Understanding Your 2024 QEP Scorecard

Keystone First

① PAYMENT CYCLE

This represents the current incentive bonus payment cycle, where each "cycle" (1 – 4) represents a quarter of the year.

② CLAIMS CYCLE / CLAIMS PAID THROUGH

This represents the claim dates-of-service used to determine your practice's performance in the program. "Claims Paid Through" represents the amount of "run-out" time allotted for claims paid outside of the claims cycle.

③ TAX INFORMATION

This is basic information about your practice, including your tax name and tax ID number. It also includes the average number of members enrolled with your tax ID during the payment cycle, the persistent severe mental illness (PSMI) members within that enrollment, and the panel status as of the last day of the claims paid through date. Please note that the impact of your panel status on your total per member per month (PMPM) payment is as follows: OPEN = 100%; RESTRICTED = 50%; CLOSED = 0% earnings.

④ QUALITY MEASURES

This section contains your tax ID's performance detail for the state-mandated quality performance metrics during the payment cycle. The results of each rate are then compared to the established targets for the particular payment cycle. If the cycle targets are achieved, then your practice will earn the allocated PMPM funding associated with the number of targets achieved during the cycle.

⑤ TOTAL COST OF CARE RANK / TOTAL COST OF CARE POINTS EARNED

These columns contain both the total cost of care (TCOC) ranking and points earned.

⑥ QUALITY INCENTIVE SUMMARY

This section contains a snapshot of incentive earnings by your tax ID.

⑦ ELECTRONIC RESULTS SUBMISSION (4th cycle scorecard ONLY)

This section contains the Electronic Results Submission calculations and earning detail. Please note that this section will only appear on the 4th cycle scorecard.

⑧ HEALTH EQUITY COMPONENT

This section contains the Health Equity component calculations and earning detail.

⑨ TOTAL COST OF CARE

This section contains the TCOC measure that demonstrates your tax ID's performance based on an actual versus expected medical cost calculation that indicates how well you performed during the cycle.

⑩ TOTAL INCENTIVE EARNED

This is the comparison of your tax ID's actual PMPM earned based on performance and the maximum potential PMPM for the payment cycle.

⑪ GROUP DETAIL

This is the breakdown of how each practice within a tax ID earns their portion of the total paid to the tax ID. The final group payment is based on the earned PMPM for the tax ID and the member months of the practice.

⑫ INFORMATION MEASURES

This section reflects inverse measures including the actual hospital admissions versus the expected Potentially Preventable Admissions (PPAs), the actual hospital ER visits versus the expected Potentially Preventable ER Visits (PPVs), Use of Opioids at High Dosage, and Use of Opioids from Multiple Providers.

Please note that a lower rate for these inverse measures indicates better performance. For example, a PPA actual rate of 105% is 5% over the max expected PPAs. The desired result is a lower rate since a score of 100% or above is showing a complete failure in providing quality care for this measure.

PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. PPAs are essentially ambulatory-sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often help avoid the need for admission. The occurrence of high rates of PPAs represents a failure of ambulatory care provided to the patient.

PPVs are emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory-sensitive conditions (e.g., asthma), which means that adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate the need for ER services.

Use of Opioids at High Dosage is the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

Use of Opioids from Multiple Providers is for members 18 years and older receiving prescription opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.

Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.

Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator-compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Your QEP reports and Care Gap reports can be accessed via NaviNet. Please contact your Provider Account Executive for further details.