Patient-Centered Medical Home
(PCMH)
Program Manual

2019 Program Year

This document is a manual to the 2019 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.
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Definitions

**Advanced Health Information Network (AHIN):** 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 Blue Shield PCMH Programs.

**All Payer Source:** The information requested should apply to the provider’s whole patient panel, without regards to insurance coverage.

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

**Attributed Members:** The Arkansas Blue Cross and Blue Shield members for whom primary care physicians and participating practices have accountability under the PCMH program. A primary care physician’s attributed members have been determined by claims, member selection, or auto-assignment.

**Attribution:** The methodology by which Arkansas Blue Cross and Blue Shield 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)

**Care Plans:** Arkansas Blue Cross and Blue Shield’s PCMH program care plans are documentation of the following required components completed during an office visit or a telephone follow up visit:
- Documentation of the patient’s appropriate problem list
- Assessment of progress to date
- Plan of Care
- Instruction for follow-up
- Patient health concerns, goals, and self-management plans

**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.

High Priority Patients: Patients that are considered high risk by the clinic or Arkansas Blue Cross and Blue Shield; Patients that require attention soon. Also referred to as HPP.

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 or TeleVox).

Measurement Number: The specific identifying information for a measure in a program. A measure that is used in multiple programs may have several measure numbers.

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.

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 participating practice is a 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 to him/her. 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 (PCPs) 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.

**Practice Support:** Support provided by Arkansas Blue Cross and Blue Shield 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, Geriatric Medicine, General Practice or Pediatric Medicine, who provides definitive care to the patient at point of the first contact and takes continuing responsibility for ensuring the patients care.

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

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

**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.

**Self-Reported Measures:** Data collected and reported by the clinic to the Arkansas Blue Cross Blue Shield portal located on AHIN.

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

The Arkansas Blue Cross and Blue Shield PCMH Program Manual orients you to the requirements and expectations of the 2019 PCMH 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 (PCMH) 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 (PCMH) 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 care team, medical home practices ensure that they are fully informed partners in establishing care plans.

3. **Coordinated Care:**
   The Patient-Centered Medical Home (PCMH) 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 are discharged from the hospital.
4. **Accessible Services:**

The Patient-Centered Medical Home (PCMH) 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 (PCMH) 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.
Program Eligibility, Enrollment, Withdrawal and Attribution

1A. Practice/Provider Eligibility

The Arkansas Blue Cross and Blue Shield 2019 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 (Family Medicine, General Practice, Geriatric Medicine, Internal Medicine, or Pediatric Medicine) enrolled in the following networks: Arkansas Blue Cross and Blue Shield PPP, Health Advantage HMO, and Arkansas' First Source PPO or True Blue PPO.

- The practice must complete the 2019 PCMH enrollment application located on the AHIN portal during the designated PCMH enrollment period.

- The practice must have returned contract amendments signed by each primary care physician who provides primary care to patients at the PCMH practice location no later than November 30, 2018.

- A provider cannot enroll in both Arkansas Blue Cross and Blue Shield’s CPC+ and PCMH with the same panel of patients.

1B. Practice/Provider Enrollment

The enrollment period for the Arkansas Blue and Cross Blue Shield 2019 PCMH program is October 12, 2018 through November 9, 2018 with contracts being completed by November 30, 2018. A representative of the practice must complete the PCMH application located 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. Original signatures are required.

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 AHIN PCMH portal will be opened for a short amount of time and once the information has been added, the portal will close. Once the new provider is added, claims based metrics and patient alignments will begin.
1C. Practice/Provider Withdrawal

In the event a physician needs to be withdrawn/terminated from the program, 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 and Blue Shield PCMH program will not impact practice/physician 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 physician withdraws;
2. The practice or physician becomes ineligible, is suspended or terminated from the participating Arkansas Blue Cross and Blue Shield PCMH provider networks.

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. Attribution of PCMH Patients (Patient Panel)

Members in participating lines of business 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.

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 member will be attributed to a PCPs as mentioned in this section. If a self-insured employer chooses not to participate in PCMH, their members will not be attributed to a PCP for the purpose of the PCMH program.
Care Coordination Payments

2A. Eligibility for Care Coordination Payments

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

To begin receiving Care Coordination Payments in the 2019 program year, a practice must have submitted a completed PCMH Provider Participation Agreement on or before November 30, 2018.

Patients assigned to your practice with no filed claims (i.e., no 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.

2B. National Committee for Quality Assurance (NCQA) PCMH Recognition

Practices that hold NCQA PCMH recognition during the enrollment period, October 12, 2018 through November 9, 2018, will receive increased Care Coordination Payments per member per month (PMPM) for their patients with a PCMH participating line of business 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 2019 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.

If a practice gains NCQA PCMH recognition during the 2019 PCMH program year, practices must submit proof of 2019 NCQA PCMH recognition to receive increased NCQA Care Coordination Payments.
# Activities and Metrics

## 3A. Activity Overview

<table>
<thead>
<tr>
<th>2019 Activities</th>
<th>Due Dates</th>
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<tbody>
<tr>
<td>Quarter 1: Program Preparation</td>
<td></td>
</tr>
<tr>
<td>Complete the 2019 Readiness Assessment and Medical Record Request for gap</td>
<td>2/15/2019</td>
</tr>
<tr>
<td>closures on an identified subset of eligible, attributed members.</td>
<td></td>
</tr>
<tr>
<td><strong>A.</strong> Identify/Update high-priority patients for 2019</td>
<td>4/30/2019</td>
</tr>
<tr>
<td>Identify/Update top 10% of high-priority patients for 2019 between 04/01/2019</td>
<td></td>
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<tr>
<td>and 4/30/2019.</td>
<td></td>
</tr>
<tr>
<td><strong>B.</strong> Provide 24/7 access to care</td>
<td>6/30/2019</td>
</tr>
<tr>
<td>Provide 24/7 Access to clinical advice where a patient can speak to a live voice.</td>
<td></td>
</tr>
<tr>
<td><strong>C.</strong> Enhanced Access &amp; Communication</td>
<td>6/30/2019</td>
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<tr>
<td>Offering same day appointments, extended hours, or weekend appointment</td>
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<tr>
<td>availability and having timely communication between the practice and the</td>
<td></td>
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<tr>
<td>patients and their care givers.</td>
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<tr>
<td><strong>D.</strong> Childhood/Adult Vaccination Practice Strategy</td>
<td>6/30/2019</td>
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<tr>
<td>A planned and proactive approach for closing gaps in vaccinations.</td>
<td></td>
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<td><strong>E.</strong> Medication Management</td>
<td>6/30/2019</td>
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<tr>
<td>Using a strategy for medication management and use of the Arkansas</td>
<td></td>
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<td>Prescription Monitoring (PMP) program.</td>
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<td><strong>F.</strong> Health Literacy Assessment Tool</td>
<td>12/31/2019</td>
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<tr>
<td>Assessment of patients’ health literacy including language barriers.</td>
<td></td>
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<td><strong>G.</strong> Care Instructions for HPPs</td>
<td>12/31/2019</td>
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<tr>
<td>Providing an after visit summary of information, from the last visit, to high</td>
<td></td>
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<td>priority patient.</td>
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</tr>
<tr>
<td><strong>H.</strong> Transitions of Care</td>
<td>12/31/2019</td>
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<tr>
<td>Receiving discharge information and following up with patients within 72 hours</td>
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<tr>
<td>or 2 business days.</td>
<td></td>
</tr>
<tr>
<td><strong>I.</strong> Care Management</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Identify patients in need of care management, in addition to high priority</td>
<td></td>
</tr>
<tr>
<td>patients.</td>
<td></td>
</tr>
<tr>
<td><strong>J.</strong> Ability to receive patient feedback</td>
<td>12/31/2019</td>
</tr>
<tr>
<td>Having a process to receive anonymous feedback from patients.</td>
<td></td>
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</tbody>
</table>
Readiness Assessment

During the first quarter of the 2019 PCMH Program year, practices are required to complete and attest to a Practice Readiness Assessment which serves as a program preparedness check-in.

A Survey Monkey link will be provided for completion and submitting the Readiness Assessment.

Quality & Risk Care Gap Closure

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 attestations are to be completed by February 15, 2019.

Activity A: Identify/Update High-Priority Patients for 2019

Clinics must identify the top 10% of High-Priority Patients (HPPs) in their clinics. Clinics can identify the top 10% of High-Priority Patients (HPPs) using one of the following methods:

- 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.
- A combination of both methods of Arkansas Blue Cross and Blue Shield’s risk score and practice’s risk score.

Submit list of High-Priority Patients via the AHIN PCMH Provider Portal.
Selection of High-Priority Patients for 2019 starts April 1, 2019 and must be completed by April 30, 2019.

If you fail to select or do not complete selection by the deadline date, Arkansas Blue Cross and Blue Shield will automatically select the necessary number of High-Priority Patients (HPPs) for the clinic based on the clinic’s previous year’s claims data.

6-Month Activities
These activities should be viewed and completed on the AHIN PCMH Portal during the first 6 (six) months of the current PCMH Program year and serve as a follow-up to the submitted Readiness Assessment.

Each 6-month activity requires 3 (three) action items to pass. Those action items are:

1. Answer all questions for each activity. If you select “other” for any questions in any activity, you must give a detailed explanation of that information.
2. Attest for each activity. 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 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.

Below is a detailed explanation of all the 6-month activities:

Activity B: Provide 24/7 Access to Care
Activity B, Provide 24/7 Access to Care, states that patients 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 (at a minimum, practices are expected to provide):

- Urgent/emergent clinical advice, with a live voice, during work hours
- Urgent/emergent clinical advice, with a live voice, after work hours
- Education on this service to patients
- Develop completed policy and procedure for meeting activity expectations
Continuous Improvement (may include, not limited to):

- Document the advice/information that was 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
- When applicable, 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 (screenshot of documentation in EHR)

**Activity C: Enhanced Access & Communication**

Activity C, Enhanced Access & Communication means providing enhanced access and communication opportunities allowing for even more ways a PCMH clinic can meet the needs of their patients. Providing same or next-day appointments to patients is a way to enhance access so that urgent needs can be addressed in a timely manner. Providing 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 (at a minimum, practices are expected to provide):**

- Provide same or next-day appointments
- Communication and/or clinical advice via patient portal
- Develop completed 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
- Three examples of portal virtual (communication with the care team, request appointments)

Activity D: Childhood/Adult Vaccination Practice Strategy

Activity D, Childhood/Adult Vaccination Practice Strategy goal is a vaccination strategy that is a proactive approach to closing gaps for patients. This is likely to help patients become engaged in their health and could help avoid illnesses.

Minimum Expectations (at a minimum, practices are expected to provide):

- Engage patients to close vaccination gaps
- If a practice does not provide vaccination(s), WebIZ should be checked and the data should be integrated in the EHR
- Develop completed 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
- Track the frequency of what the vaccination rates are

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

- An updated policy for engagement on vaccinations and/or how WebIZ is reviewed
- Three examples of where vaccinations were provided or documented
Activity E: Medication Management

Activity E, Medication Management goal is to 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.

Minimum Expectations (at a minimum, practices are expected to provide):

- Implement a medication reconciliation protocol
- Strategy to monitor if providers check the PMP system before prescribing a controlled substance to a patient
- Develop completed policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Engage with a pharmacist as a part of the care team (Shared resource for practices in the health system, contract relationship with a teaching facility, formal agreement with community/retail pharmacist(s))
- Identify patients for medication management services, beyond routine medication reconciliation. (High risk tier based on risk stratification, not achieving a therapeutic goal for a chronic condition care transition(s), direct practitioner referral number of medications taken (poly-pharmacy), use of high risk medication(s), use of high cost medication(s))
- Have a strategy for medication management/reconciliation that includes over the counter medications, herbal therapies and supplements
- Develop a medication refill protocol

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

- An updated policy that outlines medication reconciliation process
- Workflow or policy with pharmacist
- An updated policy on how patients are identified for medication management and three examples of patients
- An updated protocol for medication refills
12-Month Activities

Twelve-month activities should be viewed and completed on the AHIN PCMH Portal throughout the program year and serve as a follow up to the already submitted Readiness Assessment.

Each 12-month activity requires 3 (three) action items to pass. Those action items are:

1. Answer all questions for each activity. If you select “other” for any questions in any activity, you must give a detailed explanation of that information.
2. Attest for each activity. Each activity requires an Attestation before completion and submission. Failure to attest to the activity results in 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 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.

Activity F: Patient Literacy Assessment Tool

Activity F, Health Literacy, is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. By implementing a health literacy assessment tool the care team is able to determine the patient’s ability to read, write, compute, communicate and understand in the context of health care. Health Literacy includes education, language barrier, deafness, and/or any other communication processes that need assistance for understanding.

Minimum Expectations (at a minimum, practices are expected to provide):

- Administer a validated health literacy assessment (single item Literacy Screener such as REALM-SF, etc.) to at least 75 patients or their caregivers. (Different 75 patients each program year.)
- Results of the health literacy assessment stored in the EHR
- Develop completed policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Results of the health literacy assessment stored in the EHR in a manner that is reportable
- Have the overall results of the assessment evaluated
- Develop/adopt education materials to help patients with low health literacy
Documentation (at least one of the following is sufficient for audit):

- An updated policy to administer the assessment
- Three examples of completed assessments (screenshot of EHR where information was loaded)
- Process to evaluate the results of the assessment from a population health perspective
- Examples of education materials

**Activity G: Care Instructions for High Priority Patients (HPPs)**

Activity G, Care Instructions for High-Priority Patients (HPPs) goal is to help patients stay engaged in their care by providing them care instructions after visits. Having care instructions can help hold patients accountable for self-management in between visits.

**Minimum Expectations (at a minimum, practices are expected to provide):**

- Provide an after visit summary of information to high priority patients
- Results posted within three days of the visit (a copy of the summary mailed to the patient or made available on a patient portal)
- Develop completed policy and procedure for meeting activity expectations

**Care Instructions for HPPs are after-visit summary that provides a patient with (may include, not limited to):**

- Relevant and actionable information
- Instructions containing the patient name
- Provider’s office contact information
- Date and location of the visit
- Updated medication list
- Updated vital readings
- Reason(s) for visit
- Procedure(s) performed, scheduled date, or results

**Continuous Improvement (may include, not limited to):**

- Include patient goals
- Include clinical goals set by the care team with the patient

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

- An updated policy for providing care instructions
- Three examples of summaries provided
Activity H: Transitions of Care

Activity H, Transitions of Care, refer to 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 warmer handoffs and smooth care transitions by leveraging admit, discharge, and transfer notifications to link providers anywhere patients receive care.

Minimum Expectations (at a minimum, practices are expected to provide):

- Receive discharge information from local facility(ies)
- Develop a plan to reach out and follow-up with patients who have been discharged within 72 hours, or 2 business days
- Develop completed policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Monitor transitions of care outreach by the care team to ensure goals are met and the care team members are being used to the best of their abilities
- Flag/notify the provider of the transition of care

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

- An updated policy for care team members to follow patients after a discharge
- Three examples of documented transitions of care
- Three examples of transitions of care flagged/notification to the provider

Activity I: Care Management

Activity I, Care Management, is a set of proactive activities that aim to improve health outcome and reduce utilization, harm, and waste. Studies have shown that targeted care management services can decrease adverse outcomes in patients with chronic conditions.

Minimum Expectations (at a minimum, practices are expected to provide):

- Identify patients who are at high risk (high priority)
- At least 80% of high priority patients have a valid care plan
  - One care plan must be completed face-to-face
  - One care plan can be completed via phone call
  - Both care plans must include all five components
  - Both care plans must be stored in EHR for submission during audit
- Develop completed policy and procedure on process for meeting activity expectations.
Continuous Improvement (may include, not limited to):

- Determine a methodology to expand risk stratification from only high risk patients
- Behavioral health conditions, high cost/high utilizers, social determinates of health, etc.
- Outline members of the care team and what their roles are in care management that allows the team to work to the best of their abilities
- Include patient and/or caregiver(s) goals
- Develop a patient friendly care plan that patients can take home with them

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

- Policy or procedure for risk stratification
- Care plans must include the required components of:
  - Documentation of the patient’s appropriate problem list
  - Assessment of progress to date
  - Plan of Care
  - Instruction for follow-up
  - Patient health concerns, goals, and self-management plans

Activity J: Ability to Receive Patient Feedback

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

Feedback allows your practice to study patterns and trends to see how common individual experience are. 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 (at a minimum, practices are expected to provide):

- Develop a process for receiving anonymous feedback from patients
- Develop a way of keeping track of patient feedback data
- Analyze patient feedback and discuss as a team where to take action

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 administration of obtaining the feedback
- Three examples of patient feedback
3B. Metric Overview

Arkansas Blue Cross and Blue Shield and its family of companies assess participating practices on 15 (fifteen) Quality Metrics. The metrics are tracked starting on January 1, 2019 (first day of the current program year) continuing through the full calendar year, ending on December 31, 2019 (last day of the current program year).

Metrics 1-9 are Arkansas Blue Cross and Blue Shield claims-based metrics. The data used for measuring performance for claims-based metrics will be captured from claims data for claims throughout the 2019 program year. The status of these claims based metrics can be monitored throughout the 2019 program year in AHIN Care Management Portal under the Quality Tab. Metrics are tracked by clinic status but can also be tracked by provider status under enrolled clinic as well.

Metrics 10-15 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.

If a metric has 0 (zero) opportunities throughout the 2019 program year, the practice is still required to report this information to Arkansas Blue Cross Blue Shield.
<table>
<thead>
<tr>
<th>2019 Metrics</th>
<th>2019 Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of patients who turned 15 months old during the performance period who receive at least 6 (six) wellness visits in their first 15 (fifteen) months. (ABCBS Claims Based)</td>
<td>At least 80%</td>
</tr>
<tr>
<td>2. Percentage of patients 3-6 years of age who had one or more well-child visits during the measurement year. (ABCBS Claims Based)</td>
<td>At least 74%</td>
</tr>
<tr>
<td>3. Percentage of patients 12-21 years of age who had one or more well-care visits during the measurement year. (ABCBS Claims Based)</td>
<td>At least 52%</td>
</tr>
<tr>
<td>4. Percentage of patients who are compliant with prescribed asthma controller medications (at least 75% compliance). (ABCBS Claims Based)</td>
<td>At least 55%</td>
</tr>
<tr>
<td>5. Percentage of children who received appropriate treatment for Upper Respiratory Infection (URI). (ABCBS Claims Based)</td>
<td>At least 80%</td>
</tr>
<tr>
<td>6. Percentage of patients 18-75 years of age with a diagnosis of Diabetes that had an annual screening for nephropathy or evidence of nephropathy. (ABCBS Claims Based)</td>
<td>At least 86%</td>
</tr>
<tr>
<td>7. Percentage of patients 18 years of age and older who met the proportion of days covered threshold of 80% during the measurement year for diabetes medication. (ABCBS Claims Based)</td>
<td>At least 60%</td>
</tr>
<tr>
<td>8. Percentage of patients with Uncomplicated Low Back Pain that did NOT have imaging studies in last 12 (twelve) months. (ABCBS Claims Based)</td>
<td>At least 75%</td>
</tr>
<tr>
<td>9. Percentage of patients age 18-64 years of age with a diagnosis of acute bronchitis that did NOT have a prescription for an antibiotic one to three days after the initiating visit. (ABCBS Claims Based)</td>
<td>At least 40%</td>
</tr>
<tr>
<td>10. 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)</td>
<td>At least 68%</td>
</tr>
<tr>
<td>11. 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 performed during the measurement period. (All Payer Source)</td>
<td>No more than 30%</td>
</tr>
<tr>
<td>12. Percentage of female patients 50-74 years of age that had a screening mammogram in the past 27 (twenty-seven) months. (All Payer Source)</td>
<td>At least 58%</td>
</tr>
<tr>
<td>13. Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer. (All Payer Source)</td>
<td>At least 50%</td>
</tr>
<tr>
<td>14. Percentage of patients 18-75 years of age with a diagnosis of diabetes who had an eye exam performed. (All Payer Source)</td>
<td>At least 55%</td>
</tr>
<tr>
<td>15. Percentage of female patients 21-64 years of age who had appropriate screening for cervical cancer. (All Payer Source)</td>
<td>At least 45%</td>
</tr>
</tbody>
</table>
Claims Based Metrics:

There are 15 (fifteen) Quality Metrics. Ten of the metrics are Arkansas Blue Cross and Blue Shield claims-based metrics and five are all-payer, self-reported by the practice. Practices will have the full program year to meet both sets of metric targets.

These measures will be collected by Arkansas Blue Cross and Blue Shield through claims and reported to clinics through the PCMH and Care Management portals.

<table>
<thead>
<tr>
<th>Metric #1: Percentage of patients who turned 15 months old during the performance period who receive at least six wellness visits in their first 15 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Children in the denominator who received six or more well-child visits during their first 15 (fifteen) months of life</td>
</tr>
<tr>
<td>Denominator: All children that are 15 (fifteen) months during the measurement year (age 15 (fifteen) months through 26 (twenty-six) months on the report end date) and have continuous medical coverage from 31 (thirty-one) days of age</td>
</tr>
<tr>
<td>Target: At least 80%</td>
</tr>
<tr>
<td>Exclusions: Claim is a lab (CPT codes 80000-89999 or revenue codes 0300-0319)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric #2: Percentage of patients 3-6 years of age who had one or more well-child visits during the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Children who received at least one well-child visit with a PCP in the last reported 12 (twelve) months</td>
</tr>
<tr>
<td>Denominator: All children that are 3-6 years old during the measurement year and have continuous medical coverage</td>
</tr>
<tr>
<td>Target: At least 74%</td>
</tr>
<tr>
<td>Exclusions: Claim is a lab (CPT codes 80000-89999 or revenue codes 0300-0319)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric #3: Percentage of patients 12-21 years of age who had one or more well-care visits during the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Members who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner in the last reported 12 (twelve) months</td>
</tr>
<tr>
<td>Denominator: All males and females that are 12-21 years old at the end of the reporting period and have continuous medical coverage</td>
</tr>
<tr>
<td>Target: At least 52%</td>
</tr>
</tbody>
</table>
**Metric #4:** Percentage of patients who are compliant with prescribed asthma controller medication (at least 75% compliance).

- **Numerator:** Patients from the denominator who had asthma controller medications in their possession (measured by pharmacy refills) at least 75% of the days in the reporting period.
- **Denominator:** All patients between the age of 5 and 64 with a diagnosis of Persistent* Asthma. Patients must have continuous medical coverage for 24 (twenty-four) months and pharmacy coverage for 12 (twelve) months with Arkansas Blue Cross and Blue Shield.
- **Target:** At least 55%

*Determined by combinations of the following: a diagnosis of asthma, inpatient admissions for asthma, ED visits for asthma, outpatient visits for asthma, ongoing pharmacy refills for asthma controller medications

**Exclusions:** Diagnosis of Emphysema, COPD, Cystic Fibrosis, Acute Respiratory Failure, Other Emphysema, Obstructive Chronic Bronchitis, or Chronic respiratory conditions due to fumes/vapors; or patient does not have at least one prescription for an Asthma Controller Medication during the report period.

**Metric #5:** Percentage of children who received appropriate treatment for Upper Respiratory Infection (URI).

- **Numerator:** Patients who were NOT dispensed antibiotic medication on or within 3 (three) days after an outpatient or ED encounter for upper respiratory infection (URI) during the intake period.
- **Denominator:** All children 3 (three) months of age as of the beginning of the measurement year to 18 (eighteen) years as of June 30 of the measurement year who had an ED or outpatient visit with only a diagnosis of nonspecific upper respiratory infection (URI) during the intake period (July 1st of the year prior to the measurement year to June 30th of the measurement year).
- **Target:** At least 80%

*18-month report period

**Exclusions:** event with an antibiotic prescription 30 (thirty) days prior to the episode; event with antibiotic prescription 90 (ninety) days prior to an episode where the days supplied were greater than or equal to the number of days between the fill date and episode start date; exclude competing diagnosis; exclude all events after the first eligible event.
**Metric #6:** Patient(s) 18-75 years of age with a diagnosis of Diabetes that had an annual screening for Nephropathy or evidence of Nephropathy.

- **Numerator:** Patients from denominator who had a urine protein test or who had evidence of nephropathy* during the measurement period.
- **Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.
- **Target:** At least 86%
  *Defined as a diagnosis of ESRD, CKD stage 4, kidney transplant, or nephropathy treatment.*

**Exclusions:** None.

**Metric #7:** The number of patients 18 (eighteen) years and older who met the proportion of days covered threshold of 80% during the measurement year for Diabetes Medication.

- **Numerator:** Patients from the denominator who had diabetes medications in their possession (measured by pharmacy refills) at least 80% of the days in the reporting period.
  
  All patients that are 18 (eighteen) years of age or older as of the end of the measurement year with two or more pharmacy claims at least one day apart for a diabetes medication

- **Denominator:** At least 60%
  
  **Exclusions:** Pharmacy claims for insulin. Patients with diagnosis of ESRD.

**Metric #8:** Percentage of patients with Uncomplicated Low Back Pain that did not have imaging studies.

- **Numerator:** Adults from the denominator that did **not** have an imaging study for low back pain during the episode period (episode start date is 180 (one-hundred-eighty) days prior to an event through 28 (twenty-eight) days after an event)

- **Denominator:** All adults 18-50 years of age with a claim reporting primary diagnosis of low back pain during the measurement year, up to 28 (twenty-eight) days prior to the report period end date. Patients must have continuous medical coverage throughout the measurement year

- **Target:** At least 75%

**Exclusions:** Previous claim with diagnosis of low back pain 180 days prior to the event; imaging study is clinically indicated; diagnosis of Other neoplasms, Malignant Neoplasms, History of Malignant Neoplasm, Trauma, IV Drug Abuse, or Neurological Impairment
Metric # 9: Patient(s) 18 – 64 years of age with a diagnosis of Acute Bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.

Numerator: Patients who were NOT dispensed antibiotic medication on or within 3 (three) days after an outpatient or ED encounter for upper respiratory infection (URI) during the intake period.

Denominator: All adults that are 18 years of age as of the beginning of the year prior to the measurement year (one year prior to report period start date) and 64 years as of the end of the measurement year who had an ED or outpatient visit with only a diagnosis of nonspecific upper respiratory infection (URI) during the measurement year.

Target: At least 80%

*18-month report period

Exclusions:

Event with an antibiotic prescription 30 (thirty) days prior to the episode; event with antibiotic prescription 90 (ninety) days prior to an episode where the days supplied were greater than or equal to the number of days between the fill date and episode start date; exclude competing diagnosis; exclude all events after the first eligible event
Self-reported Metrics:

Quality metrics 10-15 are measures in which clinics will be required to enter a numerator, denominator and attest to the accuracy of data submitted on the PCMH portal on AHIN.

These measures/metric should contain ALL PAYER data and should include your entire patient panel, and report(s) from your EHR. Theses measure are subject to validation and will be audited.

If a measure/metric does not pertain to the population your clinic services, enter a zero for both the nominator and the denominator fields.

**Metric #10:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure &lt; 140 mmHg and diastolic blood pressure &lt; 90 mmHg) during the measurement period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Patients 18-85 years of age who had a diagnosis of essential hypertension within the first 6 (six) months of the measurement period or any time prior to the measurement period.</td>
</tr>
</tbody>
</table>

**Target:** At least 68%  
**CMS eMeasure ID:** CMS165v6  
**NQF#:** 0018

**Metric #11:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c >9% (poor control) during measurement period.

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Patients whose most recent HbA1c level (performed during the measurement period) is &gt;9.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period</td>
</tr>
</tbody>
</table>

**Target:** No more than 30%  
**CMS eMeasure ID:** CMS122v7  
**NQF#:** 0059
### Metric #12: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the past 27 (twenty-seven) months.

**Numerator:** Number of patients from the denominator with one or more mammogram during the measurement period or the 15 months prior to the measurement period

**Denominator:** Women 50-74 years of age with a visit during the measurement period

**Target:** At least 58%

**CMS eMeasure ID:** CMS125v7

**NQF #:** 2372

### Metric #13: Percentage of adults 50-75 years of age who had an appropriate screening for colorectal cancer during the measurement period.

**Numerator:** Number of patients from the denominator with one or more screenings for colorectal cancer. Screening types include: (1) FOBT during the measurement year, (2) Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year, (3) Colonoscopy during the measurement year or the nine years prior to the measurement year (4) FIT-DNA during the measurement period or the two years prior to the measurement period (5) CT Colonography during the measurement period or the four years prior to the measurement period

**Denominator:** Patients 50-75 years of age with a visit during the measurement period

**Target:** At least 50%

**CMS eMeasure ID:** CMS130v7

**NQF #:** 0034

### Metric #14: Percentage of patients, 18-75 years of age with a diagnosis of diabetes who had an eye exam performed.

**Numerator:** Number of patients from the denominator who had a retinal or dilated eye exam by an eye care professional in the measurement year or a negative retinal exam by an eye care professional in the year prior to the measurement year

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period

**Target:** At least 55%

**CMS eMeasure ID:** CMS131v7

**NQF #:** 0055
Metric #15: Percentage of women 21-64 years of age who were screened for cervical cancer using every 5 years.

Numerator: Women from the denominator who were screened for cervical cancer using either of the following: (1) age 21-64 who had cervical cytology performed during the measurement period or two years prior, (2) age 30-64 who had cervical cytology/human papillomavirus co-testing performed during the measurement period or four years prior.

Denominator: Women 23-64 years of age with a visit during the measurement period.

Target: At least 45%  

CMS eMeasure ID: CMS124v7  
NQF#: 0032  

Practices are expected to meet at least 5 (five) metrics. These 5 (five) metrics can be a combination of both self-reported and claims based metrics.

If a metric has 0 (zero) opportunities throughout the 2019 program year, the metric is no longer in the equation. The practice will not be held accountable.
Care Plan Expectations, Attestations, and Auditing

6A. Care Plan Expectations

A care plan is a document established for high-priority patients. Multiple team members, including physicians, non-physician practitioners, and other disciplines, may engage in care management, but each patient at high risk should have a clinically trained individual in the practice accountable for his or her active, ongoing care management that goes beyond office-based clinical diagnosis and treatment. Clinically trained individuals including an MD, DO, PA, NP, RN and LPN. Arkansas Blue Cross and Blue Shield does require a provider signature on each completed care plan.

Arkansas Blue Cross and Blue Shield provides risk scores based on claims-based data for selection of high-priority patients in AHIN but practices are encouraged to use a consistent method to assign and adjust risk status for all empaneled patients and select their high-priority patients using their own internal method.

Care plans must be contained in the patient’s medical record and updated at least twice per year for high-priority patients that were selected in Activity A, by December 31, 2019.

Arkansas Blue Cross Blue Shield will assess care plans for the 5 (five) required components:

- Documentation of the patient’s appropriate problem list
- Assessment of progress to date
- Plan of Care
- Instruction for follow-up
- Patient health concerns, goals, and self-management plans

4B. Care Plan Attestation

Practices are expected to submit attestations on the PCMH Portal for each high-priority patient who 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, 2019.

4C. Auditing, Audit Results and Feedback

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 and Blue Shield. The passing rate for the care plan audit is 80% total score.
We began offering a Fast Track audit for care plans, beginning with the 2018 PCMH program year. The Fast Track audit requires clinics to submit a total of 5 (five) care plans for their audit. To be eligible to participate in the Fast Track audit, the clinic must have passed the previous two years of care plan audits with a score of 80% or higher. Fast-track audits are conducted by Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross and Blue Shield will review submitted care plans during the regular audit within 45 (forty-five) business days after the care plan upload due date. Care plans are scored on a point system. Each of the 5 (five) 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 and Blue Shield 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 (thirty) days after the concern is received.
Quality Assurance

5A. 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 practice individually. 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.

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 located in AHIN regarding updates the practice has made since completing the Readiness Assessment at the beginning of the current program year.

The 6-Month Practice Transformation Activity attestations are due June 30, 2019. The 12-Month Practice Transformation Activity attestations are due December 31, 2019. 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.

Audit Results and Feedback
The Primary Care Team will review the practice documentation for the 6 & 12-Month activities within 30 (thirty) business days from the date the documentation was due for the audit. Audit results will be delivered during a site visit by a Coach 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 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:

- Fails to attest or complete any Practice Transformation Activity.
- Fails to attest to or submit self-reported metric data.
- Fails to meet targets on at least 5 (five) of quality Metrics.
- Fails to meet requirements during an audit.
- 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/program 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 and Blue Shield, a written response may be submitted within 15 (fifteen) days to primarycare@arkbluecross.com. All requests will be considered.

Feedback regarding the requests will be provided no later than 30 (thirty) 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

5D. Provider Performance

Arkansas Blue Cross and Blue Shield and its family of companies provide participating practices with reports containing information about their practice performance on
activities and metrics. Quarterly reports can be downloaded from the PCMH Provider Portal on AHIN. And monthly claims based metrics and utilization status can be checked by both clinic and provider monthly on the AHIN Care Management Portal.
6A. Communication

The Arkansas Blue Cross and Blue Shield Primary Care Team 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 now available for up to 6 (six) contacts). 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.

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 located on both the Arkansas Blue Cross and Blue Shield PCMH Portal and Care Management Portal located on the AHIN system. 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. Care Management Portal

The Care Management Portal (CMP) located on AHIN 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 data concerning the current 2019 PCMH program year such as:

- Quality Reports for Care gaps
- Quality Reports for Metric Status
- Cost of Care Status Report
- Emergency Department Visits status
- Prescription Utilization, and much more.