

**Updated 2025 FEHB and PSHB Programs
Plan Performance Assessment
Procedure Manual**

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Introduction

The 2025 Plan Performance Assessment (PPA) Procedure Manual provides guidance for Federal Employees Health Benefits (FEHB) Carriers to report Clinical Quality, Customer Service, and Resource Use (QCR) measures, Farm Team measures, and Contract Oversight information under the FEHB PPA 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 for measurement year (MY) 2024.

In this manual, the Office of Personnel Management (OPM) refers to FEHB Carriers and the health plan options offered by FEHB Carriers under their FEHB contracts. In some instances, for ease and simplicity, this Procedure Manual includes references to FEHB Carriers or health plan options and vice versa. In other cases, OPM may 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 an FEHB contract, the term “FEHB Carrier” or “Carrier” refers to their respective data reporting requirements under each health plan option.

[Carrier Letter 2024-19, Postal Service Health Benefits \(PSHB\) Program Plan Performance Assessment \(PPA\) Transition Guidance](#) provides the PPA information for the 2025 Postal Service Health Benefits (PSHB) contracts. OPM will not consider PSHB plans first offered in 2025 to be new contracts for the purpose of the PPA.³ In 2025 each Carrier offering a PSHB plan in 2025 will have a QCR and Contract Oversight score based on the 2024 FEHB plan performance. FEHB Carriers offering a PSHB plan will receive a service charge or performance adjustment for 2025 in a fair and equitable manner. In 2025 the Experience Rated Carriers will receive a service charge based on the 2025 PSHB projected incurred claims and allowable administrative expenses and the Community Rated Carriers will receive 2024 FEHB subscription income attributed to Postal enrollees. Any PSHB Carrier exceptions to this guidance will be addressed in writing by the PSHB Contracting Officer.

If there are questions related to the material within this manual, please contact your Health Insurance Specialist.

Section 1: Reporting HEDIS and CAHPS Data

Subsection A: OPM General Requirements for both HEDIS and CAHPS

- FEHB Carriers in their first year of offering benefits under a new FEHB contract must report HEDIS and CAHPS in their second full year of FEHB participation. Reports submitted before this time are not eligible for inclusion in the PPA. Additional details on requirements for new FEHB Carriers, including the definition of what constitutes a new health plan option, appears in [Section 4](#).
- FEHB Carriers under an existing contract with new enrollment codes or health plan options are

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).

³ 2025 PSHB Plans (with equivalent benefits and cost sharing, with the exception of Medicare Part D, to their 2025 FEHB Plan) offered by a Carrier that offered a 2024 FEHB Plan will not be considered new.

expected to report HEDIS and CAHPS data that includes the new code or option. For example, if Acme Insurance Company, Inc. had a Standard option enrollment code in the 2024 FEHB Program and added a High option enrollment code in the 2025 FEHB Program under the same contract, they would be expected to report on both the High and Standard options data for the 2025 PPA Cycle. Additional details on the requirements and exemption process are outlined in [Section 4](#).

- Carriers will not report on Health Plan enrollment code options no longer available to enrollees. This applies only to Carriers who had unique data reports for the inactive Health Plan enrollment code options.
 - As an example, in the 2024 FEHB Program, Acme Insurance Company, Inc. had Standard and HDHP enrollment code options available to enrollees. Starting in 2025, only the Standard option enrollment code remained active. If Acme had two distinct reports for the Standard and HDHP enrollment code options, OPM would only accept the data for the Standard option. However, if both the Standard and HDHP options were part of the combined commercial book of business and Acme was unable to report data only on the Standard option, OPM would accept the combined Standard and HDHP data. For questions on how to report inactive options, please email FEHBPerformance@opm.gov and copy your Health Insurance Specialist.
- FEHB Carriers will submit the 2025 Planned HEDIS and CAHPS Reporting information for MY 2024 via Benefits Plus by December 16, 2024. This information assists OPM and the Carriers to resolve reporting discrepancies prior to NCQA's Online Healthcare Organization Questionnaire (HOQ) submission.
- Questions: please email your Health Insurance Specialist and cc FEHBPerformance@opm.gov.

Subsection B: OPM General Requirements for HEDIS Collection and Reporting

- In addition to Subsection A: OPM General Requirements for both HEDIS and CAHPS, the following HEDIS requirements are outlined below.
- The National Committee for Quality Assurance (NCQA) compiles the HEDIS data on OPM's behalf; therefore, FEHB Carriers must follow [NCQA's submission process](#) when submitting data for their health plan options.
- In most cases, the HEDIS reporting product filing type submitted to OPM will align with what is submitted to NCQA. For example, if Acme Insurance Company reports an HMO/POS product filing type to NCQA, then Acme will also report HMO/POS to OPM. For questions, please email FEHBPerformance@opm.gov and copy your Health Insurance Specialist.
- 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.
- Each FEHB Plan must submit audited HEDIS results regardless of enrollment size.
- Failure to follow the OPM's HEDIS reporting policy risks some or all measure results being invalidated.
- Questions: email your Health Insurance Specialist and cc FEHBPerformance@opm.gov.

HEDIS Cost to FEHB Carriers

HEDIS measures are specified for one or more data collection methods: Administrative Method, Hybrid Method, and Electronic Clinical Data Systems (ECDS). For all measures where NCQA allows collection of a HEDIS metric by either hybrid⁴, or administrative⁵ methodology, OPM will also accept either method. In offering this choice, OPM aligns with NCQA national commercial benchmarks which contain a mix of hybrid and administrative data.

Over the next several years NCQA plans to retire the administrative and hybrid reporting methods for several measures. Therefore, only the ECDS reporting method will be used for these HEDIS Measures. HEDIS measures reported using ECDS follow NCQA's General Guidelines for Data Collection and Reporting and Guidelines for Measures Reported Using ECDS. HEDIS measures reported using ECDS include additional data sources beyond administrative data, including, but not limited to, electronic health records, health information exchanges, and case management systems.

OPM is mindful of the cost that may be associated with both hybrid and ECDS data collection. The FEHB contracts address costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data. Costs for these expenses are allowable and may be paid as administrative expenses if they are actual, reasonable, and allocable. These costs must be contained within the administrative expense ceiling under the Experience Rated Contracts (FFS and HMO).

HEDIS Timeline

Please see the timeline in Section 6: References & Resources, [Subsection F](#) for the HEDIS related dates. Additional information is also available at the [NCQA website](#).

Subsection C: OPM General Requirements for CAHPS Collection and Reporting

- In addition to Subsection A: OPM General Requirements for both HEDIS and CAHPS, the following CAHPS requirements are outlined below.
- All FEHB contracts must administer the HEDIS CAHPS Health Plan Survey 5.1H 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 Survey Vendor.
- The sample frame must be validated by an NCQA-Certified HEDIS Compliance Auditor.

⁴ 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 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 MY 2024 Technical Specifications, Volume 2).

⁵ 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.

- Members who have Medicare as their primary coverage must **not** be included in the sample as outlined in *HEDIS Volume 3: Specifications for Survey Measures*.
- In most cases, the CAHPS reporting product filing type submitted to OPM will align with what is submitted to NCQA. For example, if Acme Insurance Company reports an HMO/POS product filing type to NCQA, then Acme will also report HMO/POS to OPM. For questions, please email FEHBPerformance@opm.gov and copy your Health Insurance Specialist.
- In accordance with NCQA's HEDIS Volume 3, survey vendors must submit health plans' member-level data files to NCQA for calculation of survey results. NCQA-generated member-level data file and NCQA-generated summary reports, available to health plans in the Interactive Data Submission System (IDSS), are due to OPM's contractor, Office Remedies, Inc (ORI) by June 16, 2025. This is after you have provided NCQA with a signed Attestation of Accuracy. You or your survey vendor may submit the files via e-mail or other electronic or digital format to ORI at the following address: OPMCAHPS@orireresults.com. To comply with HIPAA privacy rules, survey vendors must use appropriate encryption technology. 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 Carriers **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*.⁶
 - Enrollees in FEHB health plan options that have fewer than 5,000 *FEHB contract holders* 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 than 5,000 FEHB contract holders to create a CAHPS sample labeled, "High option – other."
 - FEHB Carriers reporting differently for accreditation purposes, seeking to submit a larger number of samples, or with other unique circumstances must submit a written explanation and request to FEHBPerformance@opm.gov and copy their Health Insurance Specialist.
 - Questions: FEHBPerformance@opm.gov.

⁶ 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.

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. 3206-0274.”

Within the questionnaire: “This information collection has been approved by the U.S. Office of Management and Budget (Control Number 3206-0274) 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 3206-0274), Washington, DC 20415-7900. Your participation in this information collection is voluntary. The OMB Number, 3206-0274, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.”

Also, on the survey cover page, the standard NCQA instructions must be included, 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 toll-free number).”

CAHPS Processing Fee

Each FEHB Carrier that reports survey data to OPM is responsible for the cost of compiling, processing, and reporting their survey results. As in previous years, a processing fee will apply to each unique NCQA Submission ID for which data are submitted on an FEHB Carrier's behalf to OPM.⁷ OPM's CAHPS data collection contractor, ORI, will invoice each Carrier directly.

CAHPS Timeline

Please see the timeline in Section 6: References & Resources, Subsection F for the CAHPS related dates.

Subsection D: Reporting HEDIS and CAHPS Results to NCQA

All FEHB Carriers must follow NCQA's procedures for HEDIS reporting, including the [HEDIS Compliance Audit™](#).⁸ To fully understand and comply with HEDIS technical specifications and to obtain the appropriate measure specifications you will need the HEDIS MY 2024 Volume 2: *Technical Specifications for Health Plans* and Volume 5: *HEDIS Compliance Audit: Standards, Policies and Procedures*, which can be purchased at [NCQA's website](#).

All surveys must be conducted according to NCQA protocols described in *HEDIS MY 2024 Volume 3: Specifications for Survey Measures* and administered by a vendor that is NCQA-Certified for this

⁷ 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.

⁸ NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

purpose.⁹ This publication can be purchased at [NCQA's website](#).

All FEHB Carriers must generate the sample frame according to NCQA specifications.¹⁰ NCQA requires a minimum sample size of 1,100 members. Oversampling 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.

OPM is committed to ensuring that FEHB enrollees have enough information to differentiate Carriers' performance through the data displayed on the OPM website. However, OPM is not able to post data reflecting on the enrollee's experience when FEHB Carriers receive NAs (small denominators) on CAHPS measures. FEHB Carriers who have received repeated NAs on CAHPS measures and have sufficient enrollment in the commercial book of business that contains their FEHB covered lives are directed through [Carrier Letter 2019-09](#) to design and utilize an oversampling strategy in consultation with their CAHPS vendor to lessen the possibility of receiving an NA in future reporting cycles. A copy of their oversampling strategy must be shared with their OPM Health Insurance Specialist. For questions related to this issue, please email FEHBPerformance@opm.gov.

To report HEDIS and CAHPS results to NCQA, FEHB Carriers must complete NCQA's annual Healthcare Organization Questionnaire (HOQ) online application through NCQA's online portal ([My.NCQA.org](#)) using a password. When filling out the HOQ, please request the appropriate NCQA Organization ID, Submission ID, and FEHB Carrier Code(s) (two-digit carrier code) 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 HOQ online application. If the FEHB Carrier does not currently have a designated Primary HEDIS contact, you must contact NCQA's Data Collection Operations team through [My.NCQA.org](#).

NCQA has a web-based Q&A system where FEHB Carriers can track questions and answers. If you are already registered in an NCQA system, you can use existing NCQA credentials to sign into [My.NCQA.org](#). You can also create a new account at [My.NCQA.org](#).

Refer 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.

The [data submission timeline](#) includes the following:

- The date HOQ opens to plans via the NCQA website (early-December 2024).
- The deadline for plans to complete NCQA's HOQ online application (February 5, 2025).
- The date NCQA provides health plans with access to use the IDSS (mid-March 2025).

⁹ [List of NCQA Certified CAHPS 5.1H Survey Vendors](#).

¹⁰ 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 (May 30, 2025).
- The deadline for plans to submit HEDIS results to NCQA and e-sign attestations (June 13, 2025 by 9pm EST).

Subsection E: Technical Notes Regarding the Clinical Quality, Customer Service and Resource Use (QCR) Measure Set and Farm Team in 2025 (Reporting Year)

A complete list of the QCR Measure Set and Farm Team is included in Section, Subsection C of this manual. FEHB Carriers were notified of the [2025 QCR Measure Set](#) in [Carrier Letter 2023-11](#) with the Subject line, “Federal Employees Health Benefits Plan Performance Assessment 2025 Clinical Quality, Customer Service, and Resource Use (QCR) Measure Set.” For additional information on any of the technical specifications for the measures listed below, please go to [NCQA’s HEDIS Measures and Technical Resources](#).

Please note the following:

2025 QCR Measure Update:

QCR Measure Additions & Updates:

- The following measures will transition from the Farm Team to QCR Scoring in the 2025 scoring cycle:
 - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB): The total rate will be scored and will replace the 18-64 years. The measure weight will remain 2.5 with a priority level of 1.
 - Adult Immunization Status (AIS-E): The influenza rate, 19-65 years, will be scored. The measure weight will be 1.25 and a priority level of 2.
 - For MY 2024, NCQA has updated the Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD) measure name to Glycemic Status Assessment for Patients With Diabetes (GSD). OPM will continue to score GSD with the same measure priority and weight as HBD.
- Carriers are reminded to follow NCQA’s reporting guidance and timelines for transitioning measures exclusively to the ECDS reporting method. NCQA retired the administrative and hybrid reporting methods for Colorectal Cancer Screening (COL) and transitioned COL to the ECDS-only reporting method starting in MY 2024. OPM will continue to score 51–75 Years. The measure weight and priority level will remain the same.
- NCQA has announced the retirement of the administrative and hybrid reporting method for the Cervical Cancer Screening (CCS-E) and Childhood Immunization Status (CIS-E) measures and will transition to ECDS-only reporting for MY 2025 (2026 scoring cycle).

Measure Retirements:

- Antidepressant Medication Management (AMM):

- NCQA announced the Antidepressant Medication Management measure is scheduled for retirement in HEDIS MY 2025 (2026 PPA Scoring cycle).

2025 Farm Team Update:

Additions:

- Prenatal and Postpartum Care (PPC) — Postpartum Care has been added to the Farm Team.
- Adult Immunization Status —Td/Tdap: 19-65 Years has been added to the Farm Team.
- Adult Immunization Status—Zoster: 50-65 Years has been added to the Farm Team.
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB): 18-64 Years has been added to the Farm Team.

Rates No Longer Reported in the Farm Team:

- Appropriate Treatment for Upper Respiratory Infection (URI) - Total

Table 2: Summary of Measure Changes for the QCR Scoring 2025 Scoring Cycle (MY 2024)

Measure	NCQA Measure Abbreviation	QCR Scoring Measure Abbreviation	Category	Action
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Total	AAB	AAB(T)	QCR Scoring	Change: Promotion from the Farm Team to the QCR Measure Set.
Adult Immunization Status—Influenza: 19-65 Years	AIS-E	AIS-E (I)	QCR Scoring	Change: Promotion from the Farm Team to the QCR Measure Set.
Glycemic Status Assessment for Patients With Diabetes	GSD	GSD	QCR Scoring	Change: Name change from Hemoglobin A1c (HbA1c).

Table 3: Summary of Measure Changes for the Farm Team 2025 Scoring Cycle (MY 2024)

Measure	NCQA Measure Abbreviation	Scoring Measure Abbreviation	Category	Action
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchitis: 18-64	AAB	AAB (18-64)	Farm Team	Change: Moved from the QCR Measure Set to the Farm Team.
Adult Immunization Status—Td/Tdap: 19-65	AIS-E	AIS-E	Farm Team	Change: Addition to the Farm Team.
Adult Immunization Status—Zoster: 50-65	AIS-E	AIS-E	Farm Team	Change: Addition to the Farm Team.
Prenatal and Postpartum Care—Postpartum Care	PPC	PPC (Post)	Farm Team	Change: Addition to the Farm Team.
Appropriate Treatment for Upper Respiratory Infection—Total	URI	URI	Farm Team	Change: Remove from the Farm Team.

Please send questions and comments regarding measures to FEHBPerformance@opm.gov.

Section 2: QCR Scoring and Calculation Procedures

Subsection A: QCR Scoring

The FEHB PPA Methodology [Carrier Letter 2020-15](#) provides a comprehensive explanation of the QCR Scoring Process and Methodology. For more information on methodology, upcoming measures, or other guidance, please visit the [PPA website](#).

Subsection B: HEDIS Auditor Codes and QCR Scoring

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

- If an FEHB Carrier has an NA (Not Applicable) status, that measure result will not have the score, or weights included in the QCR calculation as the denominator is too small to report.
- 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 C: Contract Roll-up

In some instances, FEHB contracts are 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 2020-15](#).

Subsection D: 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 10 calendar days to review both their QCR Score and Improvement Increment. During this period, FEHB Carriers **must** actively respond during the QCR Data Preview Period. Carriers must 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 QCR Score and Improvement Increment. All queries must be accompanied by detailed questions, or a description of variances detected.

Instructions on concurrence or feedback for 2025 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. If Carriers do not respond during this ten-day period, the lack of response may be considered when calculating the Contract Oversight Score. 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 or request additional information. If OPM does not respond within the thirty days, the corrected data as submitted by the plan is considered final. QCR Scores and the underlying data will become final after the QCR review period has concluded unless feedback has been received.

If a Carrier terminates a contract for 2025, the Carrier will have an opportunity to review their QCR Preview Reports during the QCR Data Preview Period. Carriers terminating a contract for 2025 will not receive an Overall Performance Score (OPS) final report. Contracts for Community Rated Plans that are terminated will **not** receive a Performance Adjustment in 2025 and contracts for Experienced Rated

Plans that are terminated will **not** receive a Service Charge in 2025. For example, if the Acme Insurance Company terminates their FEHB contract on 12/31/2024, they will have the opportunity to preview their QCR preview report, however, they will not receive an OPS report, or a Service Charge/Performance Adjustment in 2025.

Subsection E: Data Correction Procedure

OPM's PPA 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.

If 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 proposed remediation in writing within 14 calendar days.
 - If OPM fails to respond within 14 calendar days, the proposed remediation is approved.
 - If OPM fails to respond, the proposed remediation must be completed within 35 calendar days from the date that the proposal was submitted.
- 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 proposal or accept an NR or BR
- OPM approval/disapproval of the revised remediation proposal 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, Health Insurance Specialist and FEHBPerformance@opm.gov from their third-party, certified vendor/data auditor:
 - a. Certifying that:
 - i. The resubmitted sample has been corrected based on the approved remediation.
 - ii. The sample is now in compliance with OPM requirements.
 - iii. The sample is in compliance with all NCQA specifications.
 - b. 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:
 - a. Carrier receives an NR or BR for the measure(s) for that year.
 - b. Additional data validation will be conducted at OPM's discretion.
 - c. 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 2020-15](#).

Subsection F: Corrective Action Plans

For each FEHB Contract, Carriers must submit a Corrective Action Plan (CAP) for each QCR measure below the 25th percentile. The CAP must include a plan that is designed to improve the measure result(s). All CAPs must be submitted using the [Quality Improvement Corrective Action Template](#) to your Health Insurance Specialist within 30 days of receiving the 2025 Overall Performance report.

Carriers must submit a six month follow up report to their Health Insurance Specialist using the Quality Improvement Corrective Action Plan Follow up Template provided in Section 6: References & Resources, Subsection E and Attachment 6.

FEHB Carriers may be asked for greater clarity on remediation methods. Specifically, Carriers submitting a CAP on the same measure for multiple years 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 the PPA that allows OPM to assess other dimensions of performance critical to meeting FEHB Program objectives and contractual obligations. As indicated in [Carrier Letter](#)

[2020-15](#), the Contract Oversight performance from July 1, 2024, through June 30, 2025, 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 the Methodology [Carrier Letter 2020-15](#).

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 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 2025, 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 Service Charge.

Section 4: New FEHB Carriers (Contracts)

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

1. The Carrier did not offer an FEHB plan for the 2024 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 2024, but has entered into a new contract to offer plans classified under a different paragraph of Section 8903 in 2025.

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 must obtain written confirmation regarding a reporting exception from the Contracting Officer by December 15, 2024.** If granted the exception, it is only applicable for the 2025 scoring cycle.

New Carrier Codes and options will be displayed in the Plan Comparison Tool. New options and carrier codes may not be included in the contract level rolled up results, based on the availability of enrollment data.

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 payments to plans during the initial year in the FEHB, if applicable, will be described in Appendix B of the Carrier's new 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 the carrier begins drawing down in 12 monthly installments from the Letter of Credit Account (LOC) beginning in January of the year following assessment.

For all Carriers, the calculation of the Experience Rated Carriers' Service Charge or the Community Rated Carriers' Performance Adjustment will follow the methodology described in [Carrier Letter 2020-15](#) for Community Rated and Experience Rated Carriers. In addition, [Carrier Letter 2020-15](#) 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 2020-15](#).

FEHB Carriers with new FEHB contracts do not receive a QCR score for the new contract in the 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 under the new contract until its 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 2017-15](#).

Subsection A: First Year in the FEHB

In the first year (2025) 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

In the second year (2026) in the program, the Overall Performance Score will be based on the QCR and Contract Oversight scores. The QCR score will not include the Improvement Increment. Community Rated Carriers also receive the Community Rated Adjustment.

Subsection C: Third Year in the FEHB

In the third year (2027) in the program, the Overall Performance Score will be based on the QCR score plus any Improvement Increment, and the Contract Oversight score. Community Rated Carriers also receive the Community Rated Adjustment.

Table 4: Summarizes the Scoring Cycle for a Contract's First 3 Years in the FEHB

Contract Year	Measurement Year (MY)*	Reporting Year (RY)/PPA Scoring Cycle	Report HEDIS and CAHPS	Eligible for Improvement Increment	Overall Performance Score Basis
2025 (Year 1)	N/A	N/A	Not Required	No	Contract Oversight
2026 (Year 2)	MY 2025	RY 2026	Yes	No	Contract Oversight + QCR
2027 (Year 3)	MY 2026	RY 2027	Yes	Yes	Contract Oversight + QCR + Improvement Increment

* For additional information on measure and reporting years please visit the guidance on [NCQA's HEDIS Measures and Technical Resources](#).

Section 5: Carriers Switching Contracting Rating Type

Carriers occasionally switch their rating methodology from Experience Rated to Community Rated, or from Community Rated to Experience Rated. If this change is approved by the Contracting Officer, the 2025 Plan Performance Assessment calculations are done based on data reported under the 2025 Scoring Cycle rating methodology. The Contract Oversight score will be determined by the Contracting Officer with oversight of the plan in 2025 contract year.

Subsection A: Experience Rated Methodology in 2025 to Community Rated Methodology in 2026

No Service Charge is calculated in 2025 for the 2026 contract. The net-to-carrier premium for 2026 includes the profit, and a Performance Adjustment is calculated for the 2027 contract, as is done for Community Rated Contracts. An Overall Performance Score Report without a Service Charge calculation will be issued, but not included in the 2026 contract.

Subsection B: Community Rated Methodology in 2025 to Experience Rated Methodology in 2026

No Performance Adjustment is calculated in 2025 for the 2026 contract year. The 2026 Service Charge will be calculated in the 2025 PPA cycle, an Overall Performance Score with a Service Charge calculation will be issued, and the Contracting Officer will include the Service Charge amount in the 2026 contract.

Section 6: References & Resources

The references below may also be included as a separate attachment for ease of use.

Subsection A: 2025 Scoring Cycle Planned HEDIS and CAHPS Reporting

HEDIS and CAHPS Planned Reporting

Attachment 2 titled, "Planned HEDIS and CAHPS Reporting" allows OPM to collect information related to the planned HEDIS and CAHPS reporting via Benefits Plus. This important information is critical to our planning efforts for the scoring cycle. Attachment 2 includes instructions, definitions, and examples of how to submit this information. If you have trouble accessing the document or have questions, please contact OPM at FEHBPerformance@opm.gov.

Please submit this information by **December 15, 2024**.

Subsection B: 2025 CAHPS Sample Crosswalk

CAHPS Sample Crosswalk

This information is included in Attachment 3 titled, “2025 CAHPS Sample Crosswalk”. Every CAHPS® 5.1H data submission submitted on your plan’s behalf must be accompanied by a “crosswalk” that will allow OPM to map your plan’s data to the appropriate CAHPS 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
- CAHPS code
- FEHB Plan Name

All FEHB Carriers who are not new Carriers must submit a CAHPS crosswalk file that maps your NCQA Submission ID(s) to your FEHB Plan name and CAHPS Code by **May 1, 2025**. Please email this report to OPMCAHPS@orireresults.com and FEHBPerformance@opm.gov.

information Submission Explanation (Data Dictionary)

Category	Explanation
Member-level file name	Name of the NCQA Validated Member-Level Data File
NCQA Submission ID	The NCQA-assigned Submission ID
NCQA Plan Name	The Plan Name associated with the NCQA submission
CAHPS code	The CAHPS code is broken out as follows: <ul style="list-style-type: none">• Two-character Carrier Code (dash)• Plan Filing Type (dash)• Two-character State abbreviation (dash)• Three-character Option Code Category
FEHB Plan Name	The FEHB Plan name that corresponds with the FEHB contract

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

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

Table 5: Crosswalk Example

Sample Row	Member-Level File	NCQA CAHPS SubID	NCQA Plan Name	CAHPS Code	FEHB Plan Name
1	ADULTCOM6767_DeidentifiedMemberFile.csv	6767	Acme Insurance Company, Inc.	AA-FFS-VA-000	Acme Insurance Company, Inc.
2	ADULTCOM4242_DeidentifiedMemberFile.csv	4242	Acme Insurance Company, Inc.	BB-FFS-MD-000	Acme Insurance Company, Inc.
3	ADULTCOM4242_DeidentifiedMemberFile.csv	4242	Acme Insurance Company, Inc.	BB-FFS-MD-001	Acme Insurance Company, Inc.

- Sample row 1 shows the most straightforward example where it is a one-to-one mapping between the NCQA CAHPS Sub ID and CAHPS code.
- Sample rows 2 and 3 show how the crosswalk should appear when one set of NCQA data is mapped to two CAHPS code. In this case, only one member-level file should be submitted to OPM.
- Plans are not allowed to map more than one NCQA CAHPS Submission ID to a single CAHPS code. All FEHB Carriers must submit a CAHPS crosswalk file that maps your NCQA CAHPS SubID(s) to your FEHB Plan name and CAHPS Code by **May 1, 2025** Please email this report to OPMCAHPS@orireresults.com and FEHBPerformance@opm.gov.
- Please direct questions regarding the crosswalk to ORI at OPMCAHPS@orireresults.com.

CAHPS Code in Benefits Plus

In previous years, OPM provided a CAHPS code list as part of the Procedure Manual as a reference. Since the Planned HEDIS and CAHPS reporting has transitioned to Benefits Plus, Carriers may now find their CAHPS Codes in Benefits Plus. As a reminder on how to find CAHPS codes, please see the process outlined below (along with screen shots).

Step 1: Navigate to the PPA Overview page.

The Benefits Plus (BP) portal URL is: <https://www.opm.gov/healthcare-insurance/benefits-plus/>

- After logging into Benefits Plus
 - Go to the PPA Header at the top right section of the menu.
 - Select the **HEDIS & CAHPS** drop down option.

HEDIS and CAHPS Drop Down Example:



Step 2: Select Plan

- The example below is the main screen. If at any point while entering the planned HEDIS and CAHPS information, you click the **Home** button, it will return you to the screen below.
- Once at this screen, click on the Plan name in this case, Acme Insurance under Contract to enter the HEDIS and CAHPS information.

Select Plan Example:

Select Year	Benefit Program	IACCT	CONTRACT NUMBER
2025	FEHB	Acme Insurance	9999

Step 3: Select Plan Code, Option, and State

- Once you select a Plan, you will then see the Plan Codes, Options, and States associated with that Plan.
- At this point in the process, you are on the **Plan Info** page.
- To see the CAHPS Codes, select one grouping of Plan Code, Option, and State at a time

Plan Info Example:

CONTRACT NAME: Acme Healthplan

CONTRACT NUMBER: 1234

Plan Info HEDIS Auditor CAHPS Survey Info CAHPS Vendor Contact CAHPS Health Carrier Contact CAHPS Invoice Contact

SELECT PLAN CODES OPTION STATE

☒ RR Standard OK

HEDIS CAHPS CAHPS Code Check Home

Step 4: Select CAHPS Codes Check

- Once the Plan Code, Option and State is selected, click the **CAHPS Code Check** button
- The CAHPS code is created with the following breakout: The two-digit carrier code, dash, product filing type, dash, two-digit state, dash, and three-digit option. For the product filing types, please use: FFS, PPO, HMO, or POS. For option codes, please use the following coding High=000, Standard=001, HDHP=002, CDHP=003, or Basic=004
- The example below is shown as **AA-HMO-WA-000**
- Here you can find the CAHPS code for the CAHPS Crosswalk, CAHPS Code Check and Add Additional CAHPS Code information.

CAHPS Code Example:

CAHPS CODE CHECK						
ORG ID	CAHPS SUBID	PLAN CODE	REPORTING FILING TYPE	STATE	OPTION	FULL CAHPS CODE
1234	1234	AA	HMO	WA	000 - High	AA-HMO-WA-000

Subsection C: 2025 Clinical Quality, Customer Service and Resource Use Measure Set and Farm Team Measure Set

Performance Area	Measure Title	NCQA Measure Abbreviation	QCR Scoring Identifier	Measure Source	Measure Priority	Measure Weight
Clinical Quality	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Total	AAB	AAB (T)	HEDIS	1	2.50
	Controlling High Blood Pressure	CBP	CBP	HEDIS	1	2.50
	Glycemic Status Assessment for Patients With Diabetes: — Glycemic Status <8.0%	GSD	GSD	HEDIS	1	2.50
	Adult Immunization Status—Influenza: 19-65 Years	AIS-E	AIS-E(I)	HEDIS	2	1.25
	Antidepressant Medication Management — Effective Continuation Phase Treatment	AMM	AMMC	HEDIS	2	1.25
	Asthma Medication Ratio: Total	AMR	AMR(T)	HEDIS	2	1.25
	Breast Cancer Screening	BCS-E	BCS-E	HEDIS	2	1.25
	Cervical Cancer Screening	CCS	CCS	HEDIS	2	1.25
	Childhood Immunization Status—Combination 10	CIS	CIS(10)	HEDIS	2	1.25
	Colorectal Cancer Screening: 51–75 Years	COL-E	COL-E (51-75)	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up: Total	FUA	FUA30	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up: Total	FUM	FUM30	HEDIS	2	1.25
	Prenatal and Postpartum Care —Timeliness of Prenatal Care	PPC	PPC (Pre)	HEDIS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%: Total	SPC	SPC(T)	HEDIS	2	1.25
	Use of Opioids from Multiple Providers—Multiple Prescribers	UOP	UOPPR	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CoC	CAHPS	3	1.00
	Claims Processing	CP	CP	CAHPS	3	1.00
	Getting Care Quickly	GQC	GQC	CAHPS	3	1.00
	Getting Needed Care	GNC	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	RHP	CAHPS	3	1.00
	Overall Personal Doctor Rating	RPD	RPD	CAHPS	3	1.00

Performance Area	Measure Title	NCQA Measure Abbreviation	QCR Scoring Identifier	Measure Source	Measure Priority	Measure Weight
Resource Use	Use of Imaging Studies for Low Back Pain: 18–64 Years	LBP	LBP(18-64)	HEDIS	1	2.50
	Acute Hospital Utilization—Nonoutlier Member Acute Inpatient and Observation Stay Discharges—Total Discharges—Observed-to-Expected (O/E) Ratio—Total: Total	AHU	AHU	HEDIS	2	1.25
	Emergency Department Utilization—Nonoutlier Member Number of Emergency Department Visits—O/E Ratio—Total: Total	EDU	EDU	HEDIS	2	1.25
	Plan All-Cause Readmissions—O/E Ratio: 18-64 Years	PCR	PCR	HEDIS	2	1.25

Farm Team (Measures Reported but not Scored)

- Adult Immunization Status —Td/Tdap: 19-65 Years AIS-E(Td) (Collection as of 2025) Adult Immunization Status—Zoster: 50-65 Years AIS(Z)(Collection as of 2025)
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis:18-64 Years, AAB (Scored since 2021; moved to Farm Team in 2025)
- Colorectal Cancer Screening: Total, COL-E (Collection as of 2025)
- Customer Service, CS (Scored since 2016; returned to the Farm Team in 2020)
- Prenatal and Postpartum Care: Postpartum Care, PPC (Post) (Collection as of 2025)
- Prenatal Immunization Status, PRS-E (Collection as of 2024)
- Risk of Continued Opioid Use, COU (Collection as of 2020)
- Use of Imaging Studies for Low Back Pain: Total, LBP (Collection as of 2022)
- Use of Opioids From Multiple Providers, UOP, (Multiple Pharmacies [UOPPH] and Multiple Pharmacies and Prescribers [UOPPP]) (Collection as of 2018)
- Well-Child Visits in the First 30 Months of Life, (Well-Child Visits in the First 15 months: 6 or More Well-Child Visits [W30 (15)]) (Scored since 2016; moved to Farm Team in 2024)
- Well-Child Visits First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months: 2 or More Well-Child Visits [W30 (30)] (Collection as of 2021)

Subsection D: 2025 Quality Improvement Corrective Action Plan Template

This information is included in Attachment 5 titled, “[2024 Quality Improvement Corrective Action Plan Template](#)”. For each FEHB Contract, 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 2025 do not require a CAP. The table below reflects the list of eligible CAPs measures in 2025. For more information on [2025 QCR Measure Set](#), please see [Carrier Letter 2023-11](#).

All CAPs must be submitted to your Health Insurance Specialist within 30 days of receiving the 2025 Overall Performance report, using the Quality Improvement Corrective Action Plan Template below and included in Attachment 5. Within the CAP, please specify the Quality Improvement implementation plan to improve the provision or care/services 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.

In the table below, select all the measures that apply. If there is more than one year of a CAP Submission, also check the “Multiple Year CAP” column. The measures display an “NA” where it didn’t require a CAP.

PPA: 2025 CAP Eligible QCR Measures	NCQA Measure Abbreviation	Multiple Year CAP	CAP 2025 Submission	CAP 2024 Submission	CAP 2023 Submission	CAP 2022 Submission
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis: Total	AAB	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA	NA
Controlling High Blood Pressure	CBP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%	GSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Immunization Status—Influenza: 19-65 Years	AIS-E	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA	NA
Antidepressant Medication Management:—Effective Continuation Phase Treatment	AMM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA
Asthma Medication Ratio: Total	AMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PPA: 2025 CAP Eligible QCR Measures	NCQA Measure Abbreviation	Multiple Year CAP	CAP 2025 Submission	CAP 2024 Submission	CAP 2023 Submission	CAP 2022 Submission
Breast Cancer Screening	BCS-E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer Screening	CCS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood Immunization Status — Combination 10	CIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA
Colorectal Cancer Screening: 51–75 Years	COL-E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow-Up After Emergency Department Visit for Substance Use —30 Day Follow-Up: Total	FUA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
Follow-Up After Emergency Department Visit for Mental Illness —30 Day Follow-Up: Total	FUM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
Prenatal and Postpartum Care— Timeliness of Prenatal Care	PPC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
Statin Therapy for Patients With Cardiovascular Disease —Statin Adherence 80%: Total	SPC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Opioids From Multiple Providers — Multiple Prescribers	UOP	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA	NA
Coordination of Care	CoC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claims Processing	CP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting Care Quickly	GCQ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting Needed Care	GNC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Health Plan Rating	RHP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Personal Doctor Rating	RPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PPA: 2025 CAP Eligible QCR Measures	NCQA Measure Abbreviation	Multiple Year CAP	CAP 2025 Submission	CAP 2024 Submission	CAP 2023 Submission	CAP 2022 Submission
Use of Imaging Studies for Low Back Pain: 18– 64 Years	LBP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute Hospital Utilization — Nonoutlier Member Acute Inpatient and Observation Stay Discharges —Total Discharges—O/E Ratio — Total: Total	AHU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA
Emergency Department Utilization —Nonoutlier Member Number of Emergency Department Visits—O/E Ratio —Total: Total	EDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA
Plan All-Cause Readmissions —O/E Ratio: Total	PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA

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

1. Measure:

2. Contract Number:

3. Carrier Name:

4. Carrier Codes:

5. 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.
- Impact: Estimate the number of members that need to be impacted by the proposed strategies in order to increase the score to at least the 25th percentile.

6. 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.

- Metrics: Describe the progress metrics you will use to track improvement. How does this support improvement in the QCR measure?
- Classification: OPM strongly encourages Carriers with performance below the 10th percentile benchmark to develop *nove*¹¹ actions, rather than *reinforcement*¹² 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.

¹¹ Introduction of a new practice that the Carrier has not previously explored.

¹² Modification of an existing practice current used by the Carrier.

Quality Improvement 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

☐

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 FEHB Chief:

Printed Name

Signature

Date

Subsection E: 2025 Quality Improvement Corrective Action Plan Follow-Up Template

This information is included in Attachment 6 titled, “2025 Quality Improvement Corrective Action Plan Follow-up Template”. Please complete the below follow-up report for each CAP you submitted following the 2024 QCR Scoring process. Return the completed report to your Health Insurance Specialist by June 30, 2026.

Contract Number: _____

Plan Name: _____

Carrier Codes: _____

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

1. Measure: _____

2. Action Steps

- What steps have been taken by your health plan in support of the Action Outline submitted to your FEHB Health Insurance Specialist?
- Are actions on track to meet the dates provided in the timeline? If not, what remedies are you taking?
- What progress metrics are you using to track projected improvement results? Are these metrics on track with expected progress to date?

FEHB Carrier Quality Improvement POC:

Printed Name

Signature

Date

Subsection F: 2025 Timeline

Below is the full HEDIS and CAHPS Timelines also generally referenced in Section 1 of this document. In addition, the timeline includes PPA 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 application. 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](#).

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.

OPM to Carriers (Green): As part of the PPA process, OPM provides reports to Carriers that include the QCR Preview Report, Procedure Manual, OPS Report, and a Detailed QCR Performance Summary Report.

- **December 2024:**
 - **HEDIS & CAHPS:** All FEHB Carriers must complete and submit the 2025 Planned HEDIS and CAHPS Reporting Information by December 16, via Benefits Plus (see Section 6 Subsection A and Attachment 2). Through this report, OPM and the Carriers can resolve reporting discrepancies prior to submitting data to NCQA's Online Healthcare Organization Questionnaire.
 - **HEDIS & CAHPS:** A new health plan option offered under a Carrier's existing contract or administrative renumbering or realignment of an ongoing contractual relationship is expected to provide HEDIS and CAHPS data. **Carriers with unique circumstances not defined in Section 4 must obtain written confirmation regarding a reporting exception from the FEHB Group Chief by December 16, 2024.**
 - **HEDIS:** NCQA releases the MY 2024 Healthcare Organization Questionnaire (HOQ) for health plans to request and update submissions in mid-December.
 - **HEDIS:** NCQA sends the HEDIS Data Submission Kick-off to Primary and Secondary contacts.
- **February 2025:**
 - **HEDIS** and **CAHPS:** Health plans finalize HOQ requests to obtain submission IDs for HEDIS and CAHPS.
- **March 2025:**
 - **HEDIS:** NCQA releases the MY 2024 IDSS for data loading and validation.
 - **HEDIS:** NCQA posts the XML Templates, Validations and Data Dictionaries for IDSS to the data submission webpage. **February 2025:**
 - **HEDIS** and **CAHPS:** Health plans finalize HOQ requests to obtain submission IDs for HEDIS

and CAHPS. **March 2025:**

- **HEDIS:** NCQA releases the MY 2024 IDSS for data loading and validation.
- **HEDIS:** NCQA distributes Submission IDs for survey measures to NCQA certified survey vendors.
- **May 2025:**
 - **CAHPS:** All FEHB Carriers must submit a CAHPS crosswalk file (see Section 6; Subsection B) that maps your NCQA CAHPS Submission ID(s) to your FEHB Plan name and CAHPS code by **May 1, 2025**. This crosswalk must accompany each submission of CAHPS survey results to OPM through their contractor ORI. Please direct questions regarding the crosswalk to ORI at OPMCAHPS@orireresults.com. The crosswalk includes each:
 - NCQA Member-level File Name
 - NCQA Submission ID
 - NCQA Plan Name
 - CAHPS Code
 - FEHB Plan Name
 - **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 submit CAHPS 5.1H member-level data files to NCQA on behalf of FEHB Carriers.
- **June 2025:**
 - **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 (available to health plans in IDSS) are due to OPM's contractor, ORI, by **June 16 2025**. The submission is due to ORI after the files have been processed by NCQA and you have provided NCQA with a signed Attestation of Accuracy. You or your survey vendor may submit the files via e-mail or other electronic or digital format to ORI at the following address: OPMCAHPS@orireresults.com. To comply with HIPAA privacy rules, survey vendors must use appropriate encryption technology.

- **July 2025:**
 - **HEDIS:** NCQA Releases the 2025 Quality Compass® commercial edition.
- **August 2025:**
 - **HEDIS** and **CAHPS:** NCQA releases “Projected Health Plan Ratings”. Carriers are required to confirm their rating and accreditation information (if applicable).
- **Fall 2025:**
 - **OPM to Carriers:** FEHB Carriers review the QCR Preview Report.
 - **OPM to Carriers:** OPM releases updated FEHB PPA Procedure Manual.
 - **OPM to Carriers:** OPM communicates the Overall Performance Scores (OPS Reports) to FEHB and PSHB Carriers.
 - **CAPs Reports:** Corrective Action Plans are due 30 days after the Carrier Receives the OPS report finalized QCR Score.
- **Winter 2025:**
 - **OPM to Carriers:** OPM provides Carriers with the Detailed QCR Performance Summary Report, which includes graphs showing where the FEHB Carrier’s scores are located in relation to other FEHB Carriers for each QCR measure and the QCR score.