Section 7: Cost Management (adult practices)

We value the important role you play in managing the health of our members. We created Cost Management incentives to recognize and reward you for delivering and maintaining quality and cost-effective care. The program consists of the following incentives:

- Pharmacy Cost
- Medical Cost Efficiency

Pharmacy Cost

Research indicates that not taking medication as directed leads to 125,000 preventable deaths each year and about $300 billion in avoidable health care costs.[1] To combat this, we have incorporated the Pharmacy Cost incentive into QIPS. Our goal is to help you promote medication adherence and to reduce pharmacy costs and other avoidable health care expenses.

Additional practice and member eligibility requirements

In addition to the core requirements, the following apply to this incentive:

- Members must be continuously covered by our medical and pharmacy coverage for calendar year 2023.
  - National BlueCard® Commercial PPO members are **excluded** from this metric.
- If your mean band is greater than or equal to 2.5, your practice will be measured and scored on the incentive, but the practice will be **excluded** from payment.
- You must have 25 or more members who have received multiple scripts (through our pharmacy benefit) as part of the following medication regimens:
  - statin therapy
  - hypertension management
  - diabetes management
- A member will be counted more than once if they appear in more than one medication regimen category.
- The practice's Medication Compliance rate (50th percentile or above) of members in the three medication regimens stated above will determine that practice's entrance (the quality gatekeeper) into the evaluation of pharmacy cost.
- Patients diagnosed with end-stage renal disease and in hospice care are **excluded** from the medication adherence compliance evaluation.

[1] www.heart.org/en/health-topics/consumer-healthcare/medication-information/medication-adherence-taking-your-meds-as-directed

https://patimes.org/medication-compliance/

- All specialty drugs are also **excluded,** and a high-cost threshold will be applied.
  - Family/General Practice or Internal Medicine/Geriatrics:
    - $10,000 high-cost threshold (Commercial)
    - $15,000 high-cost threshold (Medicare Advantage)

How do we calculate your Medication Compliance?

Calculating your Medication Compliance is the first step in determining if your practice is eligible to be evaluated for Pharmacy Cost. We determine this score using the number of patients who have had two or more filled scripts for one of the regimens described above (denominator) and the total number of drug-adherent members (numerator).

Members are considered "adherent" if they have filled their maintenance medication scripts for at least 80 percent of the days during which they were on said drug regimen for a given condition (e.g., 10 out of 12 months). This determination is made for each member condition. This means a member could be "adherent" for his or her cholesterol medications but "non-adherent" for his or her diabetes medications.

The resulting percentage will determine each practice's compliance rate. Each practice will then be ranked against its peers in its specialty group from highest to lowest compliance rate. A member may count toward both the denominator and numerator multiple times if they fall into multiple medication regimen categories.

If your practice is in the top 50th percentile of compliance, it will be evaluated for Pharmacy Cost.

You made it into the Pharmacy Cost incentive – How do we calculate your payment?

The Pharmacy Cost incentive payment is based on each practice's pharmacy cost risk-adjusted PMPM.* The risk-adjusted PMPM will be compared and percentile-ranked among primary care practices (PCPs) of the same specialty type (Family/General Practice or Internal Medicine/Geriatrics). Each practice, based on the percentile rank, will be assigned to one of four tiers, as shown in the chart.

**Risk-adjustment is performed using Verisk DxCG Risk Scores for commercial members and HCC Risk Scores for Medicare Advantage members. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's PMPM costs are then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on their PMPM costs, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their PMPM costs.*

The chart below illustrates Pharmacy Cost payment rates at a tier level.

Primary Care Practice Percentile Rank within Specialty	Commercial HMO/POS/PPO	Medicare Advantage† HMO/POS/PPO
	PAMPY/PMPY	PAMPY/PMPY
Tier 1 (75 – 100%)	$8.40	$9.60
Tier 2 (50 – 74.99%)	$7.20	$8.40
Tier 3 (25 – 49.99%)	$6.00	$7.20
Tier 4 (<25%)	$0.00	$0.00

†Medicare Advantage HMO/POS/PPO members are measured and ranked separately from commercial HMO/POS/PPO members. Therefore, a practice could potentially have two different rankings and two different payments.

Medical Cost Efficiency

With this incentive, we assess and reward you based on your management of medical cost in comparison to other practices in your specialty. Medical cost is the contractual allowed amount we pay to you, inclusive of member liability (e.g., copayment, coinsurance, deductible) and Coordination of Benefits funds. Costs may include, but are not limited to, Professional and Outpatient – Surgery, ED, Cardiology, Radiology, Lab, and rehab costs.

The following costs are excluded from this incentive:

- prescription drugs paid through the pharmacy benefit
- home health/hospice services
- maternity services
- mental health/substance use disorder costs
- pediatric and adult preventive costs (mammography, colon cancer screenings, immunizations)

Additional practice and member eligibility requirements

In addition to the core requirements, the following apply to this incentive:

- If your mean band is greater than or equal to 2.5, your practice will be measured and scored on the incentive, but the practice will be **excluded** from payment.
- You must have an average panel size of 200 commercial HMO/POS/PPO and National BlueCard Commercial PPO members for the measurement year to be eligible for the Commercial Medical Cost Efficiency incentive.
- You must have an average panel size of 150 Medicare Advantage HMO/POS/PPO members for the measurement year to be eligible for the Medicare Advantage Medical Cost Efficiency incentive.
- Patients under 2 years old, as of the last day of the reporting period, are **excluded**.

- High-cost claimants are **excluded**:
  - Commercial HMO/POS members with more than $65,000 in annual medical costs and Medicare Advantage HMO/POS members with more than $130,000 in total annual medical costs.
  - Personal Choice and National BlueCard Commercial PPO members with more than $75,000 in annual medical costs and Medicare Advantage PPO members with more than $150,000 in annual medical costs.

How do we calculate your payment?

The Medical Cost Efficiency incentive is based on each practice's total cost risk-adjusted PMPM‡. The risk-adjusted PMPM will then be compared and percentile-ranked among PCPs of the same specialty type (Family/General Practice or Internal Medicine/Geriatrics). Each practice, based on the percentile rank, will be assigned to one of four tiers, as shown in the chart

‡Risk-adjustment is performed using Verisk DxCG Risk Scores for commercial members and HCC Risk Scores for Medicare Advantage members. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's PMPM costs are then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on their PMPM costs, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their PMPM costs.

The chart below illustrates Medical Cost Efficiency payment rates at a tier level.

Primary Care Practice Percentile Rank within Specialty	Commercial HMO/POS/PPO	Medicare Advantage§ HMO/POS/PPO
	PAMPY/PMPY	PAMPY/PMPY
Tier 1 (75 – 100%)	$8.40	$9.60
Tier 2 (50 – 74.99%)	$7.20	$8.40
Tier 3 (25 – 49.99%)	$6.00	$7.20
Tier 4 (<25%)	$0.00	$0.00

§Medicare Advantage HMO/POS/PPO members are measured and ranked separately from commercial HMO/POS/PPO members. Therefore, a practice could potentially have two different rankings and two different payments.