# ARHOME

## (Arkansas Health and Opportunities for Me)

# Strategic Plan 2023


**Submitted by**

**Arkansas Blue Cross and Blue Shield**

(USAble Mutual Insurance Corporation d/b/a Arkansas Blue Cross and Blue Shield, a mutual insurance company organized and existing under the laws of the State of Arkansas)

**and**

**Health Advantage**

(HMO Partners, Inc. d/b/a Health Advantage) Collectively

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# Executive

This strategic plan outlines Arkansas Blue Cross and Blue Shield's (USAble Mutual Insurance Agency d/b/a Arkansas Blue Cross and Blue Shield, a mutual insurance company organized and existing under the laws of the State of Arkansas) and Health Advantage's (HMO Partners, Inc. d/b/a Health Advantage) goals for operating as a Qualified Health Plan (QHP) available to ARHOME-eligible individuals. *(**Note**: Throughout the remainder of this strategic plan, Arkansas Blue Cross and Blue Shield and its affiliates, including Health Advantage, will collectively be referred to as Arkansas Blue Cross.)*

Arkansas Blue Cross has participated in Arkansas' adult Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) since its inception in January of 2014. It is the only QHP to participate in all seven rating regions of the state from the beginning of the expansion. Our Arkansas adult expansion under the state's initial expansion program, the Arkansas Health Care Independence Program (HCIP), included 130,176 covered Arkansans after the first full year of operation. Enrollment has varied over the years, but as of August 2022, we have 126,840 Arkansas Blue Cross members and 32,430 Health Advantage members enrolled in the ARHOME program.

The ARHOME waiver focuses on QHP accountability for achieving quality performance targets for specific quality measures. The ARHOME waiver also outlines goals related to QHP support of their members' economic independence. Our strategic plan outlines how Arkansas Blue Cross proposes to address the goals set forth in the ARHOME waiver application and its stated expectations of QHPs. Goals outlined in this strategic plan include:

**Goal 1:**
**Increase the use of preventive care and health screenings**

**Goal 2:**
**Improve maternal and child outcomes**

**Goal 3:**
**Improve behavioral health outcomes and quality performance from baseline**

**Goal 4:**
**Improve healthcare quality by making targeted community investments**

**Goal 5:**
**Reduce the proportion of our ARHOME members living in poverty**

**Goal 6:**
**Reduce health inequities and outcomes disparities for rural and minority populations**

# Organizational

As Arkansas' oldest and largest health insurer, Arkansas Blue Cross has helped improve the health, financial security, and peace of mind of the people of Arkansas for more than 70 years.

The company and its family of affiliates are leaders in health insurance innovation at the state and national levels and provide a full spectrum of health insurance solutions ranging from Medicare supplement insurance for individuals to third-party administration for large, employer-sponsored health plans.

Arkansas Blue Cross was founded in 1948 as a grassroots collaboration of the **Arkansas Medical Society**, the **Arkansas Hospital Association** and the **Arkansas Farm Bureau Federation**. These organizations came together to stabilize the state's healthcare financing and delivery system in the wake of the Great Depression.

Today, Arkansas Blue Cross is one of 35 Independent Licensees of the national Blue Cross Blue Shield Association. We employ more than 3,200 people in about a dozen locations in communities throughout the state. The company serves nearly 800,000 people who live and work in Arkansas and another 1.2 million coast-to-coast through national accounts – a total of more than 2 million members. More than 10,000 healthcare providers participate in our networks.

Arkansas Blue Cross also stands out among the state's other health insurers as a **not-for-profit, mutual** health insurance company. That means we are owned by our policyholders, not by stockholders. "Mutual" simply means that every member's participation benefits every other member. All our revenue goes to process and pay current or future claims. Of every premium dollar we collect, we pay out nearly 87 cents in benefits for our customers. The remaining 13 cents goes toward operating costs and reserve funds.

This all means our primary focus is providing maximum value for our members (and ***not*** generating profits to pay dividends to investors). Accordingly, we consistently pay out more of every premium dollar in claims than anyone else in the market and have a lower administrative cost ratio.

## Plans for all Arkansans

Arkansas Blue Cross offers two basic health plan categories for Arkansans:

- **Consumer health plans** (for individuals) – We have a wide range of health, dental and vision insurance policies for individuals and families, including offerings on the Health Insurance Exchange, including coverage of ARHOME Medicaid expansion enrollees, Medicare plans and supplement policies for seniors.
- **Employer-sponsored health plans** – Employers may select from fully insured or self-insured versions of group health and dental plans to offer their employees.

# Our Mission, Vision,

Arkansas Blue Cross' ARHOME Strategic Plan is guided by our mission, vision, and values and the ARHOME 1115 Waiver.

## Our Vision

A healthcare system that provides affordable and safe care for all citizens.

## Our Mission

Improve the health, financial security and peace of mind of the members and communities we serve.

## Our Values

- We believe our strength comes from being an independent, mutual, not-for-profit health insurance company and that we deliver the best value to our customers and society by maintaining that structure.
- We manage for the long-term benefit of the communities we serve, not for short-term rewards or gains. We remain financially strong and stable in order to serve future generations.
- Our members are our owners, and we keep their interests central in our business decision-making.
- Because the best customer is an informed customer, we provide information to allow people to make knowledgeable healthcare decisions and expenditures.
- Our work environment fosters personal excellence, growth, flexibility and teamwork. We believe work is a major part of our lives and should be a fulfilling experience. Personal accountability and responsibility are cornerstones of our philosophy.
- We believe in building and maintaining collaborative, long-term relationships with physicians, hospitals and other providers. These relationships are characterized by a mutual interest in our members and a focus on improving the affordability, delivery and quality of care for our members.
- We conduct our operations with the highest degree of integrity, honesty and fairness.
- We believe in corporate citizenship and work to improve the quality of life for all Arkansans.
- We celebrate our successes, learn from our mistakes and continually strive to improve.

# Arkansas Blue Cross Goals Related to

Arkansas Blue Cross developed this ARHOME Strategic Plan to support its successful participation as a Qualified Health Plan (QHP) in achieving the goals of the ARHOME 1115 Waiver. Below we outline the goals we have established toward demonstrating that enrollees receive added value by enrolling in a private health insurance plan and our approach to meeting those goals.

## Goal 1: Increase the use of Preventive Care and Health Screenings

Arkansas Blue Cross is committed to supporting our ARHOME members in accessing preventive care and health screenings for early identification and treatment of diseases and chronic health conditions. Our approach to increasing member use of preventive care and health screenings includes:

**Gap Identification and Outreach to Resolve Gaps:** For many years, we have focused our gap closure activity on preventive health. We continue to modernize our quality data infrastructure. In addition to developing the data infrastructure and reporting needed to support performance improvement on the ARHOME selected Medicaid Adult Core Measures, we are assembling data about our members from claims, clinical information, and assessments to build a 360° Member Profile. This new quality data infrastructure will also accelerate data availability to support timely interventions and eliminate data lags. Logic in our Member Profile DataMart will compare member demographics and claims history with recommended preventive care and screenings applicable to the member based on age, gender, and diagnoses to determine whether the member has accessed the recommended service.
If a member has not received a recommended preventive service or screening, the DataMart will identify this as an Actionable Gap.

The DataMart will feed Actionable Gap alerts to all systems used to support member care. For example, our care management platform will receive Actionable Gap alerts, which will present to our care managers in the member's record. This will allow care managers to reach out and provide coaching and support to members for scheduling these services. Similarly, our new Digital Health Coach app for member engagement will receive Actionable Gaps. The Digital Health Coach app will "nudge" members to resolve these gaps via multi-channel messaging and reminders of health actions they need to take, including inline gap notification (member specific "To Do" list) and gap notification via text and email.

The DataMart will also feed Actionable Gaps:

- to our call center platform, allowing our Member Services call representatives to coach members to close gaps;
- to our platforms supporting utilization and care management for behavioral health so behavioral health team members can support members in closing gaps;
- and to digital applications we make available to members such as our Special Delivery app that supports pregnant members with information and tools to support them during pregnancy and postpartum.

We will also communicate Actionable Gaps to our providers to enable them to conduct patient engagement activities to close gaps. Our network development team and primary care practice coaches will engage with practices to ensure they understand our gap data. They will provide technical assistance and coaching to practices on using that data and effectively engage and activate patients to close gaps.

We are continuing to modernize our quality data infrastructure. We have been working on migrating the infrastructure to our Health Data Management and Exchange to build for the future of increased interoperability and standardized data exchange. This work allows more access to actionable data and allows willing providers seamless provider-to-provider and provider-to-payer data exchange, significantly limiting their administrative strain.

**Health Improvement Initiative Incentive:** Arkansas Blue Cross will provide a financial incentive to members to complete specified Health Improvement Initiative activities. The financial incentives and activities for healthy engagement will have a direct, positive influence on the outcome for the Medicaid Adult Core Measures and promote the management of chronic and polychronic conditions. The table below outlines our planned health improvement incentive.

| ARHOME Purchasing Guideline | Arkansas Blue Cross |
|---|---|
| **Required Health Improvement Incentives** | **Activities Eligible for a Financial Incentive** |
| **Encourage the use of preventive care** | ▪ Getting an annual wellness/preventative visit<br>▪ Getting screened for breast cancer<br>▪ Getting screened for cervical cancer |
| **Pregnant women, particularly those with high-risk pregnancies** | ▪ Getting recommended prenatal and postpartum care starts with engagement. Members will be rewarded for notifying us when they become or are already pregnant, triggering program engagement.<br>▪ Enroll with an Arkansas Blue Cross-sponsored care manager |
| **Individuals with mental illness** | ▪ Follow up after hospitalization for mental health<br>▪ Adherence to anti-psychotic for individuals with schizophrenia |
| **Individuals with substance use disorder** | ▪ Follow up after hospitalization for substance use disorder<br>▪ Engagement in alcohol or other abuse-dependence treatment |
| **Individuals with two or more chronic conditions** | ▪ HbA1c results within range (HEDIS)<br>▪ Controlling high blood pressure<br>▪ Asthma medication ratio (asthma control medication relative to asthma rescue medication) |
| **Individuals living in rural areas** | ▪ Attribution to a primary care provider participating in one of our value-based programs (attribution based on clinic visits)<br>▪ Attestation of attendance in a health fair or community event that promotes positive mental or physical health outcomes |

We will define the eligibility for and amount of the Health Improvement Initiative Incentives as part of the implementation. Based on utilization trends or health risks, we may choose to implement additional incentives that may be time-limited as part of a particular campaign. For example, any observed outcome disparities in differing demographics might require modifications to programs as we continuously strive for equitability of performance.

Members will use the Digital Health Coach app (described below) to view their personalized recommended actions to close gaps and any associated Health Improvement Incentive (reward), view their "reward" balance and redeem rewards from available options, which will include digital gift cards for a range of businesses.

**Member 360° Engagement and Activation Approach:** Member 360° is our member education and engagement strategy that uses a variety of communication modes to reach members and activate healthy behaviors. Modes include:

- **Quick Start Guide.** We mail our Arkansas Blue Cross and Blue Shield Your Quick Start Guide to all new members immediately following their enrollment. The guide orients members to Arkansas Blue Cross by giving them essentials on how to get information, how to use the member ID card, how to find providers and get help choosing a provider or making an appointment, choosing a Primary Care Physician and getting an annual wellness exam, where to seek care in different circumstances, and the availability of case management.
- **Blueprint Portal.** Blueprint Portal is our secure member portal giving members 24/7 access to their health plan information and various self-service functions. We encourage members to register for a Blueprint Portal account which they can access from any web-enabled device. From the Blueprint Portal, members can: find a doctor or hospital, estimate treatment costs, view what is covered on their plan, check their deductible, review the status of claims and claims history, view their personal health record, order a replacement member ID card, and review a recent doctor visit.
- **ArkansasBlue Welcome Centers:** We believe in Arkansans helping Arkansans. In keeping with this belief, Arkansas Blue Cross has eight welcome centers throughout the state. Members can visit our welcome centers to pay their bills and to get information about their current plans and benefits. Members can walk in or schedule an appointment. Welcome center staff will be trained in and knowledgeable about ARHOME, so they may engage ARHOME guests to ensure they understand the value of their insurance. Staff will share with ARHOME guests how to best use their benefits, including preventive care and health screenings, and the availability of incentives for participating in Health Improvement Initiative and Economic Independence Initiative activities.
- **Member Coverage Documents.** We provide our members with their certification of coverage, schedule of benefits, and summary of benefits. These foundational documents provide members with information about their benefits and coverage.
- **Public Website:** Our public website provides members with easy access to information about a range of topics organized by what is most popular with members. Members can search for a doctor, get answers to frequently asked questions, learn how to earn rewards for healthy behaviors, find coverage information and forms, learn how to activate a Virtual Health account for 24/7 access to virtual appointments with board-certified physicians, and access to a range of health and wellness information and resources.
- **Social Media:** We maintain a presence on all primary social media platforms and use this presence to deploy health and wellness messaging to members. Our posts focus on encouraging actions and decision-making that will advance the member's health and wellness, improve health outcomes, and result in appropriate health case usage.
- **Digital Health Coach App:** We make a digital health coach application available to members for free. Through the digital health coach app, members can review assigned health actions, complete our NCQA certified Health Risk Assessment, review available reward balances, access NCQA certified educational content, and select to receive omnichannel communications including email and text. The app provides a personalized health action plan, relevant health education, and a secure messaging center to receive timely information from Arkansas
Blue Cross.
- **Care Management:** Our URAC-accredited care management program supports members and their families in navigating the healthcare system. Care managers help members understand and maximize the benefits available, provide health education and coaching to empower members to self-manage aspects of care deemed appropriate by the member's physician, help members navigate the complexities of the healthcare system, and identify

cost-effective alternatives to high-cost treatment settings, like hospitalization. Our Care Management program is a collaborative process that provides our care managers with a 360° holistic view of the member. Our care managers use this view to engage the member, providers (when necessary), and other healthcare professionals for an interdisciplinary best-in-practice approach to managing the member's health conditions.

We identify and assist high-risk members coping with complex care or catastrophic health events. We assess, plan, facilitate, and advocate for options and services designed to meet the member's healthcare needs through communication and available resources to promote cost-effective outcomes. This approach focuses on the benefits of our in-depth data analytics-driven program that captures multiple data points risk stratifying the entire population. This innovative approach allows us to identify members requiring case management and employ an integrated approach that ensures follow-through, decreases emergency room utilization and avoids readmissions.

- **Chronic Condition Management.** In addition and coordination with Arkansas Blue Cross Behavioral Health Care Management Program (see Goal 3 below), our Chronic Condition Management (CCM) program targets emerging high costs around multiple conditions: asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), cancer, diabetes, and neurological disorders, including comorbid conditions including but not limited to depression, low back pain, hypertension, and substance use disorders. This program is member-centric and assesses where members are in their journey to managing their conditions and their commitment to changing lifestyle habits, including identifying any financial barriers that may be present. Once our CCM has established a trusting relationship with members, we can begin monitoring, analyzing, planning, and improving outcomes. A critical barrier to addressing chronic conditions is identifying if the member has access to a primary care provider to manage their condition. If they do not have access to a provider, we aim to steer them to one of our value-based providers in the state. Outcomes are driven by member engagement, retention, and completion of our programs.
- **Nurse 24SM:** Through Nurse24SM, we have nurses available 24/7 to help members understand medical tests or recent diagnoses; advise them on how to care for minor injuries or illnesses; help members prepare for their next doctor's visit; understand the side effects of medications; and help them make healthy choices in their daily lives.
- **Customer Services:** We are committed to ensuring member access to information and support and employ a no-wrong-door strategy for members to contact us. As part of that strategy, we are committed to providing live customer service at our welcome centers and self-service options using the IVR and our member portal, Blueprint Portal. Our locally based Customer Service staff are available for members via phone during regular working hours. Members can also contact Customer Service via email from our member website. Customer Services staff provides members with a broad range of information and support, helping with activities such as finding a healthcare provider, finding a local resource to meet a member's SDoH needs using FindHelp (formerly Aunt Bertha), and referring members to in-house support like care management.

**Provider Engagement via Primary Care Value-Based Programs.** In 2023, we will operate two voluntary primary care value-based programs for providers: Patient Centered Medical Home (PCMH) and Primary Care First (PCF). Each program recognizes healthcare providers for their commitment in coordinating total patient care – emphasizing prevention and wellness and helping patients better manage chronic conditions to achieve improved health outcomes.

- **PCMH.** The PCMH program – a state-approved program that began in 2015 – is designed to assist primary care providers (PCPs) in transitioning their practices to patient-centered medical homes through guidance and support while rewarding them for high-quality, coordinated, and efficient care. Practices participating in PCMH will receive per-member-per-month (PMPM) care management fees to support practice redesign and care coordination efforts. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses and lower PMPM for patients with lower risk. Practices also receive quarterly performance-based adjustments

determined by performance on utilization metrics and annual performance-based adjustments determined by performance on quality metrics, including cancer screenings, diabetes care, well-child visits, asthma medication ratio, hypertension control, emergency department visit utilization, inpatient admission utilization, and generic prescription rates.

- Arkansas Blue Cross, supporting ~1,000 Arkansas PCMH providers, assists practices in the transformation process by providing training, resources, monthly reports, and dashboard data available on the Care Management Portal. We also offer primary care representatives who support practices transforming into patient centered medical homes.
- We update our Care Management Portal monthly. The Care Management Portal shows practice progress towards reaching targets, and actionable data, such as quality gaps and utilization performance at the practice level, provider level, and individual patient level.
- Primary care representatives guide practices on using the data to drive performance. Performance-based adjustments are paid to PCPs for performance on the utilization and quality measures:
    - Utilization Performance Adjustment: Practices meeting utilization targets will be rewarded with positive adjustments to care management fees. Practices that fail to meet at least one utilization metric will receive a negative adjustment to care management fees. Utilization performance is measured and adjusted quarterly.
    - Quality Adjustment: Qualifying practices will also receive a performance-based adjustment for meeting quality measures. Quality adjustments are applied on an annual basis.

**PCF.** PCF is another voluntary program for providers, building on the PCMH model – a Center for Medicare and Medicaid Innovation (CMMI) initiative – that aims to improve quality, improve the patient care experience, and reduce expenditures. PCF builds on and replaces the previous CMMI comprehensive primary care programs – approximately 460 PCPs are participating in our PCF model in 2022. The PCF model will achieve these aims by increasing patient access to advanced primary care services and providing practice transformation support to providers, including the data and primary care representative support available for PCMH. Using a multi-pronged reimbursement model, we will incentivize practices to deliver patient-centered care that reduces avoidable hospital utilization. Metrics for performance-based payment include cancer screenings, diabetes care, well-child visits, asthma medication ratio, hypertension control, emergency department visit utilization, inpatient admission utilization, and generic prescribing rates. Participating practices will receive:

- PMPM payments to support practice redesign and care management efforts.
- Monthly professional population-based payments for innovative patient care and a steady monthly income, regardless of in-office patient visits.
- Payment for patient office visits with certain evaluation and management services paid at a discounted rate.
- Performance-based adjustments, including:
    - Modeled after the performance-based adjustments in PCMH, PCF providers have the same structure to their adjustments, but with higher incentives available.

## Goal 2: Improve Maternal and Child Outcomes

According to the ARHOME Waiver application, approximately 15,000 women on the current waiver give birth each year. Of these, about one-third are considered to have “high-risk” pregnancies. The associated costs to Medicaid for preterm deliveries, low-birthweight births, very-low birthweight births, and stays in neonatal intensive care units (NICU) are significant. The stress on the birthmother and other impacted family members also cannot be discounted.

Further, embedded in these outcomes are disparities by geography, race and ethnicity. The March of Dimes calculates a preterm birth rate disparity ratio by race and ethnicity and tracks progress toward eliminating the disparity. Arkansas' preterm birth disparity ratio is 1.25 and shows no improvement from baseline[1]. In Arkansas, the preterm birth rate among Black women is 49% higher than among all other women. Over the last decade, increasing hospital closures and shrinking budgets have led to declining access to hospital obstetric (OB) care in rural areas across the country. These closures increase the burden on women and families living in rural communities, who often must drive long distances for prenatal visits and delivery. The likelihood of a rural hospital closing its OB unit is higher in low-income areas, which can disproportionately affect women and families who may have difficulty covering the cost of traveling farther for care.[2]

As reported by the National Partnership for Women and Families in their February 2020 Issue Brief, *Maternity Care in the United States: We Can – and Must – Do Better:*

- Rural women are 9% more likely than urban women to experience a composite measure of severe maternal morbidity and maternal mortality, 63% and 59% more likely to have a substance use disorder diagnosis at the time of birth.
- Infant, neonatal and post-neonatal mortality rates are higher in rural than urban counties.
- Babies born in the Delta Regional Authority (252 counties in AL, AR, IL, KY, LA, MO, MS, TN) and the Appalachian Regional Commission (420 counties in AL, GA, KY, MD, MS, NY, NC, OH, PA, SC, TN, VA, WV) are more likely than babies born in the rest of the nation to experience preterm birth, low birth weight and infant mortality, reflecting geographic variation in levels of economic distress and disadvantage and racism.

There are a variety of causes for these poor outcomes and outcome disparities, including lack of access to health care; pre-existing chronic conditions such as pre-pregnancy obesity, hypertension, diabetes, and cardiovascular disease; increases in maternal age; increases in drug addiction; and the use of tobacco products and alcohol during pregnancy.

Our approach to improving maternal and child outcomes for all our ARHOME members seeks to drive better clinical maternal and infant outcomes. It includes promoting enrollment in Maternal Life360 HOME, operating our Special Delivery Program, and our holistic maternity and postpartum care digital engagement platform.

**Promoting enrollment in Maternal Life360 HOME**. As applicable, we will encourage enrollment in Maternal Life360 HOME through our OB nurse outreach to pregnant members. When we identify that a woman is pregnant either using claims data, through self-reporting, or from other data sources such as SHARE (the Arkansas State Health Alliance for Records Exchange), we will contact her and discuss available options for her both during her pregnancy and after she has given birth. These support tools will be available through a Maternal Life360 HOME CBO, our Special Delivery maternity program, and our digital telehealth and maternity support application. Similarly, when members self-direct enrollment into our Special Delivery Program, our Special Delivery OB nurse will review the member's options and help the member enroll in the selected available program.

**Operating our *Special Delivery Program.*** Our Special Delivery team is responsible for assisting expectant mothers with prenatal and postpartum health using three strategies to empower expectant mothers: assessment, education and intervention.

- ***Assessment.*** Members can self-direct to enroll in Special Delivery. We also identify pregnant members through claims and other data sources such as SHARE and then contact them seeking their participation in Special

1 March of Dimes, 2020 March of Dimes Report Card, Report Card for Arkansas, https://www.marchofdimes.org/peristats/tools/reportcard. aspx?reg=05

2 National Conference of State Legislators, Legisbrief, Boosting Maternal Care in Rural American, Mairin Rivett, Erik Skinner and Kate Bradford | Vol . 27, No. 39 | November 2019

Delivery. Our claim analysis includes assessment for high-risk pregnancies, looking at an array of diagnosis codes that indicate risk, including depression, substance use, and domestic violence. We prioritize outreach to members whom this analysis identifies as having high risk. Our Special Delivery team of maternity nurses reaches out to our pregnant members to encourage enrollment in Special Delivery and complete an assessment of the member's maternity risks.

- ***Education.*** Once registered for Special Delivery, expectant mothers receive educational materials encouraging good health practices during pregnancy, including materials to increase their awareness of symptoms that may signal preterm labor. Materials may address maternity topics including, but not limited to, diabetic education, mental health information, nutrition and exercise and smoking cessation. We also provide a Special Delivery Resource List on our website with contact information for organizations that support women who are pregnant, their families, and their friends. And we promote member enrollment in Text4baby, a free text messaging service that sends three text messages a week timed to a member's due date and the date of her baby's first birthday. The texts include information on prenatal and infant care, immunization, developmental milestones, nutrition, oral health, quitting smoking, safety, and more.
- ***Intervention.*** All participants receive direct outreach through the mail and our mobile app. We pair pregnant members with an OB nurse from our Special Delivery team who stays in contact with the member throughout her pregnancy and postpartum.
  - ✓ For women with low-risk pregnancies, the Special Delivery OB nurse will contact the member each trimester and postpartum. The Special Delivery OB nurse contacts women with high-risk pregnancies monthly. All enrolled members receive two postpartum calls and a postpartum depression screening. The Special Delivery OB nurses cover various topics with their assigned members depending on the member's needs, risks, and questions. Topics may include but are not limited to diet and nutrition, food safety, gestational diabetes, high blood pressure, breastfeeding, and safe sleep practices. The goals of these contacts are to ensure that members have the information they need to choose healthy behaviors; that they understand what is normal and is not normal during pregnancy and postpartum and when to seek care; that they have our support in accessing care; and that we continually assess them and provide appropriate referral and supports based on those assessments. The OB nurses may make interdisciplinary referrals or consultations with our Behavioral Health Program, Social Work team, our Medical Director, a dietician, and our Pharmacy Program.
  - ✓ All pregnant members can access our Special Delivery mobile app. The app is designed to enhance members' experience as a participant in the Special Delivery program. The app offers interactive features such as appointment trackers, contraction timers, kick counters, and newborn feeding logs, among others. The app also hosts videos and other content on caring for babies and self-care to build a member's confidence and provide information about pregnancy, birth, breastfeeding, and adjustment to parenting.
  - ✓ All pregnant members may reach out to our designated Special Delivery email to ask questions and seek support and can reach the Special Delivery team by phone during business hours.

**Offering a Digital Maternity Telehealth Platform.** Arkansas Blue Cross offers our pregnant and postpartum members a digital maternity telehealth and engagement platform. The platform goes beyond presenting information to members. It offers:

- **Care Advocacy.** Each member using the platform will have 24/7 access to a Care Advocate who will act as a healthcare concierge, connecting them to in-network specialists in their area and via video chat and messaging and informing them of information and tools available on the platform.
- **Telehealth.** Through the platform, members will have 24/7 access to video appointments with a range of

specialized health care providers, including OB/GYNs, mental health specialists, doula and midwives, and a variety of other provider types to offer physical, emotional, and social care.

- ✓ The available telehealth network includes a diverse network with support for multiple languages and all races and ethnicities.
- ✓ The platform offers provider matching based on member identity and preferences.

- **Education.** The platform offers articles, webinars, and virtual and live online classes on topics across the maternity continuum of prenatal, delivery, and postpartum.
- **Tools.** The platform offers symptom trackers, screenings, and assessments. Member completion of risk assessment will allow the platform to identify risks and provide personalized content geared to promote healthy behavior changes and other actions.

The platform is designed explicitly to meet the needs of and engage pregnant and postpartum women and to improve maternal and infant outcomes. The platform will enhance care beyond our in-house Special Delivery program and community support. It will drive better clinical outcomes in maternity care for members, reducing unnecessary C-sections and emergency room visits and lowering NICU admissions. It will also boost engagement rates for pregnant members and address health equity by providing culturally competent care and support, 24/7, regardless of location or proximity to brick-and-mortar providers.

Through August of this year, over 180 members have actively enrolled with a virtual material care manager. Of the 180, 94 are classified as either medium or high-risk pregnancies. Early and consistent intervention has a positive impact on the management of both pregnancy and pre-pregnancy-related conditions.

## Goal 3: Improve Behavioral Health Outcomes and Quality Performance from Baseline

ARWorks members with a behavioral health (BH) diagnosis were 36% of the total population. They accounted for 52% of total medical spend, with the top three most prevalent diagnoses being anxiety, depression, and post-traumatic stress disorder. With this significant portion of our ARWorks members experiencing BH conditions, and the benefits of engaging and supporting these members as manifest through their improved health outcomes and decreased costs, we have implemented behavioral health programming to increase member engagement in care management including completing a proactive crisis plan, reducing inpatient and residential cost of care, and increasing outpatient utilization. Our approach to improving behavioral health outcomes for our ARHOME members seeks to drive better outcomes in these and other areas. It includes programming already in place with a new focus on activities that will positively impact the Behavioral Health Care Medicaid Adult Core Measures identified in the ARHOME waiver, and new elements promoting enrollment in Rural Life 360 HOME, providing targeted Health Improvement Incentives, working with Collaboratives to improve performance on the FUH-AD, FUA-AD, and FUM-AD measures, and working with our providers in value-based payment arrangements toward improving performance on the other Behavioral Health Care Medicaid Adult Core Measures.

**Promoting enrollment in Rural Life360 HOME.** As applicable, we will promote enrollment in Rural Life360 HOME through our behavioral health care management outreach to members we seek to engage. When we reach out to these members, we will discuss available support options, including help through a Rural Life360 HOME CBO, or support from the Arkansas Blue Cross behavioral health care management program.

**Arkansas Blue Cross Behavioral Health Care Management Program.** The Arkansas Blue Cross Behavioral Health (BH) Care Management (CM) program includes the following key components:

- **Member Identification.** We use a variety of methods to identify members to engage for BH CM. The most frequent methods include predictive modeling, referral identified from a prior authorization request, referral

identified from a facility admission, and referral from Arkansas Blue Cross' physical health (PH) CM team. Our predictive modeling process assesses claim data including pharmacy, authorization data, and facility treatment data. The logic uses variables including diagnoses, MAT prescriptions, emergency room visits, social determinants of health, BH costs, outpatient visits and other utilization. The algorithm scores member risk using weighted variables and combines it with real time data. The process results report out on the Daily BH CM Census Report used by the BH CM team to prioritize their outreach and engagement efforts and level members for different levels of CM need.

- **Member Outreach and Engagement.** Our BH CM team members conduct telephonic outreach to reach out to members to assess their support needs and seek to engage them in CM. Post-pandemic, we plan to increase the use of targeted face-to-face outreach. When able to engage a member, we use standard BH assessments to assess member risks and needs, including PHQ-9, GAD-7, SF-12, PSC-17, Socratews-8 A &D.
- **Care Plan Development.** Our BH CMs work with engaged members to develop a care plan that may include a proactive crisis plan or an aftercare plan to support transitions from one level of care or setting to another.
- **Care Management, Coordination, and Tracking.** BH CMs monitor member progress and fulfillment of the care plan and coach members to actively engage toward achieving care plan goals and outcomes. Our BH CM team and PH CM team conduct daily rounds to co-manage members with co-occurring BH and PH CM needs. There are three levels of CM depending on member risks and needs:
  - **Care Solutions.** This level of BH CM supports members with high needs/high costs to connect with community providers and resources and to move toward recovery and self-management.
  - **Care Transitions.** This level of BH CM supports members transitioning from inpatient and residential care to lower levels of care or home.
  - **Member Care Link.** This level of BH CM supports members with acute behavioral needs to address gaps in care and link to community providers and support.

**Arkansas Blue Cross Specialized Behavioral Health Interventions.** In addition to providing care management, we operate a variety of specialized BH interventions, including:

- **7-day follow-up.** Our Utilization Management (UM) team works closely with providers to schedule follow- up appointments within seven (7) days of a member's discharge following hospitalization for mental illness.
  These follow-up appointments help improve outcomes and reduce readmissions by monitoring adherence to discharge instructions. We will increasingly leverage telehealth to ensure timely access to follow-up appointments throughout the state. After discharge, if we identify a gap in follow-up, our clinical team calls the member to help in scheduling. We will continue to offer a Health Improvement Incentive for follow-up after hospitalization for mental health, designed to positively impact performance on the FUH-AD Medicaid Adult Core Measure. We will also offer a Health Improvement Incentive for member follow-up after a substance use disorder hospitalization.
- **Member education, discharge on Medication Assisted Treatment.** Our behavioral health care management team completes a review of a member's medications after their discharge to determine whether a member is taking medication as prescribed and ensuring they have coordinated an appointment with a provider for close follow-up.
- **Autism.** Through our BH UM, we conduct utilization reviews on Applied Behavioral Analysis (ABA) service requests. Our Autism Resource Program staff coordinates the care of autism spectrum disorder (ASD)-affected members by referring both the member and their family members to community support resources, educational literature, medical and behavioral health professionals, and other appropriate services as needed.

- **Targeted facility meetings.** Our BH Clinical Network Team facilitates meetings with high-volume facilities to present a performance scorecard that provides enhanced data on discharge performance, discharge planning, and transitions of care. The scorecard offers facility-specific performance compared to local industry/Arkansas market performance.
- **Overdose notification to providers.** We notify prescribers of overdoses early in a member's hospitalization.
- **Diabetes/psychosis.** Atypical antipsychotic drugs can increase the risk of metabolic syndrome. Metabolic syndrome is a cluster of conditions that increase the risk of heart disease, stroke, and type 2 diabetes. We provide education on the risk of certain medications, such as atypical antipsychotics, which add to risk of metabolic syndrome and diabetes. The BH care management team collaborates closely with the physical healthcare management team to coordinate appropriate referrals for members experiencing psychosis who have or are at risk of developing diabetes.
- **Substance Use Prevention Program.** Our Substance Use Prevention program helps members and physicians better understand and prepare for risks that come with acute and chronic pain management. It also aims to help members understand and access resources for treatment of opioid use disorder (OUD). Our Substance Abuse Prevention Coordinator identifies members with multiple prescribers and frequent ER use.
  Prescribers receive notification of their patient's utilization patterns to stem misuse and mitigate risk of overdose and death. Our UM program uses CDC guidelines and the Institute for Clinical Systems Improvement Chronic Pain Guidelines. Medication management policies include Morphine Milligram Equivalent (MME) based quantity and days' supply limits on immediate-release opioids, prior authorization of high-dose extended-release products, and coverage of medication-assisted treatment options (with exceptions for cancer and palliative care). Our UM protocols assess dependence and coordinate with Care Management, community-based treatment centers, and providers with relevant expertise in Medication Assisted Treatment (MAT).
- **Social Determinants of Health Supports (SDOH).** Our case management for ARHOME is a community- based model that includes the Arkansas Blue Cross social services worker (SW) team. The SW team plays an integral role in the co-case management of cases where the member has both physical and behavioral health concerns and supports members' SDOH needs toward improved behavioral health and whole-person care. The SW team actively participates with assessments, outreach, care planning, and support of BH case managers. They also participate in monthly interdisciplinary care team meetings that include Grand Rounds. The most common SDOH needs are for housing, transportation and food.

**Collaboration with Provider Facilities.** Arkansas Blue Cross collaborates with provider facilities to support discharge planning, conduct quality and readmission reviews, provide technical assistance, and share peer comparisons via dashboards to help providers understand how they perform relative to peers. Peer comparison data identifies outlier trends and focuses problem solving and technical assistance.

## Goal 4: Improve healthcare quality by making targeted community investments

Arkansas Blue Cross is committed to the health and well-being of the people and communities of Arkansas. Below are examples of targeted community investments we have made.

- Our 2018 Fearless Food Fights produced more than 1.1 million meals for local food pantries.
- We partner and collaborate with the Arkansas Rural Health Partnership (ARHP), actively assisting through funding. Founded in 2008, ARHP is a nonprofit healthcare network comprised of 14 rural hospital members, two medical teaching institutions, and two FQHCs throughout south Arkansas. Among other things, our investment in the ARHP supported their ability to gain access to SHARE.

- In June 2020, in response to an identified national "COVID-19 hot spot", we partnered with the Northwest Arkansas Council and funded the hiring of 10 bilingual community health navigators (six Spanish-speaking and four Marshallese-speaking) to help people in these communities access testing, medication and contact tracing and educate them about prevention tactics.

## Goal 5: Reduce the proportion of our ARHOME members living in poverty

The ARHOME 1115 Waiver application outlines the importance of investing in activities to support individuals' achievement of economic independence. The Waiver outlines that Arkansas's three-year average poverty rate is 15% compared to the national average of 11.5% and that only four states have higher poverty rates than Arkansas.

Our approach to reducing the proportion of our ARHOME members living in poverty is to implement an Economic Independence Initiative for our ARHOME members that includes promoting member participation in activities that help them get a job or secure a better job by providing financial incentives to members for participating in qualifying Economic Independence Initiative Activities.

In 2023, we will also incentivize members who attest to taking continuing education classes to pursue a degree or trade.

We will continue to promote member participation in employment, education, and training programs through content on our website and member portal and in our welcome centers. We will train member-facing staff on the economic independence goals of ARHOME and incorporate messaging promoting participation in employment, education, and training activities in appropriate member interactions. This promotion will include referrals to the Arkansas Division of Workforce Services (ADWS) website and programming. Through a statewide delivery system, the ADWS offers a suite of services for job seekers, including workforce readiness training, job search support, academic enrichment, and work experience. ADWS has Arkansas Workforce Centers throughout the state in addition to online resources.

We will continue to support members through an Economic Independence Initiative Incentive wherein we will provide a financial incentive to members who provide proof of completion of ADWS' free Career Readiness Certificate (CRC) at the Platinum, Gold, Silver or Bronze level. The Career Readiness Certificate demonstrates workplace readiness in possessing basic foundational skills. Even if a job seeker has a high school diploma, GED or post-secondary degree, the Arkansas CRC further verifies that they can handle tasks such as reading instructions and directions, working with figures, and finding information – tasks common in today's workplace. The CRC is recognized nationally, and each certificate is entered into the ACT WorkKeys® National Career Readiness database. Individuals who have achieved the CRC can put it on their resume or job application and invite prospective employers to verify its authenticity.

## Goal 6: Reduce health inequities and outcome disparities for rural and minority populations

The COVID-19 pandemic has highlighted that health equity is still not a reality. COVID-19 has unequally affected many racial and ethnic minority groups, putting them at higher risk of getting sick and dying from COVID-19. Negative experiences are common to many people within these groups, and some social determinants of health (SDOH)
have historically prevented them from having fair opportunities for economic, physical, and emotional health. In responding to COVID-19, we have worked with new partners organized around addressing health inequities and decreasing outcome disparities. Working with these partners has helped us improve our understanding of the nature and causes of inequities and how to address them. This understanding and these partners will continue to be part of our approach to reducing health inequities and outcome disparities for rural and minority populations.

As an example, Arkansas Blue Cross partnered with a wide range of community partners to organize and deliver our Vaccinate the Natural State initiative. Vaccinate the Natural State was a source for all things related to the COVID-19 vaccine in Arkansas for all Arkansans. However, our strategies were guided by the fact that Black and Hispanic Arkansans have been significantly affected and are at a higher risk of contracting and dying from COVID-19.

Arkansas Blue Cross has designated a medical director to oversee Health Equity and Public Programs and to lead our efforts to address health disparities in our state. Our medical director for Health Equity and Public Programs provides oversight and guidance on various public programs supported by our company, including the ARHOME program. The medical director will develop, evaluate, and implement actions that will work to ensure that every person we serve has equal opportunities for equitable care and outcomes.

Through our work in communities with providers and members, we understand the myriad barriers our members face to living their healthiest life and accessing needed health care. While the factors that create barriers and inequity are multifactorial, the common thread in the human cloth is that we all want to be healthy. This axiom drives us every day to make this our reality. However, we also understand that we alone cannot remove these barriers. We are a part of the solution for our members and will work with the larger community toward reducing health inequities and outcome disparities as part of the larger ecosystem.

While our ARHOME members will receive the same insurance benefits as others who purchase a private health plan, they will still need targeted efforts to address the unique barriers they face to improve their health. We have a strong understanding of barriers unique to this population. We are committed to embedding a health equity framework across all operations and points of contact. We believe this health equity framework will result in better outcomes, reduced inequity and disparity in outcomes, and fewer marginalized individuals. The framework provides a roadmap for targeted activity within our universal quality improvement program and engagement and coordination with members, providers, and staff. Using this framework, we are focused on three priority areas: data and analytics, technology, and extenders and collaborators.

**Data and Analytics.** We continually evolve our data and analytic capabilities by bringing new data, such as SDOH (Social Determinants of Health) and member screening and assessment data, into our analytic environments; and increasing the sophistication of our analysis by examining our data by race/ethnicity (imputation models, member self-reported, or otherwise), geography, and other factors. These actions help inform the development of interventions and the implementation of predictive modeling to identify individuals we can engage to prevent and mitigate poor outcomes. We clearly understand that SDOH and Behavioral Health components significantly impact the overall cost of care. Individuals with these concerns have a poorer quality of life and often access the healthcare delivery system by either overutilizing low-value care or underutilizing primary and preventive care. We intend to fully incorporate our granular understanding of the impact of these issues as we formulate our plan to address the member’s journey toward overall improved health. We will continue to assess quality measures by race/ethnicity and geography over time to inform action plans and assess progress in rural and minority communities to determine progress. By improving the sophistication of our analytics, we increase our ability to identify high-risk and emerging high-risk members for referral to case management. This allows us to develop more successful interventions and engagement strategies specific to the population and individual needs. We will continue to implement and evaluate interventions across the continuum of care and medical management to improve health outcomes in our members and the communities in which they live. Successful interventions will be scaled while others will provide learning opportunities for population health management overall.

**Technology.** We seek to use the opportunity of technology now and in the future. For 2023, through a new vendor partnership, we will further expand our telemedicine options, especially in the behavioral health space. We will support our members by developing digital literacy that enables them to access information and tools through our mobile app and services online. For example, Arkansas Blue Cross recognizes that the expansion of telehealth among behavioral health professionals during the pandemic had positive impacts among low-access members.

Our new partnership will expand on our previous telehealth services around health interventions, health coaching, chronic care management, nutrition, dermatology, and diabetic management.

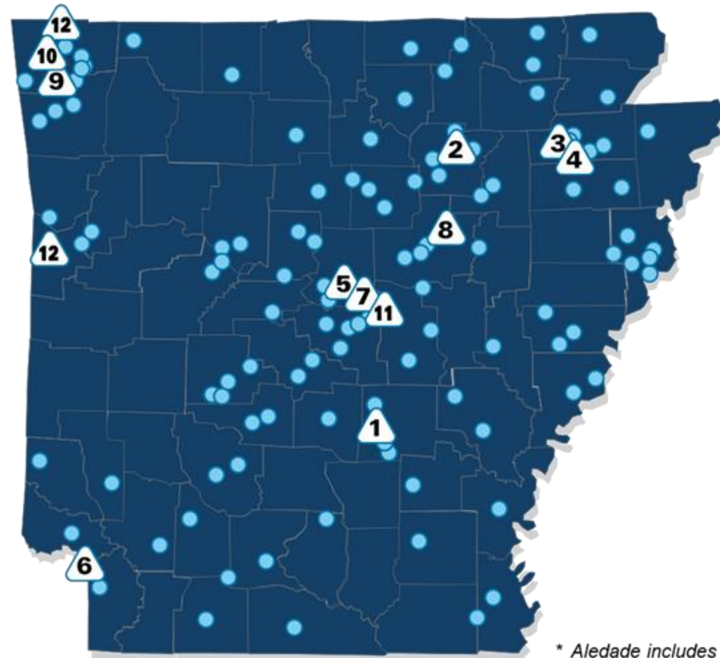
**Extenders and Collaborators.** We understand that Arkansas Blue Cross alone cannot resolve the issues and barriers that create health inequities and outcome disparities. We rely on and support a variety of extenders and collaborators to tackle these issues and barriers with us.

- Through our Collaborative Health Initiatives (Collaboratives), we engage health systems, medical centers, clinically integrated networks, and an independent provider-focused accountable care solution to partner in the transition from fee-for-service reimbursement to a value-focused delivery of care that improves quality, reduces cost, and improves the patient/member experience. We believe we can produce better results for our shared patients/members by working together rather than separately. We currently have 12 Collaboratives across the state. Appendix A identifies our 12 Collaborative partners and their locations. The payment model used varies by Collaborative partner. The models include cost targets adjusted for risk, trends of care, quality performance measures, per-member-per-month care management quality investments, utilization measures, and shared savings incentives for providers who deliver quality outcomes. We are participating in a new initiative with the Partnership for a Healthy Arkansas that provides alignment with staff on helping assist providers and patients to achieve wellness measure targets. Promising performance results of our Collaborative work, validated through difference-in-difference (DID) research analysis, have been observed.
- We partner and continually collaborate with the Arkansas Rural Health Partnership (ARHP), actively assisting with their funding. Founded in 2008, ARHP is a nonprofit healthcare network comprised of 14 rural hospital members, two medical teaching institutions, and two FQHCs throughout south Arkansas.
- We will continue to use FindHelp (formerly Aunt Bertha) to link members with community resources to help address their SDOH needs. FindHelp is an online social care network our team uses to identify and connect members needing help to verified local social care providers that serve them.

# Appendix A: Collaborative Health Initiatives

## Collaborative Health Initiatives (CHIs)

1. Jefferson Regional/ARHP CIN
2. White River Medical Center
3. St. Bernard's Medical Center
4. NEA Baptist Memorial
5. Baptist Health/BHPP
6. Collom & Carney Clinics
7. St. Vincent Health System/AHN
8. UNITY/ARcare
9. Washington Regional/MANA
10. Northwest Health/CQA
11. Aledade*
12. Mercy NWA & Ft. Smith



Collaborative Health Initiative primary presence

Cities that have one or more clinics under a value-based arrangement with Arkansas Blue Cross and Blue Shield

* *Aledade includes independent practices throughout the state.*

Collaborative Health Initiatives (CHIs)

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arkansasbluecross.com | healthadvantage-hmo.com