Arkansas
BlueCross BlueShield
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Primary Care First

(PCF)

Program Manual

2021 Program Year

This document is a manual to the 2021 Arkansas Blue Cross and Blue Shield Primary Care First program (PCF) outlining Terms and Conditions of participation. This document does not guarantee clinic participation in the Arkansas Blue Cross PCF Program. This document is subject to change without notice.

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Definitions

Aligned Members: The Arkansas Blue Cross and Blue Shield members for whom primary care providers and participating practices have accountability under the PCF 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 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.

Primary Care First (PCF): A national advanced alternative payment 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 included; 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 their Arkansas Blue Cross and Blue Shield Primary Care Primary Care Representative after receiving notice of 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 primary care clinic 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 physician practice that is enrolled in the PCF 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.

Primary Care Provider: A Physician, Primary Care Nurse Practitioner, Primary Care Physician Assistant, or Primary Care Clinical Nurse Specialist with a specialty in Family Medicine, Internal Medicine, Geriatric Medicine, General Practice, or Pediatric Medicine who provide definitive care to the patient at point of the first contact and takes continuing responsibility for ensuring the patients 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.

Introduction

Primary Care First aims to improve quality, improve patient experience of care, and reduce expenditures. The model will achieve these aims by increasing patient access to advanced primary care services, and has elements specifically designed to support practices caring for patients with complex chronic needs or serious illness. The specific approaches to care delivery will be determined by practice priorities. Practices will be incentivized to deliver patient-centered care that reduces avoidable hospital utilization.

Primary Care First reflects a regionally-based, multi-payer approach to care delivery and payment. Primary Care First fosters practitioner independence by increasing flexibility for primary care, providing participating practitioners with the freedom to innovate their care delivery approach based on their unique patient population and resources. Primary Care First rewards participants with additional revenue for taking on limited risk based on easily understood, actionable outcomes.

Primary Care First provides the tools and incentives for practices to provide comprehensive and continuous care, with a goal of reducing patients' complications and overutilization of higher cost settings, leading to higher quality of care and reduced spending.

Primary Care First is oriented around comprehensive primary care functions:

1. **Access and Continuity**
   Because health care needs and emergencies are not restricted to office operating hours, primary care practices optimize continuity and timely, 24/7 access to care guided by the medical record. Practices track continuity of care by provider or panel.

2. **Care Management**
   Participating primary care practices proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review.

3. **Comprehensiveness and Coordination**
   Comprehensiveness refers to meeting patients' medical, behavioral, and health-related social needs in pursuit of each patient's health goals. The practice will act as the hub of care for patients, playing a central role in helping patients and caregivers navigate and coordinate care. Coordinated care is associated with verall lower utilization and costs, less fragmented care, and better health outcomes.

4. **Patient and Caregiver Engagement**
   Primary care practices engage patients and their families in decision-making in all aspects of care, including improvements in the system of care. Practices integrate culturally competent self-management support and the use of decision aids for preferred sensitive conditions into usual care.

5. **Planned Care and Population Health**
   The practice will organize the care delivery to meet the needs of the entire population of patients served by the practice. Using team-based care, the practice will proactively offer timely and appropriate preventive care, and consistent evidence-based management of chronic conditions. Practices will improve population health through use of evidence-based protocols in team-based care, through identification of care gaps at the population level, and through measuring and acting on the quality of care at both the practice and panel levels.

Program Terms and Conditions: Eligibility, Enrollment, and Withdrawal

1A. Practice/Provider Eligibility

The Arkansas Blue Cross and Blue Shield PCF Program eligibility requirements include the following:

1. The practice must be approved by CMS to participate in the PCF program. CMS will notify Arkansas Blue Cross once the practice has been approved for participation.
2. The provider type must meet the CMS primary care practitioner definition: Primary Care Physicians (MD, DO); Nurse Practitioner (APRN, APN, NP); Physician Assistant (PA); or Clinical Nurse Specialist (CNS), who have a specialty designation (family medicine, internal medicine, general medicine, or geriatric medicine).
3. The practice must use 2015 Edition Certified Electronic Health Record Technology (CEHRT).
4. The provider must not be participating in the Arkansas Blue Cross PCMH, CPC+, or other value-based program or agreement for the same panel of patients.

   *Note: Enrollment in the PCF program is voluntary.

1B. Practice/Provider Enrollment

Provider enrollment for Arkansas Blue Cross PCF requires:

1. Approval from CMS for PCF participation.
2. Complete Arkansas Blue Cross PCF enrollment application.
3. Return contracts with original signatures to the Primary Care Department.

1C. Practice/Provider Changes

Adding or Withdrawing a Provider or Practice:

1. A participating practice must notify Arkansas Blue Cross of any provider changes. When submitting changes, remember to include the provider name and NPI number.
2. To add a provider to a practice currently enrolled in the Arkansas Blue Cross PCF program:
    a. E-mail the Primary Care Department at primarycare@arkbluecross.com.
    b. Once Primary Care is notified and verifies the provider's participation with CMS, the practice will receive instructions on how to add the provider by email or via 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.
3. To withdraw a provider from the Arkansas Blue Cross PCF program:
    a. Contact the Primary Care Department at Arkansas Blue Cross at primarycare@arkbluecross.com.
4. To withdraw a clinic from the Arkansas Blue Cross PCF program:
    a. Clinics may terminate the PCF agreement by February 28 of any performance year and must provide written notice 15 days prior to the expected termination date to primarycare@arkbluecross.com or by mail:

        Arkansas Blue Cross Blue Shield
        Primary Care
        P O Box 2181
        Little Rock, AR 72203

    b. Withdrawing from the PCF program will not impact clinic/physician participation in any other existing contract(s) or program with Arkansas Blue Cross and its family of companies.
    c. Questions regarding the termination process should be directed to the Arkansas Blue Cross Primary Care Department by calling 501-378-2370 or emailing primarycare@arkbluecross.com.

1D. Alignment of 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 PCF program. If a self-insured employer chooses to participate in PCF, their members will be aligned to a PCP as mentioned in this section. If a self-insured employer chooses not to participate in PCF, their members will not be aligned to a PCP for the purpose of the PCF program.

Payment Model

2A. Payment Model Overview

There are four main components to the Primary Care First payment model which are summarized below and explained in greater detail in the following subsections.

- **Care Management Fees**: Participating practices will receive per member per month (PMPM) payments to support practice redesign and care management efforts.
- **Professional Population-Based Payments**: Practices will also receive monthly professional population-based payments to care for patients in innovative ways and provide steady monthly income, regardless of in-office patient visits.
- **Evaluation and Management Services**: Patient office visits will continue to be paid, with certain Evaluation and Management services paid at a discounted rate.
- **Performance-Based Adjustment**:
    - **Utilization Performance Adjustment**: Practices meeting utilization targets will be rewarded with positive adjustments to care management fees. Practices who fail to meet at least one utilization metric will receive a negative adjustment to care management fees. Utilization performance is measured and adjusted on a quarterly basis.
    - **Quality and Patient Experience Adjustment:** Practices that qualify will also receive a performance-based adjustment for meeting quality and patient experience measures. Quality and patient experience adjustments are applied on an annual basis.

2B. Eligibility for Care Management Fees

To align with CMS, Arkansas Blue Cross will pay a risk-adjusted care management fee (CMF) on members who are aligned to providers in participating clinics. The care management fees are calculated per aligned member per month and paid monthly. These fees are non-visit-based payments to support the staffing and care demands of providing care coordination and care management.

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. Risk scores are adjusted monthly, looking back at 12 months of data.

There will be no recoupment of CMFs; however, Arkansas Blue Cross may reduce, suspend or terminate CMFs based on a clinic's performance and cooperation.

2C. Professional Population-Based Payment

Arkansas Blue Cross will pay a risk-adjusted monthly professional population-based payment (partial capitation) for members who are aligned to providers in participating clinics. The population-based payments are calculated per aligned member per month and paid monthly, regardless of face-to-face visits. Professional population-based payments are for services inside or outside the office, with the goals to improve access to care and transition from fee-for-service to population-based payments. Practices will receive professional population-based payments for all aligned members on a monthly basis, even if they did not see the patient.

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 professional population-based payment with payment increasing at each level of increased patient risk. For example, the highest-risk tier is associated with the highest population based 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. Risk scores are adjusted monthly, looking back at 12 months of data.

The professional population-based payment is a shift from regular fee-for-service to an alternative payment arrangement. In addition to receiving the monthly professional population-based payment, Evaluation and Management (E&M) services will be billed as appropriate, and practices will receive reduced fee-for-service payments for specific E&M codes:

Chronic Care Management	99487; 99489-99491; G0506
Office E&M	99201-99205; 99211-99215
Prolonged E&M	99354-99355; 99358
Home Care	99324-99328; 99334-99337; 99339-99345; 99347-99350
Wellness	99381-99387; 99391-99397
Transitional Care Management	99495, 99496
Advanced Care Planning	99497, 99498

2D. Performance-Based Adjustments

Arkansas Blue Cross will pay a performance-based adjustment (PBA) to practices in order to encourage and reward performance.

Utilization performance will be calculated on a rolling 12-month period each quarter. Utilization performance will result in a positive or negative adjustment to care management fees for the second quarter after the performance period. There is potential negative adjustment (downside risk) associated with utilization performance.

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

Table 1: Performance-Based Adjustment Timeline

	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2
Q1						
Q2						
Q3						
Q4						
	= Last quarter of 12-month performance period.					
	= Calculation and assessment of performance period.					
	= Performance-based adjustment applied to care management fees.					

The performance-based adjustment payment has three independent components for which practices are eligible to receive payments: utilization, clinical quality, and patient experience of care.

2021 PCF Performance-Based Adjustment Table	
Utilization	ED Utilization • Inpatient Admission • 30-Day Readmission
Clinical Quality	8 quality metrics
Patient Experience	Patient Experience of Care Survey

The **utilization component** includes three measures: emergency department utilization, inpatient 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 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.

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 must meet at least 1 utilization target to receive a positive adjustment. Practices who fail to meet at least one of the utilization metrics will have a negative utilization adjustment (downside risk).

The **clinical quality component** will be based on 8 quality measures. 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.

The **patient experience of care component** will be based on a 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 PBA. Payment for patient experience of care component will be on an annual basis.

Activities and Metrics

3A. Activity Overview

Arkansas Blue Cross will accept activity data entered in the CMS PCF Connect portal. The PCF practice shall follow the CMS reporting requirements.

Arkansas Blue Cross and its family of companies may add, remove, or adjust practice activities or deadlines based on new research, empirical evidence or experience from initial metrics. Arkansas Blue Cross and its family of companies will publish such extension, addition, removal or adjustment in the PCF program manual.

3B. Metric Overview

Arkansas Blue Cross and Blue Shield and its family of companies assess participating practices on quality metrics to evaluate the quality of care practices provide to their patients, our members. The metrics are tracked beginning January 1, 2021 (first day of the current program year) continuing through the full calendar year, ending on December 31, 2021 (last day of the current program year).

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

2021 Commercial Claims-Based Quality Metrics	Targets
1. **Breast Cancer Screening**: Percentage of female patients 50-74 years of age that had a screening mammogram in the past 27 months.	≥60%
2. **Colorectal Cancer Screening:** Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.	≥50%
3. **Cervical Cancer Screening:** Percentage of female patients 21-64 years of age who had appropriate screening for cervical cancer.	≥65%
4. **Diabetes Retinopathy Test:** Percentage of patients 18-75 years of age with a diagnosis of diabetes who had an eye exam performed.	≥50%
5. **Diabetes Nephropathy Test:** Percentage of patients 18 - 75 years of age with a diagnosis of diabetes that had an annual screening for nephropathy or evidence of nephropathy.	≥85%
6. **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%
7. **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%
8. **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%

Quality Assurance

4A. Quality Assurance Policy

The Arkansas Blue Cross and Blue Shield PCF program is structured to facilitate change by providing care management 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.

4B. Improvement Plan Process

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

Failure to complete an improvement plan may result in suspension of care management fees or suspension from the PCF program. If suspended from the PCF 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.

The Primary Care team reserves the right to reduce, 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, 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 (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 their findings.
- Provide documentation to support your request.

Communication

5A. Communication Methods

A 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 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 with aligned patients have data available to them in the portals.

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

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 care management portal is updated monthly using claims from a rolling 12-month look back period. Practices can view data concerning the current 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.