# Understanding Your QEP Score Card

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## 1 PAYMENT CYCLE

This represents the current incentive bonus payment cycle, where each "cycle" (1–4) represents a quarter of the year.

## 2 CLAIMS CYCLE / CLAIMS PAID THROUGH

This represents the claim dates-of-service used to determine your practice's performance in the program. Claims Paid Through represents the amount of "run-out" time allotted for claims paid outside of the claims cycle.

## 3 PRACTICE INFORMATION

This is basic information about your practice, including your practice name and provider group ID number. It also includes the average number of members enrolled with your group during the payment cycle, the persistent severe mental illness (PSMI) members within that enrollment, and the panel status as of the last day of the claims paid through date. Please note that the impact of your panel status on your total per member per month (PMPM) payment is as follows: OPEN = 100%; RESTRICTED = 50%; CLOSED = 0% earnings.

## 4 QUALITY MEASURES

This section contains your practice's performance detail for the state-mandated quality performance metrics during the payment cycle. The current and prior year rate scores are listed for each measure. The results of each current rate are then compared to the established targets for the particular payment cycle. If the cycle targets are achieved, then your practice will earn the allocated PMPM funding associated with the number of targets achieved during the cycle.

## 5 IMPROVEMENT PERCENTAGE / IMPROVEMENT ACHIEVED (4th cycle score card ONLY)

These columns contain both the improvement percentage of the current rate in comparison to the prior year rate as well as an indication if the 10% increase established in the program specification was achieved. Please note that these categories will only appear on the 4th cycle score card as the Improvement Component is only calculated during the final payment of the program year.

## 6 INCENTIVE YEAR TO DATE SUMMARY

This section contains a year-to-date snapshot of incentive earnings by your practice as well as the member months up to the claims paid through date and the prior paid incentive amount.

## ⑦ TOP PERFORMER INCENTIVE (4th cycle score card ONLY)

This section contains the Top Performer Incentive calculations and earnings detail. If your practice's percentile ranking of overall performance is 65% or higher in relation to your network, then your practice is entitled to an increased PMPM payment. Please note that this section will only appear on the 4th cycle score card as the Top Performer component is only calculated during the final payment of the program year.

## ⑧ IMPROVEMENT COMPONENT (4th cycle score card ONLY)

This section contains the Improvement Component calculations and earning detail. If your practice **did not meet** the quality measure network targets **but did show an improvement of 10%** or more for a given measure, an increased PMPM payment is achieved. Please note that this section will only appear on the 4th cycle score card as the Improvement Component is only calculated during the final payment of the program year.

## ⑨ HEALTH EQUITY COMPONENT (4th cycle score card ONLY)

This section contains the Health Equity Incentive component which will be awarded to your practice if you demonstrate year-over-year gap closure improvement in the W15 component of the Well-Child Visits in the First 30 Months of Life measure for your African American plan members. The practices whose peer comparison percentile rank is 50% or higher with regard to improvement in this measure will be awarded an additional 2.5% increase in their total earned PMPM. Please note that this section will only appear on the 4th cycle score card as the Health Equity Component is only calculated during the final payment of the program year.

## ⑩ TOTAL INCENTIVE EARNED

This is the comparison of your practice's actual PMPM earned based on performance and the maximum potential PMPM for the payment cycle, as well as the actual earnings/potential earnings by your practice to date of all program components.

## ⑪ TOTAL COST OF CARE (INFORMATIONAL) (4th cycle score card ONLY)

This section contains the new Total Cost of Care informational measure that demonstrates your practice's performance based on an actual versus expected medical cost calculation that indicates how well you performed in the calendar year. Please note that this section will only appear on the 4th cycle score card as the Total Cost of Care measure is only calculated during the final payment of the program year.

## 12 INFORMATIONAL MEASURES — INVERSE

This section reflects inverse measures including the actual hospital admissions versus the expected Potentially Preventable Admissions (PPAs), the actual hospital ER visits versus the expected Potentially Preventable ER Visits (PPVs), Use of Opioids at High Dosage (UOD), and Use of Opioids from Multiple Providers (UOP).

Please note that a lower rate for these inverse measures indicates better performance. For example, a PPA actual rate of 105% is 5% over the max expected PPAs. The desired result is a lower rate since a score of 100% or above is showing a complete failure in providing quality care for this measure.

Potentially Preventable Admissions (PPAs) are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. PPAs are essentially ambulatory-sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often help avoid the need for admission. The occurrence of high rates of PPAs represents a failure of ambulatory care provided to the patient.

Potentially Preventable ER Visits (PPVs) are emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory-sensitive conditions (e.g., asthma), which means that adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate the need for ER services.

Potentially Preventable Readmissions (PPRs) are readmissions (return hospitalizations within a specified readmission time interval) that are clinically related to the initial hospital admissions. “Clinically related” is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission.

Use of Opioids at High Dosage (UOD) is for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average morphine equivalent dose [MED] >120 mg).

Use of Opioids from Multiple Providers (UOP) is for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

1. Multiple Prescribers: The rate per 1,000 of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
2. Multiple Pharmacies: The rate per 1,000 of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
3. Multiple Prescribers and Multiple Pharmacies: The rate per 1,000 of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the rate per 1,000 of members who are numerator-compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

**Your QEP reports and Care Gap reports can be accessed via NaviNet. Please contact your Provider Account Executive for further details.**

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