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

2022 Program Year

This document is a manual to the 2022 Arkansas Blue Cross and Blue Shield Patient-Centered Medical Home program (PCMH). This document does not guarantee clinic participation in the Arkansas Blue Cross and Blue Shield PCMH Program. This document is subject to change without notice.

Contents

Definitions

Advanced Practice Providers: Nurse practitioners, Physician Assistants, Clinical Nurse Specialists working in collaboration with a physician in the same specialty.

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

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

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

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

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

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.

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

Inclusion: Information to specifically include in the measure.

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

Medical Neighborhood: A clinical-community partnership that includes medical and social supports necessary to enhance health, with the PCMH serving as the patient's

primary hub and coordinator of health care delivery (e.g., specialists, hospitals, home health, pharmacists, behavioral health, and other associated services).

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

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

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

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

Pediatrician: Medical provider credentialed with Arkansas Blue Cross and Blue Shield as a Pediatrician that specializes in healthcare for children and adolescents.

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

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

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

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

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

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

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

Five Key Functions of PCMH

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

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

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

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

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

Terms and Conditions: Program Eligibility, Enrollment, Withdrawal and Alignment

1A. Practice/Provider Eligibility

The Arkansas Blue Cross and Blue Shield 2022 PCMH Program is a voluntary program and is open to practices providing primary care to patients who meet the following requirements:

- The practice must include Primary Care Physicians (MD, DO) in the following specialties: Family Medicine, General Practice, Geriatric Medicine, Internal Medicine, or Pediatric Medicine; Primary Care Nurse Practitioners (APRN, APN, NP); Primary Care Physician Assistants (PA); or Primary Care Clinical Nurse Specialists (CNS), enrolled in the following networks: Arkansas Blue Cross and Blue Shield PPP, Health Advantage HMO, Arkansas' First Source PPO, or True Blue PPO.

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

- Practices must complete the 2022 PCMH enrollment application during the designated PCMH enrollment period.

- Practices must have returned contract amendments signed by each primary care provider who provides primary care to patients at the PCMH practice location no later than November 5, 2021.

- Practices must choose to enroll in only one program, either PCMH or PCF. Providers may only be enrolled in the program selected by the practice. Providers that practice at more than one clinic location may only be enrolled in one program, either PCMH or PCF.

    - If the clinic locations are enrolled in different programs, the provider must choose which practice/program in which to participate.
    - If the clinic locations are enrolled in the same program, the provider may participate in the program at both locations if they have a separate panel of patients at each location.

1B. Practice/Provider Enrollment

The enrollment period for the Arkansas Blue Cross and Blue Shield 2022 PCMH program is October 8, 2021 through October 22, 2021, with contracts being completed by November 5, 2021. A representative of the practice must complete the PCMH application. Providers are required to sign Exhibit B in the Provider Participation Agreement Contract. **Original signatures are required.**

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

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

1C. Practice/Provider Withdrawal

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

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

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

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

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

1D. Provider Changes

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

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

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

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

1E. Alignment of PCMH Patients (Patient Panel)

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

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

Payment Model

2A. Eligibility for Care Management Fee Payments

To begin receiving Care Management Fees (CMF) in the 2022 program year, a practice must have submitted a completed PCMH Provider Participation Agreement on or before November 5, 2021.

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

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

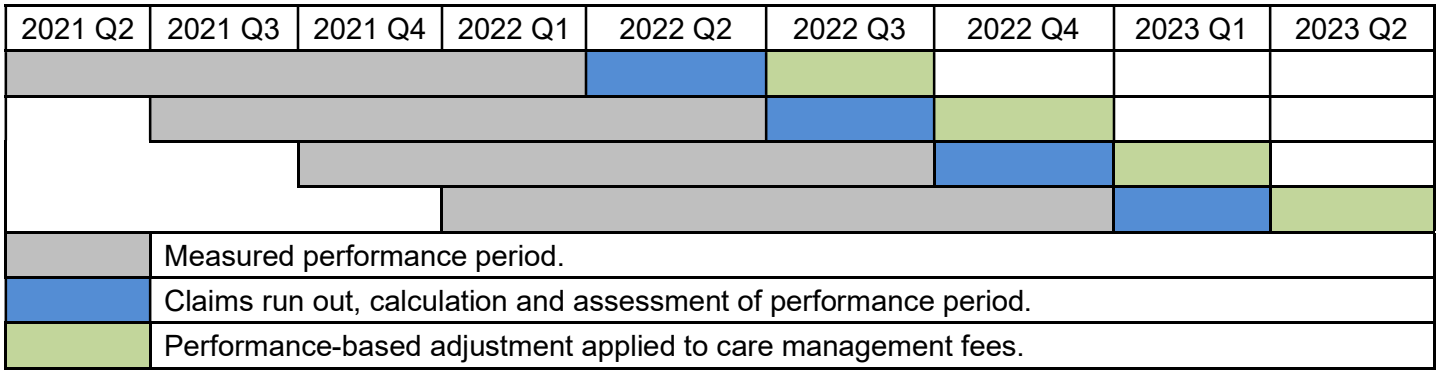
There will be no recoupment of care management fees; however, Arkansas Blue Cross may reduce, suspend, or terminate CMF based on a clinic's performance and cooperation in the program.

2B. Performance Based Adjustment (PBA)

Arkansas Blue Cross will pay performance-based adjustments to practices to encourage and reward performance on certain metrics. The performance-based adjustment payment has two independent components for which practices are eligible to receive payments: utilization performance and clinical quality performance.

Utilization performance will be calculated on a rolling 12-month period each quarter. Utilization performance will result in a positive adjustment to care management fees for the second quarter after the performance period.

Table 1: Performance-Based Adjustment Timeline



Clinical quality will be calculated annually and payments for the program year will be paid in the following year.

2022 PCMH Performance Based Adjustment Table	
Utilization	• ED Utilization • Inpatient Admission • Generic Prescribing Rate
Clinical Quality	8 quality metrics – PCMH General 8 quality metrics – PCMH Pediatrics

The **utilization component** includes three measures: emergency department utilization, inpatient hospital admissions, and generic prescribing rate. Providers may earn each of the utilization components independently of each other. Hospital utilization targets are case-mix adjusted on a per practice basis.

There will be one Generic Prescribing rate for the General track and another for the Pediatric track. Each rate is based on certain drug classes specific to that population.

Performance on the utilization component will be based on submitted claims. The utilization component will be calculated quarterly, with aligned members in the last month of the quarter serving as the reference point for per aligned member per month calculations. Practices with fewer than 250 aligned members may be pooled for utilization measures.

Performance on utilization measures determines the adjustment to the care management fees the second quarter after the performance period. Adjustments will be based on the number of targets met, with the maximum PMPM adjustment for achieving all 3 targets. Practices meeting at least 1 utilization target will receive a positive adjustment.

The **clinical quality component** will be based on 8 quality measures, one set of measures for physicians and advanced practice providers with specialties of Family Medicine, Internal Medicine, Geriatric Medicine, or General Practice, and one set of measures for Pediatricians and advanced practice providers working in collaboration with a pediatrician. Measures for Pediatricians will be specific to children. Providers will earn incentives based on performance. Clinics meeting 7+ metrics will earn the maximum clinical quality incentive. Clinics must meet a minimum of 5 metrics to earn a portion of the clinical quality component of the PBA. Performance on all 8 quality measures will be based on submitted claims, calculated, and paid annually.

Strategies and Metrics

3A. Strategies Overview

2022 Strategies
Enhanced Access & Communication Provide 24/7 Access to clinical advice where a patient can speak to a live voice. Offer same day appointments, extended hours, telemedicine, or weekend appointment availability and timely communication between the practice and the patients and their caregivers.
Childhood/Adult Vaccination Practice Strategy A planned and proactive approach for closing gaps in vaccinations.
Social Determinants of Health Process to screen patients and connect with community resources
Transitions of Care Receiving discharge information and following up with patients within 72 hours or 2 business days
Self-Management Support Systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.
Advance Care Plans Conduct Advance Care Planning with patients to document patients' wishes for treatment and end of life care
Behavioral Health Integration Process to screen and provide for behavioral health needs

Practice procedures and activities can affect hospital utilization, either directly or indirectly. Strategies are described below to help reduce utilization.

Strategy: Enhanced Access & Communication

Providing enhanced access and communication allows more opportunities for a PCMH clinic to meet the needs of their patients. Patients must have access to a live voice 24/7 to receive information and guidance on urgent and emergent care. Ensuring patients have access to their care team will enhance the relationship and increase the likelihood that patients will get the right care at the right time, potentially avoiding costly urgent and emergent care.

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

Strategy: Childhood/Adult Vaccination

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

Strategy: Social Determinants of Health

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

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

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

Strategy: Transitions of Care

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

Strategy: Self-Management Support

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

Strategy: Advance Care Plans

Advance care planning is an ongoing process that offers the patient the opportunity to have a conversation with his or her family members and physician regarding treatment wishes and the choices for care at the end of life. An advance directive consists of oral

and written instructions about a person's future medical care in the event he or she becomes unable to communicate.

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

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

Types of Advance Care Plan documents:

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

Strategy: Behavioral Health Integration

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

3B. Metrics Overview

2022 Claims-Based Quality Metrics – General Track	2022 Targets
1. **HTN Controlling Blood Pressure:** 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.	≥68%
2. **Diabetes HbA1c (Poor controlled):** 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 HbA1C test was not done during the measurement period.	≤28%
3. **Diabetes Rx Adherence:** Percentage of patients 18 years and older who met the proportion of days covered threshold of 80% during the measurement year for Diabetes Medication. *This is a pharmacy measured metric.*	≥65%
4. **Breast CA Screening:** Percentage of female patients 52-74 years of age that had a screening mammogram in the past 27 months.	≥65%
5. **Colorectal CA Screening:** Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.	≥52%
6. **Cervical CA Screening:** Percentage of female patients 21-64 years of age who had appropriate screening for cervical cancer.	≥60%
7. Asthma Controller Adherence: Percentage of patients 5-64 years of age compliant with prescribed asthma controller medication (at least 75% compliance). *This is a pharmacy measured metric*.	≥55%
8. **Antidepressant Medication Management:** Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment). *This is a pharmacy measured metric.*	≥60%

2022 Claims-Based Quality Metrics – Pediatric Track*	2022 Targets
1. **WCV-15 MO. 6 Visits:** Percentage of patients who turned 15 months old during the performance period who receive at least six wellness visits in their first 15 months.	≥75%
2. **WCV 3-6 Years:** Percentage of patients 3-6 years of age who had one or more well-child visits during the measurement year.	≥70%
3. **WCV 12-21 Years:** Percentage of patients 12-21 years of age who had one or more well-care visits during the measurement year.	≥50%
4. Weight Assessment for Children/Adolescents: Percentage of patients 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had a reported BMI.	≥55%
5. **Weight Assessment and Nutritional Counseling for Children/Adolescents**: Percentage of patients 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had nutrition counseling during the report period.	≥50%
6. **Weight Assessment and Physical Activity Counseling for Children/Adolescents**: Percentage of patients 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had physical activity counseling during the report period.	≥50%
7. **Asthma Controller Adherence:** Percentage of patients 5-64 years of age compliant with prescribed asthma controller medication (at least 75% compliance). *This is a pharmacy measured metric*.	≥55%
8. **Pediatric URI:** Percentage of children 3 months-18 years of age who received appropriate treatment for Upper Respiratory Infection (URI). *This is a pharmacy measured metric.*	≥82%

**Providers eligible for the PCMH Pediatrician track include Pediatricians and Advance Practice Providers working in collaboration with a pediatrician.*

Medical Record Submission

4A. Medical Record Submission

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

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

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

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

Quality Assurance

5A. Quality Assurance Policy

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

5B. Care Delivery Assessment

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.

All practices will complete a baseline care delivery report during the Spring of the PCMH program year. Care delivery assessments will be used for the purpose of determining practice transformation status and focusing efforts where needed.

5C. Suspension or Termination

The Primary Care Department reserves the right to suspend or terminate care management fees at any point for failure to complete any program requirements.

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

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

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

Communication

6A. Communication Methods

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

Practice Contact

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

Practice Progress

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

6B. Care Management Portal

The care management portal is available for clinics to manage their patient population. The Arkansas Blue Cross Blue Shield Care Management portal houses data available for the clinic's aligned commercial population.

The Care Management portal 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 care management portal allows practices to manage patients in a variety of ways.

Providers with a specialty in primary care (Family Medicine, Internal Medicine, Geriatric Medicine, General Practice, Pediatric Medicine, or Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) with aligned patients have data available to them in the portal.

Data found in the care management portal includes summary data at the practice level and provider level, as well as patient-level detail data.

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

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