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

2020 Program Year

This document is a manual to the 2020 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 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 Arkansas Blue Cross Blue Shield PCMH Programs.

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

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

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

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.

Care Plans: Arkansas Blue Cross and Blue Shield's PCMH program care plans are documents that include patient health concerns, goals, and self-management plans that are completed during an office visit or a telephone follow up visit.

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

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

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

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

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

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

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

High Priority Patients (HPP): Patients that are considered high risk by the clinic or Arkansas Blue Cross and Blue Shield; patients that require attention soon.

Improvement Plan (IP): 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.

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).

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.

Medi-Pak Advantage: Medi-Pak® Advantage is a Medicare Advantage plan offered by Arkansas Blue Cross and Blue Shield.

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

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

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

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

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

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

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

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

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

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

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

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

Five Key Functions of PCMH

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

2. **Patient-Centered:**

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

3. **Coordinated Care:**

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

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

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

Program Eligibility, Enrollment, Withdrawal and Alignment

1A. Practice/Provider Eligibility

The Arkansas Blue Cross and Blue Shield 2020 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, Medi-Pak Advantage HMO (in limited areas), and Medi-Pak PFFS (in limited areas).

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

- The practice must complete the 2020 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 provider who provides primary care to patients at the PCMH practice location no later than November 30, 2019.

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

1B. Practice/Provider Enrollment

The enrollment period for the Arkansas Blue Cross and Blue Shield 2020 PCMH program is September 1, 2019, through October 31, 2019, with contracts being completed by November 30, 2019. A representative of the practice must complete the PCMH application located on the AHIN PCMH portal. Returning providers are not required to submit signatures. However, providers new to the PCMH program are required to sign Exhibit B in the Provider Participation Agreement Contract. **Original signatures are required.**

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

Providers practicing medicine at an enrolled PCMH clinic can enroll in the PCMH program outside of the open enrollment period. To enroll a provider outside of the open

enrollment period the practice must contact the Primary Care Department by emailing primarycare@arkbluecross.com to initiate the enrollment process. The AHIN 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. Alignment of PCMH Patients (Patient Panel)

Members in participating lines of business will be aligned to a provider based on methodology that will include, but not be limited to, factors such as claims containing specific evaluation and management CPT codes (99201-99499) as well as annual wellness visit CPT codes; 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 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 2020 program year, a practice must have submitted a completed PCMH Provider Participation Agreement on or before November 30, 2019.

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. Risk adjusted CMF do not apply to Federal Employee Program (FEP) and the Blue Card Program. The CMF for these programs are a flat fee. These fees are non-visit based payments to support the staffing and care demands of transforming a clinic into a patient centered medical home.

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 suspend or terminate CMF based on a clinic's performance and cooperation in the program.

2B. Performance Based Incentive Payments (PBIP)

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

Both the commercial and Medi-Pak Advantage PBIP will be made in one-time payments for the program year (January 1, 2020 to December 31, 2020) to be paid in 2021.

Commercial PBIP

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

2020 PCMH Commercial PBIP	
Clinical Quality	5 of 15 metric targets (non-pediatricians) 3 of 5 metric targets (pediatricians)
Utilization	ED Utilization • Inpatient Admission • 30-Day Readmission
Patient Experience	Patient Experience of Care (CAHPS)

The commercial clinical quality component will be based on 15 quality measures. There are five measures that focus on the pediatric population. Providers credentialed with Arkansas Blue Cross as Pediatricians will be required to meet three of the five pediatric measures to earn the clinical quality component of the PBIP. All other provider types in the PCMH program will be required to meet five of the 15 quality measures to earn the clinical quality component of the PBIP. Performance on all 15 quality measures will be based on submitted claims and supplemental data provided by the submission of medical records as part of the medical record requests in the PCMH program.

The utilization component includes three measures: emergency department utilization, hospital admissions, and 30-day hospital readmissions. Providers may earn each of the utilization components independently of each other. Utilization targets are case mix adjusted on a per practice basis. Practices with fewer than 250 aligned members may be pooled for utilization measures. Performance on the utilization component will be based on submitted claims.

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

Medi-Pak Advantage PBIP

The Medi-Pak Advantage performance based incentive payment has three independent components for which practices are eligible to receive payments: clinical quality,

utilization, and patient experience of care. Payments will be calculated on a per member per month basis with aligned members in the month of December serving as the reference point for per member per month calculations.

2020 PCMH Medi-Pak Advantage PBIP	
Clinical Quality	Based on the star rating determined by the aggregate performance on 14 quality measures
Utilization	ED Utilization • Inpatient Admission • 30-Day Readmission
Patient Experience	Patient Experience of Care (CAHPS)

Clinical Quality Star Rating Component

The clinical quality component will be based on 14 quality measures. Performance on all 14 quality measures will be based on submitted claims and supplemental data provided by the submission of medical records as part of the medical record requests in the PCMH program. Performance will be compared to the Star thresholds set by CMS. Providers can earn a percentage of the available incentive dollars for the clinical quality component by meeting specific Star ratings on the aggregate performance on all 14 measures. For example, using the chart below, earning a 3-star rating will earn the provider 50% of the available quality incentive. Earning a 4-star rating will earn the provider 100% of the quality incentive and 150% if the provider earns a 5-star.

MA Quality Metric PBIP Levels	
Star Rating	**PBIP %**
1-Star	0%
2-Star	0%
3-Star	50%
3.5-Star	75%
4-Star	100%
4.5-Star	125%
5-Star	150%

The utilization component includes three measures: emergency department utilization, hospital admissions, and 30-day hospital readmissions. Providers may earn each of the utilization components independently of each other. Utilization targets will be based on the prior year's performance for the MA population. Performance on the utilization component will be based on submitted claims.

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

Activities and Metrics

3A. Activity Overview

2020 Activities	Due Dates
Quarter 1: Program Preparation Any clinic new to the Arkansas Blue Cross PCMH Program must complete the 2020 Readiness Assessment.	2/15/2020
A. Identify/Update high-priority patients for 2020 Identify/Update top 10% of high-priority patients for 2020 between 04/01/2020 and 4/30/2020.	4/30/2020
B. Provide 24/7 access to care Provide 24/7 Access to clinical advice where a patient can speak to a live voice.	6/30/2020
C. Enhanced Access & Communication Offering same day appointments, extended hours, or weekend appointment availability and having timely communication between the practice and the patients and their care givers.	6/30/2020
D. Childhood/Adult Vaccination Practice Strategy A planned and proactive approach for closing gaps in vaccinations.	6/30/2020
E. Medication Management Using a strategy for medication management and use of the Arkansas Prescription Monitoring (PMP) program.	6/30/2020
F. Health Literacy Assessment Tool Assessment of patients' health literacy.	12/31/2020
G. Care Instructions for HPPs Providing an after visit summary of information, from the last visit, to high priority patients.	12/31/2020
H. Transitions of Care Receiving discharge information and following up with patients within 72 hours or 2 business days.	12/31/2020
I. Care Management Identify patients in need of care management, in addition to high priority patients.	12/31/2020
J. Ability to receive patient feedback Having a process to receive anonymous feedback from patients.	12/31/2020

Readiness Assessment
During the first quarter of the 2020 PCMH Program year, practices new to the PCMH program are required to complete and attest to a Practice Readiness Assessment which serves as a program preparedness check-in.

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

Activity A: Identify/Update High-Priority Patients for 2020

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

- Patient panel data, provided by Arkansas Blue Cross and Blue Shield, that ranks patients by risk.
- 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.

Selection of High-Priority Patients for 2020 starts April 1, 2020 and must be completed by April 30, 2020 on the AHIN PCMH provider portal.

If clinics 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 for the clinic based on the clinic's aligned patient's risk score.

6-Month Activities

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

Activity B: Provide 24/7 Access to Care

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

Minimum Expectations:

- Urgent/emergent clinical advice, with a live voice, during and after work hours
- Education on this service to patients

- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

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

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

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

Activity C: Enhanced Access & Communication

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

Minimum Expectations:

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

Continuous Improvement (may include, not limited to):

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

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

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

Activity D: Childhood/Adult Vaccination Practice Strategy

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

Minimum Expectations:

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

Continuous Improvement (may include, not limited to):

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

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

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

Activity E: Medication Management

Most chronic and acute conditions are treated with medications, and it is common 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. Medication reconciliation is the update of active medications and should be documented in the EHR.

Minimum Expectations:

- Implement a medication reconciliation protocol

- Strategy to monitor if providers check the PMP system before prescribing a controlled substance to a patient
- Maintain a 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):

- Maintain a policy that outlines medication reconciliation process and medication refill protocol
- Workflow or policy with pharmacist
- Maintain a policy on how patients are identified for medication management

12-Month Activities

Twelve-month activities should be viewed and completed on the AHIN PCMH Portal throughout the program year.

Activity F: Patient Literacy Assessment Tool

Health literacy is the ability to obtain, read, understand, and use health care information to make appropriate health decisions, and follow instructions for treatment. By completing a health literacy assessment, the care team is able to determine the patient's ability to comprehend and communicate in the context of their health care.

Minimum Expectations:

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

Continuous Improvement (may include, not limited to):

- Having the results of the assessment reportable from the EHR
- Evaluate the overall results of the assessment
- Develop/adopt education materials

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

- A policy to administer the assessment
- Example(s) of completed assessments
- Example(s) of education materials

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

Care Instructions for HPPs help patients stay engaged in their care by providing care instructions after visits. Having care instructions help hold patients accountable for self-management in between visits.

These instructions may include, but are not limited to, the following:

- 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

Minimum Expectations:

- Maintain a policy and procedure for meeting activity expectations
- Provide an after visit summary of information to high priority patients
- Results available within three days of the visit

Continuous Improvement (may include, not limited to):

- Provide patient education/self-management materials to HPPs
- Include additional information in the care instructions:
    - Upcoming visits with the care team and/or specialist
    - Labs/test results
    - Self-management reminders

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

- A policy for providing care instructions

- Example(s) of care instructions provided

Activity H: Transitions of Care

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

Minimum Expectations:

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

Continuous Improvement (may include, not limited to):

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

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

- A policy for care team members to follow patients after a discharge
- Example(s) of documented transitions of care
- Example(s) of transitions of care flagged/notification to the provider

Activity I: Care Management

Care Management improves health and reduces utilization, harm, and waste. Targeted care management services can decrease adverse outcomes.

Care Management focuses on patients identified by the practice's risk stratification methodology to be high risk or with rapidly rising risk (e.g., those that are clinically unstable, in transition, and/or are high utilizers of services) and likely to benefit from active, ongoing, longitudinal care.

Practices should focus on a cohort of patients with complex medical and behavioral health conditions, sometimes complicated by social and economic factors, that may benefit from intensive, ongoing, relationship based (longitudinal) care management.

Minimum Expectations:

- Identify patients who are in need of episodic and longitudinal care management
- Provide care management services to patients identified in need of episodic and longitudinal care management
- Create care plans on at least 80% of high priority patients
- Maintain a policy and procedure for meeting activity expectations

Continuous Improvement (may include, not limited to):

- Implement a method to risk stratify your patient population and identify the risk score of each patient in the EHR.
- Define members of the care team and their roles in care management that allows the team to work to the top of their skillset
- Develop a patient friendly care plan that patients can take home

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

- Policy or procedure for care management
- Examples of care management service education materials/tools/rosters
- Care plans must include the required component of patient health concerns, goals, and self-management plans

Activity J: Ability to Receive Patient Feedback

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

Anonymous feedback allows your practice to study patterns and trends by providing insights of individual experiences. Patient feedback discovers if a problem is occurring more or less frequently over time and allows changes to be made to make sure problems do not continue.

Minimum Expectations:

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

Continuous Improvement (may include, not limited to):

- Develop a patient-family advisory council (PFAC)

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

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

3B. Metric Overview

Arkansas Blue Cross and Blue Shield and its family of companies assess participating practices on quality metrics to assess the quality of care practices provide to their patients, our members. The metrics are tracked beginning January 1, 2020 (first day of the current program year) continuing through the full calendar year, ending on December 31, 2020 (last day of the current program year).

Practices will be held responsible for performance on 15 quality metrics for their commercial population and 14 measures for their Medi-Pak Advantage population. Certain metrics overlap between the two populations. Performance on the quality metrics will be based on the claims submitted by the participating practices. Additionally, data received via the submission of medical records as part of the medical record requests in the PCMH program will be utilized by Arkansas Blue Cross to close care gaps and positively impact clinic performance on the quality metrics.

Practices can monitor their performance and view the metric specifications on the AHIN Care Management portals.

2020 Commercial Claims Based Quality Metrics	2020 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.	≥52%
4. **Asthma Controller Adherence*:** Percentage of patients who are compliant with prescribed asthma controller medication (at least 75% compliance). *This is a pharmacy measured metric.*	≥50%
5. **Pediatric URI*:** Percentage of children who received appropriate treatment for Upper Respiratory Infection (URI).	≥80%
6. **Diabetes Nephropathy Test:** Patient(s) 18 - 75 years of age with a diagnosis of Diabetes that had an annual screening for nephropathy or evidence of nephropathy.	≥82%
7. **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.*	≥60%
8. **Low Back Imaging:** Percentage of patients with uncomplicated low back pain that did not have imaging studies.	≥75%
9. **Adult Bronchitis – Antibiotics:** Percentage of patients 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.	≥55%
10. **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%
11. **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 an HbA1C test was not done during the measurement period.	≤28%
12. **Breast CA Screening**: Percentage of female patients 52-74 years of age that had a screening mammogram in the past 27 months.	≥50%
13. **Colorectal CA Screening:** Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.	≥55%
14. **Diabetes Retinopathy Test:** Percentage of patients 18-75 years of age with a diagnosis of diabetes who had an eye exam performed.	≥55%
15. **Cervical CA Screening:** Percentage of female patients 21-64 years of age who had appropriate screening for cervical cancer.	≥60%

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

	2020 Medi-Pak Advantage Claims Based Quality Metrics	Measure Weight*
1.	**Breast CA Screening:** Percentage of female patients age 52-74 who had a mammogram to screen for breast cancer any time on or between Oct. 1st two years prior to the measurement year and Dec. 31st of the measurement year.	4.5%
2.	**Colorectal CA Screening:** Percentage of members age 51 -75 who had appropriate screening for colorectal cancer.	4.5%
3.	**Diabetes Retinopathy Test:** The percentage of members age 18-75 with diabetes who have had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.	4.5%
4.	**Diabetes Nephropathy Test:** The percentage of members age 18-75 with diabetes who have had one of the following: • At least one screen for macro/microalbuminuria in measurement year • Received medical treating for nephropathy in measurement year • Had a visit with a nephrologist in measurement year • At least one dispensing event of ACE/ARB medication in measurement year • Evidence of Stage 4 CKD, ESRD, or kidney transplant	4.5%
5.	**Diabetes HbA1c (Well Controlled):** The percentage of members ages 18-75 with diabetes and a documented HbA1c ≤ 9% using the latest lab conducted in the measurement year.	13.6%
6.	**HTN Controlling Blood Pressure:** The percentage of members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year. • Members age 60-85 years of age with a diagnosis of diabetes whose BP was less than 140/90 mm Hg • Members age 60-85 years of age without a diagnosis whose BP was less than 150/90 mm Hg	4.5%
7.	**Statin Therapy for Patients with Cardiovascular Disease:** The percentage of male members ages 21-75 years and females ages 40-75 years who: • Were dispensed at least one moderate-to-high-intensity statin medication in the measurement year. • Remained on a moderate-to-high-intensity statin medication	4.5%
8.	**Medication Reconciliation Post-Discharge:** Patients 18 and older in the measurement year with Medicare coverage whose medications were reconciled on the date of discharge through 30 days after discharge (a total of 31 days).	4.5%
9.	**Statin Therapy for Patients with Diabetes:** Patients ages 40-75 years in the measurement year who were dispensed at least two diabetes medication refills and who received a statin medication fill in the current measurement year.	4.5%
10. 11. 12.	**Proportion of Days Covered (Adherence):** Renin-angiotensin system (RAS), Diabetes All Class, and Statins: The percentage of members ages 18 and older who met the proportion of days covered (PDC) of at least 80% during the measurement year. *This is a Pharmacy measured metric.*	13.6% 13.6% 13.6%

13.	**Osteoporosis Management in Women with Fracture:** The percentage of women ages 67-85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	4.5%
14.	**Rheumatoid Arthritis:** The percentage of members 18 years of age as of December 31st of the measurement year, who were diagnosed with Rheumatoid Arthritis and who were dispensed at least one DMARD during the measurement year.	4.5%

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

2020 Medi-Pak Advantage Quality Component Star Scale						
Medi-Pak Claims Based Metric	**1 Star**	**2 Star**	**3 Star**	**4 Star**	**5 Star**	**Measure Weight**
Breast CA Screening	< 47%	≥ 47% - < 68%	≥ 68%- < 76%	≥ 76% - < 82%	≥ 82%	4.5%
Colorectal CA Screening	< 55%	≥ 55% - < 63%	≥ 63%- < 72%	≥ 72% - < 79%	≥ 79%	4.5%
Diabetes Retinopathy Test	< 56%	≥ 56% - < 64%	≥ 64%- < 73%	≥ 73% - < 80%	≥ 80%	4.5%
Diabetes Nephropathy Test	< 80%	≥ 80% - < 87%	≥ 87%- < 95%	≥ 95% - < 97%	≥ 97%	4.5%
Diabetes HbA1c (Well Controlled)	< 39%	≥ 39% - < 68%	≥ 68% - < 78%	≥ 78% - < 87%	≥ 87%	13.6%
HTN Controlling Blood Pressure	< 51%	≥ 51% - < 62%	≥ 62% - < 75%	≥ 75% - < 82%	≥ 82%	4.5%
Statin Therapy for Patients with Cardiovascular Disease	< 70%	≥ 70% - < 76%	≥ 76% - < 81%	≥ 81% - < 85%	≥ 85%	4.5%
Medication Reconciliation Post Discharge	< 37%	≥ 37% - < 54%	≥ 54% - < 66%	≥ 66% - < 79%	≥ 79%	4.5%
Statin Therapy for Patients with Diabetes	< 72%	≥ 72% - < 76%	≥ 76% - < 80%	≥ 80% - < 83%	≥ 83%	4.5%
Proportion of Days Covered: Diabetes All Class	< 72%	≥ 72% - < 78%	≥ 78% - < 81%	≥ 81% - < 85%	≥ 85%	13.6%
Proportion of Days Covered: (RAS)	< 79%	≥ 79% - < 83%	≥ 83% - < 86%	≥ 86% - < 88%	≥ 88%	13.6%
Proportion of Days Covered: Statins	< 73%	≥ 73% - < 77%	≥ 77% - < 83%	≥ 83% - < 87%	≥ 87%	13.6%
Osteoporosis Management In Women Who Had a Fracture	< 29%	≥ 29% - < 45%	≥ 45% - < 57%	≥ 57% - < 78%	≥ 78%	4.5%
Rheumatoid Arthritis Management	<69%	≥ 69% - < 76%	≥ 76% - < 83%	≥ 83% - < 89%	≥ 89%	4.5%

**Highlighted blue sections represent Star percentages with positive clinical quality PBIP earnings if the aggregate performance is at least a 3 Star.*

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 Medi-Pak Advantage, Federal Employee Program (FEP), and Exchange members. Multiple medical record requests will be conducted by Arkansas Blue Cross Blue Shield and our contracted vendors throughout the year on specific members within these populations.

Care management fees have been increased due to the administrative burden of these medical record requests. Practices are responsible for returning at least 85% of the requested records by the due date. If a practice fails to meet the 85% target of returned records by the due date of each medical record audit, the practice's care management fees will be suspended for a minimum of 30 days. The practice must return the remaining records to meet the 85% target for the care management fees to be reinstated. Each medical record request audit is independent of each other, so practices must meet the 85% 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.

Care Plan Expectations, Attestations, and Auditing

5A. Care Plan Expectations

A care plan is a document established for high-priority patients. 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 Plan Requirements

Two care plans are required for at least 80% of the high priority patients per program year. The care plan must be completed by a clinically trained team member (MD, DO,

PA, NP, CNS, RN or LPN) and be signed by the provider (MD, DO, PA, NP, CNS). The care plan must include the following component:

- Document patient health concerns, goals, and/or self-management plans.

5B. Care Plan Attestation

Practices are expected to submit attestations on the PCMH portal for each high-priority patient. It is recommended that the attestations are done periodically throughout the year to avoid last minute attestations. Attestations must be completed by December 31, 2020.

5C. Auditing and Feedback

All care plan attestations are subject to an audit. If a patient is selected for the audit, the practice must submit 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 an 80% total score of all audited care plans.

Clinics have the opportunity to participate in the Fast Track 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. The Fast Track audit requires clinics to submit a total of 5 (five) care plans or 20%, whichever is less, for their audit.

Arkansas Blue Cross and Blue Shield will review submitted care plans during the regular audit within 45 business days after the care plan upload due date.
Care plans are scored on a pass/fail scoring method. Care plans must meet the requirements as described in section 5A to pass the audit.

Practices may call or email the Primary Care Department 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 days after the concern is received.

Quality Assurance

6A. 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.

6B. 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.

The 6-Month Practice Transformation Activity attestations are due June 30, 2020. The 12-Month Practice Transformation Activity attestations are due December 31, 2020. An audit will follow both the 6-month and 12-Month Activity attestations.

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

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

1. Answer all questions for each activity on the AHIN PCMH portal. If you select “other” for any questions in any activity, you must give a detailed explanation of that information.
2. Attest for each activity on the AHIN PCMH portal. Each activity requires an Attestation before completion and submitting. Failure to attest to the activity means failure and non-passing of activity.
3. Validation of each activity. Supporting documentation is required for each activity for validation of practice’s response to the activity. Supporting documentation can

include one of the following using the **R.E.P** method. (**R**=Report, **E**=Example/Screenshot, **P**=Policy)

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

Audit Results and Feedback

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

6C. 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 meet requirements during a transformation activity audit.
- Fails to meet care plan requirements.
- Fails to meet any deadline.

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

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

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

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

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

AHIN

7A. Communication

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 on AHIN.

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 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 Department.

7B. Care Management Portals

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

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

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

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

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

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

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