Collaborative Multi-Payer Pilot Provider Requirements Matrix

No.	Requirement	Source	Collab. Model				NCQA: Critical Factor* / must pass	Medicaid Health Homes**
Minimum Requirements for Practices to Participate in the Collaborative Pilot								
	PCMH Transformation Requirements							
1	At least Level -1 NCQA Recognition by end of year two of participation.	Provider	X					X
	Registry Requirements							
2	**Have a Registry - Phase 1** - Demonstrate ability at the onset of the pilot to provide electronically to payers a list of their health home-eligible participants (based upon the chronic disease eligibility requirements agreed upon by the Collaborative in item 1 above).	Provider	X					X
3	**Have a Registry - Phase 2** - Within 2 years of participation, practice will be required to have in place the electronic disease registry functionality.	Provider	X					X
	Collaborative Data Reporting Requirements							
4	**Data Reporting Requirement** - Report Quarterly on Two (2) Clinical Quality Measures (Disease of Choice). If Asthma is selected, all three clinical quality measures must be reported. Select measures from list below.	Provider	X					X
5	**Data Reporting Requirement** - Report Quarterly on two (2) Clinical Preventive Measures. Select measures from list below.	Provider	X					X
6	**Data Reporting Requirement** - Report Quarterly on the two (2) Practice Transformation Measures identified below.	Provider	X					X
7	**Data Reporting Requirement** - Report Quarterly on three (3) Service Utilization Measures Identified below.	Provider	X					X
	Required Clinical Quality Measures (LIST TO SELECT FROM)****							
8	**Clinical Quality Measure:** Diabetes: Hemoglobin A1c Testing (NCQA - NQF # 57).	Provider	X					X

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	Required Clinical Quality Measures (LIST TO SELECT FROM), continued							
9	**Clinical Quality Measure:** Diabetes HbA1c Poor Control (NCQA - NQF # 59).	Provider	X					X
10	**Clinical Quality Measure:** Controlling High Blood Pressure (NCQA - NQF # 18)	Provider	X					X
11	**Clinical Quality Measure:** Hypertension: Blood Pressure Measurement (AMA - PCPI - NQF # 13).	Provider	X					X
12	**Clinical Quality Measure:** Anti-Depressant Medication Management; Effective Acute Phase and Effective Continuation Phase Treatment (NCQA - NQF # 105).	Provider	X					X
13	**Clinical Quality Measure:** Screening for Clinical Depression (CMS - NQF # 418).	Provider	X					X
14	**Clinical Quality Measure:** Asthma Assessment (AMA - PCPI - NQF # 1).	Provider	X					X
15	**Clinical Quality Measure:** Asthma Pharmacologic Therapy (AMA-PCPI - NQF # 47).	Provider	X					X
16	**Clinical Quality Measure:** Management Plan for People with Asthma (IPRO - NQF # 25).	Provider	X					X
17	**Preventive Quality Measure:** Weight Assessment Counseling for Children and Adolescents (NCQA - NQF #24).	Provider	X					X
18	**Preventive Quality Measure:** Well-Child Visits in the Third, Fifth and Sixth Years of Live (NCQA - NQF # 1516).	Provider	X					X
19	**Preventive Quality Measure:** Annual Risky Behavior Assessment or Counseling from age 12 to 18 (Adapted NCQA - NQF # 1507).	Provider	X					X
20	**Preventive Quality Measure:** a. Tobacco Use Assessment; b. Tobacco Cessation Intervention (NCQA - NQF # 28a &28b).	Provider	X					X

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	Required Practice Transformation Measures							
21	**Preventive Quality Measure:** Adult Weight Screening and Follow-Up (QIP - NQF # 421).	Provider	X					X
22	**Practice Transformation Measure:** Third next available appointment (NCQA; Standard 1; Element A; Factor 1).	Provider	X					X
23	**Practice Transformation Measure:** Patient visits that occur with the selected provider/care team (NCQA Standard 1; Element D; Factor 3).	Provider	X					X
	Required Service Utilization Measures							
24	**Service Utilization Measure:** The rate of ED visits per 1,000 member months; data is reported by age categories	Payer	X					X
25	**Service Utilization Measure:** The rate of utilization of inpatient care per 1,000 member months (NCQA - HEDIS-2012).	Payer	X					X
2	**Service Utilization Measure:** The rate of utilization of readmissions per 1,000 member months	Payer	X					X
	PCMH Progress Reporting Requirements							
27	**Practice Develops Goals and Submits them to the Pilot program** by onset of participation or within the first month. Engaged leadership will drive the transformation process; goals will be established during the start process.	Provider	X					X
28	**Completion of the Patient-Centered Medical Home Assessment and submission to Pilot Program** prior to onset of participation or within the first month will help identify readiness for Patient-Centered Medical Home transformation.	Provider	X					X

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	PCMH Progress Reporting Requirements, continued							
29	**Completion of the Patient-Centered Medical Home Assessment** and submission to Pilot program every six months from beginning of participation will help the Pilot program staff monitor progress.	Provider	X					X
30	**Progress Report Narrative Submitted to Pilot program**; A progress report completed by the lead at the practice summarizes the progress on goals, challenges and technical assistance needs. This will be submitted each quarter of participation.	Provider	X					X
31	**Completion of PCMH Self-Assessment Tool and submission to Pilot Program** at 6 months, and quarterly thereafter. This PCMH Self-Assessment Tool - by Primary Care Development Corporation (PCDC) maps onto the NCQA factors, which will show progress toward meeting specific NCQA standards associated with recognition.	Provider	X					X
32	**Baseline patient Satisfaction Survey Completed and submitted to Pilot Program** at the end of the first quarter of participation. Each practice will complete patient satisfaction surveys to determine areas of excellence and improvement.	Provider	X					X
33	**On-going Patient Satisfaction Surveys Completed and submitted to Pilot Program** at 6-month intervals after baseline. Each practice will complete patient satisfaction surveys to determine areas of excellence and improvement.	Provider	X					X

No.	Requirement	Source	Collab. Model	Blue Cross	Pacific Source	Regence Blue Shield	NCQA: Critical Factor* / must pass	Medicaid
Individual Payer Requirements Over and Above the Minimum Collaborative Requirements								
	Enhanced Access Requirements							
34	**46 Hour Access at the onset of Participation in the Pilot:** the clinic must have 46 hours of clinic access to provide patient care per week. The practice may determine when to implement the additional hours.	Provider		X				X
35	Provide open access through same day appointments **NCQA Standard 1; Element A; Critical Factor 1.**	Provider		X for acute conditions		X	X /	
36	Practice must provide timely clinical advice, by telephone during office hours **NCQA Standard 1; Element A; Factor 2, or secure electronic messages, Standard 1; Element A; Factor 3.**	Provider		X Optional for additional PMPM	X	X	/ X	X
37	Practice must provide after hours coverage to triage patients and refer them to the appropriate setting for care. Coverage must include availability of an on-call physician; standard referral to the emergency room would not quality. **NCQA Standard 1, Element B, Critical Factor 3?**	Provider		X Optional for additional PMPM	X	X	X /	
38	Member is given increased access to their care team including: telephone, email and same-day visits.	Provider		X Optional	X	X	/ X	
	PCMH Transformation Requirements							
39	**Practice Requirements -** Practices who may optionally obtain NCQA Level one recognition will automatically qualify for higher pmpm (see Blue Cross payment provision below)	Provider		X Optional for additional PMPM				

40	Shared Care Plans must be developed with patients: **NCQA Standard 4; Element A; Critical Factor 3.**	Provider		X Submit Copy to BCI	X	X	X /	
No.	**Requirement**	**Source**	**Collab. Model**	**Blue Cross**	**Pacific Source**	**Regence Blue Shield**	**NCQA: Critical Factor* / must pass**	**Medicaid**
	PCMH Transformation Requirements, continued							
41	Practice must use patient information, clinical data, and evidence-based guidelines to proactively manage clinically complex patients. Data will be used to remind patients of gaps in preventive and chronic care services.	Provider		X Optional for additional PMPM		X	/ X	
42	Practice must provide care management services including the development of individual care plans for medically complex patients and give patient a written plan of care. Patients that would benefit from additional care support must also be identified and follow-up conducted to ensure compliance with the outlined care plan. NCQA Standard 3; Element B; Factor 1; NCQA Standard 3; Element C; Critical Factor 3.	Provider		X Optional for additional PMPM	X	X	/ X	
43	Practice must support self-care processes by providing educational resources to patients to assist in self-management of their chronic condition. Self-management goals and tools must be developed to support achieving these goals.	Provider		X Optional for additional PMPM	X	X	/ X	
44	Practice must develop a referral tracking mechanism and follow-up take place including giving the specialist the clinical reason for the referral along with any pertinent clinical information. Follow-up must take place to obtain a copy of the report. Coordinate agreement on further care by specialist.	Provider		X Optional for additional PMPM	X	X	/ X	

No.	Requirement	Source	Collab. Model	Blue Cross	Pacific Source	Regence Blue Shield	NCQA: Critical Factor* / must pass	Medicaid
	PCMH Transformation Requirements, continued							
45	**Assess and Improve Patient Experience of Care and Transition of Care Management:** Practices will implement timely and effective data transfer agreements with the hospitals and specialists to guide improvement in care at the provider / care team level based off of: a) Notification of ED visits at local hospitals within 24 hours of admission; b) Notification of admission and clinical information exchange at the time of hospital admission; c) Notification of discharge, clinical information exchange, and care transition management at hospital discharge; d) Practice medication reconciliation process completed within 72 hours of hospital discharge; e) Information exchange related to referrals between primary care and at least two types of services lines that provide high-volume (defined by the practice) specialty care.	Provider			X Practices will work with Pacific Source to implement timely and effective data transfer agreements with the hospitals and specialists (by the end of the two-year pilot)	X	/ X	
46	**Complete an Annual Budget or Forecast:** Project new practice revenue flow and how it will be used for anticipated practice expenses associated with practice change (Practices can submit their own budgets with defined domains, or build off of a template provided by PacificSource). Submit within 6 months.	Provider			X		N/A	
47	**Provide Care Management for High Risk Patients:** Provide practice-based care management capabilities and indicate the following: a) who provides care management services; b) process for determining who receives care management services; and c) examples of care management plans.	Provider			X	X	N/A	
48	A dedicated Nurse Care Manager employed by the Primary Care Practice, to focus on coordinating and managing the health care of the enrollee's.	Provider				X	N/A	

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	Registry Requirements							
49	**Have a patient registry or other mechanism for tracking patients.**	Provider		X		X	/ X	
	Payer Coordination Requirements, continued							
50	Coordinate patient care with Payer in-house management programs	Provider		X	X		N/A	
51	To coordinate patient care with BCI in-house management programs, pilot practices will, by the end of the first quarter, will make a contact with BCI's management programs regarding each eligible members.	Provider		X			N/A	
	Provider Eligibility Criteria							
52	Healthy Connections Provider	Provider/ Payer					N/A	X
	Per-Member-Per-Month Payer Reimbursements							
53	PMPM of $15.50 will be paid for two years, provided that the practice continues to meet Medicaid Requirements.	Payer					N/A	X
54	There will be two payment levels: 1) $15.50 PMPM if the practice meets all the criteria specified by Blue Cross except the optional criteria. Participating practices will have one year to meet the required criteria. The PMPM will be paid at this rate during that first year until criteria has been fully met; and 2) $20.00 PMPM when the practice has met all the criteria, including all of the optional criteria.	Payer		X			N/A	
55	PacificSource will pay $22.50 per member per month as a medical home management fee for those members that qualify based on the eligible population parameters above. The funds must be used as specified by PacificSource.	Payer			X		N/A	

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	Per-Member-Per-Month Payer Reimbursements, continued							
56	Regence will consider paying a per enrollee per month (PEPM) fee ranging from $33-42 to support an embedded RN Care Manager.	Payer				X	N/A	
	Participant Eligibility Criteria for Supplemental Payment							
57	**Criteria for a Health Home Qualifying Patient** will include Diabetes AND Asthma, OR Diabetes or Asthma with a co-morbidity (risk factor) of hypertension, dyslipidemia, coronary arterial disease, obesity, or tobacco use. The other qualifying chronic illness is Serious and Persistent Mental Illness and Serious Emotional Disturbance (Pediatric) as a stand alone condition. **Only specific Dx codes within these categories are eligible.**	Payer/ Provider			X		N/A	X
58	**Criteria -** Practice must have 20 medically complex fully insured commercial members who have asthma, diabetes, and/or congestive heart failure. These patients will be identified by Blue Cross of Idaho using MEDai analytical software, as having a Chronic Impact score and an Acute Impact score above 80. This threshold was selected recognizing patients above the threshold have predicted acute costs in the top 5 percentile and because it identifies members with opportunity for compliance to disease guidelines and severity of illness.	Payer/ Provider		X			N/A	
59	**Criteria for a PCMH Qualifying Patient** will include top 3-5% of the sickest patients attributed to a given primary care practitioner/clinic.	Payer/ Provider				X	N/A	

No.	Requirement	Source	Collab. Model	Blue Cross	Pacific Source	Regence Blue Shield	NCQA: Critical Factor* / must pass	Medicaid
	Opt-In - Opt-Out Requirements							
60	Participant Opts Out; Health Homes is a mandatory component of Healthy Connections	Payer/ Provider					N/A	X
61	Participant Opts In; by the end of the first quarter, patient must sign an agreement with the provider to participate in the PCMH.	Payer/ Provider		X			N/A	
62	Participant Opts In: must complete an intake visit with RN Care Manager and physician; intake visit billed with S-code for signal					X		
	Data Reporting Requirements							
63	**Clinical Quality Measure:** Implement, if applicable, a diabetes improvement program that has a goal of improving the outcome measure that decreases A1cs greater than 9 - by at least 10 percent.	Provider		X			/ X***	
64	**Data Reporting Requirement - Cost-Management Improvement:** Produce panel-based reports quarterly with quality measure(s) and utilization measure(s) chosen by both the practice and payer (in addition to the data reporting requirements of the Collaborative.	Provider/ Payer			X			
65	**Clinical Quality Measure:** LDL control for Cardiovascular Conditions (HEDIS)	Provider				X		
66	**Clinical Quality Measure:** LDL control for Diabetes (HEDIS)	Provider				X		
67	**Clinical Quality Measure**: Adult BMI value (HEDIS)	Provider				X		
68	Care Transition – Transition Record Transmitted to Health care Professional (CMS CORE)	Provider						X

69	Adult BMI Assessment (CMS CORE)	Provider						X
70	Screening for Clinical Depression (CMS CORE)	Provider						X

* Critical factors are requirements under the NCQA recognition that is a basic requirement of the Collaborative Pilot.

** Medicaid Health Homes is a separate program that is aligned with the Collaborative Pilot with regard to these requirements. Practices may participate in the Collaborative, Medicaid Health Homes, or both. If a practice participates both in the Collaborative and Medicaid Health Homes, it will complete the requirements of both, and continue participating in the Medicaid Health Homes program beyond the Collaborative Demonstration Pilot.

*** Does not have to be diabetes for NCQA

**** The "x" in these boxes indicate that these are the set of measures that Collaborative participants must select from. They do not indicate that all of the measures are required. The reporting requirements above specify the number of measures to report on.

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