The Primary Care Practitioner Quality Enhancement Program

Improving quality care and health outcomes

2025

Keystone First

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.

We are 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, MD, MBA, MS
Market Chief Medical Officer

Kim Beatty
Director, Provider Network Management

www.keystonefirstpa.com

Introduction

The Quality Enhancement Program (QEP) is an upside only reimbursement system developed by Keystone First (the Plan) 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. The Plan 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 offices whose panels averaged 50 or more members at the Taxpayer Identification Number (TIN) level for a defined average enrollment period. For tax entities with fewer than 50 members, there is insufficient data to generate appropriate and consistent measures of performance. These providers are not eligible for participation in the QEP. Additionally, a Total Cost of Care incentive will accompany the settlement for groups who performed above their peers on quality measures of the program and whose actual medical costs were lower than expected medical costs.

Performance Incentive Payment (PIP)

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

1. Quality Performance Measures
2. CPT II Code Electronic Submission

1. Quality Performance

This component is based on quality performance measures consistent with 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 providers 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	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Asthma Medication Ratio (AMR)	The percentage of members 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.	Members ages 5 – 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.	The total is the sum of the age stratifications for each product line.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage during each year of continuous enrollment.
Child and Adolescent Well-Care Visits (WCV)	The percentage of members who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	3 – 21 years as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage (e.g., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).

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Measure	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Controlling High Blood Pressure (CBP) <140/90 mm Hg	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.	Members ages 18 to 85 as of December 31 during the applicable measurement year.	The measurement year.	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
Developmental Screening in the First 3 Years	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.	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of measurement year.	Children who are enrolled continuously for 12 months prior to the child's first, second, or third birthday.	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 two months or 60 days is not considered continuously enrolled).
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at Glycemic Status >9.0%.	Members with diabetes ages 18 – 75 as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the measurement year.
Lead Screening	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.	Children who turn 2 years old during the measurement year.	12 months prior to the child's second birthday.	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
Plan All-Cause Readmissions — Observed/ Expected Ratio	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. For the Observed to Expected Ratio calculation, the rate will be represented by the count of observed 30-day readmissions (ObservedCount) divided by the count of expected 30-day readmissions (ExpectedCount) for each age group and totals.	Members ages 18 to 64 as of the Index Discharge Date.	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.	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.

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Quality Performance measures (*continued from page 6*)

Measure	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months: Well-Child Visits in the First 15 Months: six or more well visits.	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.	31 days old to 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage (e.g., a member whose coverage lapses for two months [60 days] is not considered enrolled).

Overall score calculation

Results will be calculated for each of the aforementioned Quality Performance measures for each tax entity 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 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 below.) There is no adjustment for the age or sex of the member.

2025 Incentive Timeline

Payment cycle	Measurement period	Claims period	Total cost of care period	Payment date
1	1/1/2025 – 6/30/2025	1/1/2025 – 3/31/2025	4/1/24 – 3/31/25	September 2025
2	1/1/2025 – 9/30/2025	4/1/25 – 6/30/25	7/1/24 – 6/30/25	December 2025
3	1/1/2025 – 12/31/2025	7/1/25 – 9/30/25	10/1/24 – 9/30/25	March 2026
4	1/1/2025 – 12/31/2025 + runout	10/1/25 – 12/31/25	1/1/25 – 12/31/25	June 2026

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.

2025 Quality Measure PMPM Examples

Quality measure targets achieved	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
8	$0.40	$0.20	$0.00
7	$0.35	$0.175	$0.00
6	$0.30	$0.15	$0.00
5	$0.25	$0.125	$0.00
4	$0.20	$0.10	$0.00
3	$0.15	$0.075	$0.00
2	$0.10	$0.05	$0.00
1	$0.05	$0.025	$0.00

Open office: 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.

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 members.

Note: If you do not submit encounters reflecting the measures shown on pages 5, 6, and 7 (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.

Target Rates — Cycles 1 – 4

Quality measures	Q1	Q2	Q3	Q4
Asthma Medication Ratio	80.36%	81.82%	78.95%	78.95%
Child & Adolescent Well-Care Visits (WCV)	29.64%	47.31%	61.76%	63.68%
Controlling High Blood Pressure	53.85%	60.78%	67.44%	67.14%
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%)	42.59%	33.33%	27.27%	25.93%
Well-Child Visits in the first 30 Months of Life (six or more visits)	66.67%	75.61%	76.54%	76.92%
Controlling High Blood Pressure - Health Equity Black American Population	*****	*****	*****	65th Percentile
Controlling High Blood Pressure - Health Equity Hispanic/Latino Population	*****	*****	*****	65th Percentile
Controlling High Blood Pressure - LAB Result Submission	*****	*****	*****	65th Percentile
Developmental Screening in First Three Years	*****	*****	*****	81.82%
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%) - Health Equity Black American Population	*****	*****	*****	65th Percentile
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%) - Health Equity Hispanic/Latino Population	*****	*****	*****	65th Percentile
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%) - LAB Result Submission	*****	*****	*****	65th Percentile
Lead Screening	*****	*****	*****	92.86%
Plan All Cause Readmission – Count of Observed/Expected Ratio	*****	*****	*****	0.33
Well-Child Visits in the first 30 Months of Life (six or more visits) - Health Equity Black American Population	*****	*****	*****	65th Percentile
Well-Child Visits in the first 30 Months of Life (six or more visits) - Health Equity Hispanic/Latino Population	*****	*****	*****	65th Percentile

2. CPT II Code Electronic Submission

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

Reportable CPT II codes	Description
Reportable CPT II codes for Comprehensive Diabetes Care (CDC HbA1c test). Codes payable once every 90 days.	
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 codes for Controlling High Blood Pressure < 140/90 mm Hg. Codes payable once every 90 days.	
3074F	Most recent systolic blood pressure < 130 mm Hg
3074F-U9	Most recent systolic blood pressure < 130 mm Hg*
3075F	Most recent systolic blood pressure 130 – 139 mm Hg
3075F-U9	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
3078F-U9	Most recent diastolic blood pressure < 80 mm Hg*
3079F	Most recent diastolic blood pressure 80 – 89 mm Hg
3079F-U9	Most recent diastolic blood pressure 80 – 89 mm Hg*
3080F	Most recent diastolic blood pressure ≥ 90 mm Hg

* Reimbursement higher when performed and reported in the fourth quarter.

Reportable CPT II codes	Description
Reportable CPT II codes for low risk for retinopathy. Codes payable once per year.	
3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)

Electronic results submission

Providers will receive an additional incentive during the fourth and final settlement by submitting result data throughout the program year for the following HEDIS measures:

- Glycemic Status Assessment for Patients with Diabetes (GSD) (>9%)
- Controlling High Blood Pressure (<140/90 mm Hg)

Electronic submission of data can be achieved through integration with the health information exchange (HIE) or through direct data integration with Keystone First through a data aggregator.

For more details on how to initiate data integration, please contact your assigned Provider Account Executive.

3. Total Cost of Care Component

The Total Cost of Care component for 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 a shared savings pool that is then made available to providers based on their quality performance across the state-mandated measures in the program.

Total Cost of Care — efficient use of services calculation

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]) in the measurement year. By comparing the actual cost to the expected cost, Keystone First calculates an 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 reimbursement for services rendered during the claims period and then multiplied by a factor to increase the earning potential for high performers.

Total Cost of Care — provider performance earnings example

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 $5,000 [provider spend × margin × factor] available to the provider to earn through this program.

The amount of dollars earned from this shared savings pool is then determined by how well the providers performed across the eight state-mandated measures in the program when compared to their peers. Points are earned per measure based on the percentile ranking achieved for the year:

- 60th percentile and higher = 3 points.
- 55th – 59th percentile = 2 points.
- 50th – 54th percentile = 1 point.

The total earned points across all eligible measures divided by the potential points available per measure determines the percentage of the shared savings pool to be incentivized to the provider. For example, of the eight HEDIS measures, Provider X had an adequate sample size for seven 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 21 points. Earned points divided by potential points equals 71%, and that percentage times the previously established $5,000 shared savings pool via the Total Cost of Care component of the program would result in a $3,571 incentive earned. Similar to the quality performance incentive payment, the Total Cost of Care incentive payment is also based your current panel status. If a provider is "open" they are eligible for 100% of the earned incentive. If a panel is "current patients only," they are eligible for 50% of the earned incentive. If a panel is "closed" the provider is not eligible for an incentive.

4. Health Equity Component

PCP providers who meet or exceed established targets will be awarded an additional increase in their total earned PMPM with regard to the following measures for their Black American and Hispanic/Latino populations: Well Child Visits in the First 30 Months of Life (ages 0 – 15 months only), Controlling High Blood Pressure, and Glycemic Status Assessment for Patients with Diabetes >9% (GSD).

Provider appeal of ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be made in writing.
- The written appeal must be addressed to the Market Chief Medical Officer of the Plan and specify the basis for the appeal.
- The appeal must be submitted within 60 days of receiving the overall ranking from the Plan.
- The appeal will be forwarded to the Plan's 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 the total compensation for medical and administrative services.
2. The Quality Performance measures are subject to change at any time upon written notification. The Plan will continuously improve and enhance its 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.
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.

Keystone First

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.

www.keystonefirstpa.com

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