MedStar Family Choice

DISTRICT OF COLUMBIA

Primary Care Provider

June 2024

Peak Performance Incentive Program

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GENERAL INFORMATION

A. PROGRAM OVERVIEW

MedStar Family Choice District of Columbia (MedStar Family Choice DC) has launched the Peak Performance Incentive Program, a value-based payment (VBP) program designed to incentivize and reward high-quality and high-value care provided to our Enrollees. As part of this initiative, MedStar Family Choice DC has designed a VBP program specifically for Primary Care Providers (PCPs). This program creates opportunities for network PCPs to earn annual performance-based bonus payments of up to six percent of their total outpatient revenue without any payment withholds, penalties, or downside risk.

B. ELIGIBILITY

For the purposes of the MedStar Family Choice DC Primary Care Provider Peak Performance Incentive Program, performance is measured at the practice level using an organization's tax identification number (TIN). Participating practices must **average at least 200 attributed MedStar Family Choice DC Medicaid and/or Alliance Enrollees** over the performance period to qualify for incentives. Enrollees are attributed to PCPs through the following processes:

- Upon Enrollment
    - Enrollees' self-selection of their PCP during enrollment into the Plan
    - Plan's auto-assignment if the Enrollee does not select a PCP during the first 10 days of enrollment
- Once Enrolled
    - Enrollees' selection of a new PCP after enrollment into the Plan

In accordance with the Department of Health Care Finance's (DHCF's) 2024-2027 Medicaid Managed Care Quality Strategy, by CY 2025, all Providers participating in a VBP or pay-for-performance (P4P) program will be required to work with the District's Designated HIE Entity to be credentialed to use the PopHealth Analytics tool in the DC HIE. Please visit **CRISPDC.org/PopHealth** for more information.

C. PERFORMANCE METRICS

The MedStar Family Choice DC Primary Care Provider Peak Performance Incentive Program includes separate incentives for nine individual measures chosen to align with District priorities to improve Enrollees' health outcomes and improve cost efficiency of the Medicaid program. These include:

- Six Healthcare Effectiveness Data and Information Set (HEDIS®) measures
    - One (1) measure from the Access/Availability of Care domain
    - Two (2) measures from the Utilization domain
    - Three (3) measures from the Effectiveness of Care domain
- Three quality measures related to avoidable Emergency Department (ED) visits and hospitalizations.

These nine measures, including the criteria by which MedStar Family Choice DC enrollees will be attributed in the incentive program, are described below. More information on HEDIS can be found on the National Committee for Quality Assurance's (NCQA's) website at **NCQA.org/HEDIS/Measures**.

HEDIS Access/Availability of Care and Utilization Measures (3 Measures)

Measure #1: Adults' Access to Preventative/Ambulatory Health Services (AAP)

- **Measure Description:** The percentage of Enrollees 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.
- **Eligible Population:** Enrollees 20 years of age and older as of December 31 of the measurement year.
- **Continuous Enrollment:** The measurement year.
  - **Allowable Gap:** No more than one gap in enrollment up to 45 days during each year of continuous enrollment

Measure #2: Well-Child Visits in the First 30 Months of Life (W30)

- **Measure Description:** The percentage of Enrollees who had the following number of well-child visits with a PCP during the last 15 months:
  1. **Six or more well-child visits** for children who turned 15 months old (first birthday plus 90 days) during the measurement year:
  2. **Two or more well-child visits** for children who turned 30 months old (second birthday plus 180 days) during the measurement year:
- **Eligible Population:** Enrollees aged 15 months and 30 months of age as of December 31 of the measurement year.
- **Continuous Enrollment:** From 31 days to 15 months of age and/or from 15 months of age plus 1 day to 30 months of age.
  - **Allowable Gap:** No more than one gap in enrollment up to 45 days during each continuous enrollment period.

Measure #3: Child and Adolescent Well-Care Visits (WCV)

- **Measure Description:** The percentage of Enrollees 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
- **Eligible Population:** Enrollees 3-21 years of age as of December 31 of the measurement year.
- **Continuous Enrollment:** The measurement year.
  - **Allowable Gap:** No more than one gap in enrollment up to 45 days during the measurement year.

HEDIS Effectiveness of Care Measures (3 Measures)

Measure #4: Breast Cancer Screening (BCS-E)

- **Measure Description:** The percentage of Enrollees 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
- **Eligible Population:** Women 52-74 years as of December 31 of the measurement year.
- **Continuous Enrollment:** October 1 two years prior to the measurement year through December 31 of the measurement year.
  - **Allowable Gap:** No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the prior measurement year). No gaps in enrollments are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.

Additional Notes: Administrative Gender of Female (AdministrativeGender F) or Sex Assigned at Birth (LOINC 76689-9) of Female (LOINC LA3-6) at any time in the member's (Enrollee's) history; Sex Parameter for Clinical Use of Female (SexParameterforClinicalUse Female-typical) in the MY (measurement year).

Measure #5: Lead Screening in Children (LSC)

- **Measure Description:** The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
- **Eligible Population:** Enrollees aged 2 as of December 31 of the measurement year.
- **Continuous Enrollment:** 12 months prior to the child's 2nd birthday.
  - **Allowable Gap:** No more than one gap in enrollment up to 45 days during the 12 months prior to the child's second birthday.

Measure #6: Asthma Medication Ratio (AMR)

- **Measure Description:** The percentage of Enrollees 5–64 years of age 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 Population:** Enrollees 5-64 years of age who were identified as having persistent asthma.
- **Continuous Enrollment:** The measurement year and the prior measurement year.
  - **Allowable Gap:** No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the prior measurement year).

Avoidable ED Visit and Hospitalization Measures (3 Measures)

Measure #7: Low Acuity Non-Emergent (LANE) Emergency Department Visits

- **Measure Description:** The percentage of ED visits that are low-acuity non-emergent visits, as calculated using DHCF's measurement specifications (Mercer).
- **Eligible Population:** Enrollees of all ages and genders are eligible for this measure.
- **Continuous Enrollment:** Not applicable to this measure.

Measure #8: Potentially Preventable Admissions (PPAs)

- **Measure Description:** The percentage of inpatient admissions for specific ambulatory care conditions that may have been prevented through appropriate outpatient care, as calculated using DHCF's measurement specifications (Mercer).
- **Eligible Population:** Enrollees of all ages and genders are eligible for this measure.
- **Continuous Enrollment:** Not applicable to this measure.

Measure #9: Plan All-Cause Readmissions (PCRs)

- **Measure Description:** The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 calendar days, as calculated using DHCF's measurement specifications (Mercer).
- **Eligible Population:** Enrollees of all ages and genders are eligible for this measure.
- **Continuous Enrollment:** Not applicable to this measure.

D. PAYMENT METHODOLOGY

Payment Calculation for HEDIS Measures

As seen in the following table, participating Practices will have the opportunity to earn up to a $0.40 Per-Enrollee Per-Month (PEPM) bonus for each of the six HEDIS measures. To receive incentive payments for these measures, the Practice must either:

1. Meet the 50th, 75th, or 90th National Medicaid HEDIS benchmark **OR**
2. Demonstrate improvement of at least ten (10) percentage points in a measure (e.g., increasing AAP rate from 40.0% to 50.0%) over the past Measurement Year.

National Medicaid Benchmarks			OR	10+ Percentage Point Improvement
50th Percentile	75th Percentile	90th Percentile		
$0.10 PEPM	$0.20 PEPM	$0.30 PEPM		$0.10 PEPM

A practice may receive the incentive payment for performance improvement in addition to the incentives for meeting HEDIS benchmarks.

To ensure statistical validity, Practices must have **at least 30 qualifying Enrollees for any given HEDIS measure** to qualify for an incentive payment for that measure.

Payment Calculation for Avoidable ED and Hospitalization Measures

As seen in the following table, participating Practices will also have the opportunity to earn up to **a $0.10 PEPM bonus** for each of the three Avoidable ED and Hospitalization Measures. To receive incentive payments for these measures, the Practice must either:

1. Perform better than the plan-average **AND** meet the DHCF target (once available) **OR**
2. Improve the rate of a measure by at least 10 percent in a measure (e.g., reducing the percentage of LANE ED visits from 25% to 22.5%) over the past year.

Below Plan Average and DHCF Target	OR	10 Percent Improvement
$0.05 PEPM		$0.05 PEPM

A practice may receive the incentive payment for performance improvement in addition to the incentive for performing better than the plan average while meeting the available DHCF target.

Calculating and Distributing Total Payments

MedStar Family Choice DC will calculate and distribute Providers' incentive payments on an annual basis using performance evaluation periods that align with HEDIS Measurement Years. This payment cycle ensures that all run-out claims are included in final performance calculations.

Total incentive payments cannot exceed six percent (6%) of base claims dollars paid to a Practice in any performance year.

Incentive Payment Month	Performance Evaluation Period
April (current year)	January through December (previous HEDIS Measurement Year)

Practices' total incentive payments will be calculated using the following method:

1. Adding the bonus PEPMs earned for each individual measure, if applicable
2. Multiplying the total from step 1 above by the number of Enrollees assigned to the Practice
3. Multiplying the new total from step 2 above by twelve (12), resulting in the annual payment

The total amount of incentive payments that a Practice receives in any given calendar year cannot exceed six percent (6%) of claims dollars paid to that Practice.

To better illustrate how incentives are calculated, please review the following scenario, in which a generic Primary Care Clinic has 1,500 total assigned Enrollees and $300,000 in annual paid claims.

HEDIS Measures						
Measure	**Qualifying Enrollees**	**Threshold Met?**	**Outcome (Percentile)**	**Performance Met?**	**Improvement Target Met?**	**PEPM Earned**
1. AAP	1100	Yes	75th	Yes	No	$0.20
2. W30	25	No	75th	N/A	No	$0.00
3. WCV	375	Yes	<50th	No	No	$0.00
4. BCS	100	Yes	90th	Yes	Yes	$0.40
5. LSC	82	Yes	50th	Yes	No	$0.10
6. AMR	31	Yes	<50th	No	Yes	$0.10
Avoidable ED and Hospitalization Measures						
Measure	**Met DHCF Target?**	**Above Plan Average?**	**Improvement Target Met?**			**PEPM Earned**
7. LANE ED	Yes	Yes	Yes			$0.10
8. PPA	No	Yes	No			$0.00
9. PCR	No	No	Yes			$0.05
				Total Earned Incentive Payment		**$0.95**

In this scenario, the Practice would receive a payment equaling $0.95 PEPM * 1,500 Enrollees * 12 months, or **$17,100**. With $300,000 in outpatient claims paid over the performance year, the total maximum incentive payment (6% of claims paid) to this provider would have been $18,000.

E. PRACTICE SUPPORTS

MedStar Family Choice DC is committed to supporting participating Primary Care Providers' success in the Peak Performance Incentive Program. Our Quality and Provider Relations teams work collaboratively to develop and share tools and resources to support improved outcomes in our VBP programs. This will include, but not be limited to:

- Monthly updated Enrollee panel reports
- Monthly care gap reports
- HEDIS tip sheets
- Regular and ad hoc webinars to share best practices

F. ADDITIONAL TERMS AND CONDITIONS

The Primary Care Provider Peak Performance Incentive Program (including any Alternative Payment Models used therein) does not incentivize participating Providers to reduce or otherwise limit any medically necessary services.

MedStar Family Choice DC reserves the right to modify or terminate the Primary Care Provider Peak Performance Incentive Program with written notice to participating Providers. We will review and evaluate this program on a periodic basis but at least annually to identify opportunities to improve the program, including potential changes to the set of quality metrics used to determine payment as well as how performance-based payments are distributed.

Participating Providers have a right to appeal their rankings on any of the performance measures in the program. Appeals must be submitted in writing to the MedStar Family Choice DC Director of Provider Networks and provide details demonstrating performance that varies from MedStar Family Choice DC's reported data. Appeals must be made within 60 days of the MedStar Family Choice DC's distribution of earned incentive payments for a given performance period. Appeals will be reviewed by the MedStar

Family Choice DC Quality Improvement Committee. MedStar Family Choice DC resolves all appeals within 90 business days of receipt of the initial appeal. Any payment adjustments resulting from a successful appeal will be made within 30 days of the Quality Improvement Committee's determination.

MedStar Family Choice DC looks forward to working with participating practices to improve our value-based payment programs over time. If you have any questions, concerns, or recommendations about the Primary Care Provider Peak Performance Incentive Program, please do not hesitate to reach out to your Provider Relations Associate.

For more information on Value-Based Payment, please visit the Health Care Payment Learning & Action Network's website at **HCP-LAN.org**.

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