The PerformPlus Stars Total Cost of Care Program

Improving the cost of quality care and health outcomes

2023

Keystone First
VIP Choice®

Contents

Keystone First
VIP Choice

200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Primary Care Practitioner:

Keystone First VIP Choice proudly presents our Category 3 Alternative Payment Model (APM) program, the Total Cost of Care (TCOC) program. The TCOC program provides incentives for high-quality and cost-effective care, member service and convenience, and health data submission.

Keystone First VIP Choice 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 for your commitment to our members. If you have any questions, please contact your provider Account Executive.

Sincerely,

Robert P. Hockmuth, M.D.
Market Chief Medical Officer

Kim Beatty
Director
Provider Network Management

www.keystonefirstvipchoice.com

Introduction

The Perform Plus® Stars Total Cost of Care program is a Category 3 Alternative Payment Model (APM) reimbursement system developed by Keystone First VIP Choice for participating primary care practitioners (PCPs).

The Perform Plus Stars Total Cost of Care program 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. Both efficient use of services and quality performance are the key determinants of additional compensation. As additional meaningful measures are developed and improved, the quality indicators contained in the program will be refined. Keystone First VIP Choice reserves the right to make changes to this program at any time and shall provide written notification of any changes.

Program overview

The PerformPlus Stars Total Cost of Care program is intended and designed to be a program that rewards higher performance for practices that meet financial and quality benchmarks by reducing unnecessary costs and delivering quality health care for our members.

The Total Cost of Care component of the program represents an actual versus expected medical cost analysis that determines an efficient use of services based on the population being served. This efficient use of services calculation is what ultimately establishes the shared savings pool that is then made available to the provider based on quality performance.

The Stars Quality Performance component of the program represents a comprehensive patient quality model covering availability of care, use of services, and preventive screenings. The Stars Quality Score is calculated according to the number of members for which the provider exceeds the benchmark, resulting in a Stars Rating that will be weighted and averaged across all of the quality measures. The Stars weighted average score will then be used to assign a Quality Tier that will ultimately determine the earned percentage of the previously established shared savings pool.

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 the established shared savings pool and how well a PCP office scores in the Quality Performance component relative to other qualifying Keystone First VIP Choice participating PCP offices in the program. The performance components are:

1. Total Cost of Care — Efficient Use of Services
2. Stars Quality Performance

1. Total Cost of Care — Efficient Use of Services

The incentive payment is based on a total cost of care risk-adjusted shared savings pool. This shared savings pool is available to practices whose attributed population demonstrates efficient use of services. Efficient use of services is defined as having an actual medical and pharmacy spend that is less than the expected medical and pharmacy spend (as determined using the 3M™ Clinical Risk Groups [CRGs] methodology described below) in the measurement year.

The risk-adjusted trend calculation leverages the 3M CRG platform to determine the total expected medical and pharmacy cost for all the members attributed to the practice. The expected medical and pharmacy cost for each individual member is the average of the cost observed for all members within each CRG. These calculations are adjusted to remove outlier patients with excessive medical or pharmacy costs from consideration.

Each member is assigned to a CRG based on the presence of disease and their corresponding severity level(s), as well as additional information that informs their clinical risk. CRGs can provide the basis for a comparative understanding of severity, treatment, best practice patterns, and disease management strategies, which are necessary management tools for payers who want to control costs, maintain quality, and improve outcomes.

By comparing the actual cost to the expected cost, Keystone First VIP Choice calculates the actual versus expected cost ratio. The actual versus expected cost ratio is the ratio of the actual medical and pharmacy cost to the expected cost. A practice's panel whose actual medical cost is exactly equal to the expected medical cost would have an actual versus expected cost ratio of 1, or 100%, indicating that the panel cost is exactly as expected for the health mix of the attributed population. An actual versus expected cost ratio of less than 100% indicates a lower-than-expected spend and therefore a savings. The shared savings pool would be either 50% of the actual savings or 25% of the practice's medical claims earnings, whichever is lower.

For example, provider X had an actual medical cost of $950,000 versus an expected medical cost of $1,000,000. This results in a 95% efficient use of services score, with a margin of 5%. The provider also billed $100,000 in claims during this time. In this example the savings (Expected – Actual) would be $50,000. The provider's shared savings pool would be 50% of that savings or $25,000. The amount of dollars earned from this shared savings pool is then determined by the other component of this program — Stars Quality Performance.

2. Stars Quality Performance

This component is based on quality performance measures consistent with the Centers for Medicare & Medicaid Services (CMS) specifications, Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications and predicated on the Keystone First VIP Choice 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

The Stars Quality Performance measures are:	
Breast Cancer Screening (BSC)	**Measure description/rate calculation:** The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. **Eligible members:** Women 52–74 years of age by the end of the measurement period who also meet the criteria for participation. **Continuous enrollment:** October 1 two years prior to the measurement period through the end of the measurement period. **Allowable gap:** No more than one gap in enrollment of up to 45 days for each full calendar year of the participation period. No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period. **Data Source:** Healthcare Effectiveness Data and Information Set (HEDIS®)
Colorectal Cancer Screening (COL)	**Measure description/rate calculation:** The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. **Eligible members:** Members 46–75 years as of the end of the measurement period who also meet the criteria for participation. **Continuous enrollment:** The measurement period and the year prior to the measurement period. **Allowable gap:** None. **Data Source:** Healthcare Effectiveness Data and Information Set (HEDIS®)
Eye Exam for Patients with Diabetes (EED)	**Measure description/rate calculation:** The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam. **Eligible members:** 18–75 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 measurement year. **Data Source:** Healthcare Effectiveness Data and Information Set (HEDIS®)
Hemoglobin A1c Control for Patients With Diabetes (HBD)	**Measure description/rate calculation:** The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c Poor Control (>9.0%). **Eligible members:** 18–75 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 measurement year. **Data Source:** Healthcare Effectiveness Data and Information Set (HEDIS®)

The Stars Quality Performance measures are:	
Medication Adherence - Cholesterol	**Measure description/rate calculation:** Percent of plan members with a prescription for a cholesterol medication (*a statin drug*) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **Eligible members:** 18 years and older with at least two statin cholesterol medication fills on unique dates of service during the measurement period. **Data source:** Prescription Drug Event (PDE) Data
Medication Adherence - Diabetes	**Measure description/rate calculation:** Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **Eligible members:** 18 years and older with at least two fills of diabetes medication(s) on unique dates of service during the measurement period. **Data Source:** Prescription Drug Event (PDE) Data
Medication Adherence - Hypertension	**Measure description/rate calculation:** Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **Eligible members:** 18 years and older with at least two RAS antagonist medication fills on unique dates of service during the measurement period. **Data source:** Prescription Drug Event (PDE) Data
Statin Therapy for Patients with Diabetes (SPD)	**Measure description/rate calculation:** The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1. *Received Statin Therapy*. Members who were dispensed at least one statin medication of any intensity during the measurement year. 2. *Statin Adherence 80%*. Members who remained on a statin medication of any intensity for at least 80% of the treatment period. **Eligible members:** Members ages 40–75 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year and the year prior to the measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. **Data Source:** Healthcare Effectiveness Data and Information Set (HEDIS®)

The Stars Quality Performance measures are:	
Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)	**Measure description/rate calculation:** The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit. **Eligible members:** 18 years and older as of the ED visit. Report two age stratifications and a total rate: • 18–64 years. • 65 years and older. **Continuous enrollment:** 365 days prior to the ED visit through seven days after the ED visit. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the seven days following the ED visit. **Data Source:** Healthcare Effectiveness Data and Information Set (HEDIS®)

Overall practice score calculation and payment

Results will be calculated for each of the above nine Stars Quality Performance measures as the ratio of members who received the above services as evidenced by claim and/or encounter information (numerator) to those members in the practice's panel who were eligible to receive these services (denominator) (subject to minimum sample size requirements).

These results are then averaged and weighted appropriately in accordance to the latest Centers for Medicare trends in Part C and D Star Rating Measure Cut Points in order to determine an Average Stars rate. The grid below details the Average Stars rate breakpoints and the corresponding Quality Tier that will determine both the earned per member per month (PMPM) incentive and the earned percentage of the established TCOC are shared savings pool:

Average Stars (Weighted)	Quality Tier	Earned Incentive (PMPM)	% of TCOC Shared Savings Pool Earned
4.75+	5	$75.00	100%
4.50 to 4.74	4	$60.00	80%
4.00 to 4.49	3	$40.00	60%
3.75 to 3.99	2	$20.00	40%
3.00 to 3.74	1	N/A	20%

Providers with an open panel status are eligible for 100% of the possible incentive, where those accepting current patients only will be eligible for 50%. Providers with a closed panel will not be eligible for incentive payment through this program.

Sample scorecard

Keystone First VIP Choice

PerformPlus STARS Total Cost of Care Program

Tax Name: Your Medicare PCP Practice

Tax ID: 123456789

Average Members in Period: 96
Member Months in Period: 956
Measurement Period: 1/1/2023-12/31/2023

STARS Quality Performance Detail	Numerator	Denominator	Rate	Stars Earned	Measure Weight	5 Star Target Rate
Breast Cancer Screening	19	21	90.5%	5	1x	76.0%
Eye Exam for Patients with Diabetes	13	21	61.9%	2	1x	83.0%
Hemoglobin A1c Control for Patients with Diabetes	19	21	90.5%	5	1x	86.0%
Medication Adherence - Diabetes	27	28	96.4%	5	3x	91.0%
Statin Therapy for Patients with Diabetes	11	12	91.7%	5	1x	90.0%
Medication Adherence - Cholesterol	57	62	91.9%	5	3x	91.0%
Medication Adherence - Hypertension	40	45	88.9%	4	3x	92.0%
Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions	32	47	68.1%	3	3x	80.0%
Colorectal Cancer Screening	26	37	70.3%	3	1x	83.0%

STARS Average Rate: 4.11 Quality Tier: 3 Earned PMPM: $40 STARS Quality Incentive: $38,240.00

Total Cost of Care Performance Detail

Actual Medical Cost	Expected Medical Cost	Actual vs Expected Cost Ratio	Total Claims Paid	Shared Savings Pool
$950,000.00	$1,000,000.00	95.00%	$100,000.00	$25,000.00

STARS Average Rate: 4.05 Quality Tier: 3 Pool Earned:60% STARS TCOC Incentive: $15,000.00

Incentive Summary

STARS Quality Performance Incentive		Total Cost of Care Incentive		Total Incentive Earned
$38,240.00	+	$15,000.00	=	$53,240.00

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 VIP Choice Market 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 VIP Choice.
- The appeal will be forwarded to the Keystone First VIP Choice Stars TCOC Review Committee for review and determination.
- If the Stars TCOC 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

- The sum of the incentive payments for the Total Cost of Care and Stars Quality Performance components of 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 the total compensation for medical and administrative services.
- The Stars Quality Performance measures are subject to change at any time upon written notification. We will continuously improve and enhance our quality management and quality assessment systems. As a result, new quality variables will periodically be added, and criteria for existing quality variables will be modified.
- For computational and administrative ease, no retroactive adjustments will be made to incentive payments. All per member per month (PMPM) payments will be paid according to the membership known at the beginning of each month.

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

Note:
If you do not submit encounters reflecting the measures shown on pages 4 through 7 (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.

Keystone First
VIP Choice®

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
Care of the Poor
Compassion
Competence
Dignity
Diversity
Hospitality
Stewardship

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

DISTINCTION NCQA MULTICULTURAL HEALTH CARE

www.keystonefirstvipchoice.com

Y0093_001-OTH-2317306-1