Blue Cross and Blue Shield of Kansas City

Primary Care First Program Guide

Family Medicine Track

Program Year January 1, 2022 – December 31, 2022

Kansas City

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Introduction

The aim of the Blue Cross and Blue Shield of Kansas City (Blue KC) Primary Care First (PCF) Program is to help support practice transformation efforts and changes in care delivery through programs and incentives that reward our provider partners for delivering superior patient centered care.

The PCF Program builds upon previous medical home and Advanced Primary Care programs that have been offered by Blue KC while continuing to support primary care practices that are:

- Actively identifying and focusing on Blue KC members that are most likely to benefit from interventions.
- Incorporating screening of social determinants of health and collaborating with critical stakeholders to address.
- Performing and monitoring transitions of care for all Blue KC members
- Addressing interoperability in order to easily communicate medical information securely across provider and payer systems to improve coordination of care.

This guide establishes terms and conditions for participation in the Blue KC PCF Program. As a requirement to participate in the PCF Program, Entities generally must agree to be bound by the terms and conditions of the Program. However, this guide is not intended to replace any contradictory provisions in any accountable care, network, shared savings/risk, 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Blue KC compensating the Entity for primary care services to Blue KC members, and the terms of this guide are expressly superseded by such Other Agreements according to the terms of those Other Agreements. This agreement does not constitute a provider contract or otherwise amount to a guarantee of any compensation to a Primary Care Physician. To that end, Blue KC retains the sole discretion and exclusive right to modify the PCF Program in such ways and at such times as Blue KC may deem necessary, subject to any legally required review by the Missouri Department of Insurance.

Conditions for Participation

1. Participation in the Blue KC PCF Program is open to Primary Care Physicians, Nurse Practitioners, and Physician Assistants within Blue KC's 32-county service area.
    a. PCPs are defined as physicians credentialed by Blue KC in the specialties of Family Medicine, Adolescent Medicine, Internal Medicine, Geriatrics or Pediatrics.
    b. Credentialed General Practice physicians.
    c. Credentialed Family, Adult, Geriatric and Pediatric Nurse Practitioners practicing in a primary care setting.
    d. Credentialed Physician Assistants practicing in a primary care setting.
2. Participating providers practice at a Primary Care location that is owned by a Primary Care Entity. A Practice Entity is the legal owner of the Primary Care location.
3. Entities are required to have a minimum of 250 eligible, attributed Blue KC members.
4. Entities are required to maintain patient records in an electronic health record (EHR) that has adopted the current CMS-required version of Certified Electronic Health Record Technology (CEHRT).
5. Entity Administrators, providers, and/or staff members are expected to attend 75% of the offered meetings or forums within the Program year. This includes both:
    a. Attendance and participation at quarterly meetings with assigned Healthcare Transformation Consultant.
    b. Attendance and participation at Blue KC sponsored Primary Care forums (face-to-face or virtual).
6. Entities not participating in a delegated credentialing agreement must communicate changes or updates regarding provider(s), practice location(s), name changes, and/or organization to Blue KC within 30 days, by sending an email to Provider_Data@BlueKC.com. Entities participating in a delegated credentialing agreement with Blue KC must follow the terms of the agreement.
    a. PCF payments may take up to 90 days to begin or change once notification of a change impacting payments has been received by Blue KC.
    b. Delays in notification may result in payment delays.
    c. PCF participants will not receive retroactive payments following failure to timely notify Blue KC of changes.
7. Entity must have in place and maintain all Care Delivery Principles and complete PCF Care Delivery Reporting annually by January 31st following the program year.

8. Without limiting any other data access rights set forth elsewhere in Entity's Other Agreements, Entity shall permit Blue KC to have access to and the right to perform an audit, examine, copy, excerpt and transcribe any books, documents, papers, and/or records related to any PCF Program eligible and attributed member at no cost to Blue KC.
    a. If records are not provided in the timeframe specified by Blue KC, or the records are incomplete, Blue KC reserves the right to reduce or withhold payment under the PCF Program.
9. The Entity must fully and accurately complete an attestation of Social Determinants of Health screening process.
    a. If this attestation is inaccurate, incomplete, or not received by the deadline specified by Blue KC, Blue KC reserves the right to reduce or withhold payment under the PCF Program.

Care Delivery Principles

Care Delivery Principle 1: Access to Care and Information

1.1 Provide after-hours access to its attributed members, bill at the office visit level and collect the office visit co-pay if the members access any site of service associated with the PCF location or Entity.

1.2 Provide pertinent information about the Medical Home/PCF to its patients.

1.3 Provide 24-hour access to a clinical decision maker.

1.4 Provide alternatives to office visit based care.

1.5 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. If an urgent care contract is not in place, services must be billed as an office visit and office visit benefits will apply.

Care Delivery Principle 2: Coordination of Care

2.1 Provide telephonic transitional care management including medication reconciliation within two business days of discharge for members discharged from a medical admission at an inpatient acute care hospital, long-term care hospital, and/or skilled nursing facility.

2.2 Provide telephonic transitional care management including medication reconciliation within seven calendar days of discharge for members with an Emergency Department visit.

2.3 Coordinate care across the medical neighborhood, accounting for member preferences and value of specialty care.

Care Delivery Principle 3: Care Management and Care Planning

3.1 Entity uses evidence-based risk stratification process to identify patients for focused care management.

3.2 Entity provides longitudinal care management to Blue KC members and care planning with patient-centered goals, with a focused effort to provide care management to members with uncontrolled diabetes as evidenced by an A1C greater than 9.

3.3 The Entity manages the health outcomes of its entire population.

3.4 Provide self-management, education, and support to rising and high-risk members.

3.5 Actively screen, counsel and educate patients on preventive/wellness care.

Care Delivery Principle 4: Linkage to Community Resources

4.1 Maintain a database of community resources specific to population needs.

4.2 Provide connections to community services and resources.

4.3 Proactively screens for Social Determinants of Health using standardized screening questions on at least 70% of the attributed population with a qualifying visit at least once per year.

Care Delivery Principle 5: Performance Improvement and Reporting

5.1 The Entity manages the health outcomes of its entire population through structured Performance Improvement (PI) program. The Entity must consider preventive/wellness care, complex chronic conditions, behavioral health needs and health service utilization.

5.2 Actively measure clinical quality, experience, and cost/utilization.

5.3 Develop action plans when areas of needed improvement are identified.

5.4 Evaluate outcomes of action plans and modify as necessary to ensure continuous PI.

5.5 The Entity participates in annual Care Delivery Reporting with complete and accurate reporting.

Blue KC Responsibilities

1. Provide support, training, and data to assist in understanding financial data and clinical quality information.
2. Facilitate meeting at least quarterly, or more frequently as needed or desired, and provide updates on quality and utilization performance, review the Performance Improvement Plan and provide patient lists for targeted outreach.
3. Provide access to meaningful and actionable data, including but not limited to:
    a. Gaps in care related to PCF Program quality measures
    b. Admits and Discharges
    c. Inpatient Utilization
    d. ED Utilization including list of high utilizers
4. Upon request, participate in data exchange to including a monthly transmission of membership and claims (excluding financial information) files for eligible attributed members.
5. Facilitate live and or virtual forums and educational webinars to support performance improvement and continued transformational efforts.

Application for Primary Care First Participation

Entities interested in applying to participate in the Blue KC PCF Program will need to submit a completed application. The application may be obtained, completed and returned by contacting Blue KC via email at _Value_Based_Programs@BlueKC.com or by working with a Healthcare Transformation Consultant directly.

The Blue KC team will review the application and schedule a time to discuss program eligibility and requirements to determine if the Entity is eligible. Blue KC reserves the right to decline an Entity entrance to participate in the Program if they do not meet the requirements. Final determination will be made by Blue KC within 30 days and the Entity will be notified in writing.

Program Onboarding

Upon acceptance to the Program, the new Entity will begin the on-boarding process, led by a Blue KC Healthcare Transformation Consultant. The purpose of the on-boarding is to prepare the Entity to function successfully in the PCF Program, and includes the following:

- Introduction to Program principles.
- The Entity's responsibilities for managing clinical quality, resource utilization and performance improvement.
- Review Blue KCs PCF payment methodology.
- Overview of Blue KC reporting systems, reports, and resources available.
- Discuss future development of a performance improvement plan based on performance data.

Member Eligibility

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

- Be enrolled in an eligible Blue KC product/network: Blue Care, Preferred Care, Preferred Care Blue, Blue Access, BlueSelect and BlueSelect Plus.
- Have primary insurance coverage with an eligible Blue KC product.
- Member's coverage is underwritten by Blue KC and member resides within the Blue KC 32 county service area or contiguous counties.
- If underwritten by another BCBS Plan, the Host Plan must participate in Value Based Programs.
- Member must have an Evaluation and Management (E&M) office visit claim from a qualifying provider in the last 24 months.
- Additional products and/or networks may be added in the future.

Currently members participating in the following products and programs are excluded from eligibility: Freedom Network, Freedom Network Select, Preferred Health Professionals, Away from Home Care, BCBS Short Term Security, Medicare Advantage and Direct Pay ACA Individual.

Member Attribution

Attribution is a method of associating Blue KC members to a Primary Care Physician (Physician), Nurse Practitioner (NP) or Physician Assistant (PA), collectively called the Primary Care Provider (PCP). Blue KC's Attribution methodology is based on plurality and recency (Figure A). The method considers:

- The Primary Care Provider who has had the most billed Evaluation and Management (E&M) codes over the last 12 months. E&M codes for attribution include code range 99201 – 99499. All E&Ms are equally weighted.
    - Only E&M code range 99201 – 99205, 99211 – 99215 is considered for Place of Service 02 Telehealth – Other than Home and Place of Service 10 Telehealth – In Home.
- Place of service 11 Office, 49 Independent Clinic, 50 Federally Qualified Health Center (FQHC), 71 Public Health Clinic, and 72 Rural Health Clinic
- If there aren't any billed E&M codes for the member over the last 12 months, the lookback period expands to the last 24 months. Members without eligible Primary Care Provider utilization in the prior 24 months are not attributed.
    - Nurse Practitioner and Physician Assistant attribution eligibility became effective January 1, 2022 and is not subject to the lookback period prior to January 1, 2022.

- In the case that there is equal utilization by the member between two Primary Care Providers, during the relevant period, the member will be attributed to the Primary Care Provider with the most recent utilization.

Blue KC analyzes member eligibility and Attribution monthly as part of each PBIP payment cycle. Services provided in an urgent care setting will not be included in the Attribution determination. Members will reattribute based on utilization through the Blue KC Attribution methodology as shown in Figure A.

Figure A. Attribution of Members

Plurality	**Q1**	**Q2**	**Q3**	**Q4**	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.
My Practice					
Other Practice					
Recency	**Q1**	**Q2**	**Q3**	**Q4**	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.
My Practice					
Other Practice					

PCF Program Payment Methodology

The PCF Program Payment is intended to reward performance, support non-visit-based care and augment staffing and training related to care delivery transformation goals. These activities include, but are not limited to improving access to care, care coordination across the healthcare continuum, implementing data-driven performance improvement, and enhancing targeted support to members identified as rising and high risk.

Primary Care First offers two value-based payment mechanisms: a population health payment and a performance-based incentive payment opportunity. The PCF Program Payment does not impact fee-for-service payments that may be specified in the Entity's "Other Agreements".

Entities are eligible for different payment types throughout the Program as shown in Table 1.

Table 1: Payment Types by Entity

Payment Types	New Entity	Established Entity
Population Health Payment	Yes	Yes
Performance-Based Incentive Payment	After participation is greater than 6 months of the performance year (January 2022 – December 2022)	Yes

For example: An Entity joining the Program in April 2022 will be eligible for the Performance-Based Incentive Payment effective July 2023. Participation must be six months or greater in the performance year. An Entity that joins after June 2022 will not be eligible to receive Incentive Opportunity until July 2024.

Population Health Payment

The Population Health Payment is a key component of Primary Care First, with the aim of supporting the resources an Entity needs to provide highly coordinated care for members. Designed to offer increasing payment support in alignment with increasing risk tiering, these payments support care coordination and care management, enhanced targeted support to members with high or rising risk, and care not reimbursed through fee for service.

The Population Health Payment is paid based on a member's MARA risk strata, which is defined by Milliman and updated monthly. The risk strata and payment are evaluated at the member level, not at an aggregate group level. The risk strata and corresponding per member per month payment amounts are detailed in Table 2.

Table 2 – Population Health Payment

MARA Risk Strata	Population Health Payment (PMPM)
Very Low	$0.50
Low	$1.25
Moderate	$3.25
Moderately High	$6.75
High	$10.25
Very High	$15.25

Nine care coordination-related CPT codes will be paid through the Population Health Payment and will not be reimbursed through fee for service. These codes should still be submitted on claims as appropriate. These codes will no longer be paid for any member but will be reimbursed through the Population Health Payment for eligible, attributed members. Those CPT codes are detailed in Table 3.

Table 3 – Care Coordination CPT Codes Not Fee For Service Reimbursable

CPT Code	CPT Description
99484	Care management services for behavioral health conditions, at least 20 minutes
99487	Chronic care management services, at least 60 minutes of clinical staff time
99489	Chronic care management services, each subsequent 30 minutes of clinical staff time
99490	Chronic care management services, at least 20 minutes of clinical staff time
99491	Chronic care management services, at least 30 minutes of physician time
99495	Transitional Care Management with moderate complexity within seven days of discharge
99496	Transitional Care Management with high complexity within 14 days of discharge
99497	Advance Care Planning, first 30 minutes
99498	Advance Care Planning, subsequent 30-minute intervals

All Entities will receive a monthly Value-Based Payment Summary report in a designated folder placed on Blue KC's HIPAA compliant platform, kiteworks, by the 10th of each month.

Performance-Based Incentive Payment

A performance-based incentive payment (PBIP) of up to $12 per member per month (PMPM) is available to eligible Entities based on the cost, quality, and utilization outcomes of the eligible attributed membership. The PBIP is an earned, retrospective payment awarded to Entities who have demonstrated performance outcomes meeting or exceeding program requirements. The awarded PBIP for performance in the 2022 Program Year will be paid monthly, July 1, 2023, through June 1, 2024.

The design of the performance-based incentive payment structure is intended to motivate Entities to demonstrate improved quality of care, reduction of unnecessary and avoidable utilization and achieve cost outcomes comparable to or better than the PCF cohort. The incentive structure is based on design principles that encourage high value care:

- Outcomes are the basis of the performance-based incentive payment.
- Entities are evaluated based on performance across all three domains: cost, quality, and utilization.
- Performance goals and thresholds are transparent and communicated to Entities early in the program year.
- Entities not meeting minimum thresholds will receive a punitive reduction in the awarded performance-based incentive payment.
- Performance measures closely relate to primary care and are measured at the Entity level.

PBIP Components

Entities can earn incentives based on the aggregate performance of four distinct components: 1) quality, 2) utilization, 3) Social Determinants of Health screening and intervention, and 4) cost. A total performance-based incentive payment of $12 PMPM can be awarded, based upon eligibility and performance. Additionally, a $3 PMPM bonus is available to the highest performing Entities who meet all goals at the highest level and fully participate in Social Determinants of Health screening and intervention. An up to $3 PMPM penalty will be levied for any group not meeting minimum performance thresholds.

Quality Component

The guiding principle for the selection of quality measures is to identify indicators of quality of care and measures that will influence a member's long-term health objectives. Six quality measures comprise the Quality Component of the Performance-Based Incentive Payment as shown in Table 3. All quality measures are endorsed by National Committee for Quality Assurance (NCQA) as the measure steward. The Quality Component is 30% of the total incentive opportunity.

Measure Name	NQF Number	Description	Reporting Type
Statin Therapy for Prevention and Treatment of Cardiovascular Disease – Received Statin Therapy	NA	The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.	Claims Only
Antidepressant Medication Management – Continuation Phase	00105	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).	Claims Only
Colorectal Cancer Screening	0034	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	Claims, Medical Record, Data Feed
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	0058	The percentage of episodes for members ages 18-64 with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event on or within 3 days after the episode date.	Claims Only
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose HbA1c level is >9.0% or is missing a result, for the most recent HbA1c performed during the measurement year.	Claims, Medical Records, Data Feed
Controlling High Blood Pressure	0018	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period	Claims, Data Feed

If Medical Record documentation is allowed for a clinical quality measure, records can be submitted through January 15, 2023. Medical records received after January 15, 2023 will not be accepted.

Blue KC recognizes that certain quality measures may become "topped out" or the quality steward changes the specification. These changes occur out of Blue KCs control, in which case Blue KC reserves the right to discontinue/sunset the quality measure accordingly.

Utilization Component

The guiding principle for the selection of utilization measures is to identify actionable measures that can be influenced by access to care and information, care coordination and care management activities that influence members' quality of care and total cost of care. Below are the utilization measures. All utilization measures are endorsed by National Committee for Quality Assurance (NCQA) as the measure steward. The Utilization Component is 30% of the total incentive opportunity.

Measure Name	NQF Number	Description	Reporting Type
Acute Hospital Utilization (AHU)	N/A	Risk-adjusted ratio of observed-to-expected inpatient medical admission and observation stay discharges during the measurement year total among members 18 years of age and older.	Claims Only
Plan All-Cause Readmission	1768	For members 18 years of age and older, the number of acute inpatient and observation 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.	Claims Only
Emergency Department Utilization	N/A	For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.	Claims Only

Blue KC recognizes that certain quality measures may become "topped out" or the quality steward changes the specification. These changes occur out of Blue KCs control, in which case Blue KC reserves the right to discontinue/sunset the quality measure accordingly.

Social Determinants of Health Component

Screening the Blue KC attributed membership for unmet Social Determinants of Health is a commitment to the community and the health of our membership. Systematic screening for Social Determinants and corresponding ICD-10-CM Z code submission when an unmet need is identified is a core aspect to the Primary Care First program. The Social Determinants of Health Component is 15% of the total incentive opportunity.

Measure Name	Description	Reporting Type
Social Determinants of Health (SDoH) Screening and Intervention	At least 70% of attributed members aged 0-74 screened annually for unmet Social Determinants of Health using standardized screening questions, for at least but not limited to, Transportation, Food Insecurity, Social Environment and Housing issues or concerns; and if positive, the appropriate ICD-10-CM Z code or codes are submitted on the date of the positive screen, and interventions are offered to the member. An attestation is also required to meet the measure.	Claims Only

Cost Component

Value is improving outcomes relative to the cost for delivering those outcomes. Measuring cost is central to evaluating the outcomes of Primary Care First. An accompanying guide details the Primary Care First Trend Report that Entities will receive monthly. The Cost Component is 25% of the total incentive opportunity.

Performance Scorecard

The final clinical quality scorecard for the 2022 performance year will be provided to the PCF Entity no later than May 3, 2023, via Kiteworks. Within 14 days after receiving the final reports, Entities agree to notify Blue KC in writing of any disputes regarding their final performance. Entity's written notification must include evidence of exclusion or compliance to the Scorecard results via Kiteworks, but Entity's evidence cannot include any medical records that were not previously submitted to Blue KC prior to the January 15, 2023, deadline. Blue KC will review evidence provided and respond back to Entities with final determination within 14 days of receipt of the dispute.

This is not an opportunity to provide new medical records to bolster performance rates. The dispute period is solely an opportunity for a PCF Entity to review the Scorecard for accuracy and ensure that all medical records previously submitted by the January 15, 2023, deadline were credited to the Scorecard performance.

If the PCF Entity does not dispute the final clinical quality scorecard within 14 days from the

date Blue KC provided the final clinical quality scorecard, the scorecard will be considered final and binding for purposes of the PBIP calculation.

Calculation of Performance Scores

Outcomes inform the earned performance-based incentive payment. These outcomes are based on the percent of eligible points an Entity achieves. Any Quality measure with a denominator of less than 30 will be excluded from the evaluation and eligible points. Quality Compass benchmarks are updated annually. For the Primary Care First program year 2022, the Quality Compass benchmarks from 2019 will be used.

Table 4 – Quality Component Points

Quality Component	Quality Compass 60th Percentile	Quality Compass 75th Percentile	Quality Compass 90th Percentile
Statin Therapy for Prevention and Treatment of Cardiovascular Disease – Received Statin Therapy	3 points	4 points	5 points
Antidepressant Medication Management – Continuation Phase	3 points	4 points	5 points
Colorectal Cancer Screening	3 points	4 points	5 points
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	3 points	4 points	5 points
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	3 points	4 points	5 points
Controlling High Blood Pressure	3 points	4 points	5 points

Table 5 – Utilization Component Points

Utilization Component	Quality Compass 60th Percentile	Quality Compass 75th Percentile	Quality Compass 90th Percentile
Acute Hospital Utilization	6 points	8 points	10 points
Plan All-Cause Readmission	6 points	8 points	10 points
Emergency Department Utilization	6 points	8 points	10 points

Table 6 – Social Determinants of Health Component Points

SDoH Component	Does Not Meet Criteria	Meets Criteria
SDoH Screening of 70% of eligible membership *	0 points	10 points
SDoH Screening of 70% of eligible membership and a 2% or greater positivity rate demonstrated by eligible ICD-10-CM Z codes identified in the Blue KC Primary Care First Program Measure Specifications*	0 points	15 points

*An Entity may earn points for meeting one criteria

Table 7 – Cost Component Points

Cost Component	Relative Efficiency >1.050	Relative Efficiency 1.049-0.949	Relative Efficiency <0.950
Cost Evaluation	15 points	20 points	25 points

Benchmarking Overview

The Incentive Opportunity earned is calculated by comparing a Blue KC Entity's performance with benchmark performance thresholds or cohort performance. The benchmarks are derived from national standards and, in some cases when national benchmarking is unavailable, based on historical trend benchmarking of all Entities. Cohort performance comparison for cost is based on the cost performance of all Entities, excluding the Entity being evaluated.

The benchmarks establish the points achieved towards the Performance-Based Incentive Payment (PBIP).

Calculation of Performance-Based Incentive Payment

The PBIP is calculated by determining the number of points earned divided by the number of eligible points. An Entity achieving a score of 100% will be rewarded with a $3 PMPM bonus. An Entity achieving a score of less than 50% will be penalized with a $1 PMPM reduction in PBIP for each quality and/or utilization measure performance under the 50th percentile up to a total $3 PMPM penalty. The earned PBIP matrix is shown in Table 8.

Table 8 – Earned PBIP Matrix

Performance Score	PBIP Earned
100%	$15 PMPM
75.0% to 99.9%	$12 PMPM
60.0% to 74.9%	$9 PMPM
50.0 to 59.9%	$6 PMPM
<50.0% *subject to penalty*	$3 PMPM

Continuous Performance Improvement

The emphasis is on meeting and exceeding cost, quality and utilization measure thresholds and continuous Performance Improvement (PI).

Blue KC provides access to data and additional resources that support continuous monitoring of performance during the Program year for each participating Entity. Resources include, but are not limited to:

- Clinical quality and utilization scorecard.
- Reports and data sets that include information on member Attribution, risk stratification and resource utilization. Routine review and analysis of key data during the Program Year enables the Entity to track metrics and provides an opportunity to determine whether any actions or workflow adjustments are needed to meet performance standards.
- Coaching/consultative support to provide best practices specific to PCF concepts while focused on the Quadruple Aim.
- Education provided virtually and on-site for administrators and provider-led care teams.

Continuous PI is the framework used to support Entities in the identification of priority opportunities that will drive optimization for plan development, implementation and evaluation. These opportunities are based upon best practices in PCF delivery:

- Person- and Family-Centered Care
- Access to Care and Information
- Care Management and Care Planning
- Population Health Management
- Coordination of Care
- Behavioral Health and SDoH screening with Linkages to Resources
- Performance Improvement and Reporting
- Well-developed infrastructure that supports movement from fee-for-service to value-driven, population-based care and payments
- Effective use of HIT

Collaborative PI planning between the Entity and Blue KC includes setting mutually agreed upon goals, outlining an action plan, establishing timelines and defining measures of success, implementation and evaluation. This will be accomplished with the use of performance data provided by Blue KC and data/information from the Entity as the baseline for discussion when identifying areas of strength(s) and opportunity.

PI plan development will be initiated at the beginning of the Program Year and include use of best practice tools and resources to support the Entity in continuous improvement activities that align with their organization's strategy and the PCF Program. The discussion is meant to be collaborative in nature; ultimately the Entity is responsible for development of their PI plan, updating accordingly and sharing with Blue KC on a quarterly basis (if needed). Tracking of progress and any adjustments that may be needed as part of a PI process will be discussed at each quarterly meeting with Blue KC's Healthcare Transformation Consultant.

Remediation and Termination

If the Entity's performance is below acceptable standards in clinical quality and/or utilization at the final year-end performance review, the Entity will then be placed on a Remediation Plan. The Remediation Plan will be developed by the Entity with the expectation that performance will improve within the current performance year. At the end of that time frame, if the Entity does not demonstrate improvement in the agreed upon goals, the Entity will be terminated from the Program. Failure to meet threshold requirement in any program year may result in termination from the program.

The Entity or Blue KC may terminate participation in the PCF Program at any time, for any reason or for no reason, by providing written notice of termination to the other organization. Termination Notice from Blue KC to the Entity will be sent by certified mail to the attention of the Entity Administrator or designee to the Entity address on file. Such termination notice will be effective 90 days from receipt of notice ("Termination Notice Period").

PCF Program Entities that terminate will not be eligible for proceeds for the PBIP based on their performance during the Program Year in which they have terminated. Payment periods run from July 1 through June 1 of the following Program Year. Any current PBIP based on prior Program Year performance will cease as of the last day of the Termination Notice Period.

Kansas City

11/03/21