2015-2016 Program Overview

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.
Blue Cross and Blue Shield of Louisiana (Blue Cross) is proud to present Quality Blue Primary Care (QBPC), a population health and quality improvement program designed to transform our primary care provider network from an episode-driven, physician care delivery model to a team-based care delivery model.
Recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition.¹ What’s more, chronic diseases account for more than 75 percent of overall healthcare costs. At the same time, established practice guidelines are rarely followed, patients lack active follow-up that supports good outcomes and care coordination is anecdotal in most practices.

In recognition of these challenges, Blue Cross is taking a lead role in engaging and supporting primary care physicians to redesign healthcare. Blue Cross has developed QBPC, a population health and quality improvement program for primary care physicians that optimizes patient care delivery. In QBPC, Blue Cross contracts with primary care physicians and provides, free of charge, a web-based, patient-centric information tool to support the QBPC program. This tool improves the identification and management of chronic diseases that are prevalent and burdensome, while providing practices with data and resources that enable proactive, efficient, high-quality care.

The program also equips primary care providers with an outcomes-based payment structure that supports increased value and helps to reduce costs through care coordination. QBPC promotes successful, positive change in physician groups and supports evidence-based clinical and quality improvement.

QBPC was designed with both patients and providers in mind. Honoring the physician-patient relationship as the most important element of healthcare, QBPC minimally disrupts normal provider workflows.

Instead, it seeks to provide a more robust clinical encounter and align all supporting resources to deliver effective care plans.

The bottom line is healthier patients, more satisfied providers and cost savings for all.

The QBPC program is defined by three core elements:

- **Population Management:** Integrating a health information exchange tool in practices facilitates population management by aggregating clinical and claims data.
- **Care Process Workflows and Tools:** Developing and integrating standardized chronic disease management care plans, tools, resources and best practices will transform contracted practices.
- **Continuous Quality Improvement:** A Continuing Medical Education (CME) program enhances physicians’ knowledge, competency and performance in the management of patients with cardiovascular (CV) metabolic risk factors. Educational modules are designed with evidence-based clinical content and include practice guidelines, care processes and tools to improve patient population gaps in care.

¹ Partnership for Solutions: Johns Hopkins University, Baltimore, MD for The Robert Wood Johnson Foundation
Blue Cross has partnered with two strategic collaborators, Integrated Medical Processes, LLC and Symphony Performance Health, Inc., to realize the program concept through their expert technology, data mining and practice enhancement capabilities.

Integrated Medical Processes, LLC (IMP) is a physician-led clinical integration consultancy focused on population management and value-based care models. IMP’s Integrated Medical Processes to Achieve Care Transformation Program (IMPACT Program) serves as the foundation for QBPC, providing the framework and implementation strategy to enable care transformation and clinical performance improvement.

Symphony Performance Health, Inc. (SPH) is a health information technology company that develops secure, web-based platforms to improve clinician decision-making at the point of care. QBPC incorporates SPH’s MDinsight® cloud-based technology to help practices identify, manage and improve the quality of care for their patients. This total population management tool acts as a care coordination platform for the entire medical repository and supports a patient-centered approach to care through:

- Web-based access to integrated patient data across multi-provider primary care settings for a more holistic view of patient care. Limited hospital and specialist practice data may also be provided to the practice based on available Blue Cross claims data;
- Comprehensive data aggregation from many sources, including, but not limited to, lab results, practice management notes, EMR interfaces, registry systems, claims data, pharmacy utilization;
- Identifying and highlighting care opportunities for wellness screenings and chronic patients who are out of compliance; and
- Evidence-based outcomes analysis.

QBPC optimizes primary care delivery, with the goal of improving the lives of Louisianians. In addition, the program supports future value-based benefit designs that promote quality and value. The benefits for the practice and member are numerous.

For the practice...
- QBPC aligns incentives with value, compensating physicians for clinical quality improvement via Care Management Fees in addition to traditional fee-for-service reimbursement.

For the member...
- QBPC helps to improve the efficiency of the care team and encourages the physician to do what s/he does best: treat the patient.
- QBPC provides support and resources to deliver better care.
Practice Transformation Process

QBPC uses data, technology and best practices in care coordination to transform practices.

THE MODEL

QBPC leverages the framework of the chronic care model to create a minimally disruptive, efficient and active care management process, whereby a Blue Cross-employed Quality Navigator acts as the team quarterback. Integrating the cloud-based MDinsight platform enables all team members to act on timely key patient data.
**Data Collection**

MDinsight aggregates structured clinical data from practices’ disparate existing systems (lab, practice management, EMR and registry systems) and analyzes it against evidence-based guidelines for process and outcome measures.

**Proprietary technology aggregates data from multiple sources**
Patient Identification

MDinsight aggregates and classifies data from the records of physicians, so the clinical care team can control physician and patient attribution. That means the physician is responsible for ensuring that s/he has been correctly attributed as the patient’s physician with MDinsight. The physician is also responsible for verifying and correcting the patient’s diagnosis and participation in the clinical suites.

A patient registry is created for each MDinsight clinical suite: Asthma, ADHD, Ischemic Vascular Disease, Congestive Heart Failure, Diabetes, Adolescent Diabetes, Childhood Diabetes, Hypertension, Child/Adolescent Hypertension, Metabolic Syndrome, Chronic Kidney Disease, Breast Cancer, Cervical Cancer, Colorectal Cancer, Immunizations and Tobacco Prevention.

[Note: Initially, QBPC payments will align with quality metrics for targeted clinical suites (indicated above in bold).]

Care Plan Development

- Care plans for each chronic illness are agreed upon in advance and integrated into the system.
- A Blue Cross Quality Navigator (case manager) assigned to each practice reviews chronic care opportunities highlighted in MDinsight and prepares a weekly report for the practice.
- The designated Practice Coordinator (employed by the practice) facilitates a daily care team briefing to review gaps in care for that day’s chronic-care patients.
- Between office visits, Blue Cross nurses, or health coaches, follow up with patients to make sure they are following the mutually agreed-upon treatment plans they make with their physicians, and provide the patients with support and encouragement to meet their health goals. The nurses check in with patients before and after their scheduled appointments to help them make the most of their office visits. Blue Cross dieticians and social workers may also provide health coaching.

Continuing Medical Education (CME) Program

All physicians enrolled in QBPC agree to participate in and complete the Continuing Medical Education (CME) program. This is a critical component of QBPC because it gives physicians opportunities for education and strengthening of best practices while earning CME credits.

Every year, QBPC physicians must view the QBPC Program Annual Overview module within the first quarter of that program year or within 90 days of enrollment in the QBPC program.

In addition to the Annual Overview module, physicians must view two other CME modules within the program year. These must be modules they have not previously viewed.

- The Annual Overview module and all additional modules are available on the CME portal.
- Physicians must score at least 80% on each post-test to receive CME credit for a module.
- Physicians who do not complete the CME requirements can have their CMF payments suspended.
The cornerstone of effective chronic disease management is collaborative, team-based care. QBPC is designed to foster productive interactions among physicians, practice staff, Blue Cross and patients to maximize practice efficiency and improve outcomes.

Implementing QBPC results in minimal disruption for the participating physicians and their staff, due in large part to Blue Cross’ investment in practice transformation resources, technology and support.

In an effort to provide continuous opportunities for program improvement, Blue Cross holds a series of regional QBPC collaboratives and a Statewide Collaborative each year. This gives participating clinical staff an opportunity to discuss their experiences in the program and share feedback. Physician advisory committees are held on a regular basis as well, to offer input on QBPC.
Joining QBPC

CRITERIA FOR PARTICIPATION

QBPC practice enrollment is occurring on a rolling basis, with an initial focus on primary care (family medicine, internal medicine and general practice) physician engagement. Pediatricians are not included in the initial implementation.

To participate in QBPC, physicians must demonstrate their ability to support population management-based chronic care improvement and commit to all of the following:

• Have at least six months of experience actively using a currently installed EMR system, and install MDinsight at the practice site(s) in coordination with practice IT staff, including extraction of clinical data from the practice EMR, lab, registry or other systems for submission to SPH for processing. **Providers that do not use an EMR will not qualify for participation.**

• EMR systems must have a current Health IT Certification from the Office of the National Coordinator for Health Information Technology (ONC) in order to qualify for the program. A list of certified systems is available at: www.oncchpl.force.com.

• Designation, onboarding and training of a Practice Coordinator (employed by the practice—likely an NP, RN, LPN or MA).

• Onboarding and training of practice physicians and key clinic staff.

• Active engagement in the population management process, including patient attribution (the identification and assignment of a patient to a physician practice panel).

• Participation in the QBPC CME program.

Blue Cross is making a generous investment in primary care by funding the QBPC practice transformation program and MDinsight system and providing technical and clinical support to enrolled practices. Therefore, it is expected that each enrolled practice be an engaged and active participant.

The program incorporates key quality elements: NCQA PCMH standards, HEDIS metrics, specialty and primary physician clinical protocol CME education, performance metrics and patient satisfaction measures.
CARE MANAGEMENT FEES (CMFs)

The QBPC program pays a monthly Care Management Fee (CMF) to reward care coordination activities for eligible members. The CMF is paid in addition to the fee-for-service payment system and provides a financial reward for care services that are not traditionally reimbursed.

The QBPC program CMF has two components:

1. **Patient Risk Tier Base CMF**—
   For the purpose of establishing a base CMF, eligible members are stratified into two risk tiers with a corresponding base CMF: Single Targeted Chronic Condition and Multiple Targeted Chronic Conditions. [Note: During the initial year of QBPC program participation, all eligible members, regardless of risk tier, are assigned one base CMF.]

2. **Practice and Physician Quality and Efficiency Tier Adjustment Factor**—
   Practices and physicians are scored based on clinical and efficiency outcomes of defined QBPC program measures. These scores are used to rank the practices and physicians into three tiers that have a corresponding reimbursement adjustment factor. [Note: During the initial year of QBPC program participation, all practices and physicians are paid CMF at a standard, base tier.]

Commencing in the second year of QBPC program participation, the CMF is evaluated for adjustment every six months based on how the participating practices and physicians perform on the core QBPC quality and efficiency measures, which are detailed in the QBPC Program Agreement. [Note: The reimbursement methodology for QBPC may vary based on unique strengths/characteristics of contracted practices. Participating practices should refer to their specific Program Agreement for details.]

Participants will be assessed on three efficiency measures for Blue Cross-attributed members, not just members with chronic conditions.

1. **Low Back Pain Imaging**: A risk-adjusted measure of potential preventable imaging for uncomplicated low back pain. This measure is used to assess the percentage of members ages 18-50 with a primary diagnosis of uncomplicated low back pain who do not undergo unnecessary imaging studies (plain X-ray, magnetic resonance imaging [MRI] or computed tomography [CT] scan) within 28 days of diagnosis. Low back pain is a common problem for which patients seek treatment from primary care providers, and according to the American College of Radiology, imaging studies are often not necessary to successfully treat the patients and relieve pain. Providers are asked to work with patients and educate them on when imaging studies are appropriate to avoid potentially unnecessary, costly procedures.
Exclusions are built in for this efficiency measure to account for patients whose lower back pain does require an imaging study for proper diagnosis and treatment.

2. Potentially Preventable ER Visits (PPV): PPV is a population-based outcome measure. In computing a provider PPV rate, the numerator is defined as the number of Potentially Preventable Visits. The denominator of a PPV rate is identified as the number of members in the population. Since a PPV rate can be influenced by the patient’s chronic illness burden, any comparisons of PPV rates will be adjusted for the chronic illness burden of a patient. The PPV method uses Clinical Risk Groups (CRGs) for risk stratification for comparing actual and expected PPV rates.

3. Risk-adjusted Generic Drug Utilization (GFR): For the QBPC provider’s members, all pharmacy utilization (regardless of prescribing physician) is used to calculate this measure. This is a claims-based, risk-adjusted generic pharmaceutical utilization measure that compares actual GFR vs. expected GFR utilization of all prescribing physicians for the risk-adjusted population, taking into account patients’ chronic illness burden. For this measure, the higher the index number, the better.

QBPC Clinical Quality and Efficiency measures are available online. Go to www.bcbsla.com/QBPC and click Program Measures. A table of the current measures will be displayed.
### CARE MANAGEMENT FEES (CMFs) CONTINUED

**Calculating Adjustment to Care Management Fee (CMF)**

<table>
<thead>
<tr>
<th>Number of Targeted Chronic Conditions</th>
<th>Base CMF</th>
<th>Adjustments Based on Clinical and Efficiency Outcomes</th>
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<td>Years 2 and 3</td>
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<td>$180</td>
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<tr>
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#### Example Distribution of Total Points by Practice

- **Lowest 20%**
- **Middle 50%**
- **Upper 30%**
ELIGIBLE MEMBERS

Blue Cross pays a CMF for Blue Cross and HMO Louisiana, Inc. members if all of the following requirements are met:

1. Patient has primary healthcare coverage through a Blue Cross plan that is not excluded from QBPC. (See program manual.)
2. Patient is attributed to a primary care physician at the enrolled practice.
3. Patient is diagnosed with at least one targeted chronic condition and participating in a clinical suite via MDinsight:
   - Ischemic Vascular Disease
   - Diabetes
   - Hypertension
   - Chronic Kidney Disease
4. Physician has billed an Evaluation and Management code for a face-to-face visit with the patient for a service related to the targeted chronic condition or a preventive service within the required 12-month period.
5. Physician is participating in the QBPC CME program.

The QBPC financial incentives make the right thing to do the easy thing to do.

MEASURING SUCCESS

A practice’s success with QBPC is contingent upon its performance in three key areas:

Clinical Quality Improvement

Goal: Improve individual patient outcomes and population health

- Practices are required to participate in the CME component of the program.
- Education includes traditional clinical content, in addition to population management, care processes and tools tailored to clinical care delivery gaps.

Practice Participation

Goal: Active interaction between the practice coordinator and the Blue Cross Quality Navigator to identify and manage the chronic care patient population

- The Practice Coordinator is responsible for proactively addressing and triaging gaps in care as identified by the Quality Navigator.

Claims

Goal: Improve quality

- Blue Cross is conducting a biannual review of claims data and key quality indicators to validate outcomes improvement in the management of the chronic care population.
ABOUT MDINSIGHT

MDinsight® is a web-based, multi-provider, patient-focused, interactive portal tool. MDinsight aggregates EMR, labs and claims data, including pharmacy.

MDinsight organizes data from all sources to create a report dashboard with:

- A **Patient Care Summary** (PCS), which includes medications, diagnosis and procedure history, clinical values for each clinical condition in MDinsight, exclusion history and clinical data entry history;

- **Clinical Trends** that visually show the patient’s progress in each clinical measure over time;

- A **Patient Care Opportunity Report** that displays all process measures and clinical results outside the relevant performance range;

- A **Patient List** that displays patient attribution by physician, clinical condition, patient disposition, demographic and visit information;

- A **Goal Progress Report** that displays individual measures tracked for the purpose of the QBPC Program and shows the individual physician’s performance toward each goal;

- A **Comparison Report** that allows for an aggregate view of each physician’s Goal Progress Report for a defined clinic group; and

- A **Custom Report** that allows physicians to request and view ad hoc reports on their patient population. The provider can request this type of reporting directly from Symphony Performance Health at an additional fee.
Integrated Medical Processes, LLC (IMP) is a collaboration between the Consortium for Southeastern Hypertension Control (COSEHC) and the Group Practice Forum (GPF).

**COSEHC** is a nonprofit [501(c)(3)], physician-led organization with 20+ years of extensive research and clinical consulting expertise in the development of cardiovascular metabolic disease clinical professional education modules and support tools. COSEHC’s provider clinical knowledge and clinical performance improvement templates/intervention plans assist physicians and their practice care teams in selecting proven clinical processes that improve clinical performance.

The **Group Practice Forum** (GPF) is a physician-led organization that provides group practices with knowledge and solutions to advance care and achieve maximum effectiveness. GPF enables systems of all sizes to deliver smarter, more consistent and efficient care that drives patient engagement and improved quality. GPF has worked directly with more than 100 health systems, health plans and physician practices in multiple therapeutic areas.

Jointly, GPF and COSEHC design, develop and implement integrated clinical and process care delivery models for hospital health systems, managed care groups, insurers, medical groups and primary healthcare practices. IMP develops provider and patient tools and facilitates team-based coordination of care, enabling both remote and embedded (local) case management strategies that support population management. IMP’s evidence-based clinical education reinforces treatment guidelines and appropriate therapeutic treatment selection and reduces gaps in care by ensuring relevant performance improvement opportunities are embedded into the practice workflow.
QBPC Program Contacts

Blue Cross and Blue Shield of Louisiana is here to guide you through the QBPC practice transformation process and answer questions along the way.

For information and assistance with QBPC implementation, MDinsight and payment, please contact:

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