Enhanced Personal Health Care
Frequently-Asked Questions
Answers for Providers
Contents

Q1: What is Enhanced Personal Health Care? How is it related to Blue Distinction Total Care? ..................... 3
Q2: Are medical specialists invited to participate? ............................................................................................ 3
Q3: How does Enhanced Personal Health Care help patients? .................................................................... 4
Q4: How does Empire identify my patients? .................................................................................................... 4
Q5: What is required of providers who participate? ....................................................................................... 5
Q6: How do you measure quality? .................................................................................................................. 6
   Commercial Membership ............................................................................................................................... 6
   Medicare Advantage Membership .................................................................................................................. 7
Q7: What can I do to make sure my practice succeeds in improving quality and lowering costs? ............... 8
Q8: How do you set PMPMs and determine shared savings? ......................................................................... 8
   Clinical Coordination payments .................................................................................................................. 8
   Shared savings .............................................................................................................................................. 9
Q9: What if my patients have unusually high medical expenses? .................................................................. 9
Q10: How do I find data and see reports about my attributed patients? ............................................................. 10
Q11: What is “CPC+”? How does it relate to Enhanced Personal Health Care? .............................................. 10
Q12: How is the Commercial Percent of Premium or “MLR” model pilot different than the standard Enhanced Personal Health Care arrangements? ................................................................. 11
Q1: What is Enhanced Personal Health Care? How is it related to Blue Distinction Total Care?

Enhanced Personal Health Care is Empire’s centerpiece patient-centered, value-based care program. Participant care provider organizations include both Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs). Though the provider participants may differ in size and many other characteristics, Enhanced Personal Health Care arrangements all include three things:

1. Value-based payment that rewards high quality and efficiency
2. Sharing of clinical data
3. A mutual commitment to ensuring our members receive patient-centered care.

For national employer customers, we offer a national network of providers who work under value-based payments. This national network includes Enhanced Personal Health Care within our affiliated health plans’ geographic coverage area, and value-based programs hosted by other BlueCross and BlueShield Plans. This network of patient-centered, value-based payment programs is known nationally as Blue Distinction Total Care. Providers who participate in Enhanced Personal Health Care arrangements are also part of Blue Distinction Total Care by default.

Employers and their employees, your patients, may refer to the program by either name. Our “Find a Doctor” tool may identify you as a participant in Enhanced Personal Health Care or Blue Distinction Total Care.

As our fellow Blue Cross and Blue Shield plans grow their own value-based programs, we will increasingly share information between plans, and gain the ability to share more information with participating providers even if the patient is covered by another Blue Cross Blue Shield Association member plan.

The design of other plans’ value-based payment programs will not necessarily mirror Enhanced Personal Health Care in every respect, but BCBS Association member plans share the aim of rewarding high-quality evidence-based efficient care with primary care at the heart of a patient-centered delivery system.

Q2: Are medical specialists invited to participate?

We believe primary care is the foundation of a high-functioning health care system. For that reason, we designed Enhanced Personal Health Care around the idea of primary care providers managing the overall health of their patients.

In most cases, we contract at the organizational level. Any organization, including hospitals, multi-specialty groups or ACOs that include primary care providers are eligible to participate in our program. In some special circumstances, patients may be attributed to a non-primary care specialist who is part of the participating EPHC organization. We expect those specialists to coordinate care in the same manner as their primary care provider colleagues, and for that patient to eventually move into a relationship with a primary care provider, to whom they would eventually be attributed.

We encourage primary care providers – even those who practice within a group or organization that includes specialists – to work closely with the specialists in their “medical neighborhoods.” Care Compacts between primary care providers and specialists can help clarify roles and responsibilities in support of a proactive and coordinated care model.

Additionally, the Patient-Centered Specialty Care program complements our primary care program by aligning quality, cost and care coordination incentives for specialist, providing the environment needed for providers to truly provide care in an effective, team based fashion.
Q3: How does Enhanced Personal Health Care help patients?

Enhanced Personal Health Care, known nationally as Blue Distinction Total Care, is designed to deliver improved quality, lower cost of care and a better patient experience for our members, who trust us to help make care simpler, more affordable and more accessible.

Enhanced Personal Health Care arrangements include value-based payment – compensation for care that is dependent on efficiency, on outcomes and how closely it follows evidence-based guidelines. But we realize that a payment mechanism alone is not enough to ensure our members will receive high quality care delivered in an efficient, patient-centered way.

For that reason, along with designing innovative value-based payment arrangements, we have invested our most valuable resources – our people and our data – to help providers succeed in changing the health care delivery system from the inside out.

Program results tell us that patients who see participating providers notice the difference. Compared to patients who saw non-participating providers, they were more likely to say their physicians listen to them with respect and were more likely to report that they had easy access to care from their physicians, even after office hours.

We know patient-centered, evidence-based care also translates into a better care experience and better patient outcomes. Patients benefit when they get a call from their regular primary care provider as a follow-up to an emergency room visit. They benefit when a social worker funded by our Clinical Coordination payments calls from the primary care provider’s office, as a follow up to a hospital admission or discharge. They benefit when their premiums remain affordable, thanks to a system-wide focus on cutting out waste.

Enhanced Personal Health Care helps keep care affordable by helping eliminate unnecessary and redundant care, and by preventing acute problems by delivering necessary preventive care. We know that the program is creating real savings: our analysis of three years of spending and clinical quality data shows an annual weighted savings of 3.1%, or $10.39 per member, per month on average. Savings improved the longer a provider participated, and was better for patients who were attributed to the same EPHC provider for three consecutive years.

The savings we saw did not come at the expense of quality – in our program evaluation examining three years of performance, participating providers outperformed non-participating peers in the majority of quality metrics.

Q4: How does Empire identify my patients?

In order to offer you useful data about your Empire patients and compensate you for care coordination activities, we must identify your patients who are covered by Empire.

We match Empire patients to your practice when a member selects you as PCP, when he or she is assigned by Empire to your practice, or when claims records allow us to identify a primary care relationship. The Empire patients assigned or matched to you are referred to as your “attributed” patients. Your Program Description outlines the process more fully, including some exceptions to the general rules. Typically attribution follows the pathway below:

1) Members who are in gatekeeper plans are required to select a primary care provider, and if they do not, Empire auto-assigns one to the member. In either case, the member is attributed to the designated primary care provider.

2) Optional PCP selection allows members enrolled in a non-gatekeeper plan, such as a PPO, to tell us which doctor should be considered their primary care provider. Members can make this optional designation via our online member portal or by calling Customer Service. The member is then attributed to his or her selected provider.

3) Where a PCP has not been identified or assigned, we examine patterns of visits for patients and attribute patients according to their visit patterns. We first look for evidence of a relationship with a provider in a primary care specialty. If none exists, a medical specialist or
Where HMO assignment or optional PCP selection apply, those attribution methods take precedence over the visit-based attribution method. If a patient does not select a PCP or participate in a gatekeeper plan, and we cannot identify a pattern of visits that indicates a patient-provider relationship, the patient will not be attributed to a provider.

Q5: What is required of providers who participate?

As a model designed to promote effective partnership between payers and providers, Enhanced Personal Health Care cannot succeed without the engagement of provider participants, from leadership to support staff.

Requirements and expectations begin with a commitment to patient-centered care and to continual improvement. A full set of requirements for participants varies somewhat by the type of arrangement in place and by the line of business (commercial or Medicare Advantage) under which patients are covered.

A full listing of program requirements can be found in your contract agreement.

It is important to note that participating providers are not required to purchase new software or hardware, or pay for consulting services from our health plan.

Some key expectations:

- **Establish, maintain and use a population health patient registry.** Simply stated, a registry is a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, and generate reminders and guidance around the care of patients (both in groups and individually).

- **Access reports via your population health platform.** Many Enhanced Personal Health Care reports can be exported to Excel and used to support a patient registry.

- **Use your Enhanced Personal Health Care reports to manage your attributed patient population.** Develop interventions based on your patient population needs, which will in turn support your success in the shared savings program.

- **Designate a care coordinator.** This person may be a current staff member who takes on care coordination duties in addition to existing responsibilities.

- **Participate in learning collaborative opportunities.** Many of the sessions we offer are available in recorded format on demand, and are accompanied by available CME credit.

- **Identify segments of your attributed patient population who may benefit from intervention.** This may include patients with a particular chronic illness, those who are transitioning out of an inpatient setting, or those who frequently use the emergency room.

- **Manage referrals** to direct patients to high-quality, cost-effective specialty ambulatory care, including laboratories, surgery centers, radiology services and specialty physicians.

---

1 This visit-based method is the only one used to match patients and primary care providers in Virginia – PCP assignment and optional PCP selection do not apply there.
Q6: How do you measure quality?

Enhanced Personal Health Care is designed to reward high-quality care that also is efficient and patient-centered. For more details about how we measure quality, see your Measurement Period Handbook. A high-level overview of our methodology follows below.

In order to qualify for shared savings payments, practices must meet a minimum performance threshold—referred to as a “Quality Gate.”

After the quality gate is satisfied, the portion of shared savings the provider is eligible to receive will vary depending on performance against clinical quality measures, and in some cases, on the degree of improvement on these metrics. The payment will also depend in part on utilization measures such as the volume of potentially avoidable, unnecessary emergency room visits. The better the performance, the greater the percentage of shared savings the physician is eligible to earn.

Our scorecard is based on nationally recognized measures of quality, including metrics from the CMS Accountable Care Organization set, the Medicare Stars Scorecard, state-specific Medicaid performance guarantees, HEDIS metrics and metrics used to rank health plans nationally and locally, along with other programs we sponsor.

Commercial Membership

In most cases, we measure clinical quality under the following metrics (The measures below are effective Jul 1, 2018):

- **Acute and chronic care (10 metrics):**
  - **Medication Adherence**
    - Proportion of Days Covered (PDC): Oral Diabetes
    - Proportion of Days Covered (PDC): Hypertension (ACE or ARB)
    - Proportion of Days Covered (PDC): Cholesterol (Statins)
  - **Diabetes Care**
    - Diabetes: Urine Protein Screening
    - Diabetes: HbA1c Testing
  - **Other Acute, Chronic and Safety**
    - Appropriate Testing for Children with Pharyngitis
    - Appropriate Treatment for Children with Upper Respiratory Infection
    - Medication Management for People with Asthma
    - Use of Imaging for Lower Back Pain
    - Appropriate Antibiotic Treatment for Adults with Acute Bronchitis

- **Preventive care (8 metrics)**
  - **Pediatric Prevention**
    - Childhood Immunization Status: MMR
    - Childhood Immunization Status: VZV
    - Well-Child Visits Ages 0-15 Months
    - Well-Child Visits Ages 3-6 Years Old
    - Well-Child Visits Ages 12-21 Years Old
    - Chlamydia Screening
  - **Adult Prevention**
    - Breast Cancer Screening
    - Cervical Cancer Screening
    - Chlamydia Screening

- **Utilization (3 metrics)**
  - Potentially Avoidable ER visits
  - Brand formulary compliance dispensing rate
  - Ambulatory-sensitive condition admission rate per 1,000 Members (Pediatric and Adult)
Medicare Advantage Membership

Enhanced Personal Health Care metrics for Medicare Advantage enrollees include Quality Metrics which align with the Centers for Medicare & Medicaid Services’ (“CMS”) Stars Program and internally created improvement measures. In addition to serving as a basis for Medicare Advantage Incentive Program savings calculations, these measures are used to establish a minimum level of performance expected of you under the Medicare Advantage Program, and to encourage improvement through sharing of information.

The Quality Scorecard for Medicare includes three sets of metrics: Standard measures, Enhanced measures and Improvement measures.

If a measure is categorized as information only, that measure will be evaluated for the compliance rates but does not have any shared savings potential assigned to them.

**Standard Measures**
are measures that are scored using the procedure and diagnosis codes submitted on medical or prescription drug claims that are readily available, are widely used by most providers, and provide conclusive evidence as to whether or not the measure has been achieved.

These measures' results are derived solely based on an evaluation of claims submitted. An example of a Standard Measure is “Diabetes Eye Exam.” A review of claims received during a Measurement Period for a given Medicare Advantage attributed member with diabetes will provide all the information needed to conclusively determine if the test was performed during the Measurement Period.

- **Standard Measures:**
  - Diabetes Care: Eye Exam
  - Diabetes Care: Kidney Disease Monitoring
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Readmission Rate (Informational Only)
  - COA: Medication Review (Informational Only)
  - COA: Functional Status Assessment (Informational Only)
  - Medication Adherence: Oral Diabetes
  - Medication Adherence: Hypertension
  - Medication Adherence: Cholesterol
  - Diabetes/Statin
  - COA: Pain Screening (Informational Only)
  - Rheumatoid Arthritis Management (Informational Only)
  - Osteoporosis (Informational Only)

**Enhanced Measures** require additional information to be submitted in addition to the claim (in addition to standard CPT IV and also require documentation in the Medicare Advantage attributed member’s medical record.

To evaluate success with enhanced measures, providers must submit a CPT Category 2 code or V-code on the Medicare Advantage attributed member’s claim along with a corresponding note in their medical record that supports the use of this code.

An example of an enhanced measure is “Diabetes: Blood Sugar Controlled.” A review of claims received for a given Medicare Advantage attributed member with diabetes during the measurement period, requires the inclusion of the CPT Category 2 code that identifies the member’s HbA1c level.

- **Enhanced Measures:**
  - Diabetes Care: Blood Sugar Control
  - Controlling Blood Pressure
  - Medication Reconciliation
  - Adult BMI Assessment

**Improvement Measures** are tracked year over year and reward providers who achieve a high level of success with each measure. The measures included in this composite are:
Q7: What can I do to make sure my practice succeeds in improving quality and lowering costs?

We are committed to providers’ success, and want to help you maximize shared savings and continually improve the quality of care your patients receive.

Our robust suite of care delivery tools, analytic insights and support are designed to help you succeed under a value-based payment model. The program is designed to create opportunities for you to succeed, whether you are new to the program or already have excellent outcomes and quality scores. There may be variances in program delivery depending on line of business.

Some of the elements most crucial to success include:

- Working under a team-based care model, which maximizes the effectiveness of your organization or practice’s providers and staff.
- Adopting and consistently delivering patient-centered care, which engages your patients in their care.
- Identifying discrete interventions likely to deliver higher quality care and lower the overall cost of care.
- Ensuring your patient population is appropriately risk-adjusted through complete and accurate coding.
- Taking advantage of regular learning opportunities offered to your practice.
- Meeting with Enhanced Personal Health Care field staff to review data, determine an Action Plan and implement interventions to support your patients.
- Using nationally recognized quality improvement methodologies.

We provide tools that can aid in population management and help chart your own success, because we recognize it can be difficult for providers to identify and hone in on interventions likely to have the greatest impact on quality and cost. These tools include:

- Your web-based population health management tool, which offers clear, timely insights into gaps in care, patients at risk for health complications, and opportunities to deliver evidence-based care.
- A longitudinal patient record that is available through the multi-payer portal Availity and is integrated into your population health platform for information on your attributed patients.
- Intervention Bundles, short, focused sets of information and action plans designed to address single chronic diseases or identified cost drivers.
- Practice Essentials, our web-based curriculum.

Q8: How do you set PMPMs and determine shared savings?

Our Clinical Coordination payments and shared savings opportunities are designed to support investment in quality improvement and care coordination, and to reward the positive result of those investments.

Clinical Coordination payments

Clinical Coordination payments compensate providers for the work they do to deliver evidence-based care to their patients outside of face-to-face patient visits. Those services could include care planning, maintaining patient registries, enhancing access (such as responding to emails, offering web-based visits or following up with patients via phone or e-mail). This type of proactive clinical coordination improves health and reduces costs.

Clinical Coordination PMPM payments are not payable in all arrangements, and are dependent on a variety of factors including state specific laws and existing payment models and levels.

For members of commercial health plans, we generally calculate PMPM rates as follows:
When a Clinical Coordination PMPM applies, a base rate is used as the starting point for payment. The PMPM base rate is adjusted based on the prospective risk score of each patient in the population to arrive at a risk-adjusted PMPM. The base rate may be thought of as a payment for a patient of average risk. For example, the risk score for a healthy 25-year old may be less than 1, whereas the risk score for a 55-year old with diabetes and hypertension would be greater than 1. The risk score and the PMPM payment amount itself are subject to an upper and lower limit. In a limited number of cases, we pay a flat PMPM that is not risk-adjusted.

For members of Medicare Advantage plans, the PMPM starts with a base and then is adjusted by the panel average Hierarchical Condition Category (HCC) score. That adjusted amount is paid as a flat rate to every member in the panel for the entire year.

Shared savings

Shared savings payments reward providers for successfully delivering quality care while lowering overall health care costs for their population of our patients. Generally speaking, shared savings works like this:

We will project expected costs by reviewing historical medical costs for the medical panel's attributed population to reach a Medical Cost Target (MCT). We sometimes group providers together to ensure that the Medical Cost Targets are calculated on the basis of a statistically valid pool of our patients.

At the end of a 12-month measurement period, we calculate actual costs incurred for the medical panel's attributed population. This amount is known as the Medical Cost Performance (MCP).

If the actual costs are less than the Medical Cost Targets by an amount greater than a predetermined Risk Corridor, AND the provider meets a quality threshold, then the provider group becomes eligible to receive a portion of any savings, known as a shared savings bonus. If a provider does not meet the quality threshold, the provider is NOT entitled to any shared savings bonus, regardless of the savings generated.

The quality threshold is based on the total number of points, as specified in your contract.

If the provider meets the quality threshold and, therefore, is eligible to earn a shared savings payment, the amount earned varies based on the provider's performance on the quality measures combined with utilization measures, patient engagement metrics, or both. The better the quality scores, the higher the percentage of the shared savings providers earn, subject to a maximum payment amount.

Any shared savings bonuses owed are based on the performance during an annual measurement period. Therefore, when a bonus, if earned, will be paid depends on when the annual measurement period started. Generally, provider bonus payments - if owed - will be paid on a quarterly, semi-annual, or annual basis. If quarterly or semi-annual, there is a final reconciliation after the close of the applicable annual measurement period.

Under our Percent of Premium program, also known as the MLR model, and for Medicare Advantage membership, shared savings is calculated differently than described above. See Question 12 below for more details.

Q9: What if my patients have unusually high medical expenses?

We recognize and account for differences in relative risk between different patient populations. As outlined above, Clinical Coordination payments are risk-adjusted in most cases, as a way to account for higher than average medical risk levels in providers’ patient panels.

When we calculate Medical Cost Performance, we exclude members with especially high allowed claims costs (generally, those exceeding $250,000 during a Measurement Period), as well as members with certain types of transplant claims during the Measurement Period.
Q10: How do I find data and see reports about my attributed patients?

Participating providers have access to a wealth of information about their patient population through one or more platforms, ranging from a longitudinal patient record to full data exchange for large organizations.

We also offer every participating provider a robust web-based reporting tool. Through alerts, dashboards, and reports, this web-based tool supports both population management as well as program-specific financial performance management.

Your population health platform can help stratify your attributed patient population based on risk and prevalence of chronic conditions. It also offers actionable clinical insights, such as care gap messaging and preemptive flagging of patients with high risk for readmission.

Reports offer insight into:

- Attributed and Inactive patients
- Chronic and Readmission Hot Spotters
- Care Opportunities
- Inpatient Authorizations
- Emergency Room visits and Inpatient Admissions
- Pharmacy claims information
- Care Management and Disease Management program engagement
- Integrated longitudinal patient record for attributed patients

Your population health platform is designed to help you monitor and improve your performance in the program’s payment model, connecting the dots for you between the actionable activities that tie to the program’s financial incentives. The tool will show frequently-refreshed information reflecting your quality and utilization data, along with your annual Performance Scorecard.

Q11: What is “CPC+”? How does it relate to Enhanced Personal Health Care?

Comprehensive Primary Care Plus (CPC+) is the next generation of a multi-payer value-based payment program sponsored by the Centers for Medicare and Medicaid Services Center of Medicare & Medicaid Innovation. We are proud to have been selected by CMS as one of the participating payers in this second iteration of the program after successfully working with providers under the original CPC program starting in 2012.

We consider CPC+ to be part of our Enhanced Personal Health Care approach, though it is sponsored by and named by CMS, and thus is usually discussed by its own name. CPC+ Participants have access to the same tools and reporting as other EPHC participants.


There are two different tracks under the CPC+ program: Track 1 designed for practices with existing care delivery activities and Track 2 for practices with more complex care delivery activities.

Our health plans participate in CPC+ Round 1 in the following markets:

- Ohio/N. Kentucky (Commercial and Medicare Advantage)
- Colorado (Commercial)
- New York North Hudson Capital region (Commercial)
- New Jersey (Medicaid)
- Tennessee (Medicaid)

Our health plan was approved to participate in CPC+ Round 2 for Louisiana (Medicaid Only).
Q12: How is the Commercial Percent of Premium or “MLR” model pilot different than the standard Enhanced Personal Health Care arrangements?

A small number of providers are contracted with us under a Commercial Percent of Premium pilot. Under these arrangements, the shared savings pool is set based on a percent of the members’ premium, or Medical Loss Ratio (MLR) rather than comparing spending to a Medical Cost Target (MCT).

The commercial MLR model aligns incentives for Empire and providers to work together. While Empire sets the premium, the premium is subject to various safeguards such as risk corridors and risk adjustment transfers and MLR rebate provisions of the ACA. Empire has a vested interest to find the right balance between affordability and profitability to avoid rebates, risk corridor and/or risk adjustment transfer payments.

While a provider may participate in the commercial MLR model and MCT model, the panels may be different and measurements will be different. A provider will be able to participate in the standard MCT model as well as the MLR model. However, members will only be attributed to one program at a time.

Clinical Coordination PMPMs can be offered to the provider from the local market contract teams, when appropriate. Clinical Coordination PMPMs will be similar to the MCT model in that a base rate will be set and PMPMs will be risk-adjusted. The Clinical Coordination PMPM for the MLR model will be risk adjusted using a diagnosis-based prospective risk formula for commercial membership.

Medical Loss Ratio targets and Scorecards for MLR arrangements will be shown in your population health platform during the Measurement Period. However, because the adjustments are settled annually, the reporting will be based on the information at hand at the time of the report.