

## 2025 Plan Performance Assessment Procedure Manual

### Attachment 4: 2025 Quality Improvement Corrective Action Plan Template

For each FEHB Contract, Carriers must submit a Corrective Action Plan (CAP) for each QCR measure below the 25<sup>th</sup> 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 2023. 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. 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<br>CAP Eligible QCR<br>Measures   | NCQA<br>Measure<br>Abbreviation | Multiple<br>Year<br>CAP  | CAP<br>2025<br>Submission | CAP<br>2024<br>Submission | CAP<br>2023<br>Submission | CAP<br>2022<br>Submission |
|---|---------------------------------|--------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Avoidance of Antibiotic<br>Treatment for Acute<br>Bronchitis/<br>Bronchiolitis: Total | AAB                             | <input type="checkbox"/> | <input type="checkbox"/>  | NA                        | NA                        | NA                        |
| Controlling High Blood<br>Pressure  | CBP                             | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>  |
| Glycemic Status<br>Assessment for Patients<br>With Diabetes—Glycemic<br>Status <8.0%  | GSD                             | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>  |
| Adult Immunization<br>Status—Influenza: 19-<br>65 Years                               | AIS-E                           | <input type="checkbox"/> | <input type="checkbox"/>  | NA                        | NA                        | NA                        |

| <b>PPA: 2025<br/>CAP Eligible QCR<br/>Measures</b>   | <b>NCQA<br/>Measure<br/>Abbreviation</b> | <b>Multiple<br/>Year<br/>CAP</b> | <b>CAP<br/>2025<br/>Submission</b> | <b>CAP<br/>2024<br/>Submission</b> | <b>CAP<br/>2023<br/>Submission</b> | <b>CAP<br/>2022<br/>Submission</b> |
|--|--|----------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Antidepressant<br>Medication<br>Management: —<br>Effective Continuation<br>Phase<br>Treatment      | AMM                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 | NA                                 |
| Asthma Medication<br>Ratio: Total  | AMR                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Breast Cancer<br>Screening   | BCS-E                                    | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Cervical Cancer<br>Screening   | CCS                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Childhood<br>Immunization Status —<br>Combination 10   | CIS                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 | NA                                 |
| Colorectal Cancer<br>Screening: 51–75 Years  | COL-E                                    | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Follow-Up After<br>Emergency Department<br>Visit for Substance Use<br>—30 Day<br>Follow-Up: Total  | FUA                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 |
| Follow-Up After<br>Emergency Department<br>Visit for Mental Illness<br>—30 Day<br>Follow-Up: Total | FUM                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 |
| Prenatal and<br>Postpartum Care—<br>Timeliness of Prenatal<br>Care                                 | PPC                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 |
| Statin Therapy for<br>Patients With<br>Cardiovascular Disease<br>—Statin<br>Adherence 80%: Total   | SPC                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Use of Opioids From<br>Multiple Providers —<br>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"/>           |

| <b>PPA: 2025<br/>CAP Eligible QCR<br/>Measures</b>  | <b>NCQA<br/>Measure<br/>Abbreviation</b> | <b>Multiple<br/>Year<br/>CAP</b> | <b>CAP<br/>2025<br/>Submission</b> | <b>CAP<br/>2024<br/>Submission</b> | <b>CAP<br/>2023<br/>Submission</b> | <b>CAP<br/>2022<br/>Submission</b> |
|---|--|----------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| 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<br>Rating   | RHP                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Overall Personal Doctor<br>Rating   | RPD                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Use of Imaging Studies<br>for Low Back Pain: 18–<br>64 Years  | LBP                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           | <input type="checkbox"/>           |
| Acute Hospital<br>Utilization —<br>Nonoutlier Member<br>Acute Inpatient and<br>Observation Stay<br>Discharges —Total<br>Discharges—O/E Ratio<br>—<br>Total: Total | AHU                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 | NA                                 |
| Emergency<br>Department Utilization<br>—Nonoutlier Member<br>Number of Emergency<br>Department Visits—O/E<br>Ratio —Total: Total                                  | EDU                                      | <input type="checkbox"/>         | <input type="checkbox"/>           | <input type="checkbox"/>           | NA                                 | NA                                 |
| Plan All-Cause<br>Readmissions —O/E<br>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 10<sup>th</sup> percentile benchmark to develop *novel*<sup>1</sup> actions, rather than *reinforcement*<sup>2</sup> 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.

---

<sup>1</sup> Introduction of a new practice that the Carrier has not previously explored.

<sup>2</sup> 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