Section 5: The QPM score program (adult practices)

The Quality Performance Measure (QPM) score program is a target-based system that rewards a qualifying practice for closing care gaps and meeting specific target-based thresholds among each of the quality measures in the program.

What are we evaluating?

The quality measures for the QPM score program are based on the Healthcare Effectiveness Data and Information Set (HEDIS®*), a well-established and tested set of standard measures and other established guidelines. These measures are based on services provided during the reporting period (January through December of the measurement year, unless otherwise noted). You can earn incentives on up to eight individual quality measures in categories such as cancer screenings, diabetic care, and medication management. In addition, you can earn an incentive on your Medicare Advantage members based on their visits with a primary care provider (PCP).

You can earn incentives on the following quality measures:

- Cancer Screenings:
  - Breast cancer screening
  - Cervical cancer screening
  - Colorectal cancer screening
- Controlling Blood Pressure
- Diabetic Care:
  - Hemoglobin A1C control
  - Eye exam
  - Kidney health evaluation
- Medication Management:
  - Medication adherence for high cholesterol, high blood pressure, and/or diabetes medications
  - Statin dispensed based on disease prevalence
- Other:
  - Well-care visits
  - Avoidance of antibiotic treatment for adults with acute bronchitis/bronchiolitis
  - Persistence of beta blocker treatment after a heart attack
  - Osteoporosis management in women who had a fracture
- Primary Care Visit (Medicare Advantage members only). This measure evaluates the percentage of your Medicare Advantage members who have visited a PCP within the measurement year.

**Members' benefits vary based on product line, group, or benefit contract. Preventive health services benefits coverage for members for most of the quality measures may be more frequent than HEDIS measurements. Individual member benefits should be verified.*

How are target bands determined?

Targets are determined by calculating a weighted average of Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) benchmarks for commercial and Medicare Advantage triple-weighted populations. Each quality measure has five target bands; band 1 is the highest achievement level and band 5 is the lowest achievement level.

To determine the target band you achieved for each quality measure, we calculate a percentage using the total number of members who received the services (numerator) and dividing by the total number of members who were eligible to receive the services (denominator).

A practice must have a minimum of five members who are eligible to receive the service for each measure. For the Primary Care Visit measure, a practice must have at least 25 Medicare Advantage members to meet the measure. If a member qualifies for more than one quality measure, the member is counted separately for each one. Medicare Advantage HMO/POS/PPO members are triple weighted (i.e., if a practice has 50 eligible Medicare Advantage members, the denominator will be 150 and the members meeting the measure will also be multiplied by three).

The target bands created for the Primary Care Visit measure are determined differently than the other measures. These targets were determined by evaluating the PCP visit rate performance among the QIPS providers in the most recently completed measurement year (i.e., 2021). Those results were calculated and then ranked into quintiles.

Note: These targets may be updated as changes to the national ratings are announced.

Target Bands	1	2	3	4	5
Breast Cancer Screening	78% – 100%	73% – 77.99%	68% – 72.99%	58% – 67.99%	<58%
Colorectal Cancer Screening	75% – 100%	70% – 74.99%	62% – 69.99%	52% – 61.99%	<52%
Cervical Cancer Screening†	80% – 100%	77% – 79.99%	74% – 76.99%	70% – 73.99%	<70%
Controlling Blood Pressure	77% – 100%	70% – 76.99%	62% – 69.99%	50% – 61.99%	<50%
Diabetic Care‡	72% – 100%	65% – 71.99%	57% – 64.99%	46% – 56.99%	<46%
Medication Management§	89% – 100%	85% – 88.99%	81% – 84.99%	76% – 80.99%	<76%
Other¶	70% – 100%	63% – 69.99%	60% – 62.99%	54% – 59.99%	<54%
Primary Care Visit	96.08% – 100%	93.18% – 96.07%	90.31% – 93.17%	85.71% – 90.30%	<85.70%

[†]The Cervical Cancer Screening measure applies only to Commercial members.

[‡]Each measure within diabetic care has a unique age range denominator. A member does not have to be compliant in all measures within diabetic care. For more information, please refer to the Diabetic Care Quality Measure section.

[§]Medication management does not require a member to meet both dispensed and adherence criteria.

[¶]The Other category represents the remaining quality measures – well visits, avoidance of antibiotic treatment for adults with acute bronchitis, persistence of beta blocker, and osteoporosis management in women who had a fracture. Note that well visits includes members ages 3 – 21. The targets are determined by the performance among the QIPS practices for measurement year 2022.

What is a mean band?

Each practice will have their own defined mean band. This is determined by taking the bands your practice achieved in the quality measure categories (up to 8) noted above, adding the band levels together, then dividing by the number of eligible measures for your practice. **If the result is a mean band at or below 2.5, your practice is eligible for the Cost Management and Care Efficiency programs.**

- Example: A practice location achieved a total of 18 (combined band levels) among the eight quality measures. This practice's mean band is 2.25 (18 divided by 8). Since the mean band is below 2.5, this practice **is** eligible for incentive payments.

How do we determine your payment?

The chart below illustrates QPM score program payment rates at a band level.

QPM Score Program Payments (Adult Practices)					
Band Level Achieved for Each Quality Measure[‖]	**Commercial HMO/POS/PPO**		**Medicare Advantage HMO/POS/PPO**		**Improvement Incentive**
	Open Office (PAMPY/PMPY)	**Current Patients Only (PAMPY/PMPY)**	**Open Office (PAMPY/PMPY)**	**Current Patients Only (PAMPY/PMPY)**	**Commercial/ Medicare Advantage (PAMPY/PMPY)**
Band 1	$8.00	$4.00	$13.50	$6.75	N/A
Band 2	$6.80	$3.40	$12.20	$6.10	N/A
Band 3	$3.00	$1.50	$8.40	$4.20	$2.00
Band 4	$1.80	$0.90	$7.20	$3.60	$2.00
Band 5	$0.00	$0.00	$0.00	$0.00	$2.00
Minimum average monthly panel size	200+				

[‖]PAMPY/PMPY is based on each provider's band earning for each quality measure and multiplied by the current month's membership.

Do you qualify for the improvement incentive?

If you are in band level 3, 4, or 5, and demonstrate a minimum of 5 percentage points improvement from the last measurement year, then you are eligible for an Improvement incentive. You can earn an additional $2.00 PAMPY/PMPY on each measure. This is in addition to the payment for reaching your band level for each measure.

Please note: If a quality measure is new to the measurement year, no improvement will be calculated until the measure has a full year of claims-related data to accurately assess improvement.

Note: Band level 5 receives no QPM score program incentive dollars but is eligible to earn $2.00 PAMPY/PMPY.

Participation in the QPM feedback process

The QPM feedback process is your annual opportunity to provide information to close gaps in care that may not have been received through claims in the measurement year. Information provided that closes a care gap will be added to each measure calculation, which will be reflected in your final QPM band level.

How to participate

In the 2nd quarter after the measurement year, the QPM Feedback application will be available in the PEAR portal. Practices will be notified when the application is available via the email address provided during the opt-in process, a PEAR Notification, and the QIPS Resources page.

Review the *QPM Feedback Application* user guide in the PEAR Help Center to get acclimated to the process. Then, log into the QPM Feedback application. There you will find the listing of members for your practice that have open care gaps. Please ensure you read the instruction pleat *before* filling out any records. For the feedback forms to be accepted, all records that indicate a service was rendered, or an exclusion applied, must be attested to by an authorized user (i.e., physician).

Deadline for feedback

You will have one month to fill out the forms and submit the attested records. The deadline for feedback will be announced once the application is available.

different scenarios of practice score calculations in Appendix C: Practice Payment Scenarios.

Audit

Independence may perform audits to validate the accuracy of the information provided by participating practices. Practices may be asked to provide additional documentation from their medical records to validate information submitted. After a careful review of the information submitted, practices will then be notified of the audit results.