Section 8: Care Efficiency Management (adult practices)

The Care Efficiency Management program consists of the two incentives shown below. These incentives measure a practice's accessibility to their patients for potentially avoidable conditions and coordination of care.

- ED (emergency department) utilization for potentially preventable ED visits.
- Transitions of Care
  - **Patient engagement after inpatient discharge.** This includes office visits, visits to the home, and telehealth within 30 days after discharge.
  - **Medication reconciliation post-discharge.** Review and compare the medication orders with the medication being taken on the date of discharge through 30 days after discharge (31 total days).
  - **Follow-up after ED visit for members with multiple high-risk chronic conditions.** Evaluates the percentage of ED visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Additional member and eligibility requirements

In addition to the core requirements, the following applies to **both** incentives:

- 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.

These apply to the **ED utilization for potentially preventable ED visits** incentive only:

- 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 Care Efficiency Management 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 Care Efficiency Management incentive.

These apply to the **Transitions of Care** incentive only:

- This incentive applies to Medicare Advantage members only.
- There is no average panel size requirement for this incentive.
- A practice must have a minimum of five members who are eligible to receive the service for each measure (denominator).

How do we calculate your score and payment?

Each of these incentives are scored and measured separately from each other. Practices are percentile-ranked and tiered among other practices in the same specialty type (FP/IM).

- **ED utilization for potentially preventable ED visits.** Practices are percentile-ranked and tiered based on ED visits p/1000.

- **Transitions of Care (Medicare Advantage members measured only).** Practices are percentile-ranked and tiered based on discharges for members 18 and older who had each of the following:
  - Patient engagement after inpatient discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge based on medical admissions only.
  - Medication reconciliation post-discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). The denominator for this measure is based on discharges, not members.
  - Follow-up after ED visit for members with multiple high-risk chronic conditions. Members with high-risk chronic conditions, 18 years of age or older, who received a follow-up service within 7 days after the ED visit (8 total days). Includes visits that occur on the date of the ED visit.

The chart below illustrates Care Efficiency Management 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.*