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

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ARHOME

(Arkansas Health and Opportunities for Me)

Strategic Plan 2022

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 referred to hereinafter as Arkansas Blue Cross

Draft: August 20, 2021

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Executive Summary

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 and 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 June 2021, we had 144,899 members who participated in Arkansas Works (ARWorks).

ARWorks sought to build on the achievements of HCIP, with goals of improving healthcare continuity, access, quality, and cost-effectiveness. Arkansas Blue Cross has been a committed partner, striving to help the Arkansas Department of Human Services (DHS) achieve the goals of ARWorks. Arkansas Blue Cross will continue to support DHS in the implementation of Arkansas Health and Opportunities for Me (ARHOME).

The ARWorks Interim Evaluation (released on June 30, 2021) stated: "From a policy perspective, greater monitoring of quality improvement and performance efforts carried out by the demonstration's QHP carriers would likely benefit efforts to improve client health. Building on timely and accurate data submission requirements, the demonstration would likely benefit from regular and structured reviews of patient outcomes and alignment on improvement efforts with carriers."

The ARHOME waiver application reflects the recommendations in the Interim Evaluation – focusing on QHP accountability for achieving quality performance targets for specific quality measures. The ARHOME waiver application also outlines goals related to QHP support of their members' economic independence. Our strategic plan outlines how Arkansas Blue Cross proposes to address 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 through making targeted community investments
- **Goal 5:** Reduce the proportion of our ARHOME members living in poverty

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

Organizational Description

As Arkansas' oldest and largest health insurer, Arkansas Blue Cross and Blue Shield has been helping 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 when the **Arkansas Medical Society**, the **Arkansas Hospital Association** and the **Arkansas Farm Bureau Federation** 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 and employs 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 inclusive of coverage of ARWorks 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 to their employees.

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Presence throughout Arkansas

We recognize that each part of our state is unique. That's why we've maintained sales and service ArkansasBlue Welcome Centers for more than 20 years in the **Fayetteville**, **Fort Smith**, **Hot Springs**, **Little Rock**, **Jonesboro**, **Pine Bluff** and **Texarkana** areas. Members can visit our Welcome Centers to pay their bill and ask questions about their current plan and benefits. Members can walk in or schedule an appointment. We recently added an ArkansasBlue Welcome Center in **Rogers** and are in the process of expanding our presence in **Northwest Arkansas** even further, by adding a new, 81,000-square-foot regional corporate center in **Springdale**. This new facility will allow us to better serve the sustained dynamic growth of this vital region of our state. Our statewide regional presence gives all Arkansans access to convenient, timely expertise and service, close to home, from hometown folks who understand their needs.

Commitment to Arkansas

Arkansas Blue Cross also stands out because of its commitment to the health and well-being of the people and communities of Arkansas:

- **We give back to Arkansas – in ways that make life healthier.** Here are a few examples:
    - Arkansas Blue Cross maintains a separate nonprofit giving foundation the Blue & You Foundation for a Healthier Arkansas. The Blue & You Foundation for a Healthier Arkansas is a charitable foundation established and funded by Arkansas Blue Cross and Blue Shield to promote better health in Arkansas. In its 20 years of operation, the Blue & You Foundation has awarded more than $40 million to more than 2,600 health-improvement programs reaching every county of Arkansas. To achieve the goal of better health for all Arkansans, the Blue & You Foundation seeks to strategically focus its grant funding on community-based solutions, to nurture community health leadership, foster collaboration and innovation, and leverage financial, human and community resources to produce a measurable, positive impact. The Blue & You Foundation for a Healthier Arkansas is a 501(c)(3) nonprofit organization.
        - In 2021, the Blue & You Foundation awarded 345 mini grants of $1,000 to organization across the state to help address food insecurity, place AEDs in buildings, provide naloxone kits to first responders, and help organizations with projects that teach health and wellbeing to children and teens. The foundation also granted $214,100 to organizations tasked with COVID-19 vaccine education and grassroots vaccine promotional efforts. In July 2021, the foundation announced a $5.29 million investment that strategically addresses behavioral health in the state of Arkansas, including addressing the stigma surrounding mental health, standardizing early childhood intervention, integrating behavioral healthcare into primary care practices, and providing trauma resources to educators in schools throughout Arkansas.

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- Arkansas Blue Cross is leading the Vaccinate the Natural State coalition and sponsoring an extensive awareness campaign and vaccination events, in an attempt to help reduce infection rates and hopefully end the COVID-19 pandemic in our state. To date, Arkansas Blue Cross has supported more than 120 vaccine clinics throughout the state, with more than 600 employees volunteering more than 2000 hours to support vaccine efforts.
- Arkansas Blue Cross and its employees put their resources, time, and energy into addressing key health-related issues. Our 2018 Fearless Food Fights produced more than 1.1 million meals for local food pantries.
- As a leading partner in the Together Arkansas initiative, we, along with the Arkansas State Chamber of Commerce/Associated Industries of Arkansas and AFMC, are helping employers fight opioid use disorder in the workplace.
- Additionally, Arkansas Blue Cross directly contributes about $1 million in sponsorships annually to civic, cultural, educational, and health-improvement organizations in Arkansas and consistently supports disaster-relief efforts in our state.

- **We support state and local economies by creating good jobs and paying taxes.** Arkansas Blue Cross consistently ranks among the state's top 25 employers. We've been named one of the state's "Best Places to Work" by Arkansas Business magazine for eight consecutive years. We are recognized as a state leader in having policies that promote gender equity in the workplace. And we recently were ranked 33rd nationally on Forbes magazine's list of America's Best Midsize Employers. Incidentally, we were the highest-rated insurer and Arkansas-based company among the 500 employers named to that list. We pay state and federal taxes, totaling several hundred million dollars in the last 10-15 years alone.
- **We are committed to Arkansas – first and always.** Arkansas Blue Cross began as a grassroots organization, formed by Arkansans to serve Arkansans. And we've been doing so for seven decades now. Arkansas is first … in our name, hearts, minds, and work. Here are a few examples:
  - **Commitment to Arkansas' healthcare providers.** Arkansas Blue Cross recognizes how important it is to share claims information with healthcare providers. This helps them serve their patients better, improve efficiency and coordinate services with each other. We have taken several steps during the pandemic to allow more remotely delivered care and help direct more funds to our state's provider community.
  - **Commitment to Arkansas' people.** Arkansas Blue Cross is proud to participate in programs that improve the health of all Arkansans. We're also proud of our partnership with the state on various initiatives throughout the years.

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- Arkansas Blue Cross was the only company that offered health plans in all 75 counties during the launch of the state's **Affordable Care Act's Private Option**. That allowed the state to meet the federal government's requirements for implementing the program.

  Our commitment to help Arkansas meet those federal requirements included an **initial investment of $18 million** before the program even started – and the **addition of 200 employees** to our workforce. More than a decade later, we're still the primary health insurance carrier for the most economically challenged areas of our state, where access to healthcare providers is lacking.
- Arkansas Blue Cross remains committed to **improving access** and **services** in our **rural communities** through various statewide partnerships with local entities.
- Arkansas Blue Cross has gone to extraordinary lengths to help protect our members and group health plans from the pandemic's hardships, extending a number of **voluntary, expanded COVID-19-related benefits** and **suspending some of our normal practices** (including **delinquency** and **cancellation** processes for nonpayment of premiums) for more than a year.

Commitment to Arkansas and to making our members' lives and our communities healthier is in our corporate DNA. It's who we are and what we do.

Our Mission, Vision, Values

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

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- Because the best customer is an informed customer, we provide information to allow people to make knowledgeable health-care 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 ARHOME

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 demonstration that enrollees receive added value by being enrolled 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. With ARHOME, we are broadening our quality and gap closure approach to include a wider set of measures including specific chronic- and polychronic-condition management. Aligned with implementation of ARHOME, we are rebuilding and modernizing 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 the availability of data 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, or not. If a member has not received a recommended preventive service or screening, the DataMart will identify this as an Actionable Gap. The DataMart

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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 make sure they understand the gap data we provide and provide technical assistance and coaching to practices on how to use that data and effectively engage and activate patients to close gaps.

As a second phase to modernization of our quality data infrastructure, we will migrate the infrastructure to our Health Data Management and Exchange to build for the future of increased interoperability and standardized data exchange. This work not only allows for more access of actionable data, but also allows willing providers seamless provider-to-provider and provider-to-payer data exchange, greatly limiting their administrative strain.

Health Improvement Initiative Incentive: Arkansas Blue Cross will provide a financial incentive to members for completion of specified Health Improvement Initiative activities. The financial incentives and activities for healthy engagement selected will have a direct, positive influence on outcome for the Medicaid Adult Core Measures, as well as promote management of members with chronic and polychronic conditions. The table below crosswalks the ARHOME Purchasing Guidelines requirements to our planned health improvement incentive.

ARHOME Purchasing Guideline Required Health Improvement Incentives	Arkansas Blue Cross Activities Eligible for a Financial Incentive
Encourage the use of preventive care	▪ Getting an Annual Wellness/Preventative Visit ▪ Getting screened for Breast Cancer ▪ 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

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	for notifying us when they become pregnant or are already, triggering program engagement.
Individuals with mental illness	▪ Follow up after hospitalization for mental health
Individuals with substance use disorder	▪ Follow up after hospitalization for substance use disorder
Individuals with two or more chronic conditions	▪ Completing a Diabetes Care-HbA1c test ▪ Controlling High Blood Pressure ▪ Asthma Medication Ratio (asthma control medication relative to asthma rescue medication)

We will define the eligibility for and amount of the Health Improvement Initiative Incentives as part of implementation. We may choose, based on utilization trends or health risks, to implement additional incentives that may be time limited as part of a particular campaign. As an 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 new 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 all new members our *Arkansas BlueCross BlueShield Your Quick Start Guide* immediately following their enrollment. The Guide orients members to Arkansas Blue Cross by giving them essential information about 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.
- **My BluePrint.** My Blueprint is our secure member portal giving members 24/7 access to their health plan information and a variety of self-service functions. We encourage members to register for a My Blueprint account which they can access from any web enabled device. From My Blueprint members can: find a doctor or hospital, estimate treatment costs, view what is covered on their plan, check their deductible, review status of claims and claims history, view their personal health record, order replacement member ID cards, 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 located throughout the state. Members can visit our Welcome Centers to pay

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their bill and to get information about their current plan and benefits. Members can walk in or schedule an appointment. Welcome Center staff will be trained in and knowledgeable about ARHOME and engage ARHOME guests to ensure they understand the value of their insurance, how to best use their benefits including preventive care and health screenings, and the availability of incentives for participating in Health Improvement Initiative activities 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 of 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 that provides 24/7 access to board-certified physicians for virtual health visits, and access 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 with a 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. For example, in 2021 we've used our social media messaging to provide information about vaccine clinics and promote member choice to receive a COVID-19 vaccine.
- **Digital Health Coach App:** Starting January 1, 2022, Arkansas Blue Cross will 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 as they navigate the health care 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 deal with the complexities of the health-care system, and identify cost effective alternatives to high-cost treatment settings such as 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 health care 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

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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 ensure follow-through, decreases emergency room utilization, and avoids readmissions.

- **Chronic Condition Management.** In addition and in 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, our goal is 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 24^{SM}:** Through Nurse24^{SM} we make nurses available 24/7 to help members understand medical tests or recent diagnoses; give advice 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 members 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 a live customer service option for members in addition to our Welcome Centers, and in addition to self-service options using the IVR and member portal, BluePrint. Our locally based Customer Service staff are available for members via phone during normal working hours, and members can contact Customer Service via email from our member website. Customer Services staff provide members with a broad range of information and support, helping with activities such as finding a health care provider, finding a local resource to meet a member's SDOH needs using Aunt Bertha, and referring members to in-house supports such as care management.

Provider Engagement via Primary Care Value Based Programs. In 2022, 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 –

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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 become 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, lower PMPM for patients with lower risk. Practices also receive annual performance-based adjustments determined by performance on utilization and quality metrics including cancer screenings, diabetes care, well-child visits, asthma controller medication adherence, hypertension control, emergency department visit utilization and inpatient admission utilization.
    - Arkansas Blue Cross, supporting ~900 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 that support practices in their transformation into a patient centered medical home.
    - 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 how to use the data to drive performance.
- **PCF.** PCF is another voluntary program for providers, building on the PCMH model – a Center for Medicare and Medicaid Innovation (CMMI) initiative – and aims to improve quality, improve patient experience of care, and reduce expenditures. PCF will build on and replace the previous CMMI comprehensive primary care programs – approximately 50 of our ~575 Comprehensive Primary Care Plus providers transitioned to PCF in 2021, and we are transitioning the remaining 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 supports available for PCMH. We will incentivize practices to deliver patient-centered care that reduces avoidable hospital utilization using a multi-pronged reimbursement model. Metrics included in assessment for performance-based payment include cancer screenings, diabetes care, well-child visits, asthma controller medication adherence, hypertension control, emergency department visit utilization and inpatient admission utilization. Participating practices will receive:
    - PMPM payments to support practice redesign and care management efforts.

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- Monthly professional population-based payments to care for patients in innovative ways and provide 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:
  - Utilization Performance Adjustment: Practices meeting utilization targets will be rewarded with positive adjustments to care management fees. Practices who fail to meet at least one utilization metric will receive a negative adjustment to care management fees. Utilization performance is measured and adjusted on a quarterly basis.
  - Quality Adjustment: Practices that qualify will also receive a performance-based adjustment for meeting quality measures. Quality adjustments are applied on an annual basis.

Goal 2: Improve Maternal and Child Outcomes

In 2020, the Arkansas infant mortality rate was 8.2 (8.2 infant deaths per 1,000 live births) compared to the national rate of 5.5[1]. The state of Arkansas ranks as third worst in the country for maternal mortality, with a rate of 35 maternal deaths per 100,000 live births, compared to the national rate of 20.[2] And Arkansas performs poorly on other maternal and infant relative to the national rate. The table below highlights 2017 Arkansas birth data as reported by the CDC.

CDC Arkansas Birth Data, 2017[3]

Measure	Arkansas	Rank	United States
Cesarian Delivery Rate	33.5	14th (tie)	32.0
Preterm Birth Rate	11.4	6th	9.9
Low Birthweight Rate	9.3	9th	8.3

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

[1] America's Health Rankings, United Health Foundation, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/AR

[2] https://www.aymag.com/maternal-mortality-in-arkansas/

[3] Centers for Disease Control and Prevention, National Center for Health Statistics, https://www.cdc.gov/nchs/pressroom/states/arkansas/arkansas.htm

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"high risk" pregnancies. The associated costs to Medicaid for pre-term 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 outcome disparities by race and ethnicity, and geography. 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.[4] In Arkansas, the preterm birth rate among Black women is 49% higher than the rate 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.[5]

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.

The ARHOME Waiver will test the efficacy of the use of Maternal Life360 HOME Community Bridge Organizations (CBOs) to provide intensive care coordination to

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

[5] 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

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participating women to connect them to needed services and community support, address social determinants of health, and actively engage them in promoting their own health. Because ARHOME member participation in Maternal Life360 HOME is voluntary, and because there may not be Maternal Life360 HOME CBOs available to all ARHOME pregnant members, we have also developed a multi-faceted approach to supporting our pregnant ARHOME members who do not participate in Maternal Life360 HOME so that they may also receive the maximum benefits of such services.

Our approach to improving maternal and child outcomes for all our ARHOME members seeks to drive better clinical maternal and infant outcomes and 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. We will promote 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) and contact her, we will 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 operates our Special Delivery maternity program. The 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, and we identity pregnant members through claims and other data sources such as SHARE and then contact them seeking their participation in Special 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 who this analysis identifies as having high risk. Our Special Delivery team of maternity nurses reach 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 that encourage good health practices during pregnancy, including materials to increase her 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

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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 mail and our mobile app, and 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. For women with high-risk pregnancies, the Special Delivery OB nurse makes contact monthly. All enrolled members receive two postpartum calls and a postpartum depression screening. The Special Delivery OB nurses cover a variety of topics with the members they are paired with depending on the member's needs, risks, and question. Topics may include but are not limited to diet and nutrition including food safety, gestational diabetes, high-blood pressure, breast feeding, and safe sleep practices. The goals of these contacts are to ensure that members have the information they need to choose healthy behaviors; that those members understand what is normal and is not normal during pregnancy and postpartum, and when to seek care; that those members have our support in accessing care; and that we continually assess the member 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 baby 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 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. Starting in 2022, Arkansas Blue Cross will offer 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 our members

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to in-network specialist in their area, to specialists via the platform over video chat and messaging, and informing women 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 midwifes, and a variety of other provider types to provider 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 identify 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 supports and will drive better clinical outcomes in maternity care for members, reducing unnecessary C-sections and emergency room visits, and lowering NICU admissions; 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.

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

In alignment with the ARHOME waiver, Arkansas Blue Cross seeks to improve behavioral health outcomes. ARWorks members with a behavioral health (BH) diagnosis were 36% of the total population and 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 completion of a proactive crisis plan, reduce inpatient and residential cost of care, and increase outpatient utilization. Our approach to improving behavioral health outcomes for our ARHOME members seeks to drive better outcomes in these and other areas, and 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

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toward improving performance on the other Behavioral Health Care Medicaid Adult Core Measures.

Promoting enrollment in Rural Life360 HOME. We will promote enrollment in Rural Life360 HOME through our behavioral health care management outreach to members we seek to engage. When we outreach to these members, we will discuss available options for the member's support including support available 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, 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 fulfilment 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.

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- **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 supports.

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 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 be increasingly leveraging 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. In 2022 we will implement 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 following hospitalization for a substance use disorder.
- **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 to ensure they have coordinated an appointment with a provider for close follow-up.
- **Autism.** Through our BH UM, we conduct utilization review on Applied Behavioral Analysis (ABA) service requests. Our Autism Resource Program staff coordinate 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 provides 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 occur together, increasing the risk of heart disease, stroke, and **type 2 diabetes.** We provide education on the risk of certain medications, such as atypical antipsychotics, adding to risk of metabolic syndrome and thereby diabetes. The BH care management team collaborates closely with the physical health care management team to coordinate referrals, as appropriate, for members experiencing psychosis who have or are at risk of developing diabetes.

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- **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 often 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 facilitate assessment of dependence, and coordination 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 ARWorks is a community-based model that includes and 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 focused problem solving and technical assistance.

Goal 4: Improve health care quality through 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), including actively assisting through funding. Founded in 2008, ARHP is a nonprofit healthcare network comprised of 14 rural hospital members, 2 medical teaching institutions, and 2 FQHCs throughout south Arkansas. Among other things, our investment in the ARHP supported their ability to gain access to SHARE.

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- In June 2020, in response to an identified national "COVID-19 hot spot", we partnered with the Northwest Arkansas Council, we 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 the three-year average poverty rate in Arkansas 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.

We will 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 referral to the Arkansas Division of Workforce Services' (ADWS) website and programming. The ADWS offers a suite of services for job seekers including workforce readiness training, job search support, academic enrichment, and work experience, through a statewide delivery system. ADWS has Arkansas Workforce Centers throughout the state in addition to online resources.

We will also implement 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 jobseeker 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

Through our experience as a QHP serving Arkansas' Expanded Medicaid beneficiaries, we have developed a deep understanding of the unique needs of these members. We have grown, and will continue to grow, our capabilities to reach and engage our

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member population. Our Arkansas Blue Cross employees live and work in the communities they serve and share our enterprise vision to improve the health, financial security, and peace of mind of the members and communities we serve. Reaching rural and minority members and improving health equity is consistent with this vision and aligned with the Blue Cross and Blue Shield Association National Health Equity Strategy, which Arkansas Blue Cross helped develop and continues to be a part.

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 more at 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 who are organized around addressing health inequities and decreasing outcome disparities. Work with these partners has help 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 is a source for all things related to the COVID-19 vaccine in Arkansas, for all Arkansans. However, the strategies we employ are informed by the fact that Black and Hispanic Arkansans have been significantly affected and are at a higher risk to contract and die 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 that will replace ARWorks, and will develop, evaluate, and implement actions that will work to ensure every person we serve has equal opportunities for equitable care and outcomes.

The Blue Cross Blue Shield Association (BCBSA) National Health Equity Strategy aims to confront the nation’s crisis in racial health disparities. This strategy intends to change the trajectory of heath disparities and re-imagine a more equitable health care system. BCBSA has convened a national advisory panel of doctors, public health experts and community leaders to provide guidance. The multi-year strategy will focus on four conditions that disproportionately affect communities of color: maternal health, behavioral health, diabetes, and cardiovascular conditions. BCBSA’s National Health Equity Strategy is comprehensive and relies on close collaboration with providers and local community organizations. This collaboration was essential in recent months as BCBS companies worked with local leaders to support vulnerable communities with COVID-19 vaccine access.

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Through our work in communities with providers and members, we understand the myriad barriers that 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 to human cloth is that all of us want to be healthy. This axiom drives us every day to make this our reality. However, we also understand 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, ARHOME members will still need targeted efforts to address unique barriers that they face to health improvement. We have a strong understanding of barriers unique to this population and 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 for 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 with whom we can engage to prevent and mitigate poor outcomes. We have a clear understanding that SDOH and Behavioral Health components significantly impact the overall cost of care. Individuals with concerns in these areas have a poorer quality of life and find themselves accessing the healthcare delivery system more inefficiently, 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 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 increasing the sophistication of our analytics, we are improving our ability to identify high-risk and emerging high-risk members for referral to case management and to develop more successful interventions and engagement strategies specific to 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 provide learning opportunities for population health management overall.

Technology. We seek to use the opportunity of technology now and in the future. We will expand our telemedicine options, especially in the behavioral health space, and

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support our members in developing digital literacy that enables them to access information, 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. These positive impacts led to our decision to continue this expanded benefit beyond the pandemic.

Web-based information and services brings access and options to individuals living throughout the state and increases options for providing culturally competent information and services to members. Another technology objective is to maximize the benefits of interoperability by engaging in data sharing that decreases, rather than exacerbates, health care inequities. For example, algorithms in predictive modeling for risk stratifying populations and referring them for case management or other engagement, can inadvertently include racial bias that underrepresents needs and risks of Black people.[6]

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 patient/member experience. We believe we can produce better results for our shared patients/members by working together rather than working separately. We currently have 11 Collaboratives across the state. Appendix A identifies our 11 Collaborative partners and their locations. The payment model used varies by Collaborative partner, and 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. With implementation of ARHOME, our work with CHIs will evolve to focus to collaboration to improve performance on ARHOME specified Medicaid Adult Core Measures.
- We intend to deepen relationships with Federally Qualified Health Centers, Rural Health Clinics, and other state and federal primary care innovation opportunities to support their provision of primary and ambulatory care in rural and minority

[6] Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations, Science, Vol. 366, Issue 6464, pp447-453, October, 25, 2019, Ziad Obermeyer, Brian Powers, Christine Vogel, Sendhil Mullainathan

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communities. We partnered and continually collaborate with the Arkansas Rural Health Partnership (ARHP), including actively assisting with their funding. Founded in 2008, ARHP is a nonprofit healthcare network comprised of 14 rural hospital members, 2 medical teaching institutions, and 2 FQHCs throughout south Arkansas.

- We will continue to use Aunt Bertha to link members with community resources to help address their SDOH needs. Aunt Bertha 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.

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Appendix A: Collaborative Health Initiatives Map