Payments made to participating practices to support care management services. The payment amount is calculated per aligned member, per month.

Case Mix Adjustment: Refers to the use of statistical procedures to permit comparison of treatment outcomes between providers with differing mix of patients with regard to diagnoses, severity of illness, and other variables associated with the probability of improvement with treatment.

Clinical: Relating to or based on work done with real patients, of or relating to the medical treatment that is given to patients in hospitals, clinics, etc. holding a licensure to treat patients.

Comprehensive Primary Care Plus (CPC+): A national advanced Primary Care Medical Home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

Denominator: The total number of patients in the population being analyzed; shows how many total parts/patients you have; the bottom number in a fraction.

Exclusion: Information that should be separated from the measure (not included).

Fully-Insured: An arrangement by which a licensed insurance company gives its employer-group customers financial protection against claim loss in exchange for a monthly premium.

Health Advantage Blue Classic: A Medicare Advantage plan offered by Arkansas Blue Cross and Blue Shield

Hierarchical Condition Category Coding (HCC Coding): Risk-adjustment model uses demographic information (age, sex, disability status, etc.) and a profile of major medical conditions in the base year to predict expenditures in the next year. Each HCC is assigned a value associated with that risk.

Improvement Plan (IP): A plan for improvement that practices must submit to Arkansas Blue Cross and Blue Shield Primary Care Primary Care Representative after receiving notice of attestation or validation failure. This period may also be termed as remediation until successfully completing the improvement plan.

Inclusion: Information to specifically include in the measure.

Interoperability: The ability of computer systems or software to exchange and make use of information (e.g. multiple EHRs communicating, hospital systems communicating with practices).

Medical Neighborhood: A clinical-community partnership that includes medical and social supports necessary to enhance health, with the PCMH serving as the patient's primary hub and coordinator of health care delivery (e.g., specialists, hospitals, home health, pharmacists, behavioral health, and other associated services).

Medical Neighborhood Barriers: Obstacles to the delivery of coordinated care that exists in areas of the health system external to PCMH. This could be transportation to and from office visits, food insecurities, behavioral health access, and literacy challenges.

Medicare Advantage: Medicare Advantage Plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide all your Part A and Part B benefits.

Non-clinical: Roles which do not provide any type of medical treatment or testing; not relating to, involving, or concerned with direct observation and treatment of patients.

Numerator: The number of patients affected by the measure; the top number in a fraction; the number of incidences.

Participating Practice: A primary care practice that is enrolled in the PCMH program.

Patient Alignment: The process of aligning patients with a Primary Care Provider based on recent claims data and member selection. A Primary Care Provider will then manage the patients that have been aligned to him/her. Participating practices may receive care management fees to support population health management activities for the aligned patients.

Patient Centered Medical Home (PCMH): A team-based care delivery model led by Primary Care Providers (PCPs) who comprehensively manage patients' health needs with an emphasis on the value of health care.

Performance Period: The period over which performance is aggregated and assessed.

Practice Support: Support provided by Arkansas Blue Cross and Blue Shield in the form of care management fees and practice transformation support to a participating practice.

Practice Transformation: The adoption, implementation, and maintenance of approaches, activities, capabilities, and tools that enable a participating practice to serve as a PCMH.

Primary Care First: Primary Care First is a CMS-led, multi-payer alternative payment model that rewards value and quality to support advanced primary care.

Primary Care Provider: A physician specialist in Family Medicine, Internal Medicine, Geriatric Medicine, General Practice, Pediatric Medicine, or Primary Care Nurse Practitioner, Primary Care Physician Assistant, or Primary Care Clinical Nurse Specialist who provides definitive care to the patient at point of the first contact and takes continuing responsibility for ensuring the patient's care.

Provider Portal: Portal used by participating practices for purposes of enrollment, reporting to the Primary Care Department, and receiving information.

Same-Day Appointment Request: An appointment that is not scheduled until the same day as the urgent/acute need from the patient or within 24 hours of the appointment need. This allows for urgent/acute care needs to be seen with the primary care team.

Self-Insured or Self-Funded Plan: A self-insured group health plan (or a 'self-funded' plan as it is also called) is one in which the employer assumes the financial risk for providing health care benefits to its employees.

Validation: The process of checking the accuracy of activities and/or metrics submitted or attested to by a clinic.

Five Key Functions of PCMH

1. **Comprehensive Care:**
   Comprehensive Care takes a team-based approach to providing care to patients. A team manages all aspects of care for a patient, ranging from acute to chronic, preventive, and even behavioral health. This does not mean the PCP provides all the care, but the PCP is aware of what is going on in every aspect of that patient's care. The team might include physicians, advanced practice registered nurses, physician's assistants, clinical nurse specialists, nurses, pharmacists, nutritionists, social workers, educators, care coordinators, and specialists.

2. **Patient-Centered:**
   Better health outcomes are more likely when the patient is involved in their healthcare. Having patient input that includes personal beliefs and values will help the patient take ownership of their care. The patient is better equipped to self-manage between visits with the care team if they have the resources and education to better understand their medical condition.

3. **Coordinated Care:**
   The healthcare system can seem fragmented for patients. Having a primary care team that can help patients navigate the system while bringing all information together helps a patient remain engaged. As a result, medical waste is reduced with less redundant testing, and high risk outcomes with medication is mitigated.

4. **Accessible Services:**
   Open access and accessible services benefit patients in a number of ways including lower ED utilization and Urgent Care visits. Practices accomplish this by offering 24/7 clinical advice protocol, electronic communication using a secure portal, and offering same day appointments.

5. **Quality and Safety:**
   Practicing evidence-based medicine provides care that is safe for all patients. Clinical protocols that follow these guidelines allow members of the care team to work safely at the top of their skillset. This helps with efficiency and consistency across different care teams in a clinic. The quality components include population management data, monitoring quality metrics, and utilization data.

Terms and Conditions:

Program Eligibility, Enrollment, Withdrawal and Alignment

1A. Practice/Provider Eligibility

The Arkansas Blue Cross and Blue Shield 2021 PCMH Program is a voluntary program and is open to practices providing primary care to patients who meet the following requirements:

- The practice must include Primary Care Physicians (MD, DO) in the following specialties: Family Medicine, General Practice, Geriatric Medicine, Internal Medicine, or Pediatric Medicine; Primary Care Nurse Practitioners (APRN, APN, NP); Primary Care Physician Assistants (PA); or Primary Care Clinical Nurse Specialists (CNS), enrolled in the following networks: Arkansas Blue Cross and Blue Shield PPP, Health Advantage HMO, Arkansas' First Source PPO or True Blue PPO, Medicare Advantage PFFS, Medicare Advantage Health Advantage HMO.
    - Provider participants must not be participating in other value arrangements within the Medicare Advantage networks.

- The practice must use a certified, fully functional Electronic Health Record (EHR) accessible by all people involved in the patient's care.

- New practices must complete the 2021 PCMH enrollment application during the designated PCMH enrollment period.

- The new practice must have returned contract amendments signed by each primary care provider who provides primary care to patients at the PCMH practice location no later than November 30, 2020.

- A provider cannot enroll in Arkansas Blue Cross and Blue Shield's CPC+, Primary Care First, PCMH or other value-based programs or initiatives with the same panel of patients.

1B. New Practice/New Provider Enrollment

The enrollment period for the Arkansas Blue Cross and Blue Shield 2021 PCMH program is October 12, 2020 through November 13, 2020, with contracts being completed by December 11, 2020. A representative of the practice must complete the PCMH application. Returning providers are not required to submit signatures. However, providers new to the PCMH program are required to sign Exhibit B in the Provider Participation Agreement Contract. **Original signatures are required.**

Unless terminated earlier, the PCMH Provider Participation Agreement shall be for an initial term of one year, beginning on the Effective Date, and renewing automatically for an additional year on each anniversary of the Effective Date.

Providers practicing medicine at an enrolled PCMH clinic can enroll in the PCMH program outside of the open enrollment period. To enroll a provider outside of the open enrollment period the practice must contact the Primary Care Department by emailing primarycare@arkbluecross.com to initiate the enrollment process. The PCMH portal will be opened for a short amount of time and once the new provider has been enrolled, the portal will close.

1C. Practice/Provider Withdrawal

In the event a provider needs to be withdrawn/terminated from the program, practices must send an email to primarycare@arkbluecross.com to begin the withdrawal process. Please include the name and NPI number of the provider in the email. Withdrawing a provider from the Arkansas Blue Cross and Blue Shield PCMH program will not impact practice/provider participation in any other existing contracts or programs with Arkansas Blue Cross and Blue Shield and its family of companies.

Practices enrolled in the Arkansas Blue Cross and Blue Shield PCMH program will remain in the PCMH program until:

1. The practice or provider withdraws.
2. The practice or provider becomes ineligible, suspended or terminated from the participating Arkansas Blue Cross and Blue Shield PCMH provider networks.
3. The practice becomes ineligible, suspended or terminated from the PCMH program.

Practices that are terminated from the PCMH Program cannot re-enroll in PCMH until one calendar year/program year has passed.

Questions regarding the termination process can be addressed to the Arkansas Blue Cross and Blue Shield Primary Care Department by calling 501-378-2370 or emailing primarycare@arkbluecross.com.

1D. Provider Changes

A participating practice must notify Arkansas Blue Cross of any provider changes. When submitting changes, remember to include the provider name and NPI number.

To add a provider to a practice currently enrolled in the Arkansas Blue Cross PCMH program:

a. E-mail the Primary Care Department at primarycare@arkbluecross.com.

b. Once Primary Care is notified, the practice will receive instructions on how to add the provider to the electronic application.
c. The updated contract will need to be printed, signed by the new provider, and returned to the Primary Care Department at Arkansas Blue Cross.

1E. Alignment of PCMH Patients (Patient Panel)

Members in participating lines of business will be aligned to a provider based on methodology that will include member selection and claims plurality. A member may select a provider as a PCP and will be aligned to that PCP if the member has a claim with their selected provider. If a member does not select a provider or does not have a claim with their selected provider, the member will be attributed to the provider with the most claims for that member within the past 24 months.

Self-insured employers will independently decide if they will participate in the PCMH program. If a self-insured employer chooses to participate in PCMH, their members will be aligned to a PCP as mentioned in this section. If a self-insured employer chooses not to participate in PCMH, their members will not be aligned to a PCP for the purpose of the PCMH program.

Payment Model

2A. Eligibility for Care Management Fee Payments

To begin receiving Care Management Fees (CMF) in the 2021 program year, a practice must have submitted a completed PCMH Provider Participation Agreement on or before November 30, 2020.

Arkansas Blue Cross will pay a risk-adjusted care management fee on members who are aligned to providers in participating clinics. The care management fees are calculated per aligned member per month and paid monthly.

All members aligned with coverage from a participating line of business will be stratified to one of three risk tiers. Each tier corresponds to a specific monthly CMF payment with payment increasing at each level of increased patient risk. For example, the highest-risk tier is associated with the highest CMF per member per month payment. The intention is to provide increased financial support for high-risk patients who may demand more resources. Patient risk scores are calculated using claims and information extracted from medical records provided by participating practices as part of the medical record submission requirement. Risk scores are adjusted monthly, looking back at 12 months of data.

There will be no recoupment of care management fees; however, Arkansas Blue Cross may reduce, suspend or terminate CMF based on a clinic's performance and cooperation in the program.

2B. Performance Based Incentive Payments (PBIP)

Arkansas Blue Cross will pay a performance based incentive payment (PBIP) to practices to encourage and reward performance on certain metrics. Practices will have the opportunity to earn a PBIP on their commercial members and the Medicare Advantage (MA) members independently of each other.

Both the commercial and Medicare Advantage PBIP will be made in one-time payments for the program year (January 1, 2021 to December 31, 2021) to be paid in 2022.

Commercial PBIP

The commercial performance based incentive payment has three independent components for which practices are eligible to receive payments: clinical quality, utilization, and patient experience of care. Payments will be calculated on a per aligned member per month basis with aligned members in the month of December serving as the reference point for per aligned member per month calculations.

2021 PCMH Commercial PBIP	
Clinical Quality	5 of 15 metric targets (non-pediatricians) 3 of 5 metric targets (pediatricians)
Utilization	ED Utilization • Inpatient Admission • 30-Day Readmission
Patient Experience	Patient Experience of Care

The commercial clinical quality component will be based on 15 quality measures. There are 5 measures that focus on the pediatric population. Providers credentialed with Arkansas Blue Cross as Pediatricians will be required to meet 3 of the 5 pediatric measures to earn the clinical quality component of the PBIP. All other provider types will be required to meet 5 of the 15 quality measures to earn the clinical quality component of the PBIP. Performance on all 15 quality measures will be based on submitted claims.

The utilization component includes 3 measures: emergency department utilization, hospital admissions, and 30-day hospital readmissions. Providers may earn each of the

utilization components independently of each other. Utilization targets are case mix adjusted on a per practice basis. Practices with fewer than 250 aligned members may be pooled for utilization measures. Performance on the utilization component will be based on submitted claims.

The patient experience of care component will be based on a patient experience survey that will be administered by Arkansas Blue Cross or by a vendor chosen by Arkansas Blue Cross. Practices must reach an acceptable threshold to earn this component of the PBIP.

Medicare Advantage PBIP

The Medicare Advantage performance-based incentive payment has 3 independent components for which practices are eligible to receive payments: clinical quality, utilization, and patient experience of care. Payments will be calculated on a per member per month basis with aligned members in the month of December serving as the reference point for per member per month calculations.

2021 PCMH Medicare Advantage PBIP	
Clinical Quality	Based on the star rating determined by the aggregate performance on 11 quality measures
Utilization	ED Utilization • Inpatient Admission • 30-Day Readmission
Patient Experience	Patient Experience of Care

Clinical Quality Star Rating Component

The clinical quality component will be based on 11 quality measures. Performance on all 11 quality measures will be based on submitted claims and supplemental data provided by the submission of medical records as part of the medical record requests in the PCMH program. Performance will be compared to the Star thresholds set by CMS and historical trending. Providers can earn a percentage of the available incentive dollars for the clinical quality component by meeting specific Star ratings on the aggregate performance on all 11 measures. For example, using the chart below, earning a 3.5-star rating will earn the provider 50% of the available quality incentive, earning a 4-star rating will earn 100% of the quality incentive, and 175% if the provider earns a 5-star.

MA Quality Metric PBIP Levels	
Star Rating	**PBIP %**
1-Star	0%
2-Star	0%
3-Star	0%
3.5-Star	50%
4-Star	100%
4.5-Star	125%
5-Star	175%

Utilization Component

The utilization component includes three measures: emergency department utilization, hospital admissions, and admissions without 30-day readmissions. Providers may earn each of the utilization components independently of each other. Utilization targets will be based on the prior year's performance for the MA population. Performance on the utilization component will be based on submitted claims.

Patient Experience Component

The patient experience of care component will be based on a patient experience survey that will be administered by Arkansas Blue Cross or by a vendor chosen by Arkansas Blue Cross. Practices must reach an acceptable threshold to earn this component of the PBIP.

Activities and Metrics

3A. Activity Overview

2021 Activities	Due Dates
Quarter 1: Program Preparation Any clinic new to the Arkansas Blue Cross PCMH Program must complete the 2021 Readiness Assessment.	2/15/2021
A. Provide 24/7 access to care Provide 24/7 Access to clinical advice where a patient can speak to a live voice.	6/30/2021
B. Enhanced Access & Communication Offering same day appointments, extended hours, telemedicine, or weekend appointment availability and having timely communication between the practice and the patients and their caregivers.	6/30/2021
C. Childhood/Adult Vaccination Practice Strategy A planned and proactive approach for closing gaps in vaccinations.	6/30/2021
D. Social Determinants of Health Process to screen patients and connect with community resources	6/30/2021
E. Transitions of Care Receiving discharge information and following up with patients within 72 hours or 2 business days	6/30/2021
F. Ability to receive patient feedback Having a process to receive anonymous feedback from patients.	6/30/2021
G. Self-Management Support Systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.	12/31/2021
H. Advance Care Plans Conduct Advance Care Planning with patients to document patients' wishes for treatment and end of life care	12/31/2021
I. Behavioral Health Integration Process to screen and provide for behavioral health needs	12/31/2021

Readiness Assessment
During the first quarter of the 2021 PCMH Program year, practices new to the PCMH program are required to complete and attest to a Practice Readiness Assessment which serves as a program preparedness check-in.

A document transfer request on the portal will be provided for completion and submitting the Readiness Assessment.

6-Month Activities

These activities should be viewed and completed on the PCMH Portal during the first six months of the current PCMH Program year.

Activity A: Provide 24/7 Access to Care

Patients must have access to a live voice 24/7 to receive information and guidance on urgent and emergent care. Ensuring patients have access to their care team will enhance the relationship and increase the likelihood that patients will get the right care at the right time, potentially avoiding costly urgent and emergent care.

Minimum Expectations:

- Urgent/emergent clinical advice, with a live voice, during and after work hours
- Education on this service to patients
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Document advice/information provided in the EHR
- Set an expectation of when the call needs to be documented from the time of the call (i.e., next business day) and have a process in place to ensure that this expectation is being followed
- Educate patients on the appropriateness of ED/Urgent care usage
- Person providing advice after hours has access to the patient's medical record

Documentation (at least one of the following is sufficient for audit):

- An updated policy for providing 24/7 access to care
- At least one example of how patients are educated of the 24/7 access (picture of front door with after-hours number, screen shot of public website, pamphlets, flyers)
- At least three examples of when clinical advice was provided and documented within the timeframe the practice has set as the standard
- At least one example of patient education on appropriate use of ED/Urgent care usage

Activity B: Enhanced Access & Communication

Providing enhanced access and communication allows more opportunities for a PCMH clinic to meet the needs of their patients. Offering same or next-day appointments to patients is a way to enhance access so that urgent needs can be addressed in a timely manner. Alternative ways of communication with patients may include: providing clinical advice virtually, allowing patients to request an appointment electronically, and providing a place where patients can access their medical records electronically.

Minimum Expectations:

- Provide same or next-day appointments
- Communication and/or clinical advice via patient portal
- Offer telemedicine services
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Provide access outside of normal business hours
- Providing alternative visits (group visits, diabetic education, virtual visits, dietitian led activities, etc.)
- Patients have secure two-way communication with the provider/care team

Documentation (at least one of the following is sufficient for audit):

- An updated policy on providing same or next-day appointments
- Screenshot of appointments available outside of normal business hours
- Example(s) of virtual communication

Activity C: Childhood/Adult Vaccination Practice Strategy

The goal of a vaccination strategy is to have a proactive approach to close gaps for patients. This is likely to help patients become engaged in their health and could help avoid illnesses.

Minimum Expectations:

- Engage patients to close vaccination gaps
- If a practice does not provide vaccination(s), data from WebIZ should be integrated in the EHR
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- An updated policy on how patients are engaged on vaccination gap closures
- Tracking frequency of vaccination rates

Documentation (at least one of the following is sufficient for audit):

- An updated policy for engagement on vaccinations and/or how WebIZ is reviewed
- Example(s) of documented vaccinations in the EHR
- Example(s) of outreach to patients to close vaccination gaps

Activity D: Social Determinants of Health

Social determinants of health (SDoH) are the conditions in which people are born, grow, work, live, and age, and the conditions of daily life. Social determinants are a major component of what predicts and influences an individual's health outcomes, as well as the outcomes of populations. Since these conditions play such a vital role in a patient's health, SDoH should be assessed and addressed for the best outcomes.

A community resource is anything that has the potential to improve the quality of life of an individual or family. To link a patient with needed resources, you must first identify the need and the resources available. Use of online community resources is acceptable, if it includes local community resources to meet the needs of the practice population.

Assessments that identify a patient with a need for referral to community resources are documented in the medical record to enable providers to follow-up during subsequent visits. Referrals to community resources should be tracked for high-risk patients to ensure that these high-risk patients receive the services they need.

Minimum Expectations:

- Implement screening tools to identify the patient's social determinants of health (SDoH) and the need for community resources
- Develop or use a local community resource list to address social determinants of health, such as housing instability, literacy, transportation, food insufficiency, violence and/or any other resource needs in the local community, including behavioral health providers, medical health providers, dental care, pharmaceutical, palliative care, and rare disease support associations, self-management training programs if available,
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Conduct semi-annual review of community resource list to determine accuracy and relevancy, and to verify local resource listings
- Develop a systematic approach for educating all patients about community resources
- Develop a systematic approach for tracking referrals of high-risk patients

Documentation (at least one of the following is sufficient for audit):

- Policy or procedure to conduct screening for social determinants of health and referring to community resources
- Report of percentage of patients screened
- Example of screening tool

Activity E: Transitions of Care

Transitions of Care can be defined as the coordination and continuity of care during the movement of patients between health care practitioners, settings, and home as their condition and care needs change. Knowing when, where, and why patients receive care allows for warm handoffs and smooth care transitions by leveraging admit, discharge, and transfer notifications to link providers anywhere patients receive care.

Minimum Expectations:

- Receive discharge information from local facilities
- Develop a plan to follow up with patients discharged within 72 hours, or 2 business days, which includes medication reconciliation for each transition of care
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Connect to SHARE (Arkansas' HIE) and receive transitions of care data
- Monitor the timeliness of outreach to ensure goals are being met by the care team
- Flag/notify the provider of the transition of care

Documentation (at least one of the following is sufficient for audit):

- A policy for care team members to follow patients after a discharge, including medication reconciliation
- Example(s) of documented transitions of care
- Report of the percentage of documented transitions of care

Activity F: Ability to Receive Patient Feedback

Patient feedback consists of the views and opinions of patients on the care they have experienced provided anonymously. Practices can gather patient feedback in a variety of ways including surveys, audits, comments, and complaints.

Anonymous feedback allows your practice to study patterns and trends by providing insights of individual experiences. Patient feedback discovers if a problem is occurring

more or less frequently over time and allows changes to be made to make sure problems do not continue.

Minimum Expectations:

- Develop a process for receiving and keeping track of anonymous feedback from patients
- Analyze patient feedback and take action on results
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Develop a patient-family advisory council (PFAC)

Documentation Requirements (at least one of the following is sufficient for audit):

- Policy and/or procedure for the patient feedback activity
- Example(s) of patient feedback
- Report of results of patient feedback surveys

Activity G: Self-Management Support

Self-Management Support is a systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors. Self-management support is a collaborative process that empowers patients to take better care of themselves by setting realistic goals and action plans to reach them. Action planning requires that individuals specify when, where and how to enact a goal-directed behavior.

Minimum Expectations:

- Implement action plans for three chronic conditions specific to your patient population.
- Action plans should focus on specific changes in behavior (e.g., walking around the block once a day) or concrete, tangible results (e.g., losing 2 pounds) rather than general clinical goals (such as lowering blood pressure or reducing LDL levels)
- Patient-specific action plan must be documented in medical record, enabling providers to monitor and follow-up with patient during subsequent visits

Continuous Improvement (may include, not limited to):

- Adopt Shared-Decision aids to assist patients in developing action plans
- Expand self-management support to all patients

Documentation (at least one of the following is sufficient for audit):

- A policy for use of action plans
- Example(s) of action plans used for three (3) chronic conditions
- Report of number of patients with action plans

Activity H: Advance Care Plans

Advance care planning is an ongoing process that offers the patient the opportunity to have a conversation with his or her family members and physician regarding treatment wishes and the choices for care at the end of life. An advance directive consists of oral and written instructions about a person's future medical care in the event he or she becomes unable to communicate.

Advance care planning includes the explanation, discussion and completion of advance directives or orders by the provider or other qualified health care professional. A copy of advance directive forms should be kept on file in the patient's medical record and updated periodically over time, as the patient's health status changes. Patients should keep the original and share copies with family members and other providers of care to make sure their wishes are made known.

If the patient is under age 18, the parent or guardian makes healthcare decisions. Parents with seriously ill children can discuss their wishes with the child's physician, who can complete a Physician Orders for Life-Sustaining Treatments (POLST). The POLST is a legal order outlining the patient's treatment wishes and is signed by the physician and patient or legal representative. The POLST is appropriate for any patient with a serious illness.

Types of Advance Care Plan documents:

- Advance Directives
- Living Will
- Healthcare Power of Attorney
- POLST (Physician Orders for Life-Sustaining Treatments)

Minimum Expectations:

- Develop a plan to conduct Advance Care Planning with patients; check coverage policies for billing purposes, if appropriate
- Advance care planning discussions should be documented in the medical record
- Copy of Advance Care Plan documents must be in the medical record and updated periodically
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Create Advance Care Planning packets
- Incorporate advance care planning in annual wellness visits
- Develop patient education materials to encourage advance care planning

Documentation Requirements (at least one of the following is sufficient for audit):

- Policy or procedure to conduct advance care planning by qualified health professionals
- Report of percentage of patients with completed advanced care planning documents
- Example of Advance Care Plan

Activity I: Behavioral Health Integration

Behavioral health integration is the collaborative effort of primary care providers and behavioral health providers meeting the needs of patients. There is a high prevalence of behavioral conditions in patients with chronic medical conditions, which is why it is important for behavioral health treatments to be available within the primary care setting.

Minimum Expectations:

- Develop a policy to screen for behavioral health needs, using tools such as PHQ-2, PHQ-9, or other appropriate screening tool. Check coverage policies for billing purposes, if appropriate.
- Incorporate behavioral health services into the practice or develop relationships with other clinicians to provide behavioral health services.
- Maintain a policy and procedure for meeting activity expectations.

Continuous Improvement (may include, not limited to):

- Educate all staff regarding signs/symptoms that may indicate a need for behavioral health services.
- Provide behavioral health services via telemedicine

Documentation (at least one of the following is sufficient for audit):

- Example of screening tools used
- A policy for screening for behavioral health
- Report of number of patients screened

2021 Commercial Claims Based Quality Metrics	2021 Targets
1. **WCV-15 MO. 6 Visits*:** Percentage of patients who turned 15 months old during the performance period who receive at least six wellness visits in their first 15 months.	≥75%
2. **WCV 3-6 Years*:** Percentage of patients ages 3-6 years who had one or more well-child visits during the measurement year.	≥70%
3. **WCV 12-21 Years*:** Percentage of patients ages 12-21 who had one or more well-care visits during the measurement year.	≥52%
4. **Asthma Controller Adherence*:** Percentage of patients ages 5-64 compliant with prescribed asthma controller medication (at least 75% compliance). *This is a pharmacy measured metric.*	≥50%
5. **Pediatric URI*:** Percentage of children ages 3 months-18 years who received appropriate treatment for Upper Respiratory Infection (URI).	≥82%
6. **Diabetes Nephropathy Test:** Percentage of patients ages 18-75 with a diagnosis of Diabetes that had an annual screening for nephropathy or evidence of nephropathy.	≥85%
7. **Diabetes Rx Adherence:** Percentage of patients ages 18 years and older who met the proportion of days covered threshold of 80% during the measurement year for Diabetes Medication. *This is a pharmacy measured metric.*	≥60%
8. **Low Back Imaging:** Percentage of patients ages 18-50 with uncomplicated low back pain that did not have imaging studies.	≥75%
9. **Adult Bronchitis – Antibiotics:** Percentage of patients ages 18-64 with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	≥55%
10. **HTN Controlling Blood Pressure:** Percentage of patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	≥68%
11. **Diabetes HbA1c (Poor controlled):** Percentage of patients ages 18-75 with diabetes (type 1 or type 2) whose most recent HbA1C level during the measurement period was greater than 9.0% (poor control) or was missing the most recent result, or an HbA1C test was not done during the measurement period.	≤28%
12. **Breast CA Screening**: Percentage of female patients ages 52-74 that had a screening mammogram in the past 27 months.	≥60%
13. **Colorectal CA Screening:** Percentage of patients ages 50-75 who had appropriate screening for colorectal cancer.	≥50%
14. **Diabetes Retinopathy Test:** Percentage of patients ages 18-75 with a diagnosis of diabetes who had an eye exam performed.	≥50%
15. **Cervical CA Screening:** Percentage of female patients ages 21-64 who had appropriate screening for cervical cancer.	≥60%

*Measure includes pediatric population.
Measure specifications can be found on the Arkansas Blue Cross Blue Shield Care Management Portal.

	2021 Medicare Advantage Claims Based Quality Metrics	Weight*
1.	**Breast CA Screening:** Percentage of female patients ages 52-74 who had a mammogram between October 1, 2019 to December 31, 2021	1x
2.	**Colorectal CA Screening:** Percentage of patients ages 50-75 who had appropriate screening for colorectal cancer.	1x
3.	**Diabetes Retinopathy Test:** Percentage of patients with diabetes who had an eye exam to check for damage from diabetes	1x
4.	**Diabetes: Medical Attention for Nephropathy:** Percentage of patients ages 18-75 with type 1 or 2 diabetes who had a kidney function test or appropriate medication during the measurement year	1x
5.	**Diabetes HbA1c (Well Controlled):** Percentage of patients ages 18-75 with diabetes and a documented HbA1c ≤ 9% using the latest lab conducted in the measurement year.	3x
6.	**HTN Controlling Blood Pressure:** Percentage of patients ages 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mmHg) as of the last blood pressure reading of the measurement year.	3x
7.	**Statin Therapy for Patients with Cardiovascular Disease:** Percentage of male patients ages 21-75 and female patients ages 40-75 who are identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high intensity or moderate intensity statin medication.	1x
8.	**Medication Reconciliation Post-Discharge:** Percentage of patients ages 18 and older in the measurement year whose medications were reconciled on the date of discharge through 30 days after discharge (a total of 31 days).	1x
9.	**Statin Use in Persons with Diabetes:** Percentage of patients ages 40-75 years who were dispensed a medication for diabetes that receive a statin medication	1x
10.	**Proportion of Days Covered (Adherence):** Percentage of patients who are adherent (fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication) to their diabetes, hypertension, and/or hyperlipidemia medications • Renin-angiotensin system (RASA), • Diabetes All Class, and • Statins	3x
11.	**Osteoporosis Management in Women with Fracture:** Percentage of female patients ages 67-85 who suffered a fracture and got screening or treatment for osteoporosis within 6 months	1x

*Measure weights will be adjusted based on the number of metrics with a denominator greater than zero. Measure specifications can be found on the Arkansas Blue Cross Blue Shield Care Management Portal.

2021 Medicare Advantage Quality Component Star Scale						
Claims Based Metric	**1 Star**	**2 Star**	**3 Star**	**4 Star**	**5 Star**	**Measure Weight**
Breast CA Screening	<50%	50-65%	66-75%	76-82%	≥83%	1x
Colorectal CA Screening	<50%	50-61%	62-73%	74-79%	≥80%	1x
Diabetes Retinopathy Test	<64%	64-69%	70-73%	74-77%	≥78%	1x
Diabetes: Medical Attention for Nephropathy	N/A	<80%	80-93%	94-96%	≥97%	1x
Diabetes HbA1c (Well Controlled)	<39%	39-62%	63-73%	74-86%	≥87%	3x
HTN Controlling Blood Pressure	<55%	55-66%	67-74%	75-85%	≥86%	3x
Statin Therapy for Patients with Cardiovascular Disease	<78%	78-80%	81-84%	85-88%	≥89%	1x
Medication Reconciliation Post Discharge	<53%	53-65%	66-73%	74-85%	≥86%	1x
Statin Use in Patients with Diabetes	<79%	79-81%	82-83%	84-86	≥87%	1x
Proportion of Days Covered: **Diabetes All Class** **Renin-angiotensin system** **Statins**	 <78% <82% <77%	 78-81% 82-85% 77-83%	 82-85% 86-87% 84-85%	 86-87% 88% 86-88%	 ≥88% ≥89% ≥89%	3x
Osteoporosis Management In Women Who Had a Fracture	<33%	33-42%	43-51%	52-68%	≥69%	1x

Medical Record Submission

4A. Medical Record Submission

Primary care practices are familiar with medical record requests from payers as a requirement of the Patient Protection and Affordable Care Act (PPACA). Arkansas Blue Cross and Blue Shield's medical record requests will be administered through the PCMH program.

The medical record requests will be for a subset of the clinic's population. Specifically, records will be requested for the clinic's Medicare Advantage, Federal Employee Program (FEP), and Exchange members. Multiple medical record requests will be conducted by Arkansas Blue Cross Blue Shield and our contracted vendors throughout the year on specific members within these populations.

Practices are responsible for returning at least 90% of the requested records by the due date. If a practice fails to meet the 90% target of returned records by the due date of each medical record audit, the practice's care management fees will be suspended for a minimum of 30 days. The practice must return the remaining records to meet the 90% target for the care management fees to be reinstated. Each medical record request audit is independent of each other, so practices must meet the 90% target on each medical record audit, not as an aggregate of all medical record audits combined.

Primary Care Representatives and other Arkansas Blue Cross staff will provide regular feedback to practices on their status for each medical record audit and will be available to support the practices.

Quality Assurance

5A. Quality Assurance Policy

The Arkansas Blue Cross and Blue Shield PCMH program is structured to facilitate change by providing Practice Transformation Activities, Quality Metrics, and Utilization metrics that are founded on evidence-based practice, peer reviews, and trends in health care. The Quality Assurance Policy allows Arkansas Blue Cross and Blue Shield to monitor success, evaluate the need for adjustments in the program, and collect data by assessing each participating practice individually.

5B. Transformation Activity Audits

Arkansas Blue Cross and Blue Shield and its family of companies retain the right to confirm the performance of a participating practice against deadlines and targets. It is recommended that a practice maintains PCMH documentation in a secure location in the event of a performance assessment.

Transformation Activity Audits

At a minimum, practices will undergo an audit of the 6-Month and 12-Month Transformation Activities. Practices are expected to attest to 6-month and 12-Month Practice Transformation Activities by completing the questionnaires on the PCMH Portal.

The 6-Month Practice Transformation Activity attestations are due June 30, 2021. The 12-Month Practice Transformation Activity attestations are due December 31, 2021. An audit will follow both the 6-month and 12-Month Activity attestations.

Practices will receive an email after the attestation deadline with instructions on how to submit their audit documentation and the date by which the documentation must be submitted.

Each transformation activity requires 3 action items to pass. Those action items are:

1. Answer all questions for each activity on the PCMH portal. If you select “other” for any questions in any activity, you must give a detailed explanation of that information.
2. Attest for each activity on the PCMH portal. Each activity requires an Attestation before completion and submitting. Failure to attest to the activity means failure and non-passing of activity.
3. Validation of each activity. Supporting documentation is required for each activity for validation of practice’s response to the activity. Supporting documentation can include one of the following using the **R.E.P** method. (**R**=Report, **E**=Example/Screenshot, **P**=Policy)

Supporting documentation will be requested on all activities. Failure to submit requested supporting documentation may result in an Improvement Plan.

Audit Results and Feedback

The Primary Care Department will review the practice documentation for the 6 & 12-Month activities within 30 business days from the date the documentation was due for the audit. Audit results will be delivered during a site visit by a Primary Care Representative or sent via email.

5C. Improvement Plan Process

Improvement plans are implemented when practices fail to meet requirements set by Arkansas Blue Cross and Blue Shield Primary Care. If a practice fails to meet a set requirement, the Primary Care Representative who works with the practice will initiate an improvement plan. All instructions for improvement plans will be communicated with the practice by the Primary Care Representative.

Practices will be required to complete an Improvement Plan if the practice:

- Fails to attest or complete any Practice Transformation Activity.
- Fails to meet requirements during a transformation activity audit.
- Fails to meet any deadline.

Failure to complete an improvement plan may result in suspension of care management fees. If suspended from the PCMH program, instructions for the reinstatement of good standing will be sent to the practice. If the terms are not met the practice will be terminated from the program. If terminated, the practice cannot re-enroll in PCMH until one calendar year/program year has passed.

The Primary Care Department reserves the right to suspend or terminate care management fees at any point in the improvement plan or suspension process. Improvement Plans may carry over from one program year to another.

In the event a practice disagrees with the feedback provided by Arkansas Blue Cross and Blue Shield, a written response may be submitted within 15 days to primarycare@arkbluecross.com. All requests will be considered.

Feedback regarding the requests will be provided no later than 30 business days after the response is received. The following should be included when submitting a response in regards to unfavorable feedback:

- Statement as to why Arkansas Blue Cross and Blue Shield should reconsider the Improvement Plan.
- Provide documentation to support reasons in statement.

Communication

6A. Communication Methods

The Arkansas Blue Cross and Blue Shield Primary Care Department exchanges information with participating practices in the following ways:

Practice Contact

Practices are required to submit a primary contact email and phone number on the program application. We recommend including additional contacts in the event the primary contact changes (space is available for up to 6 contacts). The contact information provided on the program application is used for email and phone communication. In addition to notifying the Primary Care Department in the event of a change in contact information practices should update the contact information in the PCMH portal.

Practice Progress

Specific information regarding a practice's progress on the individual components of the program is provided through reports and data feeds. The reports and data feeds are located on the Arkansas Blue Cross and Blue Shield PCMH portal and Care Management portals. In the event a practice is failing to meet a target, notification will be provided to the practice.

6B. Care Management Portals

There are two care management portals available for clinics to manage their patient populations. The Arkansas Blue Cross Blue Shield Care Management portal houses data available for the clinic's aligned commercial population. The Arkansas BlueMedicare Care Management portal houses similar data so that clinics can manage their aligned Medicare Advantage population.

Both portals are tools for providers to support transparency efforts by providing clinically relevant data to help them promote population health and manage the care of their patients. The care management portals allow practices to manage patients in a variety of ways.

Providers with a specialty in primary care (Family Medicine, Internal Medicine, Geriatric Medicine, General Practice, Pediatric Medicine, or Primary Care Nurse Practitioner,

Primary Care Physician Assistant, or Primary Care Clinical Nurse Specialist) with aligned patients have data available to them in the portals.

There are three main types of data included in the care management portals:

1. Summary data at the practice/provider level
2. Patient-level data detail
3. Referral tools designed to help providers make decisions regarding facility and specialist referrals (Arkansas Blue Cross Blue Shield Care Management portal only)

The care management portals are updated monthly using claims from a rolling 12-month look back period. Practices can view data concerning the current PCMH program year such as:

- Quality data for care gaps & metric status
- Cost of care
- Emergency department & inpatient utilization and 30-day readmissions
- Prescription utilization and much more.