

Attachment 1

**2017 FEHB
Plan Performance Assessment
Carrier Manual**



Updated January 27, 2017

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Introduction

This carrier manual is for health insurance carriers providing benefits through the Federal Employees Health Benefits Program (FEHB) in 2017. This document provides specific guidance for FEHB carriers for the 2017 plan year on the following topics:

- Reporting Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to the National Committee for Quality Assurance (NCQA)
- Affirming deletions and announcing additions to the Clinical Quality, Customer Service and Resource Use (QCR) Measure Set;
- Clarification of reporting timelines for selected measures;
- Reinforcing the requirement for Corrective Action Plans for below average performance on high priority measures;
- Affirming QCR calculations and scoring policies including the implementation of the Improvement Increment;
- Announcing the deletion of “most improved” and “exemplary” for public reporting of carrier performance data.

Carriers remain responsible for meeting program requirements as outlined in previous carrier letters that detailed the design and implementation of the Plan Performance Assessment. A complete list of relevant carrier letters is contained in Section 4: References and Resources.

Section 1: Reporting HEDIS and CAHPS Data

Subsection A: OPM General Requirements for HEDIS Collection and Reporting

- OPM encourages carriers to utilize hybrid collection for all measures where NCQA provides this reporting option. However, OPM permits either hybrid or administrative data collection for those measures that can be reported to NCQA using either method.
- NCQA compiles the HEDIS data on OPM’s behalf; therefore carriers must follow NCQA’s data submission process. Additional information can be found below.
- Carriers are expected to report on the book(s) of business in which FEHB members are enrolled. For many plans this will be the commercial book of business. If carriers have FEHB members enrolled in multiple plan product types under one OPM contract, OPM will use the plan product type with the highest FEHB enrollment to score all reports.
- OPM will not accept HEDIS reports before the second full year of a new plan’s participation in the FEHB.
- Each FEHB carrier must submit audited HEDIS results regardless of enrollment size.
- Questions: HEDIS@opm.gov

Subsection B: OPM General Requirements for CAHPS Collection and Reporting

- All FEHB plans must administer the CAHPS Health Plan Survey 5.0H Adult Version
- Members who have Medicare as their primary coverage should not be included in the sample

- All FEHB plans must have their sample frame validated by an NCQA-Certified HEDIS Compliance Auditor
- CAHPS reporting guidelines are listed below:
 - Plans submitting samples to NCQA from commercial products that include *FEHB contract holders* may submit those samples to OPM.
 - Plans not submitting commercial samples to NCQA should:
 - Submit a separate CAHPS sample for any plan option in a state in which that plan option has more than 5,000 *FEHB contract holders*
 - Enrollees in plan options that have fewer than 5,000 *FEHB contract holders* per state may be included in a plan option specific “all other” sample
 - For example, if a plan has 12,000 *FEHB contract holders* in New York with 3,000 in the High option and 9,000 in the Standard option, conduct one sample on the Standard option in New York. Combine the 3,000 in the High option with all other states with fewer than 5,000 *FEHB contract holders* in the High option for one “High option – other” sample.
 - Plans reporting differently for accreditation purposes, seeking to submit a larger number of samples, or with other unique circumstances should contact OPM for guidance. Plans requesting this consideration will receive a confirmation letter from their OPM Contracting Officer.
 - Questions: CAHPS@opm.gov

CAHPS Surveys and OMB Clearance

All of the following statements must be included on mailed surveys:

In the upper right corner of each questionnaire: “Form approved: OMB No. 3206-0236.”

“This information collection has been approved by the U.S. Office of Management and Budget (Control Number 3206-0236) and is in compliance with the Paperwork Reduction Act of 1995. We estimate that it will take an average of 20 minutes to complete, including the time to read instructions and to gather necessary information. You may send comments about our estimate or any suggestions for minimizing respondent burden, reducing completion time or any other aspect of this information collection to the U.S. Office of Personnel Management (OPM), Reports and Forms Officer (OMB Number 3206-0236), Washington, DC 20415-7900. Your participation in this information collection is voluntary. The OMB Number, 3206-0236, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.”

On the front cover:

“Personally identifiable information will not be made public and will only be released in accordance with Federal laws and regulations. You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders. If you want to know more about this study, please call (survey vendor number here).”

Processing Fee

Each plan reporting survey data to OPM is responsible for a pro rata share of the cost of compiling, processing and reporting the survey results. As in previous years, a processing fee will apply to each unique NCQA Submission ID for which data is submitted to OPM.¹ OPM's CAHPS data collection contractor, ORI, will invoice you directly.

Timeline

- **February 1, 2017:** All FEHB plans must complete and submit the CAHPS Survey Participation Form (see Section 4; Subsection A) to CAHPS@opm.gov. If you conduct multiple surveys, please list the name and FEHB Sub-Code for each plan or option.
- **May 1, 2017 (tentative):** All FEHB plans must submit a CAHPS crosswalk file (see Section 4; Subsection A) that maps your submission ID(s) to your FEHB plan name and Sub-Code is due two weeks after NCQA issues submission IDs and must accompany each data submission to OPM. The crosswalk includes each:
 - NCQA Member-level File Name,
 - NCQA Submission ID,
 - NCQA Plan Name,
 - FEHB Sub-Code, and
 - FEHB Plan Name.
- Please direct questions regarding the crosswalk to Sue Lynd at SueL@ORResults.com.
- **June 15, 2017:** Member level data file due. All such files must be NCQA validated by the survey vendor. We will accept your member level data files after they have been processed by NCQA and you have provided NCQA with a signed Attestation of Accuracy. Your survey vendor may submit data via e-mail or other electronic or digital format. To comply with HIPAA's privacy rules, survey vendors should use appropriate encryption technology.

Subsection C: Reporting HEDIS and CAHPS Results to the National Committee for Quality Assurance (NCQA)

All plans must follow NCQA's procedures for HEDIS reporting, including the HEDIS Compliance Audit™ which can be found at <http://www.ncqa.org/tabid/205/Default.aspx>. To fully understand and comply with HEDIS technical specifications and to obtain the appropriate measures' specifications you will need HEDIS 2017 Volume 2: Technical Specifications for Health Plans. You can purchase it through NCQA's website: <http://store.ncqa.org/index.php/performance-measurement.html>.

All surveys must be conducted according to NCQA protocols described in HEDIS 2017, Volume 3: Specifications for Survey Measures, and administered by a vendor that is NCQA-Certified for this purpose.² All plans must

¹Plans will be charged for each NCQA data file submitted. Any plan that withdraws from the FEHB Program after submitting data in accordance with these requirements is liable for the processing fee.

² A list of certified survey vendors is available at <http://www.ncqa.org/hedis-quality-measurement/certified-survey-vendors-auditors-software-vendors/hedis-survey-vendor-certification/cahps-5-0h-survey>

generate the sample frame according to NCQA specifications³ using a minimum sample size of 1,100 members. Over-sampling is allowed according to the protocols in Volume 3. You may use an enhanced protocol or add supplemental questions with prior NCQA approval.

To report HEDIS and CAHPS results to NCQA, carriers must complete NCQA's annual Healthcare Organization Questionnaire (HOQ) online through NCQA's [website](#) using a password. When filling out the HOQ, please list the appropriate NCQA Organization ID Code, Submission Code, and FEHB Carrier Codes and Carrier Subcodes associated with your submission ID(s). If your submission ID has multiple FEHB codes associated with it, please include all of the FEHB codes in the HOQ. To meet the requirements outlined in [Carrier Letter 2014-10](#), carriers currently accredited or pursuing health plan accreditation should register their submission(s) to reflect all carrier codes in that population. The HOQ screenshot below highlights where in the HOQ carriers need to enter the FEHB codes and CAHPS selections.

The screenshot shows a web form for the NCQA Healthcare Organization Questionnaire (HOQ). The form is divided into several sections:

- Product Line:** Commercial
- Reporting Product:** PPO
- Submission Type:** Other
- Special Area:** None
- Special Project:** None
- Audit:**
 - Audit Required:** Yes
 - Audit Firm:** Attest Health Care Advisors
- Software Vendor:**
 - Software used to compute HEDIS:** HEDIS Certified Software Vendor
 - HEDIS Certified Software Vendor:** Valiant Health LLC
- OPM Submission:**
 - Is this an OPM Submission?** Yes
 - FEHB Carrier Codes (Please enter 2 digit codes only.):**
 - FEHB Carrier Code 1:
 - FEHB Carrier Code 2:
 - FEHB Carrier Code 3:
 - FEHB Carrier Code 4:
 - FEHB Carrier Code 5:
- IDSS:**
 - Submitting HEDIS data via IDSS?** --UnSelected--
- CAHPS 5.0H:**

Component	Request	Survey Vendor Firm	Survey Sample Frame Result
AdultCAHPS	--UnSelected--	--UnSelected--	Not Applicable
ChildCAHPS	--UnSelected--	--UnSelected--	Not Applicable
ChildCAHPSCCC	--UnSelected--	--UnSelected--	Not Applicable

The carrier's designated HEDIS contact will receive an email notification from NCQADataCollections@ncqa.org with information on how to access the 2017 HOQ on-line. If the carrier does not currently have a designated Primary HEDIS contact, the carrier must contact NCQA's Data Collection Operations team at <https://my.ncqa.org>.

³ Plans must use the standardized layout and format for the sample frame data file described in Volume 3 and must include all required data elements in Table S-1.

Refer to the NCQA website, www.ncqa.org, or contact NCQA Customer Support at <https://my.ncqa.org> or 1-888-275-7585 for general questions regarding HEDIS and CAHPS. Submit technical questions regarding a HEDIS measure or the HEDIS technical specifications to NCQA's Policy Clarification Support system. The PCS system can be accessed through the NCQA website at <https://my.ncqa.org>. Questions about the data submission process should be addressed to carriers' assigned NCQA HEDIS Data Submission Account Manager. A list of 2017 Account Managers can be found here:

<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDISDataSubmission.aspx>.

Access <http://www.ncqa.org/hedis-quality-measurement/hedis-data-submission> to find the data submission timeline which includes the following:

- The date HOQ opens to plans via the NCQA website
- The deadline for plans to complete NCQA's on-line HOQ
- The date NCQA provides health plans with access to use the Interactive Data Submission Systems (IDSS)
- The date plan-lock must be applied to the submission to ensure HEDIS Compliance Auditors have sufficient time to review, approve and audit-lock the submission
- The date the plan must submit Patient-Level-Detail File to the auditor
- The deadline for plans to submit HEDIS results to NCQA and e-sign attestations

Subsection D: Measures Reported & Not Scored (AKA Measures Farm Team)

The QCR Measure Set contains measures that OPM has announced as being reported but not scored under the QCR methodology. These measures are referred to as the "Measures Farm Team". These measures may be moved from the Measures Farm Team to the QCR measure set and scored no earlier than the third year of reporting ([Carrier Letter 2014-19](#)). OPM will confirm the actual year of scoring in advance so that carriers have adequate notice.

A complete list of measures being reported as part of the 2017 Plan Performance Assessment is contained in Section 4: References and Resources, Subsection B in this manual.

Subsection E: Summary of Changes to Clinical Quality, Customer Service and Resource Use (QCR) Measure Set in 2017

The following changes are effective beginning January 1, 2017 for data collected and reported in 2017:

Deletions from the QCR Measure Set:

- Medical Assistance with Smoking and Tobacco Use Cessation ([Carrier Letter 2016-02](#) announced retirement);
- Comprehensive Diabetes Control (Testing) ([Carrier Letter 2015-15](#) announced retirement)

Additions to the QCR Measure Set for Use in QCR Calculation:

- Comprehensive Diabetes Care (Control - A1c <8%) (Carrier Letters [2015-15](#); [2015-19](#) announced use and priority) Note: This measure has been collected for at least two years and is eligible for scoring. OPM is affirming that it will be scored in 2017.

Additions to the Measures Farm Team:

The Measures Farm Team is discussed above in Subsection D. The 2017 Plan Performance Assessment Carrier Manual announces the addition of three measures to the Measures Farm Team. These measures are all HEDIS measures, full technical specifications can be found in the 2017 HEDIS Technical Manual for Health Plans, Volume 2. All plans must collect and submit these measures beginning in the 2017 data collection cycle. OPM will review results, but will not include them in the 2017 QCR Score.

The newly added measures are listed below:

- Follow-up after Discharge from the Emergency Department for Mental Health (7day/30 day rate) (FUM)
 - Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that by 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- Follow-up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence (7 day/30 day rate) (FUA)
 - SAMHSA further estimates that the impact of substance use alone is estimated to cost Americans more than \$600 billion each year. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) states that in 2010, alcohol misuse problems cost the United States \$249 billion. NIAAA claims that globally, alcohol misuse is the fifth leading risk factor for premature death and disability; among people between the ages of 15-49, it is the first. According to the National Council on Alcoholism and Drug Dependence Inc. (NCADD), drug abuse costs employers \$81 billion annually. Some 70 percent of the estimated 14.8 million Americans who use illegal drugs are employed.
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
 - Cardiovascular disease is the leading cause of death in the U.S. More than 85 million adults have one or more types of cardiovascular disease and it is estimated that by 2030 more than 43 percent of Americans will have a form of cardiovascular disease.

Subsection F: Corrective Action Plans

In 2017, carriers that score below the 25th percentile in any of the following measures: Controlling High Blood Pressure, Timeliness of Prenatal Care, and Plan All-Cause Readmissions are required to submit a Corrective Action Plan (CAP) designed to raise their result. All CAPs must be submitted using the Quality Improvement Corrective Action Template to your Health Insurance Specialist (Contracts) within 30 days of receiving the 2017 Overall Performance scorecard. A copy of the Quality Improvement Corrective Action Template is located in Section 4: References and Resources.

Subsection G: Clarification of Selected Measure Reporting Timelines

This notice is intended to clarify the timelines for reporting and scoring of selected Clinical Quality, Customer Service, and Resource Use (QCR) measures that contribute to the OPM Plan Performance Assessment. This list has been compiled after carrier feedback. Should carriers require clarification on any other measure timelines, please send inquiries to FEHBPerformance@opm.gov.

Measure	Clarification	Priority Level	Status
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)	Collected since 2014, eligible for scoring	2	We are affirming 2018 scoring.
Asthma Medication Ratio (AMR)	Collected since 2015 eligible for scoring	2	We are affirming 2018 scoring.
Cervical Cancer Screening (CCS)	Collected since 2016, eligible for scoring beginning 2018.	2	Carrier Letter 2015-19 announced collection. We are affirming 2018 scoring and priority level.
Inpatient Hospitalization Utilization (IHU)	Collected since 2016.	NA	We are affirming correct 3 letter code is IHU.
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	Collected and scored as part of the QCR in 2016	2	We are affirming that this measure will be dropped effective 2017.

Section 2: QCR Scoring and Calculations

Subsection A: Product Reporting Types and QCR Scoring

OPM obtains the following commercial benchmarks from the NCQA based on the NCQA plan product type:

- HMO;
- HMO/POS;
- PPO; and
- All Lines of Business (ALOB).

When a plan is reported to us as a POS it will be compared to the HMO/POS benchmark. If a plan is reported to us as any plan type other than an HMO; HMO/POS; or PPO, OPM will utilize the ALOB benchmark. If a plan would otherwise be evaluated against the ALOB benchmark and wishes to be evaluated against a different benchmark, they should submit a written request to their Health Insurance Specialist (Contracts) and OPM's Plan Performance Assessment technical team will review their request. Please reference [Carrier Letter 2016-11](#) for additional information.

Subsection B: HEDIS Auditor Codes and QCR Scoring

HEDIS auditors utilize NCQA codes when data reported by a health plan is compromised or missing. If a carrier receives a code of “Not Reported” (NR) or “Biased Rate” (BR) for measures that are scored, OPM will score that measure as a zero (0) and the measure weight will be included in the denominator of the summary QCR score. For more information about the treatment of missing or compromised data, refer to [Carrier Letter 2015-10](#).

Subsection C: Contract Roll-up

In some instances, an FEHB carrier contract may be associated with multiple QCR measure reports. When this is the case OPM aggregates QCR measures to obtain a contract level enrollment adjusted result. For example, a contract may include more than one carrier code and report QCR measures on each carrier code to OPM. Where there are multiple reports under one contract, OPM aggregates to the contract level in proportion to the number of enrollees associated with each report. An example of this aggregation process is contained in [Carrier Letter 2015-10](#).

Subsection D: QCR Data Preview

Carriers will receive a preview of their QCR calculations and score prior to finalization. The QCR Data Preview allows carriers to submit inquiries relating to data reporting or the mathematical calculation of their QCR score. Carriers have ten (10) calendar days to review their QCR score and submit written inquiries. All inquiries should be sent to FEHBPerformance@opm.gov with copies to each carrier’s Health Insurance Specialist (Contracts), and their Contracting Officer. Carriers must include documentation or materials pertinent to their inquiry and should limit inquiries to the specifics of their Data Preview. OPM has thirty (30) days in which to respond with a final determination in response to the carrier inquiry.

Subsection E: Data Correction Procedure

OPM’s Plan Performance Assessment requires that all carriers report accurate data (e.g., HEDIS, CAHPS) according to the procedures outlined in OPM communications. Data accuracy and sample compliance impact results.

If OPM staff/contractors detect anomalous data or are otherwise notified of data quality issues, the following procedures and timeline must be followed. Failure to do so will result in OPM assigning the carrier an “NR” or “BR” for the measures in question. “NR” and “BR” results are scored as zero in the Performance Assessment calculation, and will lower a carrier’s score.

Procedures for Correction:

Only written communication fulfills the requirements of these procedures. All costs associated with remediation are the responsibility of the carrier. Approval of the incurred costs under FEHB carrier administrative expenses (Experience-Rated carriers) is at the discretion of the Contracting Officers.

Upon discovery that potentially anomalous data has been received, OPM will prepare a Performance Measure Carrier Deficiency Notice (DN). The notice will describe the nature of the anomaly and provide any available supporting documentation. Within 14 calendar days of receiving the DN from OPM, the Carrier must elect and fulfill one of the following options (in writing, via email, Express Letter, Federal Express, or UPS):

Option 1: Provide verification that the original data is both correct and compliant,

- Requires supporting documentation from the plan's HEDIS/CAHPS certified vendor/data auditor

Option 2: Accept NR or BR for the measures in question

- Carrier non-response within the required timeframe will be considered acceptance of NR or BR

Option 3: Propose remediation of the anomaly for OPM approval

- Requires supporting documentation from the carrier's HEDIS/CAHPS certified vendor/data auditor
- OPM will approve/disapprove remediation plan within 14 calendar days
 - If OPM fails to respond within 14 calendar days the proposed remediation plan is approved
- Remediation must be completed within 21 calendar days of OPM's written approval
- If OPM disapproves, carrier has 7 calendar days to revise the remediation plan or accept an NR or BR
- OPM approval/disapproval of the revised remediation plan is a final action
- OPM will review the remediation data submission, and, if approved, data will be updated. If OPM rejects the remediation data submission, then the carrier will receive NR or BR for the measures in question

Please Note: During this process, OPM will leave all relevant carrier information blank on OPM health insurance webpages intended for current and prospective enrollees until such time as the question is resolved, then either data or NR or BR will be posted.

Under Option 3, when the Carrier proposes and OPM approves remediation, the procedure is:

1. Carrier must provide a letter to the Contracting Officer and Health Insurance Specialist (Contracts) from their third-party, certified vendor/data auditor:
 - Certifying that:
 - The resubmitted sample has been corrected based on the approved remediation plan
 - The sample is now in compliance with OPM requirements
 - The sample is in compliance with all NCQA specifications
 - Include the survey instrument (if CAHPS), and any other appropriate information the vendor/data auditor or OPM deems necessary
2. OPM contractor will verify that the new data corrects the anomaly. If OPM determines it is not corrected, then:
 - Carrier receives NR or BR for the measures for that year
 - Additional data validation will be conducted at OPM's discretion

Subsection F: Improvement Increment

For the 2017 Plan Performance Assessment, OPM is introducing an Improvement Increment as a method of recognizing substantial improvement on measures where performance fell below the 50th percentile in 2016.

All QCR measures that have been eligible for scoring over a two year period are eligible for consideration unless there are changes in reporting status of the carrier or measure specifications are changed by the measure

steward for the relevant time periods. Substantial improvement is defined as change that exceeds 1.645 times the standard deviation of year-to-year change observed in all carriers reporting a given measure nationally by product type. For additional details on the methodology of the Improvement Increment and an example of the calculation, please refer to [Carrier Letter 2016-11](#).

Section 3: Public Reporting of HEDIS and CAHPS Results

Subsection A: Plan Comparison Tool and OPM Website

OPM revamped and improved its Plan Comparison Tool in 2016, which is accessed through the Healthcare & Insurance, Plan Information section of the OPM website. The tool is designed to assist federal employees, annuitants and their families in choosing the health plan that best meets their needs. We will now display carrier performance on selected HEDIS and CAHPS measures in two public locations using symbols that reflect the relationship between the carrier’s performance and the relevant commercial benchmark. OPM will no longer indicate “Most Improved” or “Exemplary” status within the Plan Comparison Tool or on its website.

Section 4: References & Resources

(Continued on next page)

Subsection A: CAHPS Survey Participation Form and Sample Crosswalk

2017 CAHPS Survey Participation Form

(Please submit one form per plan and indicate each FEHB Sub-Code that is sharing data)

Plan Name: Click here to enter text.

FEHB Sub-Code(s): Click here to enter text.

Indicate which sub-codes share data: Click here to enter text.

Please check the appropriate box(es) below:

Health Plan will conduct the CAHPS® 5.0H Adult Commercial Survey

Health Plan is new to FEHB Program for 2017 and is not required to conduct CAHPS® Surveys in 2017

Name of NCQA Certified Survey Vendor that will be conducting the survey (s):

Click here to enter text.

Survey Vendor Contact Information:

Name: Click here to enter text.

Address: Click here to enter text.

Email: Click here to enter text.

Telephone Number: Click here to enter text.

Health Plan Contact for CAHPS:

Name: Click here to enter text.

Address: Click here to enter text.

Email: Click here to enter text.

Telephone Number: Click here to enter text.

Plan Contact & Address for Invoice (if different from above):

Name: Click here to enter text.

Address: Click here to enter text.

Email: Click here to enter text.

Telephone Number: Click here to enter text.

Please e-mail the completed form by **February 1, 2017** to: cahps@opm.gov

CAHPS Survey Participation Form (Page 1 of 2)

CAHPS Sample Crosswalk

Every data submission that your CAHPS[®] 5.0H Survey vendors send to OPM must be accompanied by a “crosswalk” that will allow OPM to map your plan’s data to the appropriate FEHB Sub-Code. This is the only way that OPM will be able to identify submissions and allocate data correctly. The crosswalk must include the following information:

- Member-level file name
- NCQA Submission ID
- NCQA Plan Name
- FEHB Sub-Code
- FEHB Plan Name

The Member-level filenames must follow the NCQA naming conventions.

The table below shows an example of a crosswalk for a vendor submission.

Sample Row	Member-Level File	NCQA Submission ID	NCQA Plan Name	FEHB Sub-Code	FEHB Plan Name
1	CAM1234.txt	1234	XYZ Health Plan Inc.	AA-HMO-UT-000	XYZ Health Plan
2	CAM2345.txt	2345	QRS Healthcare	BB-HMO-IN-000	QRS Healthcare
3	CAM2345.txt	2345	QRS Healthcare	BB-HMO-IL-000	QRS Healthcare
4	CAM3456.txt	3456	MNO Health S. Cal	CC-HMO-CA-000	MNO Health
5	CAM4567.txt	4567	MNO Health N. Cal	CC-HMO-CA-000	MNO Health

- Sample row 1 shows the most straightforward example where it is a one-to-one mapping between the NCQA Sub ID and FEHB Sub-Code.
- Sample rows 2 and 3 show how the crosswalk should appear when one set of NCQA data is mapped to two FEHB Sub-Codes. In this case, only one member-level file should be submitted to OPM.
- Sample rows 4 and 5 show how the crosswalk should appear when two sets of NCQA data are mapped to one FEHB Sub-Code. In this case, two member-level files must be submitted to OPM.

CAHPS Survey Participation Form (Page 2 of 2)

END

Subsection B: Complete List of Measures Required in 2017 for the QCR and Measures Farm Team

2017 Measures Scored in QCR

QCR Performance Area	Measure Scored in QCR	Measure Source	2017 (CL 2015-15)	
			Priority Level	Measure Weight
Clinical Quality	Breast Cancer Screening (BCS)	HEDIS	2	1.25
	Prenatal and Postpartum Care (Timeliness) (PPC-Timeliness)	HEDIS	1	2.50
	Well-Child Visits in the First 15 Months of Life (W15) (6 visits)	HEDIS	2	1.25
	Flu Vaccinations for Adults 18-64 (FVA)	CAHPS	2	1.25
	Controlling High Blood Pressure (CBP)	HEDIS	1	2.50
	Comprehensive Diabetes Care - HbA1C Control (< 8%) (CDC-Control)	HEDIS	2	1.25
	Medication Management for People with Asthma (75%) (MMA)	HEDIS	2	1.25
	Follow-up After Hospitalization for Mental Illness (7-day or 30-day) (FUH 7 or 30)	HEDIS	2	1.25
Customer Service	Plan Information Costs (PIC)	CAHPS	3	1.00
	Getting Care Quickly (GCQ)	CAHPS	3	1.00
	Getting Needed Care (GNC)	CAHPS	3	1.00
	Claims Processing (CP)	CAHPS	3	1.00
	Overall Health Plan Rating (RHP)	CAHPS	3	1.00
	Coordination of Care (CoC)	CAHPS	3	1.00
	Overall Personal Doctor Rating (RPD)	CAHPS	3	1.00
	Customer Service (CS)	CAHPS	3	1.00
Resource Use	Plan All-Cause Readmissions (Observed to Expected Ratio) (PCR)	HEDIS	1	2.50
	Use of Imaging Studies for Low Back Pain (LBP)	HEDIS	2	1.25

Measures Farm Team (Reported but not Scored)

- Cervical Cancer Screening (CCS) (Collection began in 2016)
- Asthma Medication Ratio (AMR) (Collection began in 2015)
- Avoidance of Antibiotics in Adults with Acute Bronchitis (AAB) (Collection begin 2014)
- Emergency Department Utilization (EDU) (Collection began in 2016)
- Inpatient Hospitalization Utilization (IHU) (Collection began in 2016)
- Follow-up after Discharge from the Emergency Department for Mental Health (7day/30 day rate) (FUM) (Collection begins in 2017)
- Follow-up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence (7 day/30 day rate) (FUA) (Collection begins in 2017)
- Statin Therapy for Patients with Cardiovascular Disease (SPC) (Collection begins in 2017)

Subsection C: Quality Improvement Corrective Action Plan Template for 2017

Carriers must submit a Corrective Action Plan (CAP) using this template for each FEHB Plan Performance Assessment measure below the 25th percentile as shown in the QCR Report which will be included with the Overall Performance Score Report. Within the CAP, please specify a 90-day implementation plan to improve the care associated with the identified measure.

In the table below, please indicate the measure(s) that require a CAP.

Measures	CAP Submission (check all that apply)
Breast Cancer Screening (BCS)	<input type="checkbox"/>
Prenatal and Postpartum Care (Timeliness of Prenatal Care) – (PPC)	<input type="checkbox"/>
Well-Child Visits in the First 15 Months of Life (W15)	<input type="checkbox"/>
Flu Vaccinations for Adults 18-64 (FVA)	<input type="checkbox"/>
Controlling High Blood Pressure – (CBP)	<input type="checkbox"/>
Comprehensive Diabetes Care - HbA1c Testing (CDC-Control)	<input type="checkbox"/>
Medication Management for People with Asthma (75%) (MMA)	<input type="checkbox"/>
Follow-up After Hospitalization for Mental Illness (7-day or 30-day) (FUH 7 or 30)	<input type="checkbox"/>
Plan Information Costs (PIC)	<input type="checkbox"/>
Getting Care Quickly (GCQ)	<input type="checkbox"/>
Getting Needed Care (GNC)	<input type="checkbox"/>
Claims Processing (CP)	<input type="checkbox"/>
Overall Health Plan Rating (RHP)	<input type="checkbox"/>
Coordination of Care (CoC)	<input type="checkbox"/>
Overall Personal Doctor Rating (RPD)	<input type="checkbox"/>
Customer Service (CS)	<input type="checkbox"/>
Plan All-Cause Readmissions – (PCR)	<input type="checkbox"/>
Use of Imaging Studies for Low Back Pain (LBP)	<input type="checkbox"/>

For each CAP, provide the following information in 750 words or less.

1. HEDIS Measure: _____

2. Plan Analysis

- Analysis: Strengths and weaknesses of current quality practices related to this measure.
- Barriers: Identify potential barriers to improvement in results. If this is a second or third CAP for this measure, include an evaluation of why you have not achieved expected results to date.
- Outreach: Estimate the number of health plan members that need to be engaged to increase the score to at least the 25th percentile.

3. Action Steps

- Action Outline: List in-depth steps in your Corrective Action Plan to raise the score to at least the minimum threshold. If your score has fallen below the threshold for 2 or more years, discuss new or different actions this year to improve performance to the minimum threshold.
- Classification: OPM strongly encourages Carriers with performance below the 10th percentile benchmark to develop *novel*⁴ actions, rather than *reinforcement*⁵ actions, to increase quality performance.
- Action Timeline: Identify the start date, and if applicable, end date of each action step.
- Progress Projection: Identify the projected improvement results including a timeline of when improvement can be expected.

Corrective Action Plan Template Submission

Each Carrier submitting one or more CAPs needs to complete the below information one time.

CAP Point of Contact: _____

Certification

The undersigned have read the attached Corrective Action Plan(s) and agree to the terms.

FEHB Carrier Quality Improvement POC:

Printed Name

Signature

Date

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⁴ Introduction of a new practice.

⁵ Modification of an existing practice.

The undersigned have read the attached Corrective Action Plan(s) and agree to the terms.

The undersigned have read the attached Corrective Action Plan(s) and do not agree to the terms. Further clarification may be required; the Contract Specialist will schedule a meeting to discuss the resolution of issues.

OPM Contract Specialist:

Printed Name	Signature	Date
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OPM Health Insurance Chief:

Printed Name	Signature	Date
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END

Subsection D: FEHB Performance Assessment Carrier Letters

The table below is a list of the FEHB Carrier Letters related to the Plan Performance Assessment.

Carrier Letter Number	Date	Title	Link Where It Can Be Found (Links for attachments are included when appropriate)	Note
2016-11	8/1/2016	Plan Performance Assessment Improvement Increment	https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-11.pdf https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-11a1.pdf https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-11a2.pdf	Released the methodology for the FEHB Plan Performance Assessment Improvement Increment that OPM will implement as part of the Fall 2017 Clinical Quality, Customer Service, and Resource Use (QCR) calculation.
2016-02	2/16/2016	2018 Clinical Quality, Customer Service, and Resource Use Measures for the Federal Employees Health Benefits (FEHB) Plan Performance Assessment	https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-02.pdf	These are the 2018 measures. Office of Personnel Management (OPM) gives two years notice on the measures scored. OPM has greater flexibility to delete a measure.

Carrier Letter Number			Link Where It Can Be Found (Links for attachments are included when appropriate)	Note
2015-19	11/06/2015	Federal Employees Health Benefits (FEHB) Plan Performance Assessment- Measure Collection (Includes HEDIS and CAHPS)	https://www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Archive https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-19a1a.pdf https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-19a2a.pdf https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-19a2b.pdf https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-19a2c.pdf	Outlines the process for collection and submission of measures to the OPM for the Federal Employees Health Benefits (FEHB) Plan Performance Assessment This combines HEDIS and CAHPS reporting info, and includes the data correction procedures.
2015-15	08/16/2015	2017 Clinical Quality, Customer Service, and Resource Use Measures for the Federal Employees Health Benefits (FEHB) Plan Performance Assessment	https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-15.pdf	Provide the FEHB Plan Performance Assessment Clinical Quality, Customer Service, and Resource Use (QCR) measures to be scored for 2017 evaluation.
201F5-10	05/12/2015	Federal Employees Health Benefits (FEHB) Plan Performance Assessment - Methodology	https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-10.pdf	Provide details on the OPM methodology for the FEHB Plan Performance Assessment (Performance Assessment). The Performance Assessment evaluation will begin in 2016.

Carrier Letter Number	Date	Title	Link Where It Can Be Found (Links for attachments are included when appropriate)	Note
2014-28	12/03/2014	Additional Information on the Performance Areas for the Federal Employees Health Benefits (FEHB) Plan Performance Assessment	https://www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Archive https://www.opm.gov/healthcare-insurance/healthcare/carriers/2014/2014-28attachment1.pdf https://www.opm.gov/healthcare-insurance/healthcare/carriers/2014/2014-28attachment2.pdf	Provides the full set of domains and components for the four proposed performance areas, including updates to the previously published measures and details of the Contract Oversight performance area, for 2016.
2014-19	08/07/2014	Initial Guidance on FEHB Plan Performance Assessment	https://www.opm.gov/healthcare-insurance/healthcare/carriers/2014/2014-19.pdf	Provides information on the Federal Employees Health Benefits (FEHB) Health Plan Performance Assessment and to request carrier feedback on the proposed measures and timeline.