



Kansas City

Blue Cross and Blue Shield of Kansas City

Medical Home Manual

Effective January 1, 2019

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I. INTRODUCTION

The purpose of this document is to outline Blue Cross and Blue Shield of Kansas City's (Blue KC) Medical Home Program for its participating entities (Entity or Entities). The Blue KC Medical Home Program is a delivery model designed to improve the following aspects of the healthcare delivery system:

- person and family-centered care,
- care that is continuous, comprehensive and equitable,
- care that is team based and collaborative,
- care that is coordinated and integrated,
- care that is accessible and of high value.

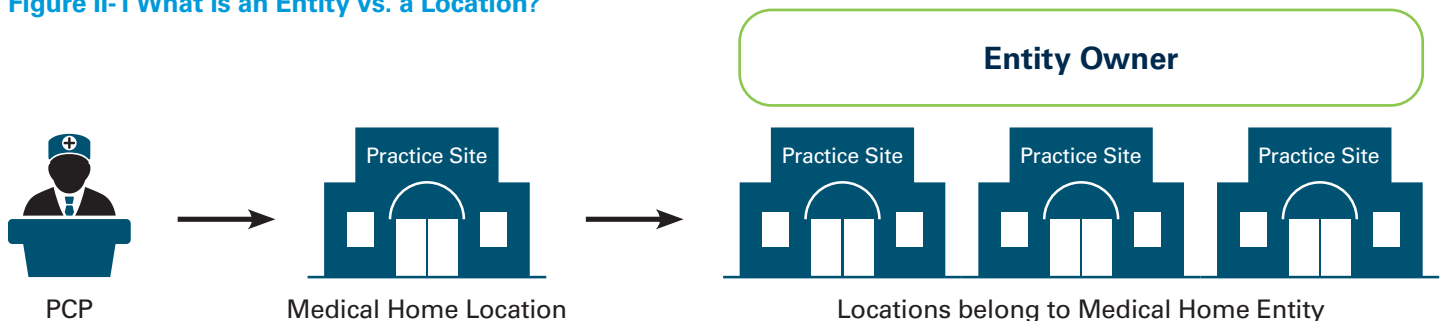
This manual establishes the terms and conditions necessary for participation in the Blue KC Medical Home Program. As a condition of participation in the Blue KC Medical Home Program, Entities agree to be bound by the terms and conditions of the Blue KC Medical Home Program. However, this manual is not intended to replace any contradictory provisions in any accountable care organization, network, shared savings, or clinical agreement ("Other Agreements") that participating entities have with Blue KC compensating the Entity for primary care services to Blue KC members, and the terms of this manual are expressly superseded by such Other Agreements according to the terms of those Other Agreements. Blue KC retains the exclusive right to modify the Medical Home Program in such ways and at such times as Blue KC in its sole discretion may deem necessary, subject to review by the Missouri Department of Insurance.

II. QUALIFICATION FOR PARTICIPATION

Are we able to join the program?

Participation in the Blue KC Medical Home Program is open to Blue KC credentialed physicians practicing in the specialties of Family Medicine, Adolescent Medicine, Internal Medicine, Geriatrics, Pediatrics, and credentialed general practice physicians (collectively referred to herein as Primary Care Providers). Qualified Entities must meet the minimum standards of the Blue KC Developmental Review Process (DRP) or otherwise meet accreditation/recognition programs outlined in Attachment II. Primary Care Providers (PCP) must maintain patient records in an electronic health record (EHR) that is 2014 and/or 2015 Edition Certified Electronic Health Record Technology (CEHRT) and must maintain ongoing communication with Blue KC. For the purpose of Blue KC's Medical Home Program, a PCP works at a Medical Home location, which is owned by a Medical Home Entity (Figure II-1). A Medical Home Entity is the legal owner of the Medical Home location.

Figure II-1 What is an Entity vs. a Location?



Changes or updates specific to PCP(s), Medical Home location(s) and/or a Medical Home Entity must be communicated to Blue KC within 30 days of change by sending an email to _provider_data@bluekc.com. Performance Based Incentive Program (PBIP) payments may take up to 90 days to begin or change once notification has been received by Blue KC. Medical Home Entities will not receive retroactive payments following failure to notify Blue KC of changes or updates to locations, Entity or PCPs in a timely manner.

III. APPLICATION

We're interested. What do we do first?

Application for the inclusion of a new Entity in the Blue KC Medical Home Program may be made by contacting Blue KC at _provider_data@bluekc.com. A Blue KC team member will set up a time to discuss program requirements and next steps in the application process. All applicants not associated with an existing Medical Home Entity will need to complete the Medical Home Program's Developmental Review Process (DRP) or meet accreditation/recognition outlined in Attachment II for entry into the program. The purpose of the DRP is to assess the readiness of the applicant for program inclusion and provide a basis for ongoing development.

A new Entity will be admitted to the program in either the Developing or Established Medical Home Tier, based on the results of the DRP or meeting accreditation/recognition outlined in Attachment II. Locations owned by an existing Medical Home Entity will be placed in the program at the DRP tier of that Entity.

IV. ON-BOARDING

What does Blue KC do to help us succeed in the program?

Upon admission to the Blue KC Medical Home Program, the new Medical Home Entity will begin the on-boarding process. The purpose of the process is to prepare the Entity to function successfully in the Blue KC Medical Home Program. This involves the following:

- Introduction to the program, including a description of how it works to support Blue KC Medical Home principles and what resources are available to the Entity for transformation efforts.
- Entity responsibilities for resource utilization management, clinical quality and performance improvement.
- Specific training on the use of Blue KC reporting systems and additional resources.

Training and consultation is provided to participating Entities throughout their participation in the program.

V. MEMBER ELIGIBILITY

Which of my patients are eligible for possible attribution in the program?

To be eligible for attribution, members must meet all of the following criteria:

- Be enrolled in an eligible Blue KC product/network: Blue Care, Preferred Care, Preferred Care Blue, Blue Access, Blue Select and Blue Select Plus.
- Primary insurance coverage with an eligible Blue KC product.
- Member resides within the Blue KC 32-county service area.
- Members Employer Group must participate in Value Based Programs.
- The Host Plan participates in Value Based Programs.
- Member must have an Evaluation and Management (E&M) office visit claim from their Blue KC Medical Home PCP in the last 24 months. E&M codes for attribution include those within the code range 99201 to 99499.

At this time, members in the following Blue KC networks will not be attributed: Freedom Network, Freedom Network Select, Preferred Health Professionals, Away from Home Care, BCBS Short Term Security and Medicare Advantage.

Blue KC analyzes member eligibility monthly as part of each Performance Based Incentive Program (PBIP) payment cycle (See Attachment I).

VI. MEMBER ATTRIBUTION

How are my patients identified by Blue KC?









Attribution is a process used to assign Blue KC members to a PCP. The PCPs patient panel is made up of the attributed members. The physician-led care team is responsible for managing the care of their attributed members, which includes preventive care, chronic disease management, acute care needs, population health management and care coordination.

The attribution methodology is based on plurality and recency (Figure VI-1). The process considers:

- The PCP who has had the most billed eligible Evaluation and Management (E&M) codes over the last 12 months. Only eligible primary care visits count toward attribution.
- Should there be no billed E&M codes for the patient over the last 12 months the period is expanded to the last 24 months. Patients with no eligible utilization in the past 24 months are not attributed.
- In the case that there is equal utilization between two primary care providers during the relevant evaluation period, the patient will be attributed to the provider with the most recent utilization.

Blue KC analyzes attribution monthly as part of each PBIP payment cycle. Services provided in an urgent care setting will not be included in the attribution determination. Blue KC will not “force attribution” or move attributed members from one Entity and/or Location to another based on requests. Members will reattribute based on utilization through the Blue KC attribution methodology.

Figure VI-1. Attribution of Members (for illustration purposes only)

Plurality	Q1	Q2	Q3	Q4					
My Practice						In this scenario, the patient had multiple visits to My Practice in the past 12 months, and only one visit to Other Practice. This patient will be attributed to My Practice.			
Other Practice									
Recency	Q1	Q2	Q3	Q4					
My Practice						In this scenario, the patient had the same number of visits to My Practice and Other Practice over the past 12 months, but because the visit to My Practice was most recent, the patient was attributed to My Practice.			
Other Practice									

VII. DEVELOPMENTAL REVIEW PROCESS

How is our progress in the program assessed?

The purpose of the Developmental Review Process (DRP) is to assess the Entity’s level of readiness to meet the requirements of the Blue KC Medical Home Program and provide a basis for ongoing development. The results of the DRP analysis will determine the coaching support needed and tier assignment. Tier assignment will be made to one of two tiers: Developing Medical Home or Established Medical Home. The specific components of the DRP and its administrative requirements are attached (Attachment II).

VIII. AFTER-HOURS ACCESS

What is the access requirement for Blue KC Medical Home Members?

It is expected that a Medical Home Entity will provide after-hours access to its attributed members, bill those visits at the office visit level and collect the office visit co-payment if the members access any site of service associated with the Blue KC Medical Home location or Medical Home Entity.

For the purposes of this program, “regular business hours” will mean 8 a.m. to 5 p.m. Monday through Friday. “After hours” and/or “after hours visit” is related to any service provided outside of regular business hours.

For those entities that provide urgent care services, Blue KC requires an urgent care contract for a physician to bill for and be reimbursed under urgent care benefits. If an urgent care contract is not in place, services must be billed as an office visit and office visit benefits will apply.

IX. COMPENSATION

How do Medical Home Entities get paid under the Blue KC Medical Home Program?

IX.1. FEE-FOR-SERVICE PAYMENT AMOUNTS

All Medical Home Entities receive fee-for-service payments for the services provided to their attributed patients. For the Medical Home Entities, 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. Payment for Evaluation and Management (E&M) codes are differentiated by tier assignment (Table IX-I). The applicable E&M code ranges for differentiated payment include 99201 through 99215, and 99381 through 99420.

Table IX-I Financial Components of the Blue KC Tiers

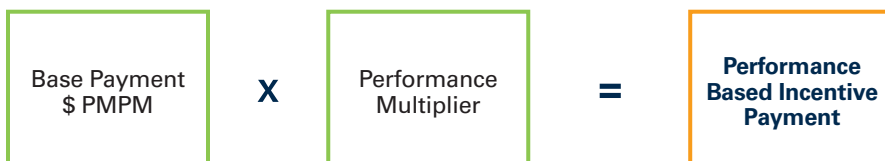
Tier Assignment	E&M FFS Payment as % of Applicable Schedule	Performance Multiplier
Developing	100%	0.5 year 1, 0.75 year 2
Established	105%	New entrants 1.0 year 1, PBIP thereafter

IX.2. PBIP PAYMENT

In addition to fee-for-service payments, Established Medical Home Entities are eligible to receive a Performance Based Incentive Program (PBIP) payment based on their performance relative to their eligible, attributed members. 2019 Performance year will be paid July 1, 2020 through June 30, 2021. The PBIP payment is calculated by multiplying the base payment by the performance multiplier (Figure IX-I). The PBIP payment is defined in Attachment I and Attachment IA.

All Entities will receive a monthly Value Based Program Payment Summary report in a designated folder placed on Blue KC’s HIPAA compliant platform, kiteworks (formerly known as Accellion) by the 10th of each month. Entities are responsible for reviewing these summaries every month and must notify Blue KC of any changes to locations or PCPs within 30 days of such change. Failure to provide timely notification may result in entities not receiving retroactive payments for locations or PCPs that weren’t included in the summary.

Figure IX-I: PBIP Payment Calculation



IX.2.a. THE USE OF THE RISK SCORE

The scoring of risk is used in two distinct ways in the administration of the Blue KC Medical Home Program. First, in recognition of different levels of acuity that require differing levels of care, risk scoring is used to adjust the base payment made to entities for their individual populations. Secondly, it is used to make risk-adjusted comparisons of costs among entities and ultimately provide the basis for the assessment of the Resource Utilization metric of the PBIP.

In each use of the risk score methodology used is the Milliman Advanced Risk Adjustors, referred to as the MARA risk score.

RISK CORRIDORS AND ASSOCIATED BASE PAYMENTS:

The risk scoring mechanism employed is the Milliman Advanced Risk Adjustors (MARA) concurrent risk scoring methodology. Risk is evaluated based on clinical diagnosis (ICD-10 coding), age, sex and utilization variables.

Blue KC establishes risk range payment levels for MARA risk score ranges. The risk of the patient population of each Blue KC Medical Home will be assessed monthly and applied to generate the Base Payment for the current PBIP being administered. The risk ranges and associated payments appear to the right.

By way of example, a patient with a MARA risk score of 1.25 would be in the risk range of 1.23 to 1.34 to the right. The Base Payment for this member would then be \$3.25. That Base Payment would then be multiplied by the Performance Multiplier associated with the patient's attributed PCP to get the total payment made for that member.

ENTITY RISK ADJUSTED TOTAL ALLOWED COST:

The Entity's average risk score is used to determine the Entity's risk adjusted total allowed cost. This is derived by taking the entities total allowed cost per member per month (PMPM) and dividing it by that Entity's average risk score. For example, an Entity with a total allowed cost PMPM of \$400 with an aggregate risk of 2.0 would have a \$200 Entity risk-adjusted total allowed cost PMPM.

Base Payments for Specified MARA Risk Score Ranges

Risk Score Range		Risk Range Payment
Low	High	
0.00	0.19	\$0.33
0.20	0.49	\$0.66
0.50	0.54	\$1.31
0.55	0.59	\$1.44
0.60	0.66	\$1.59
0.67	0.72	\$1.76
0.73	0.80	\$1.93
0.81	0.88	\$2.14
0.89	0.98	\$2.36
0.99	1.09	\$2.63
1.10	1.22	\$2.93
1.23	1.34	\$3.25
1.35	1.43	\$3.52
1.44	1.54	\$3.77
1.55	1.66	\$4.06
1.67	1.80	\$4.38
1.81	1.96	\$4.76
1.97	2.16	\$5.22
2.17	2.39	\$5.75
2.40	2.69	\$6.42
2.70	3.17	\$7.40
3.18	Greater	\$11.09

$$\frac{\text{Entity Total Allowed Cost PMPM}}{\text{Entity Average Risk Score}} = \frac{\$400 \text{ PMPM}}{2} = \$200 \text{ Entity Risk-adjusted Total Allowed Cost}$$

IX.2.b. PBIP MULTIPLIER FOR DEVELOPING TIER:

Entities admitted to the Developing Tier will receive a 0.5 multiplier in the first year of participation, and a 0.75 multiplier in the second year of their participation as a Developing Medical Home. Entities may only remain in the Developing Tier for two years unless reassigned from the Established to the Developing Tier, in which case they may only remain in the Developing Tier for one year (see Suspension and Termination below).

An Entity admitted to the Developing Tier with a base payment of \$4.00 would receive a multiplier of 0.5 in the first year, i.e. their monthly payment would be $\$4.00 \times 0.5$ or \$2.00 per member per month (PMPM). After one year in the program, if the Entity had not advanced to the Established Tier, and if their base payment remained at \$4.00, they would receive \$3.00 PMPM ($\$4.00 \times 0.75 = \3.00 PMPM).

IX.2.c. PBIP MULTIPLIER FOR ESTABLISHED TIER:

Developing Medical Homes that advance to the Established Tier will receive the 1.0 multiplier until the next July 1st payment cycle.

New entities entering the program at the Established Tier level will receive a multiplier of 1.0 in lieu of a Performance Multiplier for their first Performance Year of participation.

Established Medical Home Entities reassigned to the Developing Tier based on Developmental Review Process (DRP) assessment or accreditation/recognition lapse will have their performance multiplier reduced to 0.5. This new performance multiplier will remain in place until the Entity reestablishes itself as an Established Tier or is suspended from program (see Attachment II).

IX.3. BLUE DISTINCTION TOTAL CARE + (BDTC+)

Medical Home Entities that meet or exceed the 70th percentile in both the Resource Utilization and Clinical Quality may be designated as BDTC+. This designation is visible to members and employers accessing the Blue Cross Blue Shield National Provider Finder. BDTC+ recognizes high performing providers that deliver better quality outcomes and lower total cost of care. Eligibility for BDTC+ designation is reviewed annually. Entities that receive BDTC+ designation will remain designated for two years. There is no additional compensation for this designation.

X. SUSPENSION AND TERMINATION**What happens if we don't meet minimum program expectations?**

Either the Medical Home Entity or Blue KC may terminate the Medical Home Entity's participation in the Blue KC Medical Home Program at any time, for any reason or for no reason, by providing written notice of termination to the other organization. Such termination notice shall not be effective until the last day of the third calendar month following the date on the notice of termination, excluding the month in which the notice of termination was provided ("Termination Notice Period").

During the Termination Notice Period, Blue KC will notify the affected attributed members of the impending change in the status of the Medical Home Entity and present attributed members with available Medical Home participating Entity/physician alternatives. Members may elect to remain with the terminating Entity at their applicable (non-Medical Home) benefit levels.

Medical Home Entities that are terminated are not eligible for the Performance Based Incentive Payment (PBIP) during the program year in which they terminated. Program years run from July 1 through June 30 of the following performance calendar year. Any current PBIP payments based on prior program year performance will cease as of the last day of the Termination Notice Period, although amounts owed for eligible months of participation will be paid. The terminated Entity will be eligible for readmission to the Blue KC Medical Home 12 months after the start of the Termination Notice Period.

A Medical Home Entity's participation in the Blue KC Medical Home Program may also be temporarily suspended.

An Entity admitted to the Developing Tier of the program may remain in that level for 24 months. If, after that time, they have not yet advanced to the Established Tier, they will be suspended from the program until they can meet the requirements of an Established Medical Home Entity. During the period of suspension, the Entity will not be eligible for any enhanced payments from Blue KC including Base Payment, PBIP or any enhanced FFS payments.

An Entity moving from the Established Tier to the Developing Tier will have 12 calendar months to regain Established status. A review of the specific requirements of the Established Tier that the Entity did not meet may be held four months after the Entity was reassigned to the Developing Tier. If, after that time, the requirements are met, the Entity may be reinstated into the Established Tier within 90 days of successful reinstatement. If, after 12 months, they have not yet requalified for the Established Tier, they will be suspended from the program until they can meet the requirements of an Established Medical Home Entity. During the period of suspension, the Entity will not be eligible for any enhanced payments from Blue KC including Base Payment, PBIP or any enhanced FFS payments.

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



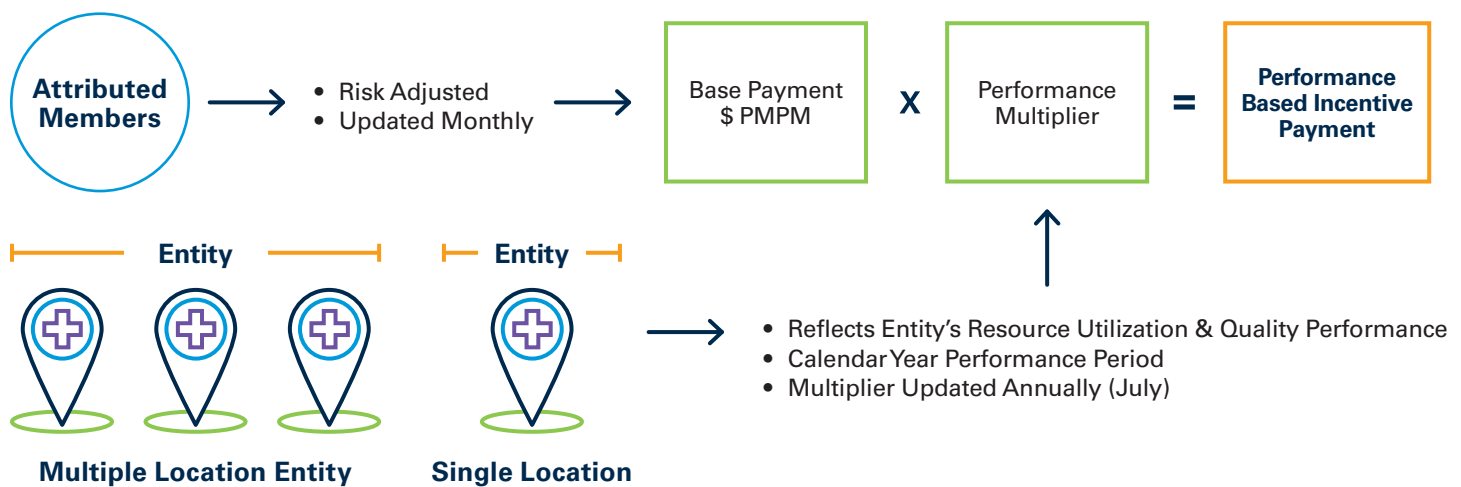
ATTACHMENT I

THE PERFORMANCE BASED INCENTIVE PROGRAM (PBIP)

The Performance Based Incentive Program (PBIP) provides a monthly population-based payment to Medical Home Entities in addition to the fee for service payment the Entity receives for submitted claims. The PBIP payment is calculated by multiplying the base payment by the performance multiplier (see below). The 2019 Performance Year will be paid July 1, 2020 through June 30, 2021.

Current Medical Home Performance Based Incentive Program

Eligible Blue KC Members



1. BASE PAYMENT

The base payment is the first component of the monthly PBIP payment that supports the additional Entity infrastructure and resources needed to achieve the Triple Aim. The base payment is an amount paid per eligible, attributed member per month based on the Milliman Advanced Risk Adjustors (MARA) risk scores of the attributed population. Blue KC provides a list of attributed members monthly and adjusts the base payment accordingly.

2. PERFORMANCE MULTIPLIER

The performance multiplier is the second component of the monthly PBIP payment and is based on the Entity's performance in the program's resource utilization and clinical quality measures. Each individual measure has a performance multiplier value assigned, and the Entity's performance in each measure will contribute to the overall performance multiplier. The two components that compose the multiplier are described below in sections 3.a. and 3.b.

3. COMPONENTS OF THE PERFORMANCE MULTIPLIER

3.a. The Resource Utilization Measure.

The resource utilization measure gauges the individual Entity's total cost of care, compared to that of the Medical Home cohort. It is based on the Entity risk-adjusted total allowed cost compared to that of the relevant Medical Home cohort average risk adjusted total allowed cost. The result of the calculation will comprise the resource utilization component of the performance multiplier. **Entities with a ratio of 0.80 or less will receive zero multiplier points for this measure.** An individual Entity's resource utilization measure will be calculated as follows:

$$\frac{\text{C} = \text{Cohort average risk-adjusted total allowed cost PMPM}}{\text{E} = \text{Entity risk-adjusted total allowed cost PMPM}} = \text{Resource Utilization Measure}$$

For purposes of calculating resource utilization performance, a member with annual costs more than \$75,000 will have the amount more than \$75,000 excluded from the calculation. In such case, the member's risk score will be adjusted corresponding to the \$75,000 amount.

3.b. Clinical Quality Measures

The clinical quality measures are defined in Attachment IA Clinical Quality Measures. The measures include Family/Adult Medicine and Pediatric Medicine core and menu measures. Entities must choose between Family/Adult Medicine or Pediatric Medicine Tracks. All six core measures in the chosen track are mandatory and will be used in the quality calculation. The Entity must also choose three menu measures. A total of nine measures will be used to determine the final clinical quality score. The choice of menu measures must be made and communicated to Blue KC no later than November 15, 2019.

An Entity receiving less than 60 percent of applicable quality points will receive zero multiplier points for the quality component. Applicable points are those assigned to core measures in which the Entity has no fewer than 30 members in the HEDIS data set. The expectation is that entities pick three menu measures in which they have at least 30 members in the HEDIS data set.

Please note that some of the measures carry a single weight and some are double weighted.

The final multiplier for an Entity in this measure will be the percentage of applicable points received.

For example, if there are 13 quality points that are applicable to the Entity, and the Entity receives nine of those points the Entity will earn 69 percent of applicable points in this measure set. The Entity will receive 0.69 points toward their final performance multiplier (Example 3b-1).

Example 3b-1: Family/Adult Medicine Quality Example

Family/Adult Medicine Quality Example						
	Measure	Weight	Goal	Score	Earned Points	Available Points
Core Measures	Cervical Cancer Screening	Single	80.00%	84.00%	1	1
	Colorectal Cancer Screening	Single	70.00%	78.00%	1	1
	Diabetes Care: Nephropathy	Double	93.00%	83.00%	0	2
	Medication Management for People with Asthma	Single	57.00%	61.00%	1	1
	Plan All-Cause Readmission (lower the better)	Double	0.67	0.40	2	2
	Avoidance of Antibiotic Treatment in Adults with acute bronchitis	Single	31.00%	35.00%	1	1
Menu Measures (Pick 3)	Diabetes Care: Poor Control	Double	40.00%	38.00%	2	2
	Adult BMI Assessment	Double	77.00%	15.00%	0	2
	HbA1c testing	Single	94.00%	94.00%	1	1
Total Points					9	13
Quality Multiplier					0.69	

Pediatric Medicine Quality Example						
	Measure	Weight	Goal	Score	Earned Points	Available Points
Core Measures	Weight Assessment Children/ Adolescents	Double	71.00%	71.00%	2	2
	HPV Vaccination	Single	22.63%	10.00%	0	1
	Well Child Visits within the first 15 months of life	Single	88.33%	84.00%	0	1
	Well child visits in the third, fourth, fifth and sixth years of life	Single	82.70%	79.00%	0	1
	Medication Management for People with Asthma	Double	44.27%	31.00%	0	2
	Appropriate Treatment for Children with Upper Respiratory Infection	Single	8.5%	6.9%	1	1
Menu Measures (Pick 3)	Chlamydia Screening	Single	44.00%	42.00%	0	1
	Adolescent Well-Care Visit	Double	58.00%	68.00%	2	2
	Appropriate Testing for Children with Pharyngitis	Double	90.00%	91.00%	2	2
Total Points					7	13
Quality Multiplier					0.5385 = 0	

4. FINAL DETERMINATION

The final determination of the performance multiplier will be the sum of the points from the resource utilization and clinical quality measures. This sum will be multiplied by two to create the final Performance Multiplier.

For example, an Entity with an Entity Risk Adjusted Total Allowed Cost of \$350 PMPM compared to a relevant Cohort Average Risk Adjusted Total Allowed Cost of \$375 PMPM would receive a multiplier of 1.07 ($\$375/\$350 = 1.07$ resource utilization measure).

If that Entity also scored 75 percent of applicable clinical quality points, it would receive a multiplier of 0.75 for the clinical quality measure. $75\% = 0.75$.

The Entity's final performance multiplier will be the sum of their points in these measures or $(1.07+0.75) = 1.82$. This amount will then be multiplied by 2.0, yielding a final performance multiplier of 3.64. If their base payment produced approximately \$3.15 PMPM their monthly PBIP payment will be approximately \$11.47 PMPM (3.64 times \$3.15). $2(1.07+0.75) \times \$3.15 = \11.47 .

Example Calculation of PBIP:

$$\text{PBIP Payment} = \text{Base Payment} \times 2 \text{ (Performance multiplier)}$$

$$\text{Performance Multiplier} = 2 \text{ (Cohort average risk adjusted total allowed cost pmpm)} \\ / \text{ (Entity risk adjusted total allowed cost pmpm) + Quality Performance)}$$

$$\text{Performance Multiplier} = ((\$375/\$350)=1.07) + .75 = 1.82 \times 2 = 3.64$$

$$\text{PBIP Payment} = \$3.15 \times 3.64 = \$11.47 \text{ PMPM}$$

ATTACHMENT IA

Clinical Quality Measures

Core Family/Adult Medicine Measures

Measure Name	NQF Number	Steward	Description	Weight	Reporting Type	Targeted Goal
Core Measures						
Cervical Cancer Screening	0032	National Committee for Quality Assurance	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer	Single	Claims, Medical Records, or Data Feed	80%
Colorectal Cancer Screening	0034	National Committee for Quality Assurance	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer	Single	Claims, Medical Records, or Data Feed	70%
Avoidance of Antibiotic Treatment in Adults with acute bronchitis	0058	National Committee for Quality Assurance	Percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within 3 days after the episode date	Single	Claims based only	31%
Medication Management for People with Asthma	1799	National Committee for Quality Assurance	Percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period	Single	Claims based only	57%
Plan All-Cause Readmission	1768	National Committee for Quality Assurance	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Count of Expected 30-Day Readmissions	Double	Claims based only	0.67
Comprehensive Diabetes Care: Medical Attention for Nephropathy	062	National Committee for Quality Assurance	Percentage of members 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	Double	Claims and Medical Records	93%

Core Pediatric Medicine Measures

Measure Name	NQF Number	Steward	Description	Weight	Reporting Type	Targeted Goal
Core Measures						
Medication Management for People with Asthma	1799	National Committee for Quality Assurance	Percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.	Double	Claims based only	44.27 %
HPV Vaccination	1407	National Committee for Quality Assurance	HPV vaccinations either 2 or 3 dose as recommended by the age of 13 years. Where the first and second vaccine are at least 146 day apart. Measure contains both males and females	Single	Claims and Medical Records can be submitted	22.63%
Well Child Visits within the first 15 months of life	1392	National Committee for Quality Assurance	Percentage of members who turned 15 months old during the measurement period, who had 6 or more well-child visits with a PCP that were 14 days apart during their first 15 months of life.	Single	Claims based only	88.33%
Well child visits in the third, fourth, fifth and sixth years of life	1516	National Committee for Quality Assurance	Percentage of children ages 3 -6 that had one or more well-child visits with a PCP during the measurement year.	Single	Claims based only	82.70%
Child Weight Assessment	0024	National Committee for Quality Assurance	Percentage of members ages 3-17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender	Double	Claims or Data Feed	71.00%
Appropriate Treatment for Children with Upper Respiratory Infection	0069	National Committee for Quality Assurance	Percentage of children ages 3 months to 18 years who were given a diagnosis of URI and not prescribed antibiotics	Single	Claims based only	8.5%

Menu Measures for Family Medicine, Adult and Pediatric

Menu Measures (Pick 3)						
Adolescent Well-Care Visit	1407	National Committee for Quality Assurance	Percentage of members ages 12-21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Double	Claims based only	58.00%
Appropriate Testing for Children with Pharyngitis	0002	National Committee for Quality Assurance	The percentage of children 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received group A strep test within 3 days prior or 3 days after, the episode date.	Double	Claims, Medical Records, or Data Feed	90%

Menu Measures (Pick 3) (Continued)						
Adult BMI Assessment	1690	National Committee for Quality Assurance	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	Double	Claims or Data Feed	77%
HbA1c testing	0057	National Committee for Quality Assurance	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year	Single	Claims, Medical Records, or Data Feed	94%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059	National Committee for Quality Assurance	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who's HbA1c level is >9.0% or is missing a result, for the most recent HbA1c performed during the measurement year.	Double	Claims, Medical Records, or Data Feed	40%
Comprehensive Diabetes Care: Eye Exam	0055	National Committee for Quality Assurance	Percentage of members 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	Single	Claims and Medical Records can be submitted	59%
Chlamydia Screening	0033	National Committee for Quality Assurance	Percentage of women 16-24 years of age that were identified as sexually active and had at least one test for Chlamydia in the measurement year	Single	Claims or Data Feed	44%
Use of Imaging Studies for Low Back Pain	0052	National Committee for Quality Assurance	Percentage of members 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis	Single	Claims only	80%
Controlling High Blood Pressure	0018	National Committee for Quality Assurance	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	Double	Claims or Data Feed	57%
Antidepressant Medication Management – Continuation Phase	0105	National Committee for Quality Assurance	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 180 days (6 months).	Single	Claims based only	56.00%

ATTACHMENT II

Administration of the Developmental Review Process (DRP)

ENTITIES SUBJECT TO DRP IN 2019:

Medical Home Entities *will* be required to go through the Development Review Process (DRP) assessment in 2019 unless they meet any of the following criteria:

- An Entity who completed the DRP in 2018 is not required to complete a DRP in 2019.
- An Entity in the top 70th percentile of the Medical Home cohort in resource utilization and quality performance from the previous performance year is not required to complete the DRP.
- An Entity that chooses or is required to advance from one tier to another must complete the DRP unless the Entity is in the top 70th percentile of the Medical Home cohort for resource utilization and quality performance from the previous performance year.
- An Entity PCMH recognized, certified or accredited by National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) or Accreditation Association for Ambulatory Health Care (AAAHC). Other PCMH CMS approved accrediting body recognition or certification may be accepted on a case-by-case basis.

Blue KC's Medical Home Program accepts recognition or accreditation under certain third-party programs as meeting the DRP standards for participation in the Blue KC Medical Home Program. Practice location(s) or Entities must have active recognition, certification or accreditation at the highest level of performance in any one of the following PCMH programs will not need to complete the DRP (Table 1. below). Recognition or accreditation must be active and maintained as active throughout the practice locations participation in the Blue KC Medical Home Program. Entities must report ongoing recertification/reaccreditation results **before** the date of expiration to _medical_home@bluekc.com. Entities must inform Blue KC by November 15 of their intent to re-accredit/re-certify a location who will expire in the following calendar year. A Medical Home Entity may meet the tier requirements with a mix of qualifying components (i.e. if an Entity needs to qualify six locations, some may be accredited/recognized, and some may complete the DRP). Blue KC will not send reminders to practices that their recognition status is about to expire.

New applicants not recognized or accredited will be subject to an initial review at the time the new Entity applies for admission into the Blue KC Medical Home Program. Existing Blue KC Medical Home Entities, regardless of their Tier assignment will be reviewed every two years, except as otherwise noted herein.

Recognition, Accreditation or Certification Programs

Recognizing Agency	Level of Performance	Program Requirements
National Committee for Quality Assurance NCQA-PCMH	Current Recognition	<ul style="list-style-type: none"> • Provide the Evaluation Report from NCQA • Application only for Medical Home locations in Established Medical Home Entities
Accreditation Association of Ambulatory Health Care AAAHC	Current Accreditation	<ul style="list-style-type: none"> • Provide a Letter of Accreditation and Feedback Report • Application only for Medical Home locations in Established Medical Home Entities
The Joint Commission TJC	Current Accreditation	<ul style="list-style-type: none"> • Provide a Letter of Accreditation and Report • Application only for Medical Home locations in Established Medical Home Entities

DEVELOPMENTAL REVIEW PROCESS (DRP):

For Medical Home Entities with more than one location, Blue KC will select the locations for review at its sole discretion and notify the Entity within 30 days of notification of DRP submission. Documentation provided by the location to demonstrate adherence to the DRP requirements should be no older than January 1, 2018. For those Entities with more than one location, documentation that applies to all locations can be submitted once with a notation that it applies to all locations (i.e. policy or procedure).

If an Entity has questions about the process, a phone call or site visit can be set up for guidance and coaching on document preparation, or to preview examples of documentation of DRP requirements.

Documentation Required

The source of information for the DRP will come from documentation provided by the Entity and/or from on-site review of the Entity by Blue KC. Documentation required for each element is outlined in "Evidence Required" below.

Submission of Documentation

Entities may begin submission of documentation January 1, 2019 through December 31, 2019. No documentation will be received after December 31, 2019 for the 2019 DRP. Entities are asked to notify Blue KC in advance of documentation submission and when submission is complete by emailing _medical_home@bluekc.com. In addition, a key contact person for the Entity must be identified in the email with information on how to contact him/her in case of questions. DRP information is to be submitted via Blue KC's HIPAA compliant platform, kiteworks (formerly known as Accellion). Folders for each location associated with Entity can be found in kiteworks and should be used accordingly. It is recommended that names of any individuals who serve as a back-up to the key contact also be provided to Blue KC.

DRP Review and Report

Blue KC will evaluate DRP documentation within 30 days of receipt of all documents. Blue KC may contact an Entity with questions or for clarification during this time.

Entities will receive a written report containing results and Tier assignment via email from _medical_home@bluekc.com at the end of the evaluation. The Tier assignment will be administered in the July 1, 2020 PBIP payment.

Appeals

Entities wishing to appeal findings have 14 calendar days from receipt of Blue KC determination to provide additional documentation. Blue KC will provide a written response to the Entity following review of additional information within 14 calendar days. All decisions are final and subject to Blue KC's sole discretion.

All patient examples [MUST BE de-identified](#). Documentation containing Protected Health Information (PHI) will be destroyed and not considered for evaluation, and will require a new submission within the seven-day window.

Blue Cross and Blue Shield of Kansas City (Blue KC) as a HIPAA covered Entity is committed to protecting Personal Health Information (PHI). Blue KC strives to eliminate non-Blue KC member PHI from our environment. Any non-Blue KC member PHI erroneously submitted for the DRP review will NOT be retained or returned. All such documentation will be immediately (securely) discarded.

DEVELOPING MEDICAL HOME REQUIREMENTS

Entities new to Blue KC's Medical Home Program (with no prior equivalent accreditation/recognition), will be initially assessed using the DRP framework to determine their readiness to function as a Medical Home Entity, and identify developmental opportunities as they progress.

1.A. ACCESS

ELEMENT	EVIDENCE REQUIRED
1.A. The Entity evaluates supply and demand for routine and same-day appointments.	<p>1.A.1. The Entity provides evidence of at least two reviews of supply and demand within a 12-month period by practice location for routine and same day appointments. For example, working days to 3rd next available appointment by appointment type (preventive, routine, and same-day). Written documentation of evidence is required, e.g. schedules.</p> <p>1. A.2. The Entity demonstrates goals toward same day access (SMART: Specific, Measurable, Achievable, Relevant, Time-bound). The Entity also shows evidence of performance improvement for goals not met for same day access and evaluation of effectiveness.</p> <p>1.A.3. Entities applying to the Blue KC Medical Home Program that are unable to meet 1.A.1. and 1.A.2. must provide a documented process of how supply and demand will be evaluated and a schedule of the frequency of ongoing review and performance improvement plan.</p>

1.B. ROLES AND RESPONSIBILITIES

1.B. The Entity provides practice staff job descriptions of key roles and training/ orientation protocols.	<p>1.B.1. The Entity clearly outlines key functional roles and responsibilities to include care management, referral tracking, care coordination and physician/ administrative leadership. Examples of evidence include job descriptions, policies, guidelines, etc.</p> <p>1.B.2. The Entity has a draft of training/ orientation resources covering care management and care coordination role training. Evidence may include Blue KC training resources</p>
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1.C. MEDICAL HOME INFORMATION

1.C. The Entity provides pertinent information about the medical home to its patients.	<p>11.C.1. The Entity provides drafts of materials planned to be provided to patients describing their role and responsibilities and that of the medical home including information on hours of operation, making appointments, after-hours access, scope of services, availability of patient education resources, self-management support and practice points of contact.</p> <p>1.C.2. For Entities that provide medical home information online, evidence on how this information is communicated to patients is required.</p> <p>1.C.3 For new entities, a specific timeline of implementation is required</p>
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1.D. COLLABORATION/ENGAGEMENT WITH BLUE KC

1.D. The Entity works collaboratively with and maintains ongoing communication with Blue KC Value Based Programs.	<p>1.D.1. Blue KC maintains this information:</p> <p>Attendance at no less than 75% of Blue KC meetings to include:</p> <ul style="list-style-type: none"> • Joint Operating Committee (JOC) meetings. These are scheduled meetings between Entity leadership and Blue KC. • Care Coordination Forums (Documentation at Forums is by signature during registration of the event). • Collaboration with assigned Healthcare Transformation Consultants. Documentation of visit dates and summaries are maintained by Blue KC.
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ESTABLISHED MEDICAL HOME REQUIREMENTS

Entities submitting documentation for the Established Tier will use the following set of elements:

2.A. ACCESS

ELEMENT	EVIDENCE REQUIRED
2.A. The Entity evaluates supply and demand for routine and same-day appointments.	<p>2.A.1. The Entity provides evidence of at least two reviews of supply and demand within a 12-month period by practice location for routine and same day appointments. For example, working days to 3rd next available appointment by appointment type (preventive, routine and same day). Written documentation of evidence is required, e.g. schedules.</p> <p>2.A.2. The Entity demonstrates goals toward same day access (SMART: Specific, Measurable, Achievable, Relevant and Timebound). The Entity also shows evidence of performance improvement for goals not met for same day access and evaluation of effectiveness.</p>

2.B. ROLES AND RESPONSIBILITIES

2.B. The Entity provides practice staff job descriptions of key roles and training/orientation protocols.	<p>2.B.1. The Entity clearly outlines key functional roles and responsibilities to include: care management, referral tracking, care coordination and physician/provider and administrative leadership. Examples of evidence include: job descriptions, policies, guidelines, etc.</p> <p>2.B.2. The Entity has training/orientation protocols covering care management and care coordination role training.</p>
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2.C. MEDICAL HOME INFORMATION

2.C. The Entity provides pertinent information about the medical home to its patients.	<p>2.C.1. The Entity provides materials to patients describing their role and responsibilities and that of the medical home including information on hours of operation, making appointments, after-hours access, scope of services, availability of education, self-management support and practice points of contact.</p> <p>2.C.2. For Entities that provide medical home information online, evidence on how this information is communicated to patients is required.</p>
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2.D. COLLABORATION/ENGAGEMENT WITH BLUE KC

<p>2.D. The Entity works collaboratively with and maintains ongoing communication with Blue KC Value Based Programs.</p>	<p>2.D.1 Blue KC maintains this information:</p> <p>Attendance at not less than 75% of Blue KC meetings to include:</p> <ul style="list-style-type: none"> • Joint Operating Committee (JOC) meetings. These are scheduled meetings between Entity leadership and Blue KC. • Care Coordination Forums (Documentation at Forums is by signature during registration of the event). • Collaboration with assigned Health Care Transformation Consultants. Documentation of visit dates and summaries are maintained by Blue KC.
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2.E. CARE MANAGEMENT AND CARE PLANNING

<p>2.E. The Entity uses an evidence-based risk stratification process to identify patients for focused care management.</p> <p>In addition, the Entity has a functioning population health tool or process that generates reports/lists for specific rising and high-risk subpopulations.</p>	<p>2.E.1. The Entity provides a written description of the risk stratification process it uses to identify rising and high-risk patients.</p> <ul style="list-style-type: none"> • This could be an algorithm, a list of criteria, or population level stratification. It MUST be an evidence-based approach. <p>Examples:</p> <ul style="list-style-type: none"> • https://nf.aafp.org/Shop/practice-transformation/risk-stratified-care-mgmt-rubric • https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf • Risk stratification methodology may include medical, behavioral, social needs, and utilization metrics as reported in BDTC Insights <p>2.E.2. The Entity provides a list of Blue KC rising and high-risk members with assigned risk categories within the last 12 months (from submission).</p> <ul style="list-style-type: none"> • Preferably within the EHR if capability is present. • If EHR does not have risk stratification capability, please provide written evidence. <p>2.E.3. For the five Blue KC members with assigned risk categories in 2.E.2, the Entity provides evidence of longitudinal care management.</p> <p>2.E.4. Entities are also required to submit five patient-centered care plans which must include the following:</p> <ul style="list-style-type: none"> • Patient preferences • Patient goals • Progress towards goals • Identified barriers • Self-management tools <p>In addition:</p> <ul style="list-style-type: none"> • Care plans must be in easy to understand language and dated within the last 12 months. • Examples of self-management tools are available upon request. <p><i>*Treatment/SOAP notes will NOT meet this requirement.</i></p> <p>2.E.5. The Entity provides at least one redacted sample report/list for its relevant subpopulations (criteria-specific) based on care needs in any of the following areas:</p> <ul style="list-style-type: none"> • Preventive Care/Wellness/Screenings • Complex Chronic Conditions (e.g. DM, Asthma, etc.) • Behavioral health needs • Health services utilization (Inpatient & ED discharges) <p>List can be generated from an Internal Registry, a Decision Support tool or a similar report.</p>
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2.F. POPULATION HEALTH MANAGEMENT

<p>2.F. The Entity manages the health outcomes of its entire population through a structured performance improvement program.</p>	<p>2.F.1. The Entity selects a TOTAL of four measures with no more than two in each of the following categories:</p> <ul style="list-style-type: none"> • Preventive Care (Screenings, Immunizations, etc.) • Acute Care (URI, UTI, Otitis Media, etc.) • Chronic Care (HTN, DM, etc.) • Resource Utilization (ED, Readmissions, etc.) <p><i>Note: A written document showing a list of selected measures is required; medical home measures are recommended.</i></p> <p>2.F.2. The Entity clearly states goals (SMART) around selected measures, progress made, identified barriers and evidence of performance improvement.</p> <p><u>For example:</u></p> <p>An Entity may set a goal to screen 80% of its eligible patient population for breast cancer within the measurement period (Jan - Dec). At the end of the year, only 65% of those eligible got mammograms. In other words, the goal of 80% was not met. The Entity will then be required to submit documentation that outlines why the goal was not met, opportunities for improvement and selected actions for the next measurement period. If goal was met, then clearly identify and state with a focus on performance improvement.</p> <p>2.F.3. The Entity must also provide evidence of quarterly meetings involving a multidisciplinary team.</p> <ul style="list-style-type: none"> • Dated meeting minutes are mandatory for this requirement. • Quarterly meetings – Entity must provide at least two meetings within the last 12-month period from the date of submission. • Multidisciplinary team – Must involve at least two types of healthcare professionals preferably, but not limited to, MD, DO, APRN/RN/LPN, Pharmacist, Behavioral Health Professional, Practice Manager, MA, etc. <p>Evidence of selected quality measures (2.F.1), Performance Improvement (2.F.2) and Multidisciplinary team meetings (2.F.3) can be demonstrated within the same document.</p>
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2.G. REFERRAL TRACKING

<p>2.G. Entity shows the system used to track referrals to Specialist, Imaging and Labs.</p>	<p>2.G.1. Entity provides five examples of referral tracking to include: three Specialists and two of either Lab or Imaging.</p> <p>Evidence should show:</p> <ul style="list-style-type: none"> • Referral Tracking (specialist report and PCP follow-up). • Imaging and Lab results/report. • PCP receipt of results/report. • Timely patient notification of results. <p>2.G.2. Entity provides evidence of one collaborative care agreement. Agreement must outline:</p> <ul style="list-style-type: none"> • Responsibilities of both parties. • Timely exchange of test results and Specialist report. • A clear definition of communication responsibilities. <p>Collaborative care agreements should be documents in which primary care practices and specialty practices agree on expectations for communication to improve care transitions and build stronger relationships. Your practice should formalize these agreements in a manner acceptable to your practice and the specialty group. This formalization often includes securing signatures by leaders from both practices.</p>
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2.H. TRANSITIONS OF CARE (TOC)

<p>2.H. The Entity manages its population during care transitions including medication reconciliation.</p> <p>**Specific care settings for TCM includes, but is not limited to: IP Acute Care Hospital, IP Psychiatric Hospital, LTC Hospital, SNF, IP Rehab Facility, Hospital outpatient observation or partial hospitalization, Partial hospitalization at a Community Mental Health Center</p>	<p>2.H.1. The Entity provides five examples of Blue KC patients that were contacted within two business days of an inpatient discharge via interactive means (e.g., phone calls, email or face-to-face). Evidence must show the following:</p> <ul style="list-style-type: none"> • Discharge dates and contact dates • A follow-up PCP appointment should be made per patient complexity as follows: <ul style="list-style-type: none"> o Transitional care management services with high medical decision complexity (face-to-face visit within seven days of discharge). o Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge). <p>2.H.2. Entities must provide three examples of comprehensive medication reconciliation (preferably within the EHR) following an inpatient stay.</p> <p>Evidence MUST include:</p> <ul style="list-style-type: none"> • A medication list prior to admission. • A current medication list post-discharge. • Documents must be dated and signed by physician.
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2.I. BEHAVIORAL HEALTH INTEGRATION

<p>2.I. The Entity has a protocol for annual and chronic care follow-up visits to assess patients' behavioral needs.</p>	<p>2.I.1. The Entity provides written description of the tool used to assess behavioral health.</p> <ul style="list-style-type: none"> • Identify which evidence-based or certified screening tools are used and what the protocol for use is. (e.g. PHQ2, PHQ9, GAD-7) • Provide at least three redacted patient examples where the tool was utilized. <p>2.I.2. For positive findings on behavioral screenings, the Entity provides three redacted patient examples of actions taken to address patient needs.</p> <ul style="list-style-type: none"> • Documentation must be included in the EHR. • DO NOT submit examples of patients with alcohol or substance abuse concerns.
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2.J. PATIENT EXPERIENCE

<p>2.J. The Entity assesses patient experience with a survey at least twice a year OR conducts patient advisory meetings at least twice a year to assess core elements of patient experience within the practice.</p> <p>Recommended focused topics around medical home concepts:</p> <ul style="list-style-type: none"> • Access to care • Patient-centered care • Responsiveness of care team • Care coordination 	<p>2.J.1. Provide a blank patient experience survey.</p> <p>A summary report for the last two surveys showing all aggregate scores for locations selected for the DRP.</p> <p>OR</p> <p>2.J.2. Provide a summary of the most recent patient advisory meeting(s) that includes:</p> <ul style="list-style-type: none"> • A summary of the most recent quarter's meeting; • A list of attendees (redacted PHI); • A summary of items discussed and action planning by location/Entity. <p>2.J.3. The Entity clearly states goals (SMART) around selected performance improvement opportunities and includes a summary of staff assessment/discussion of goals, progress toward the goals, barriers and performance improvement opportunities from the survey or advisory meeting results.</p>
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IMPORTANT INSTRUCTIONS REGARDING ACCEPTABLE DOCUMENTATION

The following are requirements **for ALL DOCUMENTATION** submitted. Documents that are missing any of these elements will not be considered for evaluation and no credit will be given. This can have significant impact to the final Developmental Review Process (DRP) scoring and could affect Tier assignment.

1. Each submitted document **MUST** contain the name of the practice clearly identified at the top of the page. Practice branded documents are preferred. (See example below.)
2. The following annotation is required:
 - a. Which element is covered in the documentation in a text box at the top right-hand of the document:
 - b. In addition, there must be annotation to describe how the policy or process meets the requirement to meet the expected documentation. For patient examples show how the documentation meets the requirement.

IA) Access to Care/Practice Assess
appointment availability.

For example, for care plans show where the patient had input to their care plan by completing a summary for the provider. Or, for referral tracking use examples and describe the process for how the specialists' referrals are tracked to completion.

Written documentation must include an explanation of how tracking is done and documented in the patient's record.

2D) Example: Patient self-care goals are incorporated
in providers' notes and scanned in the record.

Name of Practice Address City, State Phone number	DRP Element
Element/documentation can go here	

1. Data for examples cannot be more than 12 months old (January of 2018).
2. Naming documents: Due to limitations within the HIPAA complaint kiteworks platform, file naming conventions must have a limited number of letters and numbers. **No characters such as &, #, or @ can be accepted, as these documents cannot be downloaded for review from kiteworks.** Documents should contain labels as follows (where PRAC is equivalent to a practice's first four letters or the 3-4 initials of the practice.) A list of Entity/practice names can be reviewed prior to submission. TIF formatted documents cannot be accepted.

DEVELOPING

PRAC1A Accs
PRAC1B Roles
PRAC1C Info
PRAC1D BKC

ESTABLISHED

PRAC2A Accs
PRAC2B Roles
PRAC2C Info
PRAC2D BKC
PRAC2E Risk
PRAC2F Qual
PRAC2G Refr
PRAC2H TOC
PRAC2I BEHV
PRAC2J PtExp



ATTACHMENT III

Glossary of Terms

Accreditation Association for Ambulatory Health Care (AAAH) – An accrediting body that accredits ambulatory care locations as medical homes.

After Hours Visit – A routine visit provided outside of 8:00 A.M. to 5:00 P.M. Monday through Friday.

Attribution – The method of associating patients with a Primary Care Physician.

Base Payment – The portion of the Performance Based Incentive Program that is driven by the risk of the attributed patient population.

Comprehensive Primary Care Payment (CPCP) – The amount paid on a per-attributed-member-per-month (PMPM) basis that reflects a specific discount from the eligible Blue KC fee schedule for Evaluation and Management CPT Codes. This payment also includes factors for the ratio of paid to billed patients and specific inflation factors and incentives.

Continuous Quality Improvement (CQI) – A method of performance improvement focusing on incremental process, workflow and systems development.

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. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options for primary care physicians participating in Medicare.

Developing Tier – The entry level to the Blue KC Medical Home Program.

Entity – The legal owner of a medical practice.

Established Tier – The level at which mature Medical Home Entities participate in the Blue KC Medical Home Program.

Evaluation and Management Codes (E&M) – The specific CPT codes denoting cognitive services provided by a primary care physician that are used to drive the attribution process.

Home Member – A member of an employer group or an individual with a Blue Cross and Blue Shield of Kansas City insurance agreement.

Host Member – A member of an employer group or an individual with a Blue Cross and Blue Shield insurance agreement written by a plan other than Blue Cross and Blue Shield of Kansas City that is receiving services in the Blue KC service area.

Medical Home – A primary care practice that meets the requirements of the Blue KC Medical Home Program and pursues improved quality, lower cost and higher patient satisfaction using population health management, care management and coordination, and patient engagement. Often referred to as a Patient Centered Medical Home (PCMH).

Medical Home Entity – The legal owner of the Medical Home and its Medical Home Locations.

Medical Home Location – A physical site at which primary care services are rendered by primary care physicians employing the Medical Home model.

National Committee for Quality Assurance (NCQA) – An accrediting body that accredits ambulatory care locations as Patient Centered Medical Homes.

Performance Multiplier (PM) – The portion of the Performance Based Incentive Program that is based on the performance of the Medical Home Entity and is used as a multiplier to the base payment to determine the Medical Home Entity's payment under the Performance Based Incentive Program.

Practice Transformation (transformation) – The process of moving primary care away from the traditional delivery model to focus on achievement of the triple aim; improving quality, patient experience and cost performance. This also involves migration from a total fee-for-service payment model to a model that includes population-based payments as well.

Primary Care Physician (PCP) – A Blue KC credentialed physician practicing in the specialties of Family Medicine, Adolescent Medicine, Internal Medicine, Geriatrics or Pediatrics. Credentialed general practice physicians are also eligible.

Risk Score – The evaluation of the actuarial risk of an attributed patient based on the Milliman Advanced Risk Adjustors concurrent risk assessment process (MARA) which utilizes several factors including clinical acuity, age, sex and utilization factors to determine the effect of these factors on the expected cost of that patient.

Routine Office Visit – An appointed or walk-in visit for non-emergent services.

The Joint Commission (TJC) – An accrediting body that accredits ambulatory care locations as medical homes as well as hospitals and other medical providers.

Urgent Care Visit – A non-appointed visit for non-emergent services at a location holding an Urgent Care contractual agreement with Blue KC.



Kansas City

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