blueprint | Primary Care

2026 Benefits of Program Participation

The Blueprint Primary Care program combines the elements of the patient-centered medical home **care delivery model** with an **advanced payment model** for the organization and delivery of healthcare that helps to improve the patient's experience of care, improve the health of populations, and reduce or control the costs of healthcare. Blueprint Primary Care allows the primary care provider and the patient to be the center of the healthcare system, to know what is going on and help the patient be in control of their health.

By participating in the Blueprint Primary Care program, clinics will receive per-member, per-month (PMPM) payments to support practice redesign and care coordination efforts. Practices that qualify will also receive incentives for quality performance.

Patient Benefits

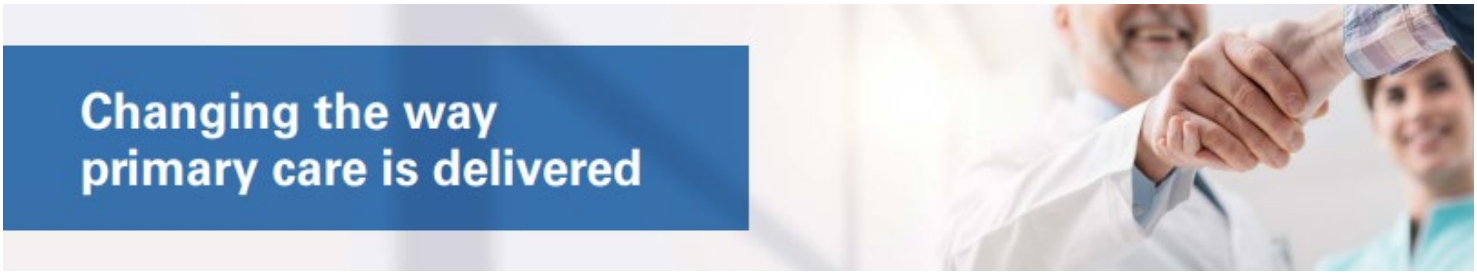
The Blueprint Primary Care program combines the expertise of medical staff with the efficiency of electronic health records (EHRs) to manage and coordinate the patient experience through the entirety of continuum of care. This integrated approach makes navigating the complicated healthcare system easier for individual patients. In addition to saving time and easing frustration, patients also enjoy:

- ✓ Enhanced access to care
- ✓ An improved patient experience
- ✓ Improved quality of care
- ✓ Better outcomes
- ✓ Care inclusion and accountability
- ✓ Coordinated care

Provider Benefits

While integrating new responsibilities and technology can be challenging, it can also be rewarding. The team approach allows physicians to shift many of their patient's preventative and maintenance needs to supporting team members. In turn, physicians can focus their attention on the patients who truly need medical attention, resulting in:

- ✓ Better quality performance and gap closure
- ✓ Improved population management techniques
- ✓ Improved patient and staff communication
- ✓ Improved office efficiency and time management
- ✓ Better utilization outcomes and cost savings
- ✓ Access to a coach, reports of data, and status updates for better performance



Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Octave BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Better Quality Outcomes and Cost Savings

Practices participating in the Blueprint Primary Care program will receive per member per month (PMPM) Care Management Fees (CMFs) to support practice design and enhance care coordination efforts. These fees are monthly payments not based on the volume of office visits and can be used to support staffing and training demands of transforming a practice. Care Management Fees are risk-adjusted with a higher PMPM for patients with more severe illnesses.

Performance Based Adjustment/Incentives (PBA) Quality

Practices participating in the Blueprint Primary Care program can earn performance-based adjustments/incentives (PBA) to encourage and reward accountability. The PBA for quality is based on submitted claims and if earned, are paid annually at the end of the program year completion. Blueprint Primary Care program has two tracks, General Track and Pediatric Track, with specific quality metrics for each track population. Quality performance incentives will be based on these quality metrics with each track having three required core metrics before incentive can be earned. PBAs, if earned, are paid in addition to monthly Care Management Fees and clinics have the whole program year to meet targets.

Pay-For-Performance Metrics Incentives

Practices participating in the Blueprint Primary Care program will also have an opportunity to earn incentives for two Pay-For-Performance Metrics that are specific to the ACA population. These Pay-For-Performance Metrics include completion of Preventative Health Visits (PHVs) and Hierarchical Condition Category Assessments (HCCs).

Clinics will have access to a list of both PHVs and HCCs needed for each provider participating in the Blueprint Primary Care at the start of the program year. Incentives are paid monthly based upon the number submitted and completed by the clinic.

Preventative Health Visits (PHVs) are identified using ICD-10 and CPT codes to indicate the appropriate wellness was completed. Once the claim is processed and completed, incentive payment is then issued.

Hierarchical Condition Category Health Assessments (HCC) forms will be provided and HCCs are considered complete with all diagnoses on the form are assessed and supporting codes are included on the claim for that date of service. Once the claim is processed and codes verified, incentive payments are then issued.

PHVs and HCCs are paid once per program year (calendar year) per member if applicable.

Care Coordination and Connection

Care coordination facilitates communication, coordinates services, addresses barriers and promotes resources while balancing clinical quality and cost management. Each clinic may oversee care coordination differently, and the role may include medical assistants, registered nurses, and even nontraditional multidisciplinary team members, including social workers, pharmacist, and registered dieticians.

Key activities of care coordination include connecting patients with community resources, transitions of care from hospital/emergency department settings, identifying care opportunities/gaps, and patient outreach and education.

Members of a care coordination team may include:

- ✓ Patient and family members
- ✓ Providers and clinical staff
- ✓ Community resources
- ✓ Hospitals
- ✓ Specialist
- ✓ Other healthcare professionals