The Total Cost of Care Program

Improving the cost of quality care and health outcomes

2023

Keystone First

Community HealthChoices

Contents

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200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Primary Care Practitioner:

Keystone First Community HealthChoices (CHC) 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, Participant service and convenience, and health data submission.

Keystone First CHC 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 Participants.

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

Sincerely,

Erica David-Park, MD
Market Chief Medical Officer
Community HealthChoices

Kim Beatty
Director
Provider Network Management

www.keystonefirstchc.com

Introduction

The Total Cost of Care (TCOC) program is a Category 3 Alternative Payment Model (APM) reimbursement system developed by Keystone First CHC for participating primary care practitioners (PCPs).

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

Program overview

The TCOC 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 Participants.

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 Quality Performance component of the program represents a comprehensive patient quality model covering availability of care, use of services, and preventive screenings. The quality score is calculated according to the number of Participants for which the Provider exceeds the benchmark, multiplied by the points available per measure. The composite average score across all quality measures will then be used to 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 CHC participating PCP offices in the program. The performance components are:

1. Total Cost of Care — Efficient Use of Services
2. 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 [CRG] 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 Participants attributed to the practice. The expected medical and pharmacy cost for each individual Participant is the average of the cost observed for all Participants within each clinical risk group (CRG). These calculations are adjusted to remove outlier patients with excessive medical or pharmacy costs from consideration.

Each Participant 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 CHC 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 savings percentage is then calculated using the difference between 100% and the practice's actual versus expected cost ratio. This savings percentage is capped at 10%. If the result of this calculation is greater than 10%, 10% will be used. The shared savings pool will be equal to the savings percentage multiplied by the practice's annual paid claims for primary care services and then multiplied by 3 to increase the earning potential for high performers.

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, which would result in establishing a shared savings pool of $15,000 [Provider spend × margin × 3] available to the Provider to earn through this program. The amount of dollars earned from this shared savings pool is then determined by the other component of this program — Quality Performance.

2. 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 CHC 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 Quality Performance measures are:	
Ambulatory Care (ED Visits) (AMB) — Adult (22 and over)	**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. **Eligible Participants:** All active Participants within age range. **Continuous enrollment:** n/a **Allowable gap:** n/a
Adults' Access to Preventive/ Ambulatory Health Services (AAP)	**Measure description/rate calculation:** The percentage of Participants 20 years of age and older who had an ambulatory or preventive care visit during the measurement year. **Eligible Participants:** 20 years and older 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.

Adult Immunizations Status (AIS-E)	**Measure description/rate calculation:** The percentage of Participants ages 19 and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, and pneumococcal. **Eligible Participants:** 19 years and older within 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.
Asthma Medication Ratio (AMR)	**Measure description/rate calculation:** The percentage of Participants who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. **Eligible Participants:** Participants ages 5 to 64 as of December 31 of the measurement year. Report the following age stratifications and total rate: • 5 – 11 years. • 12 – 18 years. • 19 – 50 years. • 51 – 64 years. • Total. **Continuous enrollment:** The total is the sum of the age stratifications for each product line. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Community HealthChoices beneficiary for whom enrollment is verified monthly, the Participant may not have more than a one-month gap in coverage during each year of continuous enrollment.
Hemoglobin A1c Control for Patients with Diabetes (HBD) (<8%)	**Measure description/rate calculation:** The percentage of Participants 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 <8%. **Eligible Participants:** Participants 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.
Kidney Health Evaluation for Patients with Diabetes (KED)	**Measure description/rate calculation:** The percentage of Participants 18 – 85 years of age with diabetes (Type 1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year. **Eligible Participants:** Participants ages 18 to 85 with diabetes (Type 1 and Type 2) as of December 31 of the measurement year. Report three age stratifications and a total rate: • 18 – 64 years. • 65 – 74 years. • 75 – 85 years. • Total. **Continuous enrollment:** The measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year.

Eye Exam for Patients with Diabetes (EED)	**Measure description/rate calculation:** An eye screening for diabetic retinal disease as identified with administrative data. **Eligible Participants:** Participants 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.
Controlling High Blood Pressure <140/90 mm Hg	**Measure description/rate calculation:** The percentage of Participants ages 18 to 85 with a documented outpatient diagnosis of hypertension with a most recent blood pressure reading of <140/90 mm Hg. **Eligible Participants:** Participants 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
Cervical Cancer Screening (CCS)	**Measure description/rate calculation:** The percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed every three years. • Women ages 30 to 64 who had at least one cervical high-risk human papillomavirus (hrHPV) test performed within the last 5 years. • Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus co-testing within the last 5 years. **Eligible Participants:** Women ages 24 to 64 during 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.
Plan All-Cause Readmission	**Measure description/rate calculation:** The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. **Eligible Participants:** Participants ages 18 to 64 as of the Index Discharge Date. **Continuous enrollment:** 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.

Overall practice score calculation and payment

Results will be calculated for each of the above 10 HEDIS Quality Performance measures as the ratio of Participants who received the above services as evidenced by claim and/or encounter information (numerator) to those Participants in the practice's panel who were eligible to receive these services (denominator) (subject to minimum sample size requirements). These scores will then be compared to the scores for all other qualifying practices to determine the practice percentile ranking for each measure. Points are then earned per measure based on the percentile ranking achieved. The grid below details the percentile breakpoints and the points awarded for each:

Percentile	Points
60th +	**3**
55th – 59th	**2**
50th – 54th	**1**

The total of earned points across all eligible measures divided by the potential points available per eligible measure determines the percentage of the shared savings pool to be incentivized to the Provider. 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.

For example, of the 10 HEDIS measures, Provider X had an adequate sample size for eight of them, and performed among the other Providers in the program within the above-illustrated percentile rankings to earn 15 of a total potential of 24 points. Earned points divided by potential points equals 62.5%, and that percentage times the previously established shared savings pool via the Total Cost of Care component of the program would result in a $9,375.00 performance incentive payment earned.

Reporting period and payment schedule

Reporting period	Claims paid through	Payment date
January 1, 2023, to December 31, 2023	March 31, 2024	June 2024

Note:
The submission of accurate and complete encounters is critical to make sure your practice receives the correct calculation, based on the services performed for Keystone First CHC Participants.

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.

Sample scorecard

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Total Cost of Care Program

Measurement Period: January 1, 2023 - December 31, 2023

Tax ID:	1234567	**Panel Average Enrollment:**	150
Entity Name:	ABC HealthNetwork	**Total Member Months:**	1,800

HEDIS Measure Detail	Percent Rank	Percent Category	Points
Ambulatory Care (ED Visits)(AMB) Adult (22 Over)	90%	60th +	3
Adults' Access to Preventive Ambulatory Health Services	50%	50th – 54th	1
Adult Immunizations Status (AIS-E)	40%	<50th	0
Asthma Medication Ratio (AMR)	*	*	*
Hemoglobin A1c Control for Patients with Diabetes (<8%)	80%	60th +	3
Kidney Health Evaluation for Patients with Diabetes (KED)	55%	55th – 59th	2
Eye Exam for Patients with Diabetes (EED)	20%	<50th	0
Controling High Blood Pressure <140/90 mm Hg	60%	60th +	3
Cervical Cancer Screening (CCS)	*	*	*
Plan All Cause Readmission	70%	60th +	3

Actual Cost	Expected Cost	Actual vs Expected Cost	Claims Paid Amount In Measurement Period	Max Potential Program Pool
$950,00.00	$1,000,000.00	95.00%	$100,000.00	$15,000.00

Incentive Summary

Total Earned Points/Total Potential Points:	Total Percentage Points:	Program Payout:
15 / 24	62.5%	$9,375.00

Provider appeal of ranking determination

- If a Provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be in writing.
- The written appeal must be addressed to the Keystone First CHC 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 CHC.
- The appeal will be forwarded to the Keystone First CHC TCOC Review Committee for review and determination.
- If the 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 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 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.

Keystone First

Community HealthChoices

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

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