

Arkansas Blue Cross and Blue Shield Patient-Centered Medical Home Program Manual

2018

This document is a manual to the 2018 Arkansas Blue Cross and Blue Shield Patient-Centered Medical Home program (Arkansas Blue Cross PCMH). This document does not guarantee clinic participation in the Arkansas Blue Cross PCMH Program. This document is subject to change without notice.

PATIENT-CENTERED MEDICAL HOME (PCMH)

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1. DEFINITIONS

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| AHIN (Advanced Health Information Network) | AHIN is a web-based portal that provides the Arkansas provider community real-time access to the information needed to manage a practice efficiently. AHIN's functionality includes eligibility, claim information, remittance information, and access to the State PCMH Episode Reporting and Arkansas Blue Cross PCMH Programs |
| Attributed Members | The Arkansas Blue Cross members for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician's attributed members have determined claims, member selection, or auto-assignment. |
| Attribution | The methodology by which Arkansas Blue Cross determines members for whom a participating practice may receive practice support. |
| Care Coordination | The ongoing work of engaging members and organizing their care needs across providers and care settings. |
| Care Coordination Payments | Payments made to participating practices to support care coordination services. The payment amount is calculated per attributed member, per month. (Referred to as Care Management Fees on Remittance Advice) |
| 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. |
| Fully-Insured | An arrangement by which a licensed insurance company gives its employer-group customers financial protection against claim loss in exchange for a |

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| | monthly premium. |
| 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 or TeleVox). |
| Medical Neighborhood | A clinical-community partnership that includes medical and social supports necessary to enhance health, with the PCMH servicing 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. (e.g., lack of staff, limited Primary Care Clinician involvement in in-patient care), limited Health IT infrastructure and interoperability, misperceptions regarding HIPAA provisions information exchange) |
| Participating Practice | A participating practice is physician practice that is enrolled in the PCMH program. |
| Patient Alignment | The process of aligning members with a Primary Care Provider based on recent claims data, member selection and, in some cases, geographic considerations. A Primary Care Provider will then manage the patients/members that have been assigned/attributed. Participating practices may receive care coordination payments to support population health management activities for the attributed members (patients). |
| Patient-Centered Medical Home (PCMH) | A team-based care delivery model led by Primary Care Physicians (PCP) who comprehensively manage member's health needs with an emphasis on the value of health care. |
| Performance Period | The period over which performance is aggregated and assessed. |

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| Practice Support | Support provided by Arkansas Blue Cross in the form of care coordination payments 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 Physician | A specialist in Family Medicine, Internal Medicine or Pediatrics who provides definitive care to the patient at the point of the first contact and takes continuing responsibility for ensuring the patient's care. |
| Provider Portal | Portal located on AHIN used by participating practices for purposes of enrollment, reporting to Primary Care, and receiving information. |
| Improvement Plan (IP) | IP is a plan for improvement that practices must submit to Arkansas Blue Cross Primary Care team after receiving notice of attestation or validation failure. |
| Remediation Time | The period during which participating practices which failed to meet deadlines on relevant activities tracked for practice transformation may remain enrolled in the program while improving performance. |
| Same-day appointment request | A member's request to be seen by a clinician within 24 hours. |
| Self-Insured (Self-Funded) Plan | A health plan through which an employer or another group sponsor, rather than an insurance company, is financially responsible for paying plan expenses including claims made by group plan members. |

2. INTRODUCTION

The PCMH Program Manual orients you to the requirements and expectations of the 2018 program year. This manual provides general guiding principles in practice participation, transformation, reporting guidelines, and resources to support your work in PCMH. This work involves building capability within your practice to meet the ongoing needs of your patient population. You will report on your progress toward fulfilling these requirements based on the reporting guidelines.

Five Comprehensive Primary Care Functions of PCMH as described by Patient-Centered Primary Care Collaborative (PCPCC)

1. Comprehensive Care

The Patient-Centered Medical Home is accountable for meeting the vast majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. The team might include physicians, advanced practice registered nurses, physician's assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

2. Patient-Centered

The Patient-Centered Medical Home provides health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, cultures, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their care at the level the patient chooses. Recognizing that patients and families are core members of the

Primary Care

care team, medical home practices ensure that they are fully informed partners in establishing care plans.

3. Coordinated Care

The Patient-Centered Medical Home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients discharged from the hospital.

4. Accessible Services

The Patient-Centered Medical Home delivers available services with shorter waiting times for urgent needs, same day appointments, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access.

5. Quality and Safety

The Patient-Centered Medical Home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities. Evidence-based medicine and Clinical Decision Support (CDS) are tools used to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing sound quality and safety data and improvement activities publicly is also an important marker of a system level commitment to quality.

3. PROGRAM ELIGIBILITY, ENROLLMENT, & WITHDRAWAL

3A. Practice Eligibility

The Arkansas Blue Cross and Blue Shield 2018 PCMH Program eligibility requirements are:

1. The practice must include primary care physicians (Family Medicine, General Practice, Geriatrics, Internal Medicine, or Pediatrics) enrolled in the following networks: Arkansas Blue Cross and Blue Shield (Preferred Payment Plan), Health Advantage HMO, and Arkansas' First Source PPO or True Blue PPO.
2. The practice must complete the PCMH enrollment application located on the AHIN portal during the designated PCMH enrollment period.
3. The practice must return contract amendments signed by each primary care physician who provides primary care to patients at the PCMH practice location no later than December 15, 2017.
4. A provider cannot enroll in both Arkansas Blue Cross Blue Shield's CPC+ and PCMH with the same panel of patients.

3B. Practice Enrollment

The enrollment period for the Arkansas Blue and Cross Blue Shield 2018 PCMH program is October 1, 2017-December 1, 2017. Enrollment in the PCMH program is voluntary and is open to physicians providing primary care to patients. A representative of the practice must complete the PCMH application locatable on the AHIN PCMH

portal. Returning physicians are not required to submit signatures. However, physicians new to the PCMH program are required to sign Exhibit B in the Provider Participation Agreement Contract.

Practices participating in the Arkansas Blue Cross and Blue Shield 2018 PCMH program must notify Arkansas Blue Cross of any additions to the list of physicians who practice at the practice location, outside of open enrollment.

3C. Practice/Provider Withdrawal

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

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

1. The practice or physician withdraws;
2. The practice or physician becomes ineligible, is suspended or terminated from the network or the Arkansas Blue Cross PCMH program.

If a physician or practice wishes to terminate their PCMH agreement, provide a written 30-day notice to Arkansas Blue Cross Blue Shield Primary Care Department is required. Mail the written notice to:

**Arkansas Blue Cross Blue Shield
Primary Care, 4S
601 S. Gaines
Little Rock, AR 72201**

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

3D. Attribution of Patients (Patient Panel)

Fully-insured members will be attributed to a physician based on methodology that will include, but not be limited to, factors such as claims containing specific evaluation and

management CPT codes (99201-99499); assignment through recent dates of service; and a member PCP selection process.

If a member cannot be attributed based on paid claims or the member declines to select a PCP, geographic proximity will be used to assign the member to a participating practice. Members assigned to participating practices but who have not established care at the practice (no paid claims for E&M codes 99201-99499) will not be included in the patient panel of attributed members until the participating practice receives payment for an eligible E&M service code (99201-99499) or the member selects a provider, from the clinic, as a PCP.

Self-insured employers will independently decide if they will participate in the PCMH program and will be responsible for setting the care coordination payment amounts for their members.

4. CARE COORDINATION PAYMENTS-TERMS AND CONDITIONS

In addition to the enrollment eligibility requirements listed in Section 3A, participating practices must meet the practice transformation activities identified in sections 5A and 5B in order to receive Care Coordination Payments.

4A. Eligibility for Care Coordination Payments

Care Coordination Payments are calculated per attributed member, per month and paid monthly. Care Coordination Payments support practice transformation and care coordination services.

To begin receiving Care Coordination Payments in the 2018 program year, a practice must submit a completed PCMH Provider Participation Agreement on or before December 15, 2017.

Patients assigned to your practice with no filed claims (i.e., no previous previously paid claims for E&M codes 99201-99499) will not be included in monthly Care Coordination Payments. However, once the patient establishes care with the practice and an eligible claim is paid, Care Coordination Payments will begin. Practices are responsible for ensuring the accuracy of Care Coordination Payments. There will be no retroactive payments.

4B. National Committee for Quality Assurance (NCQA) PCMH Recognition

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Practices that hold NCQA PCMH recognition during the enrollment period 10/1/17-12/1/17 will receive increased Care Coordination payments per member per month for their patients with a fully-insured policy based on the level of recognition during the time of enrollment. Practices must submit proof of NCQA PCMH recognition at the time of enrollment.

If a practice's NCQA PCMH recognition expires during the PCMH program year, monthly care coordination payments may default to base level pay if not renewed. Submit NCQA PCMH recognition updates to primarycare@arkbluecross.com. Once the updates are received and an active status is confirmed, the increased payments will resume.

5. ACTIVITIES, METRICS, AND ACCOUNTABILITY FOR PAYMENT INCENTIVES

This subsection describes the change concept, why it is essential to your practice and provides guidance and suggestions on how you can implement related change tactics in your practice.

Using the PCMH Provider Portal on AHIN, participating practices must complete and document the activities as described in the Quality Assurance portion of the manual.

5A. Activity Overview

3-Month Activities

Readiness Assessment

During the first quarter of the 2018 PCMH Program year, practices are required to complete and attest to a Practice Readiness Assessment which serves as a program preparedness check-in.

Quality & Risk Care Gap Closure

Primary Care

By the Affordable Care Act (ACA) provisions, the Department of Health and Human Services (HHS) has established guidelines that require issuers of Marketplace and non-Marketplace individual and small group health plans to annually validate adjustable risk conditions and to ensure a complete and accurate clinical profile.

Practices are now required to attest to their ability to respond to medical record requests for gap closures on an identified subset of eligible, attributed members. The medical records requested from practices will support validation of submitted diagnoses and have a direct impact on the member premium stabilization in Arkansas while ensuring compliance with the provisions of the Affordable Care Act (ACA).

The Practice Readiness Assessment and Quality & Risk Gap Closure are to be completed by 2/16/2018.

Activity A: Identify/Update High-Priority Patients for 2018

Identify top 10% of high-priority patients using

- Patient Panel data that ranks patients by risk at the beginning of performance period.
- The practice's patient-centered assessment to determine which patients are high-priority

6-Month Activities

Activity B: 24/7 Access to Care

Access refers to the timely use of needed health services. Evidence suggests that improving access to care increases the likelihood that patients get the right care at the right time, potentially avoiding costly urgent and emergent care.

Defining the change

Improving access means working to diminish or remove appointment backlog and delay between initiation of demand and delivery of service. The gap between supply and demand not only contributes to delays in meeting patients' needs but also generates waste.

Change Tactics

1. Provide 24/7 access, guided by the medical record, the practitioner and care team for advice about urgent and emergent care; for example, through:

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- a. The practitioner and care team with real-time access to the medical record.
 - b. Cross-coverage by another practitioner external to your practice with access to medical record.
 - c. Protocol-driven nurse line with access to the medical record or ability to escalate to a practitioner with access.
2. Ensure that your patients are aware of your after-hours contact information.
 - a. Include contact information on a public website.
 - b. Provide printed material (e.g., brochure, flyer).
 - c. Post after-hours contact information on all entry and exit points at each site.
 3. Document all after-hour communication in patient's EHR.

Activity C: Enhanced Access & Communication

Enhanced access is a fundamental concept of the PCMH Model of Care because it is an essential key to improving patient outcomes, improving patient experience, and reducing health care costs. This concept requires access goals and tactics to deal with the variations that occur on a day-to-day basis. The best systems are designed to anticipate and respond to these differences in real-time.

Defining the Change

Enhancing patient access begins with a commitment to eliminating barriers to care. This concept means providing patients with access to their care team during office hours (portal communication), same-day appointments, and expanded hours that increase the practice's efficiency and capacity to care for all patients who need care in real-time.

Change Tactics

1. Expand office hours in early mornings, evenings, and weekends with access to the patient medical record, either directly through the practice or through coordination with other practitioners.
2. Provide same-day or next-day access to the patient's practitioner and care team for urgent care or transition management.
3. Use a patient portal and secure messaging for a patient and designated caregiver access to health information in languages that align with the patient population.

Activity D: Childhood/ Adult Vaccination Practice Strategy

Vaccine-preventable diseases cause tens of thousands of deaths each year. These disorders can lead to reduced quality of life, overutilization of health care resources (e.g., hospitalizations, emergency department visits), and increased cost to the healthcare system.

Defining the Change

Vaccination practice strategies will allow practices to identify gaps in vaccinations. One of the primary ways to reduce barriers to immunizations is not to rely on physician memory for their delivery. Engaging the entire practice team from the clerical staff, who obtain immunization records, to the nursing staff who implement standing order protocols and deliver the vaccines, can reinforce the commitment of the medical home to wellness and disease prevention.

Change Tactics

1. Develop a process for identifying vaccination gaps.
2. Implement reminder/recall system for tracking future and missed appointments.
3. Utilize electronic immunization registry for tracking and submitting vaccinations.

Activity E: Health Literacy Assessment Tool

Health literacy is the degree to which individuals can obtain, process, and understand necessary health information and services needed to make appropriate health decisions. Health literacy is dependent on individual systemic factors and communication skills of laypersons and professionals.

A common barrier to patients' participation is not able to understand the educational materials provided to them. Patients are often reluctant to admit they struggle with written documents. Accordingly, you will want to consider incorporating tools to assess patients' literacy levels, preferred language, and selected teaching modality. You may want to use or create materials that are appropriate for lower literacy levels. You may find visual aids, photos, and illustrations suitable (i.e., recommended portion size for weight control programs).

Defining the Change

Administering the health literacy tool informs your practice of those patients who may need assistance in completing their medical paperwork. Also, your care team may

learn from patients who don't understand their care instructions and may require an alternate method to gain understanding (i.e., Teach-Back Method).

Change Tactics

1. Choose any health literacy tool and administer to at least 50 beneficiaries enrolled in PCMH or their caregivers (i.e., Single Item Health Literacy Screener).
2. Document results of the Health Literacy Assessment Tool in EHR.
3. Evaluate assessment results.
4. Develop and describe a plan to help low literacy beneficiaries to understand instructions and educational materials.

12-Month Activities

Activity F: Care Instructions for HPPs

Giving every patient a clinical summary after each office visit is one of the most challenging of all meaningful use elements because of the complexity of both the information flow and the workflows involved. Care instructions for HPPs are an after-visit summary that provides a patient with:

- relevant and actionable information
- instructions containing the patient name
- provider's office contact information
- date and location of the visit
- updated medication list
- updated vitals
- reason(s) for visit
- procedures performed or scheduled and results

Defining the Change

An after-visit summary enhances the ability of patients to remember and, if necessary, convey to family members the content of interactions with their care team. After-visit summaries also support greater patient engagement in making good choices about healthy behaviors and self-management of chronic conditions, which is essential to improving clinical and patient-oriented quality outcomes. After-visit summaries improve quality of information in the EHR through transparency. Errors can be identified and corrected by giving patients and family members an opportunity to view information in their records.

Change Tactics

1. Ensure that the information for the after-visit summary (orders for tests, treatments, and referrals, etc.) has been entered, updated, and validated in the EHR before the end of the visit or within 24 hours.
2. Develop process steps for ensuring that each patient receives an after-visit summary before the end of the visit.
3. Upload after-visit summary to the patient portal.

Activity G: Transitions of Care

Transitions of care refer to the movement of patients between health care practitioners, settings, and home as their condition and care need change.

Defining the Change

Your practice will develop a process that provides for timely post-discharge follow-up with patients. Telephone or in-person follow-up, support, and coordination by a case manager, social worker, nurse, or another health care professional 72 hours or 2 business days after discharge helps patients achieve successful recovery.

Change Tactics

1. Establish a partnership with reporting facility to access their EHR to obtain discharge information.
2. Establish guidelines for when documentation is expected (e.g., within 72 hours of discharge).
3. Develop a process for following up within two business days of an inpatient stay.

Activity H: Care Management

Care management is a set of proactive activities that aim to improve health outcomes and reduce utilization, harm, and waste. In the 2018 Arkansas Blue Cross PCMH program year, you will tailor care management services to patients at the highest risk for adverse, preventable outcomes. The high-risk patients are those Arkansas Blue Cross patients in your top 10%.

Defining the Change

Primary Care

Your patients with complex needs will benefit from support from their primary care team to ensure they are getting the care and treatment they need. Studies have shown that targeted care management services can decrease adverse outcomes in patients with chronic conditions. Providing care management services during transitions of care is especially important for older adults with multiple chronic conditions.

Change Tactics

1. Develop a process for identifying patients in need of care management (patients in addition to your HPPs).
2. Designate dedicated clinically trained staff to work closely with the practitioner in a team-based approach to care for individuals with complex health needs.
3. Complete a minimum of two care plans (an initial care plan with at least one update or two updates to a care plan from the previous year). The provider (physician/APN/PA) must complete one care plan in a face-to-face visit and one update may be completed via phone call as long as long as it is within the contacting person's scope of practice. The care plan must be accessible through the patient's EHR.
4. The Care plan should include:
 - a. Documentation of the patient's appropriate problem list
 - The problem list should consist of any active, significant clinical condition (chronic).
 - Each visit related encounter should include a list of current problems (chronic).
 - b. Assessment of progress to date
 - Documentation and assessment of each problem (stability or change of condition).
 - For example, "diabetes controlled", "uncontrolled based on HbA1c", "worsening", "stable per labs", "controlled per patient's compliance with prescribed medications", etc.
 - If a problem noted in the problem list is no longer an active problem, a status such as "resolved" should be indicated.
 - If a specialist follows the patient, the most recent findings should be documented, if available.
 - c. Plan of Care
 - The documentation should include a specific plan of care related to the problem.

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- For example, “Continue Lisinopril 5mg daily”, “ordering labs”, “provided patient education”, “follow-up with specialist”.
- d. Instructions for follow-up
- The documentation should include the timing of a future follow-up visit (related to the problem).
 - For example, “return to office in 6 months” is acceptable; “return if no improvement or as needed” is not acceptable.
 - If problems/conditions are followed by a specialist, the timing of the follow-up visit with the specialist should be noted. For example, “follow-up with an endocrinologist in 6 months” is acceptable; “follow-up with an endocrinologist” is not acceptable.

Activity I: Patient Feedback

Patient feedback consists of the views and opinions of patients and service users on the care they have experienced. Healthcare organizations can gather patient feedback in a variety of ways including surveys, audits, comments, and complaints. Also, reliable evidence can be collected systematically using a range of techniques including an advisory council.

Defining the Change

Gathering feedback informs your practice of patient satisfaction/dissatisfaction. Feedback allows your practice to study patterns and trends to see how common individual experiences are. Patient feedback discovers if a problem is occurring more or less frequently over time.

Change Tactics

1. Develop a process for receiving anonymous feedback from patients.
2. Start a patient advisory council.
3. Analyze patient feedback and discuss as a team where to take action.

Activity J: Medication Management

Your practice will create a policy for medication reconciliation. Most chronic and acute conditions are treated with medications, and it is not uncommon for patients to be on several medications at a time. Such instances create challenges for patients and their care teams to prevent and manage medication-related problems. Updates to active medication should be documented in the EHR for high priority patients.

Prescription Monitoring Program (PMP)

Your practice must create a policy for PMP workflow and enrollment. PMP usage should be documented in EHR.

Managing medication includes an assessment of specific patient medication-related needs to determine if the patient is experiencing drug therapy problems. PMP is a tool used to identify and prevent prescription drug abuse. The identification of prescription drug abuse through the PMP can be used to initiate treatment and rehabilitative services. Providers who hold DEA# must be enrolled in the PMP.

Defining the Change

Medication management is an evidence-based approach to improving patient outcomes. A critical factor in the success of the PCMH for both adults and children is maximizing the benefits medications offer in improving outcomes related to chronic conditions. Therefore, health care reform and delivery system changes must include the comprehensive management of drugs to identify, resolve, and most importantly, prevent medication-related problems.

Change Tactics

1. Develop a process for monitoring providers/designee to ensure the PMP is checked before prescribing a controlled substance (opioid from Schedule II or III every time or a benzodiazepine for the first time).
2. Determine appropriate model of care or strategy for medication management services (e.g., SafeMed Model or Match model).
3. Engage a pharmacist as part of the care team (e.g., contract, direct hire, or shared resource).
4. Develop a process for identifying patients who may require medication management services (e.g., risk stratification, direct referral, and unfulfilled therapeutic goal).

5B. Metric Overview

Arkansas Blue Cross and Blue Shield and its family of companies assess participating practices on 15 Quality Metrics. The metrics are tracked starting on the first day of the first calendar year in which the participating practice is enrolled in the PCMH program and continuing through the full calendar year.

Metrics 1-8 are claims-based metrics. The data used for measuring performance for claims-based metrics will be captured from claims data.

Primary Care

Metrics 9-15 are self-reported metrics. These metrics are to include data from all payer sources. Practices will need to calculate a numerator and denominator based on their entire patient panel regardless of the insurance carrier. Since metrics 9-15 are annual measures, practices are expected to self-report in January 2019 for the 2018 PCMH program year.

5C. Provider Performance

Arkansas Blue Cross Blue Shield and its family of companies provide participating practices with reports containing information about their practice performance on activities and metrics. Reports will be locatable on the AHIN PCMH Provider Portal.

5D. Care Management Portal (CMP)

The CMP is a tool 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 CMP allows practices to manage patients in a variety of ways.

Providers with a specialty in primary care (general/family practice, internal medicine, pediatrics, and geriatrics) with aligned patients have data available to them in the portal. Nurse practitioners and physician assistants who participate in certain value-based programs also have aligned patients and will have data available to them as well.

There are three main types of data included in the CMP: (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. The CMP is updated monthly using claims from a year of data. Practices can view some metrics concerning aligned patients, such as care gaps, cost of care, emergency department visits, and prescription utilization.

6. QUALITY ASSURANCE POLICY

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 practices individually. The Arkansas Blue Cross PCMH

program is structured to facilitate change by providing Practice Transformation Activities and Quality Metrics that are founded on evidence-based practice, peer reviews, and trends in health care.

6A. Notification

The Arkansas Blue Cross Primary Care Team exchanges information with participating practices in several ways:

1. 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. The contact information provided on the program application is used for email and phone communication. Practices are responsible for contacting the Primary Care Department in the event of a change in contact information. Any user with access to the AHIN PCMH portal can update the practice contact information.

2. Requirements

Program requirements, expectations, and reporting are provided for participating practices through the following: Arkansas Blue Cross and Blue Shield PCMH Program Contract, 2018 PCMH Program Manual, Specification Manual, Regional Information Sessions, AHIN, PCMH and Care Management Portals, and Primary Care email.

3. Practice Progress

Specific information regarding a practice's progress on the individual components of the program is provided through reports or data feeds. The reports or data feeds are locatable on both the Arkansas Blue Cross PCMH Portal and Care Management Portal. In the event a practice is failing to meet a target, notification will be provided to the practice via AHIN and the Primary Care Team.

6B. Transformation Activity Audits

Arkansas Blue Cross 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. Section 9 outlines acceptable documentation formats for each activity during the reviews.

1. After completing the Readiness Assessment, a Transformation Coach will collaborate with the practice to create a work plan. The work plan will include activities the practice chooses to focus on for the program year. The Arkansas Blue Cross and Blue Shield's Primary Care Team will request documentation on these activities to validate.
2. Practices are expected to attest to 6 & 12-Month Practice Transformation Activities by completing the questionnaires on the PCMH Portal regarding updates the practice has made since completing the Readiness Assessment.
3. The 6-Month Practice Transformation Activity attestations are due June 30, 2018. 12-Month Practice Transformation Activity attestations are due December 31, 2018. An audit will follow both the 6 & 12-Month Activity attestations.

Audit Results and Feedback

The Primary Care Team will review the practice documentation for the 6 & 12-Month activities within 30 business days from the date submitted. Audit results will be delivered during a site visit by a transformation coach or sent via email.

6C. Quality Metric Audits

There are 15 Quality Metrics. Eight of the metrics are claims-based and seven are self-reported by the practice. Practices will have a full year to meet the targets. For quality metrics 9-15, clinics will be required to enter a numerator, denominator and attest to the data submitted on the PCMH portal. Self-reported measures should include your entire patient panel, report from your EHR, and are subject to audit. Practices are expected to meet, at least, 5 of the 15 metric targets.

6D. Care Plan Expectations, Attestations, and Auditing

Activity H Care Management, a 12-Month Activity, includes care plans for high-priority patients.

Expectations

Practices who do not meet the following criteria will be expected to submit an improvement plan. Additional information regarding care plan requirements can be found under Activity H: Care Management change tactics on pages 18 & 19.

1. Update care plans twice, for high-priority patients selected in Activity A, by December 31, 2018.
2. Care plans must be contained in the patient's medical record.
3. The Arkansas Blue Cross Primary Care Team will assess care plans for the four required components (See section 5A Activity H). It is recommended that a list or copy of care plans completed on high-priority patients are kept in a secure location for ease of assessment.
4. At least 80% of high-priority patients must have a minimum of two care plans.
5. Addendums to care plans are acceptable if completed within a reasonable period of no more than two weeks after the care plan has been created or updated.
6. Complete attestations as outlined in the attestation section below.
7. Comply with the request of care plan submission as outlined in the audit section below.
8. Successfully pass the care plan audit with an 80% total score.

Care Plan Attestation

Practices are expected to submit attestations on the PCMH Portal for each high-priority patient that has at least two care plans. It is recommended that the attestations are done periodically throughout the year to avoid last minute attestations. Attestations must be completed by December 31, 2018.

Auditing

All care plan attestations are subject to an audit. If a patient is selected for an audit, the practice is to upload two care plans per patient for review. At the time of the audit, 20% of attested care plans will be randomly selected and reviewed by Arkansas Blue Cross Blue Shield. The passing rate for the care plan audit is 80% total score.

In the event an early audit for care plans is offered, practice eligibility will require at least 50% of second care plans to be completed and attested to on the PCMH portal. Early audits are conducted at the discretion of the Primary Care Team. The early audit option is not required for participation in the 2018 PCMH program; however, practices who participate will receive feedback in advance of the regular care plan audit. The results of the first audit will be included in the regular care plan audit in early 2018.

Participating in the early audit will not exempt a practice from participating in the regular care plan audit.

Audit Results and Feedback

Arkansas Blue Cross will review submitted care plans during the regular audit within 45 business days after the care plan upload due date. Care plans are scored on a point system. Each of the four care plan components is worth one point, and the total score is calculated by each point achieved.

Practices are welcome to call or email the Primary Care office at Arkansas Blue Cross with any questions or comments. If a practice disagrees with feedback provided by Arkansas Blue Cross, the practice will need to show a subset of care plans that they feel were scored incorrectly and identify where the documentation component is in the care plans.

All requests will be considered. The subset of care plans will be reviewed, and a decision will be made to determine the need for further review. Feedback regarding the requests will be provided no later than 30 days after the concern is received.

6E. Unscheduled Audits

Unscheduled Audits: There will be no “unscheduled” audits in the 2018 program year. Practices will receive a minimum notice of 5 business days for audit requests.

6F. Improvement Plan Process

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

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

1. Fails to attest or complete any Practice Transformation Activity.
2. Fails to attest to or submit self-reported metric data.
3. Fails to meet targets on at least 5 of the 15 Quality Metrics.
4. Fails to meet requirements during an audit.
5. Fails to meet any deadline.

Failure to complete an improvement plan may result in suspension of care coordination payments. 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 has passed.

The Primary Care team reserves the right to suspend or terminate care coordination payments 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, a written response may be submitted within 15 days to primarycare@arkbluecross.com or mailed to:

**Arkansas Blue Cross Blue Shield
Primary Care, 4S
601 S. Gaines
Little Rock, AR 72201**

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:

1. State why Arkansas Blue Cross should reconsider the audit results.
2. Provide documentation to support your decision

Improvement Plan Timeline

1. Notification by Primary Care via portal or email
2. Initiate Improvement Plan
 - Three checkpoints over a three month period
3. Work on Improvement Plan
 - Deadlines
 - Three months from notice of failure for Activities
 - Six months for Quality Metrics
 - Other deadlines at transformation coach discretion
4. Submit Supporting Documents
 - Documents may be required during or at the end of the improvement plan process. Details will be provided in writing

7. SUMMARY OF EXPECTATIONS

| 3-Month Activities | |
|--|--|
| Initial Practice Readiness Assessment | <ul style="list-style-type: none"> ➤ Complete survey on survey monkey. ➤ If not completed by the deadline, practice will be expected to complete the Arkansas Blue Cross Improvement Plan Process. |
| Quality & Risk Care Gap Closure | <ul style="list-style-type: none"> ➤ Attest to submitting medical records promptly. |
| Activity A | <ul style="list-style-type: none"> ➤ Select patients. ➤ Attest. ➤ If not completed by the deadline, your high-risk patient panel will be selected for you based on the Arkansas Blue Cross risk score. |
| 6-Month Activities | |
| Activities B-E | <ul style="list-style-type: none"> ➤ This component requires 3 action items to pass: <ol style="list-style-type: none"> a. Answer all questions b. Attest to each Activity c. Validation ➤ If a practice does not complete a. or b. by the deadline, they are expected to contact the Primary Care Department within five business days. ➤ If a practice fails to contact the Primary Care Department within five business days, the practice will be placed on an Improvement Plan. ➤ If a practice fails to complete validation requirements, an Improvement Plan process will be implemented. |
| 12-Month Activities | |
| Activities F-K <i>Excludes Activity H</i> | <ul style="list-style-type: none"> ➤ This component requires 3 action items to pass: <ol style="list-style-type: none"> a. Answer all questions. b. Attest to each Activity. c. Validation: |
| Activity H | <ul style="list-style-type: none"> ➤ This component requires 2 action items to pass: <ol style="list-style-type: none"> a. Attest to completing a minimum of 80% of care plans. b. Submit both care plans for a randomly selected 20% of your high-priority patients. Care plans should include the four components. |
| Annual Quality Metrics | |
| 1-8 | <ul style="list-style-type: none"> ➤ Arkansas Blue Cross will report the status of these metrics utilizing claims data. |

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| | <ul style="list-style-type: none"> ➤ Practices will have a full year to meet the targets. ➤ If a practice fails to meet the targets, an Improvement Plan process will be implemented. |
| 9-15 | <ul style="list-style-type: none"> ➤ This component requires 2 action items to pass: <ol style="list-style-type: none"> a. Enter a numerator/denominator for each measure. b. Attest to the data submitted. ➤ Practices will have a full year to meet the targets. ➤ If a practice fails to meet the targets, an Improvement Plan process will be implemented. |

8. SUPPORTING DOCUMENTATION GUIDE FOR ACTIVITIES

This guide gives examples of documentation that may be requested by primary care to support a practice's response to certain activities. This list is not all-inclusive and is subject to change.

| 2018 Activity | Documentation | |
|---|--|----------|
| R= Report (5 day minimum) | E= Example/ Screenshot | P=Policy |
| A. Identify/Update High-Priority Patients for 2018 | <ul style="list-style-type: none"> ➤ N/A | |
| B. Provide 24/7 access to care Access to clinical advice where a patient can speak to a live voice | <ul style="list-style-type: none"> ➤ R: Log for after-hour calls, log for checking the functionality of the machine, log for returned call times, etc. ➤ E: Displaying after-hours number, invoice from call service, sample of EMR documented encounter ➤ P: After-hours policy | |
| C. Enhanced Communication & Access Offering same-day appointments, extended hours, or weekend appointment availability having timely communication between the practice and the patients and their caregivers | <ul style="list-style-type: none"> ➤ R: Log of SDA availability, log of messages sent ➤ E: Screenshots of SDA on schedule, screenshot of electronic messages exchanged ➤ P: Policies for SDA, for returning messages during and after office hours, and the patient portal | |
| D. Childhood/ Adult Vaccination Practice Strategy A planned and proactive approach to closing gaps in vaccinations | <ul style="list-style-type: none"> ➤ R: Registry for vaccinations, EMR gap report ➤ E: Communication script/letter/postcard, screenshot of alerts/flags, vaccination record, or electronic submission of record ➤ P: Vaccination policy | |
| E. Health Literacy Assessment Tool | <ul style="list-style-type: none"> ➤ R: Log of patients who received | |

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|---|---|
| <p>Administer a health literacy assessment (Single Item Literacy Screener, REALM-SF, etc.), evaluate the results and implement an intervention plan</p> | <ul style="list-style-type: none"> ➤ assessment, log of assessment results ➤ E: Copy of assessment tool, screenshot of assessment documented in medical record, screenshot of alert on patient's medical record ➤ P: Policy on health literacy assessment |
| <p>F. Care Instructions for HPPs</p> <p>Create and share with the patient an after-visit summary which includes updated/reconciled medication list, vital signs, purpose of visit, procedures and other information or instructions based on clinical discussions that took place during the visit, summary of topics covered/considered, and follow-up instructions</p> | <ul style="list-style-type: none"> ➤ R: Rate of after-visit summaries distributed, rate of lab results made available within three days ➤ E: Sample of an after-visit summary, screenshot of template in the medical record ➤ P: Policy for after-visit summaries including a process for monitoring |
| <p>G. Transitions of Care</p> <p>40% of patients with an inpatient stay had an in-person visit or follow-up phone call within two days of discharge</p> | <ul style="list-style-type: none"> ➤ R: Log of discharged patients, rate of follow-ups, log of TOC billed visits ➤ E: Screenshot of discharge reports/feeds, screenshot of documented follow-up or attempts ➤ P: Transitions of Care policy |
| <p>H. Care Management</p> <p>Activities that aim to improve the health outcomes of the clinic's high-risk (top 10%) patients (HPP) or target population</p> | <ul style="list-style-type: none"> ➤ R: Report of patients who received Care Management, population health registries that identify patients for care management ➤ E: Screenshot of activities used to improve health outcomes (patient-centered goals, plans for self-management), screenshot or template used for patient education ➤ P: Care Management Policy, documented process for identifying patients in need of care management, care plan policy |
| <p>I. Ability to receive patient feedback</p> <p>Having a process to receive anonymous feedback from patients</p> | <ul style="list-style-type: none"> ➤ R: Results of feedback, rate of patients surveyed ➤ E: Copy of survey tool, summary of changes made as a result of patient feedback ➤ P: Patient satisfaction policy |
| <p>J. Medication Management</p> <p>Using strategy for medication management and use of the Arkansas Prescription Drug Monitoring Program (PMP)</p> | <ul style="list-style-type: none"> ➤ R: Rate of medication reconciliation, log of PMP usage ➤ E: Screenshot of medication reconciliation form from medical record, screenshot of PMP registration, screenshot of documentation in EMR that PMP was checked |

➤ **P:** Policy for medication reconciliation, policy of PMP enrollment and workflow

9. ACTIVITIES & METRICS

| 2018 Activities | Due Dates |
|--|------------|
| Quarter 1: Program Preparation Complete the 2018 Readiness Assessment and Medical Record Request for gap closures on an identified subset of eligible, attributed members. | 2/17/2018 |
| A. Identify/Update high-priority patients for 2018 Identify/Update top 10% of high-priority patients for 2018 between 04/01/2018 and 4/30/2018. | 4/30/2018 |
| B. Provide 24/7 access to care Provide 24/7 Access to clinical advice where a patient can speak to a live voice. | 6/30/2018 |
| C. Enhanced Access & Communication Offering same day appointments, extended hours, or weekend appointment availability and having timely communication between the practice and the patients and their care givers. | 6/30/2018 |
| D. Childhood/Adult Vaccination Practice Strategy A planned and proactive approach for closing gaps in vaccinations. | 6/30/2018 |
| E. Health Literacy Assessment Tool Assessment of patients' health literacy. | 6/30/2018 |
| F. Care Instructions for HPPs Providing an after visit summary of information, from the last visit, to high priority patient. | 12/31/2018 |
| G. Transitions of Care Receiving discharge information and following up with patients within 72 hours or 2 business days. | 12/31/2018 |
| H. Care Management Identify patients in need of care management, in addition to high priority patients. | 12/31/2018 |
| I. Ability to receive patient feedback Having a process to receive anonymous feedback from patients. | 12/31/2018 |
| J. Medication Management Using a strategy for medication management and use of the Arkansas Prescription Monitoring (PMP) program. | 12/31/2018 |

| 2018 Metrics | 2018 Targets |
|---|------------------------------------|
| 1. Percentage of patients who turned 15 months old during the performance period who receive at least five wellness visits in their first 15 months. | At least 91% |
| 2. Percentage of patients 3-6 years of age who had one or more well-child visits during the measurement year. | At least 73% |
| 3. Percentage of patients 12-21 years of age who had one or more well-care visits during the measurement year. | At least 50% |
| 4. Percentage of patients who are compliant with prescribed asthma controller medication (at least 75% compliance). | At least 50% |
| 5. Percentage of children who received appropriate treatment for Upper Respiratory Infection (URI). Inverted measure | At least 78% |
| 6. Percentage of a clinic's high-priority patients who have been seen by a member of the PCP's care management team at least twice in the past 12 months. | At least 90% |
| 7. Percentage of patients 18 years and older who met the proportion of days covered threshold of 80% during the measurement year for Diabetes Medication. | At least 55% |
| 8. Percentage of patients with uncomplicated low back pain that did not have imaging studies. | At least 72% |
| 9. Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period. (All payer source) | At least 65% Self-report |
| 10. Percentage of patients 18-75 years of age 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. (All payer source) | No more than 35% Self-report |
| 11. Percentage of female patients 50-74 years of age that had a screening mammogram in the past two years. (All payer source) | At least 58% Self-report |
| 12. Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer. (All payer source) | At least 45% Self-report |
| 13. Percentage of patients 18-75 years of age with a diagnosis of diabetes who had an eye exam performed. (All payer source) | At least 48% Self-report |
| 14. Percentage of female patients 21-64 years of age who had appropriate screening for cervical cancer. (All payer source) | At least 40% Self-report |
| 15. The percentage of adolescents 13 years of age who have completed the human papillomavirus (HPV) vaccine series by their 13 th birthday. (All payer source) | At least 25% Self-report |