The Primary Care Practitioner Quality Enhancement Program

Improving quality care and health outcomes

2020

Keystone First

Contents

Welcome letter....2

Introduction....3

Program overview....3

Performance Incentive Payment (PIP)....3

1. Quality Performance....4

2. CPT II Code Electronic Submission....8

3. Top Performer Incentive/Improvement Component....11

Provider appeal of ranking determination....12

Keystone First

200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Primary Care Practitioner:

Keystone First's Quality Enhancement Program (QEP) provides incentives for high-quality and cost-effective care, member service and convenience, and health data submission.

Keystone First is excited about our enhanced incentive program and will work with your primary care practice so you can maximize your revenue while providing quality and cost-effective care to our members.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your provider Account Executive.

Sincerely,

Lily Higgins, M.D., M.B.A., M.S.
Market Chief Medical Officer

Kim Beatty
Director
Provider Network Management

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

www.keystonefirstpa.com

Introduction

The Quality Enhancement Program (QEP) is a reimbursement system developed by Keystone First for participating primary care practitioners (PCPs).

The QEP is intended to be a fair and open system that provides incentives for high-quality and cost-effective care, member service and convenience, and submission of accurate and complete health data. Quality performance is the most important determinant of the additional compensation. As additional meaningful measures are developed and improved, the quality indicators contained in the QEP will be refined. Keystone First reserves the right to make changes to this program at any time and shall provide written notification of any changes.

Program overview

The QEP is intended to be a program that provides financial incentives over and above a PCP practice's base compensation. Incentive payments are not based on individual performance, but rather the performance of your practice, unless you are a solo practitioner.

Certain QEP components can only be measured effectively for PCP offices whose panels averaged 50 or more members. The average of 50 is based on a defined average enrollment period for the particular measurement year. For offices with fewer than 50 members, there is insufficient data to generate appropriate and consistent measures of performance. These practices are not eligible for participation in the QEP. Additionally, a Top Performer Incentive will accompany the final settlement for groups whose average peer comparison percentile ranking across all Quality measures is 65% or higher. PCP groups that did not meet network targets but did show an improvement of 10% or more for a given measure over the prior year will also be awarded an Improvement Incentive payment as well (see page 11).

Performance Incentive Payment (PIP)

A Performance Incentive Payment (PIP) may be paid in addition to a practice's base compensation. The payment amount is calculated based on how well a PCP office scores on each measure relative to established targets. The two performance components are:

1. Quality Performance
2. CPT II Code Electronic Submission

1. Quality Performance

This component is based on quality performance measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications and predicated on the Keystone First Preventive Health Guidelines and other established clinical guidelines.

These measures are based on services rendered during the reporting period and require accurate and complete encounter reporting. Please note that each measure requires participating PCP groups to have a minimum of five members who meet the HEDIS eligibility requirements detailed next to the HEDIS measure.

The Quality Performance measures are:

Measure	Details
Adolescent Well-Care (AWC) Visit	**Eligible members:** Members ages 12 to 20 during the applicable measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year. **Measure description/rate calculation:** The percentage of enrolled members ages 12 to 20 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Ambulatory Care (ED Visits) (AMB) — Child (21 and under)	**Eligible members:** All active members within age range. **Continuous enrollment:** n/a **Allowable gap:** n/a **Measure description/rate calculation:** The provider score will equal the number of emergency department (ED) visits that do not result in an inpatient encounter once, regardless of the intensity or duration of the visit, per 1,000 member months. The requirements to receive the incentive are based on the peer ranking of the score, the published benchmarks, and the improvement compared to its prior score.
Ambulatory Care (ED Visits) (AMB) — Adult (22 and over)	**Eligible members:** All active members within age range. **Continuous enrollment:** n/a **Allowable gap:** n/a **Measure description/rate calculation:** The provider score will equal the number of emergency department (ED) visits that do not result in an inpatient encounter once, regardless of the intensity or duration of the visit, per 1,000 member months. The requirements to receive the incentive are based on the peer ranking of the score, the published benchmarks, and the improvement compared to its prior score.

Comprehensive Diabetes Care (CDC HbA1c poor control >9.0%) Refer to the CPT II Code Reporting Incentive on page 8.	**Eligible members:** Members ages 18 to 75 with diabetes (type 1 and type 2) during the applicable measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year. **Measure description/rate calculation:** The percentage of members ages 18 to 75 with diabetes (Type 1 and Type 2) who had HbA1c tests performed during the measurement year and the most recent HbA1c level is >9.0%.
Controlling High Blood Pressure <140/90 mm Hg	**Eligible members:** Members ages 18 to 85 as of December 31 during the applicable measurement year **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. **Measure description/rate calculation:** The percentage of members ages 18 to 85 with a documented outpatient diagnosis of hypertension with a most recent blood pressure reading of <140/90 mm Hg. Results are based on reporting of appropriate CPT II codes.
Developmental Screening in the First 3 Years	Eligible members: Children who turn 1, 2, or 3 years of age between January 1 and December 31 of measurement year Continuous enrollment: Children who are enrolled continuously for 12 months prior to the child's first, second, or third birthday. Allowable gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a one-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled). Measure description/rate calculation: The percentage of children screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.
Lead Screening	**Eligible members:** Children who turn 2 years old during the measurement year **Continuous enrollment:** 12 months prior to the child's second birthday **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday **Measure description/rate calculation:** The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Medication Management for People with Asthma (MMA)	**Eligible members:** Members ages 5 to 64 as of December 31 during the applicable measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year. **Measure description/rate calculation:** The percentage of members ages 5 to 64 with a documented diagnosis of asthma that remained on an asthma controller medication for at least 75% of their treatment period.
Reducing Potentially Preventable Readmissions (RPR) - PA Specific Performance Measure (PAPM)	**Eligible members:** All ages, categorized in the age bands below. **Continuous enrollment:** Member must be enrolled on the date of discharge from the first hospitalization even and on the date of admission of the second hospitalization event. Allowable gap: None. **Measure description/rate calculation:** The members identified with a readmission hit under the following age bands: less than 1 year, 1 to 12 years, 13 to 20 years, 21 to 44 years, 45 to 64 years.
Well-Child Visits in the First 15 Months of Life (W15)	**Eligible members:** Members age 15 months during the measurement year. **Continuous enrollment:** 31 days to 15 months of age. 31 days of age is calculated by adding 31 days to the child's date of birth. 15 months is calculated as the child's first birthday plus 90 days. • For example, a child born on January, 9, 2016, and included in the rate of "six or more well-child visits" must have had six well-child visits by April 9, 2017. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. **Measure description/rate calculation:** The percentage of members who turned 15 months old during the measurement year and who had at least six or more well-child visits during the first 15 months of life.
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	**Eligible members:** Member ages 3 to 6 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. **Measure description/rate calculation:** The percentage of members ages 3 to 6 who had one or more well-child visits with a PCP during the measurement year.

Overall practice score calculation

Results will be calculated for each of the previously mentioned Quality Performance measures for each practice, and then compared to the established targets in each payment cycle. Providers who meet the established targets will qualify for a per member per month (PMPM) payment for that particular measure.

Quality Performance Incentive

This incentive is paid quarterly according to the schedule in the table below. Payments are on a fixed PMPM basis, based on the number of Keystone First members on your panel as of the first of each month during the quarter. PMPM amounts will be calculated based on meeting established target rates as illustrated below (see quarterly targets table). There is no adjustment for the age or sex of the member.

Payment cycle	Enrollment	Claims paid through	Payment date
1	Q1	June 30, 2020	September 2020
2	Q2	September 30, 2020	December 2020
3	Q3	December 31, 2020	March 2021
4	Q4	March 31, 2021	June 2021

The following table is an example of potential earnings based on the program's past payment history. The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

Note:
The submission of accurate and complete encounters is critical to ensure your practice receives the correct calculation, based on the services performed on Keystone First members.

Note:
If you do not submit encounters reflecting the measures shown on pages 4 through 6 (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.

Quality Measure targets achieved	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
11	$0.55	$0.28	$0.00
10	$0.50	$0.25	$0.00
9	$0.45	$0.22	$0.00
8	$0.40	$0.20	$0.00
7	$0.35	$0.18	$0.00
6	$0.30	$0.15	$0.00
5	$0.25	$0.12	$0.00
4	$0.20	$0.10	$0.00
3	$0.15	$0.08	$0.00
2	$0.10	$0.05	$0.00
1	$0.05	$0.02	$0.00

Open: Accepting all new patients (includes providers who have reached panel maximum).
Current patients only: Open only to current patients or their relatives.
Closed: Not accepting new patients.

“Target” cycles 1 – 4 example PMPMs

Quality measures	Q1	Q2	Q3	Q4
Adolescent Well-Care Visits	24.56%	42.95%	56.77%	58.75%
Ambulatory Care — ED Visits (Adult)*	37.94	59.08	77.87	81.14
Ambulatory Care — ED Visits (Child)*	24.59	35.75	48.42	50.05
Comprehensive Diabetes Care - HBA1c Poorly Controlled (>9%)	58.57%	47.81%	41.56%	40.45%
Controlling High Blood Pressure	13.47%	15.85%	20.20%	23.23%
Developmental Screening in First Three Years	*****	*****	*****	56.92%
Lead Screening	*****	*****	*****	80.01%
Medication Management for People with Asthma (HEDIS) — Total 75% Covered	11.85%	30.37%	44.14%	46.75%
Reducing Potentially Preventable Readmissions (lower scores are better)	*****	*****	*****	16.07%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	39.77%	59.07%	74.68%	76.24%
Well-Child Visits in the first 15 Months of Life (six or more visits)	42.61%	49.83%	52.36%	52.76%

*Ambulatory Care is a per 1,000 rate measure.

2. CPT II Code Electronic Submission

A $10 reimbursement per occurrence for the electronic submission of a claim containing a valid combination of the following CPT codes:

Reportable CPT II codes for HbA1c test	Description
3044F	Most recent HbA1c level less than 7.0%
3046F	Most recent HbA1c level greater than 9.0%
3051F	Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%

Reportable CPT II code Medical Attention for Nephropathy	Description
3062F	Positive macroalbuminuria test result documented and reviewed (confirm positive with lab results)
3060F	Positive microalbuminuria test result documented and reviewed (DM)
3061F	Negative microalbuminuria test result documented and reviewed (DM)
3066F	Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) (DM)
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy

A diabetes or hypertension related diagnosis is required for the following:

Reportable CPT II codes for Controlling High Blood Pressure <140/90 mm Hg	Description
3074F	Most recent systolic blood pressure <130 mm Hg
3075F	Most recent systolic blood pressure 130-139 mm Hg
3077F	Most recent systolic blood pressure >=140 mm Hg
3078F	Most recent diastolic blood pressure <80 mm Hg
3079F	Most recent diastolic blood pressure 80-89 mm Hg
3080F	Most recent diastolic blood pressure >=90 mm Hg
4010F	ACE inhibitor and ARB prescribed

Reportable CPT II codes for low risk for retinopathy	Description
3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy

A qualifying Body Mass Index (BMI) qualifying diagnosis is required for the following:

Reportable CPT II codes	Description
3008F	Body Mass Index (BMI), documented

3. Top Performer Incentive/Improvement Component

A Top Performer Incentive will accompany the final payment for those groups whose average peer comparison percentile ranking across all Quality measures is 65% or higher. See table below for example PMPM rates.

Top Performer Incentive

PCP office rank	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
95th	$4.41	$2.20	$0.00
90th	$4.12	$2.06	$0.00
85th	$3.85	$1.92	$0.00
80th	$3.57	$1.78	$0.00
75th	$3.30	$1.65	$0.00
70th	$3.02	$1.51	$0.00
65th	$2.75	$1.37	$0.00

An Improvement Incentive will also be awarded to PCP groups that did not meet network targets but did show an improvement of 10% or more for a given measure over the prior year. This incentive will be calculated at the final payment of the program year. The payment will equal half of the incentive that would have been awarded if the group had met the target for that measure. See table below for example PMPM rates.

Improvement Component

Quality Measure targets achieved	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
11	$0.28	$0.14	$0.00
10	$0.25	$0.12	$0.00
9	$0.22	$0.11	$0.00
8	$0.20	$0.10	$0.00
7	$0.18	$0.09	$0.00
6	$0.15	$0.08	$0.00
5	$0.12	$0.06	$0.00
4	$0.10	$0.05	$0.00
3	$0.08	$0.04	$0.00
2	$0.05	$0.02	$0.00
1	$0.02	$0.01	$0.00

SAMPLE

Provider appeal of ranking determination

- If a provider wishes to appeal his or her percentile ranking on any or all incentive components, this appeal must be in writing.
- The written appeal must be addressed to the Keystone First Chief Medical Officer and specify the basis for the appeal.
- The appeal must be submitted within 60 days of receiving the overall ranking from Keystone First.
- The appeal will be forwarded to the Keystone First QEP Review Committee for review and determination.
- If the QEP Review Committee determines that a ranking correction is warranted, an adjustment will appear on the next payment cycle following committee approval.

Important notes and conditions

1. The sum of the incentive payments for the program will not exceed 33% of the total compensation for medical and administrative services. Only capitation and fee-for-service payments are considered part of total compensation for medical and administrative services.
2. The quality performance measures are subject to change at any time upon written notification. Keystone First will continuously improve and enhance its quality management and quality assessment systems. As a result, new quality variables will be added periodically, and criteria for existing quality variables will be modified.
3. For computational and administrative ease, no retroactive adjustments will be made to incentive payments. All PMPM payments will be paid according to the membership known at the beginning of each month.

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Our Mission

We help people get care, stay well, and build healthy communities.

We have a special concern for those who are poor.

Our Values

Advocacy	Dignity
Care of the Poor	Diversity
Compassion	Hospitality
Competence	Stewardship

www.keystonefirstpa.com

All images are used under license for illustrative purposes only.
Any individual depicted is a model.

KF_19743356