2019 FEHB
Plan Performance Assessment
Procedure Manual

Date: October 25, 2018

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Introduction

The 2019 Procedure Manual provides guidance for FEHB Carriers to report Clinical Quality, Customer Service and Resource Use (QCR) measures, Farm Team measures, and Contract Oversight information under the FEHB Plan Performance Assessment in fulfillment of their FEHB contractual obligations. The manual also outlines specific reporting instructions for the Healthcare Effectiveness Data and Information Set (HEDIS®)[1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] measures.

In this manual, OPM refers to FEHB Carriers and the health plan options offered by FEHB Carriers under their FEHB contract. In some instances, FEHB Carriers and their health plan options are synonymous. In other cases, the FEHB contract that FEHB Carriers have entered into with the Office of Personnel Management (OPM) contain multiple health plan options in different geographic areas. In this annual procedure manual, OPM will refer to FEHB Carriers or their health plan options depending on the intent of the section. If an FEHB Carrier has multiple health plan options under a FEHB contract, the term "FEHB Carrier" or "Carrier" in this procedure manual refers to their respective data reporting requirements under each health plan option.

If there are questions related to the material within this manual, please contact your Health Insurance Specialist and/or email FEHBPerformance@opm.gov.

Section 1: Reporting HEDIS and CAHPS Data

Subsection A: OPM General Requirements for HEDIS Collection and Reporting

- The National Committee for Quality Assurance (NCQA) compiles the HEDIS data on OPM's behalf; therefore, FEHB Carriers must follow NCQA's data submission process when submitting data for their health plan options. Additional information is outlined below and can also be found at: www.ncqa.org/hedis-quality-measurement/hedis-data-submission.
- FEHB Carriers are expected to report on the book(s) of business in which FEHB members are enrolled. For many FEHB Carriers this will be the commercial book of business. If there are FEHB members enrolled in multiple health plan product types under one FEHB contract, OPM will use the plan product type with the highest FEHB enrollment to score all reports.
- FEHB Carriers that are in their first year of offering benefits under a new FEHB contract must report HEDIS and CAHPS in the second full year of participation in the FEHB. Reports submitted before this time are not eligible for inclusion in the Plan Performance Assessment. Additional details on requirements for new FEHB Carriers, including the definition of what constitutes a new health plan option are defined for this purpose, appear in Section 4.

[1] HEDIS®, IDSS and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Existing FEHB Carriers with new enrollment codes or health plan options are expected to report HEDIS and CAHPS data that includes the new code or option. For example, if Acme Insurance Company had a Standard Health Plan enrollment code option in the 2018 FEHB Program and added a Basic Option Enrollment Code in the 2019 FEHB Program under the same contract, they would be expected to report on both the Basic and Standard Option data for the 2019 Plan Performance Cycle.
- Each FEHB Plan must submit audited HEDIS results regardless of enrollment size.
- Questions: FEHBPerformance@opm.gov

HEDIS Cost to FEHB Health Plans

As stated in the FEHB contract, "costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility." For all measures where NCQA allows collection of a HEDIS metric by either hybrid[3] or administrative[4] methodology, OPM will also accept either method. In offering this choice, OPM aligns with national commercial benchmarks which contain a mix of hybrid and administrative data, while remaining mindful of the cost that may be associated with hybrid collection. Experience-Rated Carriers should note that OPM will not cover the additional cost of hybrid collection if NCQA allows administrative reporting. For metrics that are collected via hybrid methodology exclusively, Experience-Rated Carriers may submit a justification of expenses associated with collecting this measure that exceed their administrative services cost breakdown.

HEDIS Timeline

- December 2018:
    - NCQA sends the HEDIS Data Submission Kick-off to Primary and Secondary contacts.

      NCQA posts the XML Templates, Validations and Data Dictionaries for Interactive Data Submission System© (IDSS) to the data submission webpage.
- January 2019:
    - NCQA releases the 2019 Online Healthcare Organization Questionnaire (HOQ) for health plans to request and update submissions.

[3] Organizations look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Organizations should review administrative data to determine if members in the systematic sample received the service and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who are found to have received the service required for the numerator. (HEDIS Technical Specifications, Volume 2, page 26.)

[4] Transaction data or other administrative databases are used to identify the eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service required for the numerator.

- February 2019:
    - Carriers finalize their HOQ requests to obtain access to the IDSS and submission IDs for HEDIS and CAHPS.
- April 2019:
    - NCQA releases the 2019 IDSS for data loading and validation.
    - NCQA distributes Submission IDs for survey measures to NCQA certified survey vendors.
- May 2019:
    - NCQA sends the *Conditions for Public Reporting* letter to Primary and Secondary HEDIS contacts. This letter includes the rules used for displaying data in NCQA's public reporting program (i.e., Health Plan Ratings).
    - Carriers verify their Health Plan Ratings. Carriers verify the information that will determine how their organization is displayed in the ratings (e.g., states and accreditation statuses).
- June 2019:
    - IDSS Plan-lock must be applied for all audited submissions to ensure Auditors have sufficient time to review plan results.
    - Carriers submit FINAL HEDIS (non-survey data) results via the IDSS.
    - All HEDIS Attestations must be submitted to NCQA via electronic signature.
    - NCQA's implements the "Health Plan Ratings Data Freeze." The ratings are based on HEDIS and CAHPS data and accreditation standards scores as of this date.
- July 2019:
    - NCQA releases the 2019 Quality Compass® commercial edition.
- August 2019:
    - NCQA releases "Projected Health Plan Ratings" via the Health Plan Ratings website. Carriers are required to confirm their rating and accreditation information (if applicable).

- For specific dates and additional information, please visit the NCQA HEDIS timeline: www.ncqa.org/hedis-quality-measurement/hedis-data-submission/hedis-data-submission-timeline

Subsection B: OPM General Requirements for CAHPS Collection and Reporting

- All FEHB contracts must administer the CAHPS Health Plan Survey 5.0H Adult Commercial Version following the NCQA requirements set forth in HEDIS Volume 3: Specifications for Survey Measures.

- The survey must be administered by an NCQA-certified CAHPS vendor.
- The sample frame must be approved by an NCQA-certified HEDIS compliance auditor.
- Members who have Medicare as their primary coverage must **not** be included in the sample.
- FEHB Carriers with new contracts entering the FEHB program must report HEDIS and CAHPS in the second full year of participation in the FEHB. Reports submitted before this time are not eligible for inclusion in the Plan Performance Assessment. Additional details on requirements for FEHB Carriers entering into new FEHB contracts, including how a new contract is defined for this purpose, appear in Section 4.
- Existing FEHB Carriers with new enrollment codes or health plan options are expected to report HEDIS and CAHPS data that includes the new code or option. For example, if Acme Insurance Company had a Standard Health Plan enrollment code option in the 2018 FEHB program and added a Basic Health Plan enrollment code option in the 2019 FEHB Program under the same contract, they would be expected to report data on both their Basic and Standard health plan options for the 2019 Plan Performance Cycle.
- Each FEHB Carrier reporting CAHPS survey data to OPM must also report the CAHPS Effectiveness of Care measure related to Flu Vaccinations for Adults Ages 18–64.
- CAHPS survey results must be submitted to NCQA. Files generated by NCQA, after the submission has been processed, will be provided to OPM.
- CAHPS reporting guidelines are listed below:
    - FEHB Carriers submitting samples to NCQA from commercial products that include *FEHB contract holders* may submit those samples to OPM.
    - FEHB Plans **not** submitting commercial samples to NCQA must:
        - Submit a separate CAHPS sample for any FEHB health plan option in a state in which that health plan option has more than *5,000 FEHB contract holders*[5].
        - Enrollees in FEHB health plan options that have fewer than *5,000 FEHB contract holders*[5] per state may be included in a health plan option specific CAHPS sample labelled as "Other." An example is outlined below:
            - An FEHB Carrier has 12,000 FEHB contract holders in New York with 3,000 in the High option and 9,000 in the Standard option. The FEHB Carrier must conduct one FEHB specific CAHPS sample on the Standard option in New York. The FEHB Carrier is required to then combine the 3,000 FEHB enrollees in the High option with all other states with fewer

[5] Members who have Medicare as their primary coverage must **not** be included in the sample. Given the typical mix of annuitant and non-annuitant enrollees in FEHB, this population threshold (5,000 FEHB contract holders) should ensure a sufficient number of survey respondents.

than 5,000 FEHB contact holders to create a CAHPS sample labelled, "High option – other."

- FEHB Carriers reporting differently for accreditation purposes, seeking to submit a larger number of samples, or with other unique circumstances should submit a written explanation and request to their Health Insurance Specialist and copy FEHBPerformance@opm.gov.
- Questions: FEHBPerformance@opm.gov.

CAHPS Surveys and OMB Clearance

All the following statements must be included on mailed surveys:

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

The following language must also be included within the questionnaire: "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."

The questionnaire must also include the standard NCQA instructions which state: "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)."

CAHPS Processing Fee

Each FEHB Carrier that reports 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 on an FEHB Carrier's behalf to OPM.[6] OPM's CAHPS data collection contractor, Office Remedies, Inc. (ORI), will invoice you directly.

[6]Plans 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.

CAHPS Timeline

- February 1, 2019: All FEHB Carriers must complete and submit the CAHPS Survey Participation Form (see Section 5; Subsection A) to FEHBPerformance@opm.gov. If you conduct multiple surveys, please list the name and FEHB Subcode for each survey.
- May 1, 2019: All FEHB Carriers must submit a CAHPS crosswalk file (see Section 5; Subsection A) that maps your NCQA Submission ID (s) to your FEHB Plan name and Carrier Subcode no later than two weeks after NCQA issues submission IDs. This crosswalk must also accompany each submission of CAHPS survey results to OPM though its contractor ORI. The crosswalk includes each:
    - NCQA Member-level File Name
    - NCQA Submission ID
    - NCQA Plan Name
    - FEHB Plan Subcode
    - FEHB Plan Name
- Please direct questions regarding the crosswalk to ORI at OPM2019@oriresults.com.

June 15, 2019:

- NCQA-generated Member level data file and NCQA-generated summary reports are due. ORI accepts your 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 OPM's contractor, ORI, at the following address: OPM2019@oriresults.com.
- To comply with HIPAA privacy rules, survey vendors should use appropriate encryption technology.

Subsection C: Reporting HEDIS and CAHPS Results to NCQA

All FEHB Carriers must follow NCQA's procedures for HEDIS reporting, including the HEDIS Compliance Audit™[7] for which a summary can be found at www.ncqa.org/hedis-quality-measurement/data-reporting-services/hedis-compliance-audit-program/hedis-compliance-audit-program. To fully understand and comply with HEDIS technical specifications and to obtain the appropriate measure specifications you will need HEDIS 2019 Volume 2: *Technical Specifications for Health Plans and Volume 5: The HEDIS Compliance Audit: Standards, Policies and Procedures and Technical Specifications for Health Plans*, which can be purchased at NCQA's website: store.ncqa.org/index.php/performance-measurement/hedis-publications-outline.html.

[7] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

All surveys must be conducted according to NCQA protocols described in HEDIS Volume 3: *Specifications for Survey Measures*, and administered by a vendor that is NCQA-certified for this purpose.[8] This document can be purchased at NCQA's website: store.ncqa.org/index.php/performance-measurement.html.

All FEHB Carriers must generate the sample frame according to NCQA specifications[9]. NCQA requires a minimum sample size of 1,100 members. Over-sampling is allowed, as outlined in HEDIS Volume 3: *Specifications for Survey Measures*. You may use an enhanced protocol or add supplemental questions with prior NCQA approval.

To report HEDIS and CAHPS results to NCQA, FEHB Carriers must complete NCQA's annual Healthcare Organization Questionnaire (HOQ) online through NCQA's website at my.ncqa.org using a password. When filling out the HOQ, please list the appropriate NCQA Organization ID Code, Submission ID, 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** the FEHB codes in the HOQ.

The FEHB Carrier's designated HEDIS contact will receive an email notification from NCQADataCollections@ncqa.org with information on how to access the 2019 HOQ on-line. If the FEHB Carrier does not currently have a designated Primary HEDIS contact, you must contact NCQA's Data Collection Operations team at my.ncqa.org.

My.ncqa.org is a web-based Q&A system where FEHB Carriers can track questions and answers. If you are already registered in an NCQA system (other than ISS, the Interactive Survey System), you can use existing NCQA credentials to sign into my.ncqa.org. New accounts can also be created at my.ncqa.org.

Refer to the NCQA website, www.ncqa.org, or submit a request to my.ncqa.org for general questions regarding HEDIS and CAHPS or HEDIS technical specifications. Questions about the data submission process should be addressed to the FEHB Carrier's assigned NCQA HEDIS Data Submission Account Manager.

Access 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 System (IDSS)

[8] A list of certified survey vendors is available at http://www.ncqa.org/hedis-quality-measurement/data-reporting-services/cahps-5-0-survey

[9] 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.

- 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 deadline for plans to submit HEDIS results to NCQA and e-sign attestations

Subsection D: Summary of Changes to Clinical Quality, Customer Service and Resource Use (QCR) Measure Set and Farm Team in 2019

The following changes apply to data collected and reported in 2019. A complete list of the QCR Measure Set and Farm Team is contained in Section 5; Subsection B of this manual. FEHB Carriers were notified of these changes in Carrier Letter 2017-11, titled "2019 Clinical Quality, Customer Service, and Resource Use Measures."

Measures Being Added to QCR Score in 2019:

- Emergency Department Utilization (Priority Level 2; Measure Weight 1.25)
- Statin Therapy for Patients with Cardiovascular Disease – Adherence Rate (Priority Level 2; Measure Weight 1.25)

Measure Retired in 2019:

- Medication Management for People with Asthma will be retired in 2019

Farm Team Update for 2019:

- No new measures will be added to the 2019 Farm Team

For FEHB Carriers requiring clarification regarding any measure, please send inquiries to FEHBPerformance@opm.gov.

Section 2: QCR Scoring and Calculation Procedures

Subsection A: Product Reporting Types

In order to compare FEHB contracts to the most appropriate benchmark, OPM aligns the health plan options data reported to NCQA with NCQA Quality Compass Benchmark Level Breakouts illustrated in Table 1, below. OPM will normally compare measure results to the Level 3 benchmark that corresponds to the reporting product selected by the contract when submitting data to NCQA. In the event that NCQA does not issue a complete set of Level 3 benchmarks, OPM will use the Level 2 benchmarks. For example, if NCQA does not have a Point of Service (POS) benchmark for each QCR measure, a contract with a POS Reporting Product would be scored against the All LOBs (Excluding PPO and EPO) benchmark. In the event that NCQA does not issue a complete set of Level 2 benchmarks, OPM will use the Level 1 benchmarks. This situation could occur if NCQA determines that not enough health plans submitted data for particular reporting products to generate valid benchmarks at Level 3 or Level 2. Additional

information can be found in Carrier Letter 2018-02 and at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2018/2018-02.pdf.

TABLE 1:

Reporting Product	Quality Compass Benchmark Level 3	Quality Compass Benchmark Level 2	Quality Compass Benchmark Level 1
HMO	HMO	All LOBs (Excluding PPO and EPO)	All LOBs
HMO/PPO Combined			
HMO/EPO Combined			
HMO/PPO/EPO Combined			
HMO/POS Combined	HMO/POS		
HMO/POS/PPO Combined			
HMO/POS/EPO Combined			
HMO/PPO/POS/EPO Combined			
POS	POS		
POS/PPO Combined			
PPO/POS/EPO Combined			
POS/EPO Combined			
PPO	PPO and EPO	PPO and EPO	
PPO/EPO Combined			
EPO			

Subsection B: QCR Scoring

The FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (2017-15) provides a comprehensive explanation of the QCR Scoring Process and Methodology. For more information on methodology, upcoming measures, or other guidance, please visit the Plan Performance Assessment website at www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Performance-Assessment.

Subsection C: HEDIS Auditor Codes and QCR Scoring

HEDIS auditors make determinations about the usability of the data and code it accordingly. OPM incorporates three of these codes into the QCR calculations. The codes are NA, NR, and BR.

- If an FEHB Carrier receives an NA (Small Denominator) designation, that measure result will not have the score or weights included in the QCR calculation.
- For NR (Not Reported) or BR (Biased Rate) measure codes, OPM will score that measure as a zero and the measure weight will be included in the denominator of the QCR score.

Subsection D: Contract Roll-up

In some instances, an FEHB 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 overall FEHB enrollment associated with each report, as detailed in Carrier Letter 2017-15.

Subsection E: QCR Data Preview Period

FEHB Carriers will have an opportunity to preview their QCR calculations and score prior to the Final QCR Score during the QCR Data Preview Period. FEHB Carriers will receive their QCR Data Preview report annually in the fall. Carriers will then have ten calendar days to review both their QCR Score and Improvement Increment. For 2019, FEHB Carriers must actively respond during the QCR Data Preview Period. Carriers can concur with their score or provide feedback to point out factual errors, omissions or miscalculations during this timeframe. The QCR Data Preview Period is the dedicated opportunity for Carriers to review and concur, or ask specific questions regarding the calculation of the Initial QCR Score and Improvement Increment. All queries must be accompanied by detailed questions or a description of variances detected.

Instructions on concurrence or feedback procedures for 2019 will be included with the QCR Preview Report. Concurring responses, as well as questions or feedback, must be provided within the ten day review period. Carriers must include documentation or materials pertinent to their response that point out factual errors, omissions or miscalculations. All FEHB Carriers responses are limited to the specifics of their data preview. OPM has thirty days in which to consider any responses related to questions or feedback and render a final determination.

Subsection F: Data Correction Procedure

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

In the event that OPM staff/contractors detect anomalous data or are otherwise notified of data quality issues, the procedures and timeline below apply. Only written communication fulfills the requirements of these procedures. The data correction options available in any specific situation will be determined by the type of error. OPM will leave all relevant information blank on OPM health insurance webpages intended for current and prospective enrollees until remediation is complete.

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

FEHB Carrier must elect and fulfill one of the following options (in writing, via email, or OPM designated portal as applicable):

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

- Requires supporting documentation from the contract's HEDIS/CAHPS certified vendor/data auditor, including verifiable information from NCQA when applicable

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

- If an FEHB Carrier does not respond within the required timeframe, it will be considered acceptance of an 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, including verifiable information from NCQA, when applicable
- OPM will approve/disapprove the remediation within 14 calendar days
    - If OPM fails to respond within 14 calendar days the proposed remediation is approved
- Remediation must be completed within 21 calendar days of OPM's written approval
- If OPM disapproves, the Carrier has 7 calendar days to revise the remediation or accept an NR or BR
- OPM approval/disapproval of the revised remediation 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 an NR or BR for the measure(s) in question

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

1. The FEHB Carrier must provide a letter to the Contracting Officer and Health Insurance Specialist from their third-party, certified vendor/data auditor:
    - Certifying that:
        - The resubmitted sample has been corrected based on the approved remediation
        - 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 will verify that the new data corrects the anomaly and can be used to calculate an updated score. If OPM determines it is not corrected or an updated score cannot be calculated:
    - Carrier receives an NR or BR for the measure(s) for that year
    - Additional data validation will be conducted at OPM's discretion
        - Based on this additional data validation, OPM may assign an NA rather than an NR or BR

Failure to follow these procedures will result in OPM assigning an NR or BR for the measure(s) in question. An NR or BR designation will result in a score of zero for that measure and the measure weight will be included in the denominator of the QCR score. This will result in a lower QCR score and potentially has implications for the calculation of the Improvement Increment. Improvement Increment eligibility is described in greater detail in Carrier Letter 2017-15.

Subsection G: Corrective Action Plans

In 2019, FEHB Carriers that score below the 25th percentile on any QCR measure 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 within 30 days of receiving the 2019 Overall Performance report. A copy of the Quality Improvement Corrective Action Template is located in Section 5, Subsection C.

FEHB Carriers may be asked for greater clarity on remediation methods. Specifically, Carriers submitting the third or subsequent CAP on the same measure will be subject to additional OPM reviews and discussions to ensure that the listed actions can be expected to produce improvement.

Section 3: Contract Oversight Procedures

Contract Oversight is the area of Plan Performance Assessment that allows OPM to assess other dimensions of performance critical to meeting FEHB program objectives and contractual obligations. As indicated in Carrier Letter 2017-15 (https://www.opm.gov/healthcare-insurance/healthcare/carriers/2017/2017-15.pdf), the Contract Oversight performance from July 1, 2018 through June 30, 2019 will be assessed against four domains: Contract Performance; Responsiveness to OPM; Contract Compliance, and Technology Management and Data Security.

OPM will notify FEHB Carriers regarding the timeframe for submitting input for Contract Oversight scoring. Input should include any/all pertinent information for the Contracting Officer to consider in assessing performance in the domains and components listed in Carrier Letter 2017-15. Complete responses must include all items in Table 9 of Carrier Letter 2017-15, or an explanation of why any omitted item is not applicable.

Input may also include other matters as discussed with the Contracting Officer or designated Health Insurance Specialist during the performance period. In addition to providing evidence of contract fulfillment, Carrier may submit descriptions of problems that occurred and how these were addressed. Examples include significant events, accreditation deficiencies, audit findings, and/or member disruption. Performance issues may be scored in one or multiple Oversight domains, or within multiple components of a domain, according to the Contracting Officer's assessment of severity and impact.

For 2019, Contract Oversight scoring will account for 35% of the Overall Performance Score (OPS). The OPS forms the basis of each Carrier's Performance Adjustment or the Service Charge.

Section 4: New FEHB Carriers (Contracts)

An FEHB contract is considered to be in its first year if any of the following conditions are met:

1. The Carrier did not offer FEHB plans for the 2018 contract year.
2. The Carrier adds a separate and distinct service area under a separate contract
3. The Carrier adds a new plan option under a separate contract
4. The Carrier is offering plans classified under one paragraph of Section 8903 of Title 5 in 2018 but has entered into a new contract to offer plans under a different paragraph of Section 8903 in 2019.

A new health plan option offered under a Carrier's existing contract or administrative renumbering or realignment of an ongoing contractual relationship is not an FEHB contract in its first year. Carriers with unique circumstances not defined in this section are strongly encouraged to obtain written confirmation regarding "first year" status from the Contracting Officer.

At the end of each contract year, OPM determines the Performance Adjustment or Service Charge based on the Carrier's Overall Performance Score. Performance Adjustment or Service Charge Payments are made in the following year. Any plan payments during the course of the initial year in the FEHB, if applicable, will be described in appendix B of the new Carrier's contract. For an Experience-Rated Carrier, sufficient funds must exist from the premiums after drawdown for claims and administrative expenses to pay a Service Charge, which may be drawn down in 12 monthly installments from the Letter of Credit Account (LOC).

For all Carriers, the calculation of the Service Charge or Performance Adjustment will follow the methodology described in Carrier Letter 2017-15 for Community-Rated and Experience-Rated Carriers. In addition, Carrier Letter 2017-15 addresses the unlikely event that a very low Overall Performance Score results in a very low Service Charge, or a very High Performance Adjustment. When this is the case, the Contracting Officer will base the threshold amount on the Contract Group Size Element minimum value range shown in Carrier Letter 2017-15.

FEHB Carriers with new FEHB contracts do not receive a QCR score their first year. For Community-Rated Carriers, the Community-Rated Adjustment does not apply to the first year of a new contract. Carriers with new contracts are not eligible for the Improvement Increment until their third year in the FEHB. Year by year details of Overall Performance Score determination for Carriers with new FEHB contracts are described in the following paragraphs. More information on the Community-Rated Adjustment may be found in Carrier Letter 2017-02 at https://www.opm.gov/healthcare-insurance/healthcare/carriers/2017/2017-02.pdf.

Subsection A: First Year in the FEHB

At the end of the first year in the program, the Overall Performance Score will be based on the Contract Oversight score as determined by the Contracting Officer. The period of performance runs from the acceptance of the contract by OPM through June 30. Community-Rated Carriers may receive up to their full net-to-carrier premium and Experience-Rated Carriers may receive up to the full service charge amount.

Subsection B: Second Year in the FEHB

At the end of the second year in the program, the Overall Performance Score will be determined based on the QCR and Contract Oversight scores. The QCR score will not include the Improvement Increment. Community-Rated Carriers may also receive the Community-Rated Adjustment.

Subsection C: Third Year in the FEHB

At the end of the third year in the program, the Overall Performance Score will be based on the QCR, Contract Oversight, plus any earned Improvement Increment. Community-Rated Carriers may also receive the Community-Rated Adjustment.

Table 2 below summarizes Overall Performance Scoring for a contract's first 3 years in the FEHB.

TABLE 2:

Contract Year	Report HEDIS and CAHPS	Eligible For Improvement Increment	Overall Performance Score Basis
End of YR 1	Not Required	No	Contract Oversight
End of YR 2	Yes	No	Contract Oversight + QCR
End of YR 3	Yes	Yes	Contract Oversight + QCR + Improvement Increment

Section 5: References & Resources

Subsection A: CAHPS Survey Participation Form and Sample Crosswalk

2019 CAHPS Survey Participation Form
(Please submit one form per Plan and indicate each FEHB Subcode that is sharing data)

Plan Name: Click here to enter text.

FEHB Subcode(s): Click here to enter text.

Indicate which subcodes 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 2019 and is not required to conduct CAHPS® Surveys in 2019

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, 2019** to: FEHBPerformance@opm.gov

CAHPS Survey Participation Form (Page 1 of 3)

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 Subcode. 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 Subcode
- FEHB Plan Name

Information Submission Explanation (Data Dictionary)

Category	**Explanation**
Member-level file name	• Name of the NCQA IDSS Submission
NCQA Submission ID	• Use previous NCQA Submission ID
NCQA Plan Name	• The Plan Name associated with the NCQA submission
FEHB Subcode	The FEHB Subcode is broken out as follows • Two digit Carrier Code (dash) • Three digit Plan Filing Type (dash) • Two digit area code (dash) • Three digit Plan Level Category
FEHB Plan Name	• The FEHB Plan name that corresponds with the FEHB contract

Please note that the Member-level filenames must follow the NCQA naming conventions. Any variation will not be accepted.

CAHPS Survey Participation Form (Page 2 of 3)

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 Subcode	FEHB Plan Name
1	AdultCom1234.txt	1234	XYZ Health Plan Inc.	AA-HMO-UT-000	XYZ Health Plan
2	AdultCom2345.txt	2345	QRS Healthcare	BB-HMO-IN-000	QRS Healthcare
3	AdultCom2345.txt	2345	QRS Healthcare	BB-HMO-IL-000	QRS Healthcare

- Sample row 1 shows the most straightforward example where it is a one-to-one mapping between the NCQA Sub ID and FEHB Subcode.

- Sample rows 2 and 3 show how the crosswalk should appear when one set of NCQA data is mapped to two FEHB Subcodes. In this case, only one member-level file should be submitted to OPM.

CAHPS Survey Participation Form (Page 3 of 3)

END

Subsection B: 2019 Clinical Quality, Customer Service and Resource Use Measure Set and Farm Team Measure Set

Performance Area	Measure Title	Measure Source	Measure Priority	Measure Weight
Clinical Quality	Controlling High Blood Pressure	HEDIS	1	2.50
	Prenatal Care (Timeliness)	HEDIS	1	2.50
	Breast Cancer Screening	HEDIS	2	1.25
	Well-Child Visits First 15-Months of Life (6 visits)	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	CAHPS	2	1.25
	Cervical Cancer Screening	HEDIS	2	1.25
	Comprehensive Diabetes Care HbA1C <8%	HEDIS	2	1.25
	Asthma Medication Ratio	HEDIS	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	HEDIS	2	1.25
	Follow-up after Hospitalization for Mental Illness (7-day and 30-day)	HEDIS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	HEDIS	2	1.25
Customer Service	Plan Information on Costs	CAHPS	3	1.00
	Getting Care Quickly	CAHPS	3	1.00
	Getting Needed Care	CAHPS	3	1.00
	Claims Processing	CAHPS	3	1.00
	Overall Health Plan Rating	CAHPS	3	1.00
	Coordination of Care	CAHPS	3	1.00
	Overall Personal Doctor Rating	CAHPS	3	1.00
	Customer Service	CAHPS	3	1.00
Resource Use	Plan All-Cause Readmissions	HEDIS	1	2.50
	Emergency Department Utilization	HEDIS	2	1.25
	Use of Imaging Studies for Low Back Pain	HEDIS	2	1.25

Farm Team (Measures Reported but not Scored)

- Acute Hospital Utilization (Collection as of 2018)
- Follow-up after Discharge from the Emergency Department for Mental Illness (30 day rate) (Collection as of 2017)
- Follow-up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence (30 day rate) (Collection as of 2017)
- Use of Opioids From Multiple Providers (Collection as of 2018)
- Colorectal Cancer Screening (Collection as of 2018)

Subsection C: Quality Improvement Corrective Action Plan Template for 2019

Carriers must submit a Corrective Action Plan (CAP) for each QCR measure below the 25th percentile. Measures set to retire or transition to the Farm Team in 2020 do not require a CAP. The table below reflects the list of measures for CAPs in 2019. For more information on 2020 QCR measures, please see Carrier Letter 2018-07.

All CAPs must be submitted using this Quality Improvement Corrective Action Template to your Health Insurance Specialist within 30 days of receiving the 2019 Overall Performance report. Within the CAP, please specify the Quality Improvement implementation plan to improve the care associated with the identified measure.

Please note that FEHB Carriers submitting a third or subsequent CAP on the same measure will be subject to additional OPM reviews and discussions to ensure that the listed actions can be expected to produce improvement.

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

Measures	**CAP Submission (check all that apply)**
Breast Cancer Screening	☐
Prenatal Care (Timeliness)	☐
Well-Child Visits First 15-Months of Life (6 visits)	☐
Flu Vaccinations for Adults (18-64)	☐
Controlling High Blood Pressure	☐
Cervical Cancer Screening	☐
Comprehensive Diabetes Care - HbA1c <8%	☐
Asthma Medication Ratio	☐
Avoidance of Antibiotics in Adults with Acute Bronchitis	☐
Statin Therapy for Patients with Cardiovascular Disease (Adherence)	☐
Plan Information Costs	☐
Getting Care Quickly	☐
Getting Needed Care	☐
Claims Processing	☐
Overall Health Plan Rating	☐
Coordination of Care	☐
Overall Personal Doctor Rating	☐
Emergency Department Utilization	☐
Use of Imaging Studies for Low Back Pain	☐

2019 Corrective Action Plan Submission (Page 1 of 3)

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

1. **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 a CAP for this measure has been submitted previously, include an evaluation of why you have not achieved expected results to date.
   - Outreach: Estimate the number of 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*[10] actions, rather than *reinforcement*[11] 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: _____

[10] Introduction of a new practice.
[11] Modification of an existing practice.

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

☐ 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 Health Insurance Specialist will schedule a meeting to discuss the resolution of issues.

OPM Health Insurance Specialist:

Printed Name	Signature	Date

OPM Health Insurance Chief:

Printed Name	Signature	Date

2019 Corrective Action Plan Submission (Page 3 of 3)

END

Subsection D: Timeline

Below is a compilation of the HEDIS and CAHPS Timelines previously provided in Section 1 of this document. In addition, the timeline includes Plan Performance Assessment related reports that OPM provides to the Carriers.

Label/Color codes:

HEDIS (Blue): To report HEDIS metric results, FEHB Carriers must complete NCQA's annual Healthcare Organization Questionnaire (HOQ) online. Major timeline dates are listed below, with a blue **HEDIS** at the beginning of the bullet to indicate that this is a HEDIS action item. For specific dates and additional information, please visit the NCQA HEDIS timeline: www.ncqa.org/hedis-quality-measurement/hedis-data-submission/hedis-data-submission-timeline

CAHPS (Orange): Action items related to CAHPS are highlighted with an orange **CAHPS** at the beginning of each bullet. For these dates, Carriers are expected to submit information either to OPM or ORI/CSS.

OPM to Carriers (Green): As part of the Plan Performance Assessment Process, OPM provides reports to Carriers that include the QCR Preview Report, Procedure Manual, Performance Assessment Scores, and a Detailed QCR Performance Summary Report.

- December 2018:
    - **HEDIS**: NCQA sends the HEDIS Data Submission Kick-off to Primary and Secondary contacts.
    - **HEDIS**: NCQA posts the XML Templates, Validations and Data Dictionaries for Interactive Data Submission System© (IDSS) to the data submission webpage.
- January 2019:
    - **HEDIS**: NCQA releases the 2019 Healthcare Organization Questionnaire (HOQ) for health plans to request and update submissions.
- February 2019:
    - **HEDIS** and **CAHPS**: Health plans finalize HOQ requests to obtain access to the IDSS and submission IDs for HEDIS and CAHPS.
    - **CAHPS**: All FEHB Carriers must complete and submit the CAHPS Survey Participation Form (see Section 5; Subsection A) to FEHBPerformance@opm.gov. If you conduct multiple surveys, please list the name and FEHB Subcode for each survey.

- April 2019:
    - **HEDIS**: NCQA releases the 2019 IDSS for data loading and validation.
    - **HEDIS**: NCQA distributes Submission IDs for survey measures to NCQA certified survey vendors.
- May 2019:
    - **HEDIS**: NCQA sends the Conditions for Public Reporting letter to Primary and Secondary HEDIS contacts. This letter includes the rules used for displaying data in NCQA's public reporting program (i.e. Health Plan Ratings).
    - **HEDIS**: Carriers verify their ratings in NCQA's "Health Plan Ratings." Carriers verify the information that will determine how their organization is displayed in the ratings (e.g., states and accreditation statuses).
    - **CAHPS**: NCQA certified survey vendors begin submission of CAHPS 5.0H member-level data files to NCQA on behalf of FEHB Carriers.
    - **CAHPS**: All FEHB Carriers must submit a CAHPS crosswalk file (see Section 5; Subsection A) that maps your submission ID(s) to your FEHB Plan name and Carrier Subcode no later than two weeks after NCQA issues submission IDs. This crosswalk must accompany each submission of CAHPS survey results to OPM though their contractor ORI. Please direct questions regarding the crosswalk to ORI at OPM2019@oriresults.com. The crosswalk includes each:
        - NCQA Member-level File Name
        - NCQA Submission ID
        - NCQA Plan Name
        - FEHB Subcode
        - FEHB Plan Name
- June 2019:
    - **HEDIS**: IDSS Plan-lock must be applied for audited submission to ensure Auditors have sufficient time to review plan results.
    - **HEDIS**: Health plans submit FINAL HEDIS (non-survey data) results via the IDSS.
    - **HEDIS**: All HEDIS Attestations must be submitted to NCQA via electronic signature.
    - **HEDIS**: Health Plan Ratings Data Freeze. The ratings are based on HEDIS and CAHPS data and accreditation standards scores as of this date.
    - **CAHPS**: NCQA-generated Member level data file and NCQA-generated summary reports are due. ORI accepts your 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 OPM's contractor, ORI, at the following address: OPM2019@oriresults.com. To comply with HIPAA privacy rules, survey vendors should use appropriate encryption technology.

- July 2019:
    - **HEDIS**: NCQA Releases the 2019 Quality Compass® commercial edition.
- August 2019:
    - **HEDIS**: NCQA releases "Projected Health Plan Ratings" via the Health Plan Ratings website. Carriers are required to confirm their rating and accreditation information (if applicable).
- Fall 2019:
    - **OPM to Carriers**: FEHB Carriers review the QCR Preview Report.
    - **OPM to Carriers**: OPM releases updated FEHB Plan Performance Assessment Procedure Manual.
    - **OPM to Carriers**: OPM communicates the Overall Performance Assessment scores to FEHB Carriers.
- Winter 2019:
    - **OPM to Carriers**: OPM provides Carriers with the Detailed QCR Performance Summary Report, which includes graphs showing where FEHB Carrier's scores are located in relation to other FEHB Carriers for each QCR measure and the Final QCR score.