Blue Cross and Blue Shield of Kansas City

Medical Home Provider Manual

Effective 1 January 2017

Kansas City

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The purpose of this document is to articulate Blue Cross and Blue Shield of Kansas City's (Blue KC) philosophy, principles and program guidelines related to its Medical Home program. The Blue KC Medical Home program is a delivery model designed to improve specific aspects of the healthcare delivery system. The Primary Care Physicians (PCP) engaged in this delivery model will play a key role in the performance of the delivery system, and it is the intent of Blue KC to support these PCPs to that end. This manual is specific to the Blue KC Medical Home Program and its Medical Home Participating Entities. It is not intended to supplant any other provisions related to any other Blue KC program.

GUIDING PRINCIPLES

Blue KC has designed compensation methodologies that reward physicians for managing the care of their patients by giving attention to the appropriate use of resources, quality and patient experience. We provide Medical Home participating physicians with information to assist them in caring for our members and are available as a resource to assist them with analytics and problem-solving resources.

With our support, we believe that the primary care physician acting as the hub of the healthcare delivery system can coordinate the care of his or her patients in a way that improves quality, continuity, access and satisfaction as well as lowers the total cost of care. We will assist Medical Home participating physicians in providing information to our members to engage them as knowledgeable partners in the managing their health.

We believe that embracing these principles will guide us to an improved and transformed healthcare delivery system that will provide tangible benefits to us and our constituents. To our members, this new system will provide improved access to their physician and an increased ability to partner with their doctor to manage their own health. To our physician partners, the system will support evidence-based medicine with enhanced reimbursement opportunities, as well as access to expanded data and technology. To our employer clients, the system will provide higher quality, accessible care to their employees at a lower cost, and at a cost trend that is manageable over time.

OVERVIEW

This document describes the Medical Home program for 2017, along with presentation of its basic tenets. In 2017, there are changes to the way risk is measured and paid for, as well as the way performance is recognized and rewarded. As in 2016, a base payment, Care Coordination Fee (CCF) will be made for your population based on their clinical risk. In 2017, we will include in the base payment a consideration for the development of your infrastructure, in similar fashion to the Comprehensive Primary Care Plus Program of the

Centers for Medicare and Medicaid Innovation (CMMI). Additionally, there will be a change from the 3M/Treo Clinical Risk Grouping (CRG) methodology for clinical risk assessment, to the Milliman and Robertson (MARA) methodology. As in 2016, the base payment will be multiplied by a factor related to your performance. In the 2017 program, rather than using a grid, each factor will be weighted individually. This change will provide a mechanism to recognize incremental improvement with increased reward. General descriptions follow with specifics in the Attachments.

ELIGIBILITY AND PARTICIPATION

Participation in the Blue KC Medical Home Program is open to PCPs in practices that have met the minimum standards of the Blue Cross and Blue Shield of Kansas City Developmental Review Program (Attachment III). Primary care physicians are defined as Blue KC credentialed physicians practicing in the specialties of Family Medicine, Internal Medicine, Geriatrics or Pediatrics. Participating physicians must maintain patient records on an electronic medical record system, must meet quality and accessibility standards as defined herein, and must maintain ongoing communication with the Blue KC Medical Home Program leadership and staff. Issues related to changes of practice ownership and/or the relocation of a practice must be communicated to Blue KC in a timely manner and will be adjudicated on a case by case basis by the Blue KC Medical Home leadership.

APPLICATION

Application for inclusion of new entities in the Blue KC Medical Home Program may be made by contacting program staff:

Blue KC Medical Home Program
Department of Health Innovation
Attn: Ana Jensen, Ph.D.
Blue Cross and Blue Shield of Kansas City
P.O. Box 419169
Kansas City, MO 64141
Ana.Jensen@BlueKC.com

Upon receipt of an expression of interest, an initial teleconference will be scheduled to orient the applicant to program requirements. Subsequently, a Developmental Review Program screening will be scheduled to assess the readiness of the practice for program inclusion and provide a basis for ongoing development. The screening will be completed within 60 days of the initial teleconference, and a final determination will be made within the following 30 days. Upon admission to the Medical Home program, the practice will begin the Provider On-Boarding process as defined below.

Medical Home entities adding new physicians to their Medical Homes must notify the Blue KC Medical Home program. Payment for members attributed to new physicians will not be made until notification is received and no retroactive payments will be administered.

PROVIDER ON-BOARDING

The purpose of the Provider On-Boarding process is to prepare the practice to function successfully as a Blue KC Medical Home Program provider. This involves training on the use of Blue KC analytical systems and internal resources. While this process begins after acceptance into the Medical Home program, it is ongoing as systems, approaches and standards are modified over time.

Data

The primary data sources for the Medical Home program includes a claims-based analytical tool, patient experience surveys and clinical information provided through the claims process as well as direct clinical data exchange through appropriately secured electronic channels. The process for submitting and adjudicating claims will be unmodified for the Medical Home program. Claims-related support systems and processes also will not change.

Attribution

The identification of patients assigned to a specific Medical Home PCP, referred to as the "Attribution Process," is a critical component of the Medical Home program and foundational to all data analytics and performance measures. This process first considers the primary care provider who has had the most billed Evaluation and Management codes over the last 12 months. Should there be no utilization in that period; the period is expanded to the last 24 months. Patients with no utilization in the past 24 months are not attributed. In the case that there is equal utilization between two primary care providers, the patient will be attributed to the provider with the most recent utilization. Services provided in an urgent care context will not be included in the attribution decision.

At this time, patients in the following Blue KC networks will not be Attributed Members: Freedom Network, Freedom Network Select, Preferred Health Professionals and patients who have primary coverage with another carrier (including Medicare).

Analysis

The Medical Home analytical tools identify utilization in several categories including: hospital admissions, readmissions, emergency room utilization and ancillary services. This retrospective look at attributed patients' use of services across the whole delivery system will help the primary care physician identify opportunities to improve quality and lower cost by eliminating redundancy and inappropriate use of resources, as well as improving the integrity of the delivery system itself.

Additionally, the Medical Home patient population will be stratified based on its clinical risk and its relationship to expected healthcare expenditures. Patients are placed into risk groups based on the assigned International Classification of Disease (ICD) diagnoses. These groupings account for primary diagnosis as well as multiple comorbidities that may affect cost of healthcare services. Specifics of the risk stratification process can be found in Attachment I, Risk Scoring and Associated Payments.

Support

In each case, the practice will be guided through orientation and implementation of these tools by Blue KC staff. A Medical Home staff member will meet with the practice on a regular basis and will assist the practice in meeting the goals of the Medical Home program and optimizing their results.

DEVELOPMENTAL REVIEW PROCESS

Purpose

The purpose of the Developmental Review Process (DRP) is to assess the level to which the infrastructure of the practice has developed to meet the requirements of the Medical Home program. Meeting the minimum requirements will be required before a practice will be admitted into the Blue KC Medical Home Program, and maintaining standards will be a requirement of maintaining the assigned category and ongoing participation.

Overview

There will be an initial review at the time the practice applies for admission into the Blue KC Medical Home Program, and then periodic reviews thereafter. The Developmental Review will assess the development of the practice's infrastructure, inform consulting and support needs and establish the practice into one of three categories: Developing Medical Home, Established Medical Home or Advanced Medical Home. The category assignment will affect the monthly Care Coordination Fee.

Components

The DRP for 2017 includes nine components: Access, Team Based Care/Patient Education, Population Health Management, Care Management Support, Care Coordination/Transitions, Addressing Psycho-Social Needs, Information Technology Infrastructure, and Patient Experience. Each components has multiple factors which present specific targets with weighted values for each. Several components have factors that are considered "must-pass" and are required for both program entry and ongoing participation. Details of the components, including weight/points and must-pass designated components will be published on April 1. At that time the document containing the details of the components will be attached to this document as Attachment III and is incorporated herein by this reference.

Assessment

The source of information for many components of the DRP reviews will come from practice-provided documentation and some from on-site review of the practice by a Blue KC Medical Home staff member. An applying or existing practice receiving an unfavorable review will receive a detailed description of the components not meeting standards. If the practice wishes to provide additional information in response to the determination of the review, such information must be provided within 30 days of the receipt of the review. Blue KC will provide a formal response to the additional information. All decisions are final and subject to Blue KC's sole discretion.

AFTER-HOURS ACCESS

It is expected that Medical Home practices will provide after-hours access to their attributed members, bill at the office visit level and collect the Office Visit co-payment if the members access any site of service associated with the practice or its parent organization. For the purposes of this program, "regular business hours" shall mean 8 a.m. through 5 p.m. Monday through Friday. Further, "routine appointments" shall mean appointed visits for non-emergent services; "urgent care appointments" shall mean non-appointed visits for non-emergent services. Members not attributed to the practice who are seen outside of regular business hours should be charged the Medical Home Urgent Care co-payment, and relevant clinical information should be passed on to the attributed Medical Home provider if possible. This policy will also apply to "alternate clinical encounters" such as e-visits, as they become available.

Medical Home members will not be attributed on the basis of Urgent Care visits, and providers are encouraged to engage individuals using their Urgent Care services to be integrated into their routine care via an appointed office visit.

COMPENSATION –THE PERFORMANCE-BASED INCENTIVE

In addition to traditional fee-for-service payments, Medical Home practices are eligible to receive a Performance-Based Incentive payment, as defined below, based on their performance relative to attributed membership in eligible products. Incentive compensation under the Medical Home Performance-Based Incentive Program is based on several factors including quality, patient experience, resource utilization, the level of development of the Medical Home's infrastructure and the inherent illness burden of the patient population.

Commensurate with Blue KC's efforts to align with CMMI requirements as a CPC+ payor partner, it is our expectation that if your Medical Home entity is owned by a person, entity or organization other than the clinical leaders who work at practice sites associated with your entity, your organization is expected to use funds received from the Performance-Based Incentive payments on infrastructure and/or salaries of team members within the participating practice site(s). Payments may also be used to support centralized infrastructure that is dedicated to the delivery of primary care services within Medical Home practice sites. If, at any time CMMI/CPC+ should find that your entity has not complied with this requirement, and recoups compensation from your entity on that basis, Blue KC reserves the right to seek recoupment of monies paid in this program as well.

The fee-for-service payment is a payment based on claims submitted to Blue KC under the terms of the applicable Network Agreement. The claims will be adjudicated on the then-current applicable Blue KC fee schedule for Medical Home providers, and submission and remittances will be handled in the same manner as for other Blue KC lines of business.

The 2017 Performance-Based Incentive Program will maintain the two components of the Performance-Based Incentive program from previous years, but with three significant modifications:

1. The Care Coordination Fee will now include a component reflecting the development of the individual practice's infrastructure based on the DRP score, as well as the component reflecting the specific illness burden of their population.
2. The risk scoring methodology will change from the Clinical Risk Grouping of 3M/Treo to the Milliman and Robertson MARA risk model. Specific information about the MARA risk model may be found in Attachment I.
3. The Performance Multiplier, previously presented in a grid format, will now be in a formula-base format as described below. Specific information about the Performance Multiplier may be found in Attachment II.

The monthly payment that a Medical Home entity will receive (i.e. the Performance Based Incentive payment) will be based on the product of the Care Coordination Fee and the Performance Multiplier and will be paid out beginning in July of 2018 and continuing through June of 2019.

The Care Coordination Fee (CCF) is the first component of the monthly payment that supports the additional practice infrastructure needed to achieve better outcomes; and the physician and non-physician work that falls outside of a face-to-face patient visit. The CCF as an amount paid per Attributed Member per month, based on the illness burden of the attributed population and the level of development of the practices' infrastructure as represented by their Developmental Review Program score.

New practices entering the program will experience an approximate 90-day processing lag prior to the inception of the CCF payments. This lag is necessary to allow for the accurate attribution and risk scoring of attributed patients and align the payment made with the specific population being managed.

Blue KC will provide a list of attributed Blue KC members monthly. The data will serve as the definitive list of patients that data measurements and calculations will be based upon.

The Performance Multiplier is the second component of the monthly payment and is based on the entity's performance in the program's clinical quality, resource utilization and patient experience measures in the 2016 program year. Each measure will have a performance multiplier assigned, and the practice's percentage of applicable points achieved in the measure will determine the contribution of that measure to the overall performance multiplier. Specific information about the 2017 Performance Multiplier may be found in Attachment II.

SUSPENSION AND TERMINATION

Should a practice, for whatever reason, cease to participate in the Blue KC Medical Home Program, it shall continue to provide services to Medical Home patients, at the discretion of Blue KC, for a period of up to three calendar months following the first day of the month following notification of termination (Termination Period). During this Termination Period, Blue KC will notify the attributed members of the change in the status of the practice, and present the patients with available alternatives. The Medical Home practice will not be eligible for proceeds of the Performance-Based Incentive program during the Program Year in which they were terminated, and any current PBI payments will cease at the beginning of the Termination Period, although amounts owed for eligible months of participation will be paid. The terminated practice will be eligible for readmission to the Blue KC Medical Home Program 12 months after the start of the Termination Period.

A practice admitted to the "Developing" level of the program (based on their DRP score) will only be allowed to remain in that level for 24 months. If, after that time, they have not yet advanced to the "Established" level, they will be suspended from the program until such time as they can meet the requirements of an Established Medical Home Practice. During the period of suspension, the practice will not be eligible for any enhanced payments from Blue KC including CCF, PBI, or any enhanced FFS payments.

A practice moving from the "Established" level to the "Developing" level will have 12 months to regain Established status. If, after that time, they have not yet returned to the "Established" level, they will be suspended from the program until such time as they can meet the requirements of an Established practice. During the period of suspension, the practice will not be eligible for any enhanced payments from Blue KC including CCF, PBI, or any enhanced FFS payments.

A practice may remain on suspended status for no more than 12 months. After that time has elapsed they will be terminated from the program.

Attachment I

RISK CORRIDORS AND ASSOCIATED PAYMENTS

The risk scoring mechanism will transition from the 3M/Treo Clinical Risk Grouping (CRG) methodology to the Milliman and Robertson concurrent risk scoring methodology (MARA), with risk corridors established by Blue KC.

Payments per Unit of Risk (PUR) levels have been established by Blue KC and will continue to approximate CCF levels. The PUR will be administered at the member level and will adjust over the 2017 program year. Adjustments will be based on Blue KC fine tuning of claims lag and risk components. Updates to the PUR will be published quarterly as attachments to this Provider Manual.

As in the past, the risk of the patient population of each Medical Home will be assessed each month, and the PUR applied to generate the base payment for the current PBI program being administered. Practices in the Established tier will have an initial PUR of $3.15; practices in the Developing tier will have an initial PUR of $1.50. The result of these initial PUR levels are represented in the charts below. Transition from the CRG system to the MARA system will occur in January of 2017 and consequently will affect the payout of the 2015 PBI for the balance of the payout period (the 2015 PBI pays out from July of 2016 through June of 2017).

Reporting on the 2017 performance will be made using the MARA risk scoring system and a performance dashboard will be made available to track progress toward program goals. A model of the MARA system appears below for your reference.

Payment per Unit of Risk $1.50		
MARA Risk Range		Risk Range Payment
Low	High	
0	0.19	$0.00
0.2	0.49	$0.39
0.5	0.54	$0.78
0.55	0.59	$0.85
0.6	0.66	$0.94
0.67	0.72	$1.04
0.73	0.8	$1.15
0.81	0.88	$1.27
0.89	0.98	$1.40
0.99	1.09	$1.56
1.1	1.22	$1.74
1.23	1.34	$1.93
1.35	1.43	$2.09
1.44	1.54	$2.23
1.55	1.66	$2.41
1.67	1.8	$2.60
1.81	1.96	$2.82
1.97	2.16	$3.09
2.17	2.39	$3.41
2.4	2.69	$3.81
2.7	3.17	$4.38
3.18	Greater	$6.58

Payment per Unit of Risk $3.15		
MARA Risk Range		Risk Range Payment
Low	High	
0	0.19	$0.00
0.2	0.49	$0.82
0.5	0.54	$1.64
0.55	0.59	$1.79
0.6	0.66	$1.98
0.67	0.72	$2.19
0.73	0.8	$2.41
0.81	0.88	$2.66
0.89	0.98	$2.94
0.99	1.09	$3.27
1.1	1.22	$3.65
1.23	1.34	$4.05
1.35	1.43	$4.38
1.44	1.54	$4.69
1.55	1.66	$5.05
1.67	1.8	$5.46
1.81	1.96	$5.93
1.97	2.16	$6.49
2.17	2.39	$7.16
2.4	2.69	$7.99
2.7	3.17	$9.21
3.18	Greater	$13.81

Attachment II

BLUE KC MEDICAL HOME PERFORMANCE MULTIPLIERS

The Performance Multiplier is based on the entity's performance in the program's clinical quality, resource utilization and patient experience measures in the 2016 program year. A performance multiplier is assigned to clinical quality and patient experience. The resource utilization measure will be based on the practice's risk-adjusted total allowed cost compared to that of their cohort of Medical Home practices. The sum of the multipliers for Clinical Quality and Patient Experience, plus the Resource Utilization measure, will determine the final multiplier.

More detailed descriptions of the multipliers and their specific measures follow in this attachment and Attachment IIA.

RESOURCE UTILIZATION

The Resource Utilization measure is meant to gauge the individual entity's cost of care, compared to that of its peer entities. It is based on the practice's risk-adjusted total allowed cost compared to that of the applicable cohort of practices. The cohorts will be differentiated by developmental categories(i.e. there will be a cohort for developing entities and established entities). An individual entity's measure will be based on the risk-adjusted allowed cost of its cohort, divided by its risk-adjusted allowed cost.

C_i = Cohort average risk-adjusted total cost per member per month

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Ei = Entity risk-adjusted total cost per member per month

The product of this calculation will comprise the Resource Utilization component of the performance multiplier. Entities with a ratio of 0.80 or less will receive zero (0) multiplier points for this measure.

CLINICAL QUALITY MEASURES

The Clinical Quality measures include measures for diabetes care, cancer screening, pediatric care and use of imaging studies for low back pain. Measures are individually weighted and the goal target for each measure is shown in Attachment II. A. Two (2) multiplier points are available for the Clinical Quality Measures, and the final multiplier for the practice in this measure will be determined by the percentage of applicable points the practice receives, multiplied by two (2); i.e. a practice receiving 75 percent of applicable points in this measure set will receive 0.75 x 2 or 1.5 multiplier points. Practices receiving less than 50 percent of applicable quality points will receive zero (0) multiplier points for this measure set.

Selected text below is excerpted from the 2016 HEDIS Guidelines for Effectiveness of Care.

DIABETES CARE – ADULTS

Members identified as having diabetes either by claims/encounter data or pharmacy data, and continuously enrolled for the performance year are eligible. Patients with steroid-induced diabetes, gestational diabetes, or polycystic ovaries will be excluded from diabetes care measures. Pharmacy data is also used to identify diabetic patients, based on use of prescription drugs commonly used for the treatment of diabetes. Glucophage/Metformin utilization is not used to identify diabetics for this measure, as this drug is also used to treat conditions other than diabetes (e.g., polycystic ovaries).

Prescriptions to Identify Members with Diabetes

Description	Prescription	
Alpha-glucosidase inhibitors	• Acarbose • Miglitol	
Amylin analogs	• Pramlinitide	
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Empaglifozin-linagliptin • Empagliflozin-metformin • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rrosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin human inhaled	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human
Meglitinides	• Nateglinide • Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Liraglutide • Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride • Glipizide	• Glyburide • Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone • Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin

1. HbA1c Testing Twice per Year

This measure evaluates the percentage of adults with diabetes who have HbA1c testing at least two times during the program year.

2. Nephropathy Screening

This measure evaluates the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the program year.

This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test.
- Evidence of treatment for nephropathy or ACE/ARB therapy.
- Evidence of stage 4 chronic kidney disease.
- Evidence of ESRD.
- Evidence of kidney transplant.
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event including:

Description	Prescription		
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril • Enalapril • Fosinopril	• Lisinopril • Moexipril • Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan • Eprosartan	• Irbesartan • Losartan • Olmesartan	• Telmisartan • Valsartan
Anti-hypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Hydrochlorothiazide-losartan • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide	• Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Trandolapril-verapamil	

CANCER SCREENING

1. Breast Cancer Screening

This measure evaluates the percentage of women 50-74 years of age during the program year, who had a mammogram to screen for breast cancer during the program year or the year prior to the program year.

Women who have had a bilateral mastectomy or two unilateral mastectomies are excluded from the patient population for this measure.

2. Cervical Cancer Screening

The measure evaluates the percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years.
- Women age 30–64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every five years.

Women who have had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year are excluded. Documentation of "hysterectomy" meets exclusion criteria if "complete," "total" or "radical" with no residual cervix. Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

3.Colorectal Cancer Screening

This measure evaluates the percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

Appropriate screening includes:

- Fecal occult blood test (FOBT) during the program year. Regardless of FOBT type, guaiac (gFOBT) or immunochemical (iFOBT),
- Flexible sigmoidoscopy during the program year or the four years prior to the program year.
- Colonoscopy during the program year or the nine years prior to the program year.

Patients with a diagnosis of colorectal cancer or a total colectomy are excluded from the patient population for this measure.

PEDIATRIC CARE

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

This measure evaluates the percentage of children three months to 18 years of age with a diagnosis of URI who were dispensed an antibiotic medication. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through three days after the Episode Date (34 total days). Patients are excluded who have a competing diagnosis or are refilling a prescription written prior to the Episode Date. Cases are also excluded in which the antibiotic is not prescribed by the diagnosing provider or a related provider.

WELL-CARE VISITS FOR PEDIATRIC AND ADOLESCENT PATIENTS

1. Well-Child Visits in the First 15 Months of Life

This measure evaluates the percentage of patients who turned 15 months old during the program year and who had six or more well-child visits with a PCP during their first 15 months of life.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

This measure evaluates the percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the program year.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

3. Adolescent Well-Care Visits

This measure evaluates the percentage of enrolled patients 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the program year.

The Adolescent Well-Care visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Human Papilloma Virus

The measure assesses the percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine between their 9th and their 13th birthday. The patient must be continually enrolled for 12 months prior to their 13th birthday.

Exclusion criteria include:

- Anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components, with a date of service prior to October 1, 2011.

Use of Imaging Studies for Low Back Pain

The measure assesses the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. The date of diagnosis is defined as the earliest date of service for an outpatient or ED encounter with a principal diagnosis of low back pain.

Individuals in this measure will include:

- Outpatient visit, with a principal diagnosis of low back pain.
- Observation visit, with a principal diagnosis of low back pain.
- ED visit, with a principal diagnosis of low back pain. ED visits that result in an inpatient admission are excluded.
- Osteopathic manipulative treatment, with a principal diagnosis of low back pain.

For each member identified above, the earliest episode of low back pain will be determined. If the member had more than one encounter, only the first encounter will be included.

Members with a diagnosis of low back pain during the 180 days prior to the earliest episode will be excluded.

Members will also be excluded who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- Cancer. Cancer any time during the member's history through 28 days after initial onset.
- Recent trauma. Trauma any time during the 12 months (one year) prior to the initial onset through 28 days after the initial onset.
- Intravenous drug abuse. IV drug abuse any time during the 12 months (one year) prior through 28 days after the initial onset.
- Neurologic impairment. Neurologic impairment any time during the 12 months (one year) prior to, through 28 days after the initial onset.

PATIENT EXPERIENCE

Patient Experience will be measured by patient responses to four statements which will each be single weighted. These statements will be evaluated by the Medical Home on a regular basis and at year end. Results will be based on 100 percent of the responses, and adjudicated against 70 percent of the scale value. At least 30 responses are required for each statement, per physician over the course of the performance year. The statements include:

- "I can get in to see my doctor when I need to."
- "I understand my care plan and my role in it."
- "I would recommend my physician/practice to family and friends."
- "I would recommend this physician/practice to family and friends."

Blue KC will verify the data from the practice's survey on a periodic basis. One (1) multiplier point is available for the Patient Experience Measures, and the final multiplier for the practice in this measure will be determined by the percentage of points the practice receives (i.e. a practice receiving 75 percent of applicable points in this measure set will receive 0.75 multiplier points).

FINAL DETERMINATION

The final determination of the Performance Multiplier will be the sum of the points from the Resource Utilization, Clinical Quality and Patient Experience measures. By way of example, a practice with a Risk-adjusted Allowed Amount of $350 pmpm compared to a Cohort Risk-adjusted Allowed Amount of $375 pmpm would receive a multiplier of 1.07 (which is 375 divided by 350) for the Resource Utilization measure.

If that practice also scored 75 percent of applicable Clinical Quality points, it would receive a multiplier of 1.5 (that is 0.75 times 2) for the Clinical Quality measure.

If that practice also scored 50 percent of the Patient Experience points, it would get 0.5 points for the Patient Experience measure.

The practices final performance multiplier would be the sum of their points in these three measures or 3.07 (1.07+1.50+0.50). If their CCF produced approximately $2 pmpm their monthly PBI payment would be approximately $6.14 pmpm (3.07 times $2).

Attachment IIA.

Performance Metrics

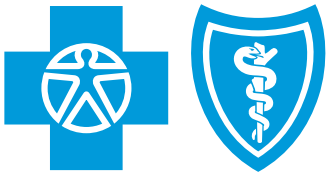
CLINICAL QUALITY MEASURES

Available Multiplier	ADULT - DIABETES	GOAL	WEIGHT
	HbA1c Testing - Adults with Diabetes (2x year)	92%	Double
	Nephropathy Screening	87%	Single
2.0	**OTHER CLINICAL PROCESS MEASURE**	**GOAL**	**WEIGHT**
	Use of Imaging Studies for Low Back Pain	80%	Single
	CANCER SCREENING	**GOAL**	**WEIGHT**
	Breast Cancer Screening	76%	Single
	Cervical Cancer Screening	79%	Single
	Colorectal Cancer Screening	68%	Single
	PEDIATRIC	**GOAL**	**WEIGHT**
	Inappropriate Treatment for URI	10% or less	Single
	HPV Vaccination	14%	Single
	PEDIATRIC: WELL-VISITS		
	First 15 months of life - 6 or More Visits	84.01%	Single
	3-6 years old - At Least Annual Well-Child Visit	79.57%	Single
	Adolescent Well Care Visits	47.63%	Single

PATIENT EXPERIENCE MEASURES

		GOAL	WEIGHT
Available Multiplier	I can get in to see my doctor when I need to.	70% of scale value	Double
	I understand my care plan and my role in it.	70% of scale value	Double
1.0	I would recommend this physician to family and friends.	70% of scale value	Single
	I would recommend this practice to family and friends	70% of scale value	Single

Attachment III: Developmental Review Detail
(available 4/1/17)



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