QIPS program

Independence's value-based program for primary care practices

Measurement year 2021

Independence

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About QIPS

The Quality Incentive Payment System (QIPS) program offers primary care practices incentives for providing quality health care and effectively managing the care of their Independence Blue Cross (Independence) HMO and PPO membership, including the management of National BlueCard® PPO members.

The QIPS program is recognized as a Total Care℠ (TC) program by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® plans and recognized by the Centers for Medicare & Medicaid Services (CMS) as an Advanced Alternative Payment Model (APM). This means that Comprehensive Primary Care Plus (CPC+) practices may use their participation in the QIPS program to achieve Advanced APM status in the Medicare Access and CHIP Reauthorization Act of 2015's Quality Payment Program.

Detailed information regarding TC, CPC+, as well as member attribution, is available in ***Appendix A: General information*.**

QIPS program goals:

- Provide incentive programs to drive quality, improve access to quality care, and help to improve medical cost effectiveness. As such, the measures included in the QIPS program may be further developed, enhanced, or refined.
- Create a culture of collaboration and teamwork with our primary care practices through engagement and improvement programs,
- Offer relevant metrics, based on quality and cost effectiveness, that reward exceptional performance to pediatric primary care practices.

Note: We reserve the right to make changes to the QIPS program upon prior written notice to primary care practices.

Participation requirements

In order to participate in the QIPS program, each practice must elect to opt-in via PEAR Analytics & Reporting (AR), formerly IndexPro™, our provider reporting application within the Provider Engagement, Analytics & Reporting (PEAR) portal, during the designated enrollment time frame. Enrollment occurs in the last quarter of each year – prior to the start of the measurement year (i.e., measurement year 2021 enrollment occurs October 2020 – December 2020).

Detailed information regarding PEAR AR and the PEAR portal is available in ***Appendix A: General information*.**

As part of the opt-in process, and during every enrollment period, a practice must provide the following information:

- **Clinical Champion.** Practice must identify a physician, practicing at that office location, who is responsible for coordinating value-based clinical activities. The Clinical Champion must be unique to each practice.
- **Practice Champion.** Administrator who is responsible for coordinating value-based administrative activities at the office location. The Practice Champion does not have to be unique to each practice location and, therefore, can be assigned at multiple office locations if applicable.
- **Official practice email address.** Indicate the best email address to contact the practice's Practice and/or Clinical Champion. This email address should NOT be a personal email address.

- **Practice phone number.** Indicate the phone number to best contact the practice's Practice and/or Clinical Champion.
- **Alternate phone number.** Indicate an alternate phone number to be used to contact the practice's Practice and/or Clinical Champion.
- **Attestation.** An electronic signature is required by an authorized representative of the practice, attesting that all information entered is true and accurate.

In addition to providing the above information, practices **must** comply with the terms of this Program Manual and the following additional participation requirements:

- The practice has reviewed all requirements for participation in the QIPS program for the applicable measurement year and will further review any changes made by Independence that are communicated in writing to each practice.
- The practice understands the incentive payment and CMF (ending in December 2021) that can be earned under the QIPS program are paid on an annual basis.
- The Practice Champion and Clinical Champion understand and review QIPS program performance annually and communicate performance results to the practice(s).
- The practice must use the NaviNet® web portal (NaviNet Open), PEAR Practice Management, or other electronic means identified by Independence as the primary mechanism for claims status inquiries, adjustment requests, referrals, and initiation of applicable authorizations.
- The practice must be registered for electronic funds transfer (EFT) and must complete the following transactions electronically:
  - member eligibility inquiries
  - claims submissions
  - encounters
- The practice must be enabled to use PEAR AR to view all QIPS program-related reports in addition to other valuable value-based data. Access to applications within the PEAR portal is subject to acceptance of certain Terms of Use.
- CPC+ practices are required to use the Certified Electronic Health Record Technology that meets the Office of the National Coordinator for Health Information Technology 2015 guidelines, which may be periodically updated. The CPC+ program will be ending in December 2021.
- Certain Family/General Practice or Internal Medicine/Geriatrics practices that fail to meet average performance thresholds will be placed in an engagement program to aid in improving performance.
- To the extent any of the information is found to be inaccurate or untrue, or the practices are not in compliance with such representations and warranties, the practice's participation in the QIPS program will be immediately terminated and may result in the forfeiture of any unpaid QIPS program incentive payments.
- Independence has the right to verify such information, in its sole discretion, at any time.

Once all the required information is completed for each practice, click the *Submit* button. The practice will receive an on-screen confirmation of their election as well as an email notification.

For larger entities that have multiple office locations, one person with PEAR AR access can complete the form for each office location, but they must ensure to coordinate with the offices on the Clinical Champions that will represent each office location.

Refer to the reference guide for step-by-step instructions on how to complete the opt-in process.

Eligibility requirements

Once a practice has elected to participate in the QIPS program, a practice must also meet specific eligibility and membership requirements. These required attributes are:

- Practices must be located in the Pennsylvania counties of Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northampton, or Philadelphia.
- Reimbursement for HMO members is on a capitated basis.
- Practices must have a specialty type of Family/General Practice, Internal Medicine/Geriatrics, or Pediatrics.
- Practices must accept members based on one of the following:
  - **Open office:** Accepts all new Independence HMO, POS, and PPO benefit plans.
  - **Current office:** Accepts existing Independence HMO, POS, and PPO patients currently in the practice and existing patients who switch from other health insurance to an Independence HMO, POS or PPO benefit plan during a measurement year.

  Note: Practices that are not accepting new members and/or existing patients are not eligible for the QIPS program. These practices are referred to herein as "frozen offices."
- Practices must be participating with Independence during the entire measurement year and at the time of payment in order to be eligible to receive an incentive payment.
- Practices must meet specific membership thresholds among their HMO/PPO population, the membership threshold could vary among each QIPS program. Membership thresholds are further defined in the program manual under each QIPS program.

Other important terms and conditions

Please make note of the following terms and conditions regarding participation in the QIPS program:

- QIPS will be comprised of measures for Family/General Practice and Internal Medicine/Geriatrics (Adult practices) and those specifically geared toward the pediatric population (Pediatric practices). While some of the components of the QIPS program are the same for both adult and pediatric practices, differences are identified throughout this manual.
- Independence reserves the right to modify the QIPS program and will provide prior written notification to participating practices of such modifications.
- HMO members (e.g., Away From Home Care® members, members on the primary care practice's Long Term Care panel), for whom reimbursement to the primary care practice is fee-for-service, are excluded from QIPS program payments and program measures.
- If changes to your practice composition occur during the measurement year, please review ***Appendix B: How changes to your practice composition affect your QIPS program eligibility and payment*****,** which outlines various scenarios and describes how each would affect your QIPS program eligibility and payments. Additionally, all changes to practice composition must comply with the terms of the practice's Independence provider participation agreement.
- In support of our various transparency initiatives, practice-level performance data may be made available to both current and prospective members.

- Incentive payments are based on the performance of primary care practices and not on individual practitioner performance, unless the practice consists of a solo practitioner.
- PPO members who are part of the Federal Employee Program are excluded from QIPS.
- Practices that become contracted to participate with Tandigm Health (hereinafter "Tandigm Health Practices") during the applicable measurement year will be paid for a specific member population in accordance with their Tandigm Health Practices contract. Primary Care Physician (PCP) group practices that participate in a Primary Care incentive program, which includes downside risk for provision of services to associated fully insured members, are not eligible to participate in the QIPS program. Note that for purposes of the QIPS program, deficit sharing under Independence's Total Value of Care (TVOC) program is not considered downside risk for this purpose.

QIPS program summary

The QIPS program offers a variety of incentive opportunities to primary care practices (adult and pediatric) across their entire membership population (commercial and Medicare Advantage HMO/POS/PPO, National BlueCard PPO). The chart below identifies the incentive programs applicable to adult and pediatric practices as well as those practices that have a participation exception due to other contractual obligations.

Program components	Adult practices	Tandigm Health Practices*	CPC+ practices	Pediatric practices
QPM score program	X	X	X	X
Improvement Incentive	X	X	X	
Engagement Program	X		X	
Pharmacy Cost	X	X	X	X
Medical Cost Efficiency	X	X	X	X
Potentially preventable ED utilization	X	X	X	
Transition of Care†	X	X	X	
Urgent care/ED utilization				X
Care Management Fee (CMF) (ending in December 2021)		X	X	

**Tandigm Health Practices are paid on a specific member population. Refer to the applicable program for more details and the "Other important terms and conditions" section.*

†Transition of care includes the following – Patient engagement after inpatient discharge and Medication reconciliation post-discharge.

QIPS program reporting

Reports will be available online through PEAR AR via the PEAR portal throughout the measurement year. PEAR AR is a valuable informational resource to assist in improving QIPS program performance, such as identifying gaps in care closure rates, disease management information, recently discharged patients, emergency room/department (ED)/urgent care utilization, and medication management. Practices can also run current PPO member attribution snapshots and receive timely information related to the QIPS program.

Standard QIPS reports (i.e., year-end performance reports) can be found on PEAR AR under Published Reports in the Output Manager section, located at the top of the page. These reports can be printed and/or downloaded to keep for your records. We will notify practices when reports are available.

QIPS program payments schedules and calculations

The chart below identifies the anticipated payment schedules for the QIPS program incentives available to primary care practices and explains how each program payment is calculated, based on PAMPY/PMPY (per attributed member per year/per member per year).

Note: These dates are targets and may vary depending on availability of data and other factors.

Incentive program	Payment cycle	Notification of results	Payment determination
QPM score program (All PCPs)	Annually*	August†	PAMPY/PMPY (based on each provider's band earning for each quality measure) X current month's membership *Note: Addition of an improvement PMPY/PAMPY if applicable (adult practices only)*
Engagement incentive (Adult practices)	Monthly	January 2021	PMPY/PAMPY (based on meeting engagement criteria) x current month's membership
Cost and Care Efficiency Management (Adult practices)†	Annually	October	PAMPY/PMPY (based on percentile rank) X current month's membership
Cost Management and Access to Care (Pediatric practices)‡	Annually	October	PAMPY/PMPY (based on percentile rank) X current month's membership

**QIPS program payments will be reimbursed on both HMO and PPO membership in one program payment on the applicable payment cycle.*

†This includes Pharmacy Cost, Medical Cost Efficiency, Potentially preventable ED utilization, and Transition of Care.

‡This includes Pharmacy Cost, Medical Cost Efficiency, and Urgent care/ED utilization.

Please note the following regarding payment for these incentive programs:

- The Quality Performance Measure (QPM) score program is based on how well each practice performs in closing gaps in care for each program measure. The practice will be paid based on reaching specified targets. Each target is assigned a PAMPY/PMPY.
- **Adult practices only:**
  - An improvement incentive can be added to the practice's total PMPY/PAMPY if they meet the qualifications as outlined in the *Improvement incentive* subsection of the *QPM score program* section.
  - The Cost and Care Efficiency Management metrics are percentile ranked amongst peers of the same specialty type. The tier the practice earns corresponds to a PAMPY/PMPY.
- **Pediatric practices only:** The Cost Management and Access to Care metrics are percentile ranked amongst your peers. The tier the practice earns corresponds to a PAMPY/PMPY.
- Pediatric practices will be measured separately and distinctly from adult practices and measures will vary among the specialties.
- Payments are based on multiplying the PAMPY/PMPY associated with the particular program's scoring method (band/target based) or percentile rank (tournament method) the practice earned by the membership of record in the payment month.
- HMO and PPO membership populations will be combined and reimbursed annually on the specified payment cycle.
- Program payment reports are available at a member level and can be viewed via PEAR AR.
- Retroactivity will NOT apply to payments. Payment is based on panel size at the time of payment. A practice must be participating with Independence at the time of payment to be eligible to receive payment. If a practice merges with or is acquired by another practice, the surviving/acquiring practice will be eligible to receive the merged/acquired practice's QIPS program payment. Please review ***Appendix B: How changes to your practice composition affect your QIPS program eligibility and payment*****,** which outlines various scenarios and describes how each would affect your QIPS program eligibility and payments.
- Tandigm Health Practices, although measured on their entire membership population, will only receive payments on their specific member population (in accordance with their Tandigm Health Practices contract) on record at the beginning of the payment month in which the payment is made for the QIPS program components for which they are eligible.

QIPS program

Components

QPM score program

The QPM score program is a target-based system that rewards each practice for meeting specific target-based thresholds among the quality measures. For example, cancer screenings, diabetic care, and statin therapy for adult practices and well visits and vaccinations for pediatric practices.

Quality measures

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). Accurate encounter and claims submissions are important to document these services.

Please refer to ***Appendix C: Quality measures for measurement year 2021*** for the specific details of the quality measures that will be used for scoring.

**Quality measures are based on HEDIS and are used as the baseline measurement for performance measure frequency of preventive health services. Note, however, that 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.*

Quality measure targets

Each quality measure has 5 target bands; band 1 is the highest achievement level and band 5 is the lowest achievement level. For each quality measure a practice is placed in a band by calculating 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).

Adult practices

The following charts identify the 5 bands and targets for each quality measure. Please note that these targets may be updated as changes to the national ratings are announced. A practice must have a minimum of five members who are eligible to receive the service for each measure (denominator). Medicare Advantage HMO, POS, and PPO members in the numerator and denominator 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).

Target Bands‡	Breast cancer screening	Colorectal cancer screening	Cervical cancer screening
Band 1	≥81%	≥77%	≥82%
Band 2	76% – 80.99%	70% – 76.99%	79% – 81.99%
Band 3‡	70% – 75.99%	63% – 69.99%	75% – 78.99%
Band 4‡	61% – 69.99%	53% – 62.99%	71% – 74.99%
Band 5‡	<61%	<53%	<71%

Target Bands†	Diabetes composite	Statin therapy composite§	Other¶
Band 1	≥73%	≥82%	≥75%
Band 2	66% – 72.99%	78% – 81.99%	65% – 74.99%
Band 3‡	59% – 65.99%	75% – 77.99%	61% – 64.99%
Band 4‡	49% – 58.99%	72% – 74.99%	55% – 60.99%
Band 5‡	<49%	<72%	<55%

†Targets are determined by calculating a weighted average of CMS and National Committee for Quality Assurance (NCQA) benchmarks for commercial and Medicare Advantage triple weighted populations.

‡Only Bands 3, 4, and 5 are eligible for an Improvement incentive. More information about this incentive and earning criteria can be found in the 'Improvement incentive' section.

§ The statin therapy composite requires 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. Important to note that well-visits include members ages 3 – 21. The targets are determined by the performance among the QIPS practices for measurement year 2019.

Pediatric practices

The following charts identify the 5 bands for the well-visit composite measure and the vaccination composite measure. Please note that these targets are subject to change as peer performance ratings are refreshed. A practice must have a minimum of five members who are eligible to receive the service for each measure (denominator).

Target Bands	Well-visit composite	Vaccination composite
Band 1	86% – 100%	69% – 100%
Band 2	82% – 85%	62% – 68%
Band 3	74% – 81%	53% – 61%
Band 4	52% – 73%	38% – 52%
Band 5	<52%	<38%

Notes:

Well-visit composite targets are established by incorporating the HEDIS benchmarks (90th, 75th, 50th, and 25th national percentiles) for each measure's constituent components into synthesized rates.

Well-visit composite consists of Well visits in the first 30 months of life and child and adolescent well-care visits.

Vaccination composite consists of DTaP, IPV, HIB, MMR, VZV, PCV, Flu, Rotavirus, HPV, Tdap, and Meningococcal. Childhood immunizations are not measured by each individual immunization. To receive credit, a patient must receive all required immunizations based on their age. The targets for this composite are established by evaluating the QIPS pediatric offices measurement year performance among that composite. Practices are percentile-ranked from highest to lowest, which establishes the band level targets based on an even distribution.

Practice and member eligibility requirements

The QPM score program includes the following additional practice and member eligibility requirements:

- **Adult practices.** Practices must have an average panel size of 200 or more members (combination of commercial and/or Medicare Advantage HMO/POS/PPO and National BlueCard PPO members) during the measurement year.
- **Pediatric practices.** Practices must have an average panel size of 200 or more members (combination of commercial HMO/PPO/POS and National Blue Card PPO members) during the measurement year.
- HMO/POS members must be with the practice for at least 11 months of the measurement year. PPO members must be continuously enrolled with Personal Choice®, Personal Choice 65℠ PPO, or a National BlueCard PPO plan for at least 11 months of the measurement year. National BlueCard PPO members are based on a limited set of measures, which are identified in ***Appendix C: Quality measures for measurement year 2020.***
- Member eligibility for services is based on the definitions in Appendix C and the member's qualification for inclusion in the population for a specific quality measure. If an individual member qualified for more than one quality measure, the member is counted separately for each one.
- Practices must be classified as either Family/General Practice, Internal Medicine/Geriatrics, or Pediatrics.
- Tandigm Health Practices, although measured on their entire membership population, will only receive payments on their specific member population (in accordance with their Tandigm Health Practices contract) on record at the beginning of the payment month in which the payment is made for the QIPS program components for which they are eligible.
- The practice's panel status must be open or current. This is defined in the eligibility requirements on page 4.

QPM score program incentive payment

The QPM score program incentive is a one-time lump sum payment paid annually via EFT. This is prospectively paid on a fixed PAMPY/PMPY basis, based on the following:

- Each band level PAMPY/PMPY the practice achieves for each individual quality measure will be added together.
- Retroactivity will NOT apply to payments. Payment is based on panel size at the time of payment. A practice must be participating with Independence at the time of payment to be eligible to receive payment. If a practice merges with or is acquired by another practice, the surviving/acquiring practice will be eligible to receive the merged/acquired practice's QIPS program payment. Please review ***Appendix B: How changes to your practice composition affect your QIPS program eligibility and payment*****,** which outlines various scenarios and describes how each would affect your QIPS program eligibility and payments.
- HMO and PPO membership populations will be combined and reimbursed annually on the applicable payment cycle.
- Tandigm Health Practices, although measured on their entire membership population, will only receive payments on their specific member population (in accordance with their Tandigm Health Practices contract) on record at the beginning of the payment month in which the payment is made for the QIPS program components for which they are eligible.
- The practice must be opted into the QIPS program.

- **Adult practices only.** An Improvement incentive, if applicable, will be added to the sum of the band level PAMPY/PMPY earned.

Payments for Adult practices

The following chart outlines QPM score program payments (based on PAMPY/PMPY applicable to HMO and PPO members and band level achieved for each quality measure:

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	$7.80	$3.90	$13.20	$6.60	N/A
Band 2	$6.60	$3.30	$12.00	$6.00	N/A
Band 3‖	$3.00	$1.50	$8.40	$4.20	$1.20
Band 4‖	$1.80	$0.90	$7.20	$3.60	$1.20
Band 5‖	$0.00	$0.00	$0.00	$0.00	$1.20
Minimum average monthly panel size	200+				

¶*Frozen offices are not eligible for QPM score program payments.*

‖*Bands 3, 4, and 5 are eligible for an Improvement incentive. More information about this incentive and earning criteria can be found in the 'Improvement incentive' section below.*

Improvement incentive (Adult practices only)

This new, additional incentive bonus is for those lower performing practices that have demonstrated significant improvement from the previous measurement year. A practice must reach the following criteria in order to be eligible:

- Practices are in a band level of 3, 4, or 5 in any of the quality measures that are part of the QPM score program.
- Practices must show a minimum of a 5 percentage point improvement from the previous measurement year in any of the quality measures that are part of the QPM score program (i.e., prior year score of 50 percent requires current year performance to be at least 55 percent for a given measure).

Practices that meet the above standards will be eligible to earn an additional $1.20 PMPY on each measure that has shown improvement as shown in the table above. This $1.20 PMPY will be in addition to the payment that they have earned for reaching their band level for each measure. Please note, band level 5 receives no QPM score program incentive dollars but is eligible to earn $1.20 PMPY.

You can review different scenarios of practice score calculations in ***Appendix D: Practice payment scenarios.***

Payments for Pediatric practices

The following chart outlines QPM score program payments (based on PAMPY/PMPY applicable to HMO and PPO members and band level achieved for each quality measure composite:

QPM score program payments (Pediatric practices)¶		
Band Level achieved for each quality measure composite‖	**Commercial HMO/POS/PPO**	
	Open office (PAMPY/PMPY)	**Current patients only (PAMPY/PMPY)**
Band 1	$28.80	$14.40
Band 2	$19.20	$9.60
Band 3	$12.00	$6.00
Band 4	$2.40	$1.20
Band 5	$0.00	$0.00
Minimum average monthly panel size	200+	

¶*Frozen offices are not eligible for QPM score program payments.*

‖*These PAMPY/PMPYs are applicable to each quality measure composite.*

You can review different scenarios of practice score calculations in ***Appendix D: Practice payment scenarios.***

Practice-specific reports to aid in closing care gaps

The following QPM score program communications are available to each potentially eligible practice that has opted into the QIPS program:

- ***Gaps in Care* report.** This monthly real-time report is available to practices **only** through PEAR AR and identifies HMO/PPO members who are due to receive certain preventive services, based on Independence claims data. This report can be used as a supplement to assist in closing care gaps, which can help your practice reach its band level measure goal.
- **Preliminary score report.** This report will be available to each practice in April following the measurement year through PEAR AR. It provides a preview of the practice's year-end quality performance at a measure level. The report will include a summary of each quality measure showing the number of HMO/PPO eligible members, the number of HMO/PPO members who received services, preliminary band level, and potential improvement flag (only applicable to adult practices).

  Note: The band level and potential improvement flag on the preliminary score report is **preliminary** and may not reflect final payment or performance. Regardless of participation in the feedback process (described on the next page), a practice's band level for each measure may change as we receive additional claims data.
- **Final report.** This report will be available to practices in August of the year following the measurement year through PEAR AR. It provides the final resulting performance for each practice at a measure level including earning an improvement incentive.

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.

How to participate

In the second 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.

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.

Engagement incentive program (Adult practices only)

This new incentive program encourages collaboration and teamwork between Independence and practices. It will assist practices that have not performed well in the QPM score program improve their performance. Practices will be eligible for monthly incentives when they meet specific engagement requirements. The practices will be reviewed quarterly to ensure the engagement requirements are being met.

Practice eligibility requirements

Practices will be notified by Independence via mail at the end of the fourth quarter prior to the start of the measurement year (i.e., December 2020 for measurement year 2021), if their practice has been selected to participate in this engagement incentive program.

The practice must meet the following qualifications:

- Must have earned a QPM tier of 5 for QPM HMO or tier of 4 for QPM PPO for two measurement years in a row. For measurement year 2021, measurement years 2018 and 2019 will be evaluated.
- Must not be participating with Tandigm Health.
- Must accept all Independence HMO, POS, and PPO benefit plans.
- Must be a specialty of Family/General Practice or Internal Medicine/Geriatrics.
- Must have opted into the QIPS program for the measurement year with accurate and up-to-date (i.e., Clinical Champion, Office Champion) required information supplied.

Practice participation requirements

Practices that have been selected to be part of the Engagement incentive program must meet certain requirements throughout the year. These requirements show that the practice is committed to working with Independence to improve performance.

The requirements are:

- Must meet with a population health specialist from Independence at least six times a year in person or via telephone.
- Must log into PEAR AR monthly.
- Must download from PEAR AR their practice's *Gaps in Care* report quarterly.
- Must show evidence of member outreach to proactively address the member's gap in care (i.e., cancer screenings, well visits, vaccinations).
- Must participate in at least one available quality program (i.e., ePASS®, FIT, HbA1c, Nephropathy).

Incentive payments

Practices will receive a monthly incentive payment of $0.60 PMPM for meeting the above requirements. If a provider does not adhere to the required engagement criteria, which will be evaluated quarterly, they will be temporarily ineligible for engagement payments until adherence guidelines are again met. Practices will be notified by a population health specialist in advance of any payment termination.

The practice will remain in a probationary period until such time as the practice becomes compliant. Once the practice becomes compliant, the population health specialist will notify the practice and payment will resume the following month. Practices will NOT be reimbursed retrospectively for the probationary period.

At the end of every year, practices are evaluated for participation in the next year's engagement program. If at the end of the year a practice is in the shut-off period, and is eligible for engagement for the next year, that practice will NOT receive a payment in that new year until engagement requirements have been met.

Cost and Care Efficiency Management (Adult practices only)

Given the important role of the primary care practices in the overall management of the health of our members, Independence recognizes and rewards practices that deliver and maintain quality and cost-effective care. The Cost and Care Efficiency Management programs are comprised of the following incentives:

- Pharmacy Cost;
- Medical Cost Efficiency;
- Emergency room/department (ED) utilization;
- Transition of Care, measured on the following two components:
  - Patient engagement after inpatient discharge
  - Medication reconciliation post-discharge

Cost Management

Pharmacy Cost

Research indicates that medication non-adherence leads to 125,000 preventable deaths each year and about $300 billion in avoidable health care costs.[1] Independence is bringing awareness to medication adherence by incorporating this program into QIPS. The goal of this program is to incentivize practices to promote medication adherence and to reduce both avoidable health care costs and pharmacy costs.

Practice and member eligibility requirements

In addition to the QIPS program participation and eligibility requirements outlined on pages 2 – 4, the following practice and member eligibility requirements are specific to the Pharmacy Cost incentive:

- Practice must have 25 or more members who have received multiple scripts (through our pharmacy benefit) as part of the following medication regimens:
  - statin therapy
  - hypertension management
  - diabetes management
- A member will be counted more than once if they appear in more than one medication regimen category.
- The practice's Medication Compliance rate (50th percentile or above) of members in the three medication regimens stated above will determine that practice's entrance (the quality gatekeeper) into the evaluation of pharmacy cost.
- HMO/POS members must be with the practice for at least 11 months of the measurement year. PPO members must be continuously enrolled with Personal Choice, Personal Choice 65 PPO, or a National BlueCard PPO plan for at least 11 months of the measurement year.
- A member must be continuously covered by Independence's pharmacy coverage for calendar year 2021.
- Only practices with a mean band of **less than or equal to 3.0** for all measures in the QPM score program for the measurement year are eligible for the Pharmacy Cost incentive payment.
  - Each practice will have their own defined mean band. This is determined by taking the bands your practice achieved in the six quality measure categories noted on pages 9 – 10, adding the band levels together, then dividing by six. If the result is a mean band at or below 3.0, your practice is eligible for the Pharmacy Cost incentive payment.
  - **Example:** A practice location achieved the following bands for their quality measures: 3 (Breast cancer screening), 3 (Colorectal cancer screening), 4 (Cervical cancer screening), 1 (Diabetes composite), 1 (Statin therapy composite), and 2 (Other). The six bands equal 14. Divide 14 by the six quality measures. This practice's mean band is 2.3. Since the mean band is below 3.0, this practice is eligible for payment.
  - The mean band does not apply to Pediatric practices.
- National BlueCard PPO members are excluded from this metric.

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[1] *www.heart.org/en/health-topics/consumer-healthcare/medication-information/medication-adherence-taking-your-meds-as-directed*

https://patimes.org/medication-compliance/

Practice score calculation for Medication Compliance (Adult practices only)

To determine Medication Compliance, a percentage will be calculated using the number of members who have had two or more filled scripts for one of the regimens described above during the measurement year (denominator) and the total number of drug-adherent members (numerator).

Members are considered "Adherent" (i.e., in the numerator) if they have filled their maintenance medication scripts for at least 80 percent of the days during which they were on said drug regimen for a given condition (e.g., 10 out of 12 months). This determination is made per member condition. This means a member could be "adherent" for his or her cholesterol medications but "non-adherent" for his or her diabetes medications.

The resulting percentage will determine each practice's compliance rate. Each practice will then be ranked against its peers in its specialty group from highest to lowest compliance rate. A member may count toward both the denominator and numerator multiple times if they fall into multiple medication regimen categories.

Practices in the top 50th percentile of compliance will be evaluated on Pharmacy Cost.

Practice score calculation for Pharmacy Cost

The Pharmacy Cost incentive payment is based on each practice's pharmacy cost risk-adjusted PMPM.* The risk-adjusted PMPM will be compared and percentile-ranked among primary care practices of the same specialty type (Family/General Practice or Internal Medicine/Geriatrics). Each practice, based on the percentile rank, will be assigned to one of four tiers, as shown in the chart on page 17.

**Risk-adjustment is performed using Verisk DxCG Risk Scores. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's PMPM costs are then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on their PMPM costs, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their PMPM costs.*

Member exclusions

Members diagnosed with end-stage renal disease and in hospice care will be excluded from the medication adherence compliance evaluation.

Prior to evaluating pharmacy costs, all specialty drugs will be excluded, and a high-cost threshold will be applied to the following practice specialty types:

- Family/General Practice or Internal Medicine/Geriatrics:
  - $10,000 (commercial)
  - $15,000 (Medicare Advantage)

Incentive payment

The incentive is paid via EFT in a one-time lump sum payment paid the year following the measurement year (e.g., measurement year 2021 performance; anticipated payment in October 2022). This is paid on a fixed PMPY basis, based on the following:

- Practices that performed in the top 50th percentile of Medication Compliance;
- Pharmacy costs in comparison to your peers. Pharmacy cost is calculated at a PMPM level and includes all prescriptions paid for by our pharmacy benefit for any member capitated or attributed to your practice. The prescription did not have to be written by a physician within your office.

- Capitated and current attributed membership on record as of the month during which the Pharmacy Cost incentive is paid;
- Medicare Advantage HMO/POS/PPO members are measured and ranked separately from commercial HMO/POS/PPO members. Therefore, a practice could potentially have two different rankings and two different payments.
- HMO and PPO membership populations will be combined and reimbursed annually on the applicable payment cycle.
- Tandigm Health Practices, although measured on their entire membership population, will only receive payments on their specific member population (in accordance with their Tandigm Health Practices contract) on record at the beginning of the payment month in which the payment is made for the QIPS program components for which they are eligible.

The following chart outlines the Pharmacy Cost payments for measurement year 2021:

Primary care practice percentile rank within specialty†	**Commercial HMO/POS/PPO**	**Medicare Advantage HMO/POS/PPO**
	PAMPY/PMPY	**PAMPY/PMPY**
Tier 1 (75 – 100%)	$8.40	$9.60
Tier 2 (50 – 74.99%)	$7.20	$8.40
Tier 3 (25 – 49.99%)	$6.00	$7.20
Tier 4 (<25%)	$0.00	$0.00

†Frozen offices are not eligible for Cost Management program payments.

Medical Cost Efficiency

The Medical Cost Efficiency incentive assesses and rewards practices on the management of their total overall medical cost in comparison to their peers of the same specialty type. Medical cost is defined as Independence's contractual allowed amount paid to the practice inclusive of member liability (e.g., copayment, coinsurance, deductible) and Coordination of Benefits funds.

The following costs and members are excluded from this incentive:

- prescription drugs paid through the pharmacy benefit;
- members younger than 2 as of the last day of the reporting;
- home health/hospice services;
- maternity services;
- mental health/substance use disorder costs;
- pediatric and adult preventive costs (e.g., mammography, colon cancer screenings, immunizations);
- high-cost claimants:
  - **Family/General Practice or Internal Medicine/Geriatrics:**
    - Commercial HMO/POS members with greater than $65,000 in total annual medical costs and Medicare Advantage HMO members with greater than $130,000 in total annual medical costs.

  - Personal Choice and National BlueCard PPO members with greater than $75,000 in total annual medical costs and Medicare Advantage PPO members with greater than $150,000 in total annual medical costs.
- HMO/POS members must be with the practice for at least 11 months of the measurement year. PPO members must be continuously enrolled with Personal Choice, Personal Choice 65 PPO, or a National BlueCard PPO plan for at least 11 months of the measurement year.

Practice and member eligibility requirements

In addition to the QIPS program participation and eligibility requirements outlined on pages 2 – 4, the following practice and member eligibility requirements are specific to the Medical Cost Efficiency incentive:

- Practices must have an average panel size of 200 commercial HMO/PPO/POS and National BlueCard PPO members for the measurement year to be eligible for the commercial Medical Cost Efficiency incentive.
- Practices must have an average panel size of 150 Medicare Advantage HMO/POS/PPO members for the measurement year to be eligible for the Medicare Advantage Medical Cost Efficiency incentive.
- Only practices with a mean band of **less than or equal to 3.0** for all measures in the QPM score program for the measurement year are eligible for the Medical Cost Efficiency incentive.
  - Each practice will have their own defined mean band. This is determined by taking the bands your practice achieved in the six quality measure categories noted on pages 9 – 10, adding the band levels together, then dividing by six. If the result is a mean band at or below 3.0, your practice is eligible for the Medical Cost Efficiency incentive payment.
  - **Example:** A practice location achieved the following bands for their quality measures: 3 (Breast cancer screening), 3 (Colorectal cancer screening), 4 (Cervical cancer screening), 1 (Diabetes composite), 1 (Statin therapy composite), and 2 (Other). The six bands equal 14. Divide 14 by the six quality measures. This practice's mean band is 2.3. Since the mean band is below 3.0, this practice is eligible for payment.
  - The mean band does not apply to Pediatric practices.

Practice score calculation

The Medical Cost Efficiency incentive is based on each practice's total cost risk-adjusted PMPM.‡ The risk-adjusted PMPM will then be compared and percentile-ranked amongst primary care practices of the same specialty type (Family/General Practice or Internal Medicine/Geriatrics). Each practice, based on the percentile rank, will be assigned to one of four tiers, as shown in the chart on the next page.

‡Risk-adjustment is performed using Verisk DxCG Risk Scores. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's PMPM costs are then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on their PMPM costs, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their PMPM costs.

Incentive payment

The Medical Cost Efficiency incentive is paid in a one-time lump sum payment annually via EFT in the year following the measurement year (e.g., measurement year 2021 performance; anticipated payment in October 2022). Practices whose total risk-adjusted medical costs fall within the four tiers will be paid on a fixed PMPY basis, based on the following:

- Capitated and current attributed membership on record as of the month during which the Medical Cost Efficiency incentive is paid;
- Product (i.e., commercial or Medicare Advantage HMO/POS/PPO and/or National BlueCard PPO);
- HMO and PPO membership populations will be combined and reimbursed annually on the applicable payment cycle.
- Tandigm Health Practices, although measured on their entire membership population, will only receive payments on their specific member population (in accordance with their Tandigm Health Practices contract) on record at the beginning of the payment month in which the payment is made for the QIPS program components for which they are eligible.
- The tier corresponding to the percentile rank earned, as indicated in the chart below.

The following chart outlines Medical Cost Efficiency payments for measurement year 2021:

Primary care practice percentile rank within specialty	Commercial HMO/POS/PPO	Medicare Advantage HMO/POS/PPO
	PAMPY/PMPY	PAMPY/PMPY
Tier 1 (75 – 100%)	$8.40	$9.60
Tier 2 (50 – 74.99%)	$7.20	$8.40
Tier 3 (25 – 49.99%)	$6.00	$7.20
Tier 4 (<25%)	$0.00	$0.00

Care Efficiency Management

The Care Efficiency Management component consists of the following incentives:

- ED utilization for potentially preventable ED visits
- Transition of Care

Practice and member eligibility requirements

In addition to the QIPS program participation and eligibility requirements outlined on pages 2 – 4, the following practice and member eligibility requirements are specific to the Care Efficiency Management component:

- Only practices with a mean band of **less than or equal to 3.0** for all measures in the QPM score program for the measurement year are eligible for the Care Efficiency Management incentive.
  - Each practice will have their own defined mean band. This is determined by taking the bands your practice achieved in the six quality measure categories noted on pages 9 – 10, adding the band levels together, then dividing by six. If the result is a mean band at or below 3.0, your practice is eligible for the Care Efficiency Management incentive payment.

  - **Example:** A practice location achieved the following bands for their quality measures: 3 (Breast cancer screening), 3 (Colorectal cancer screening), 4 (Cervical cancer screening), 1 (Diabetes composite), 1 (Statin therapy composite), and 2 (Other). The six bands equal 14. Divide 14 by the six quality measures. This practice's mean band is 2.3. Since the mean band is below 3.0, this practice is eligible for payment.
  - The mean band does not apply to Pediatric practices.
- Practices must have 200 or more commercial members HMO/POS/PPO (includes National BlueCard PPO members).
- Practices must have 150 Medicare Advantage HMO/POS/PPO members.
- HMO/POS members must be with the practice for at least 11 months of the measurement year. PPO members must be continuously enrolled with Personal Choice, Personal Choice 65 PPO, or a National BlueCard PPO plan for at least 11 months of the measurement year.

Practice score calculations

Each incentive of the Care Efficiency Management component is calculated and scored separately.

- **ED utilization for potentially preventable ED visits.** Each primary care practice will be percentile ranked and tiered among their peers in each specialty type (Family/General Practice or Internal Medicine/Geriatrics).
- **Transition of Care (Medicare Advantage only).** Transition of care consists of the following measures. Each primary care practice will be percentile ranked and tiered among their peers in each specialty type (Family/General Practice or Internal Medicine/Geriatrics).
  - Patient engagement after inpatient discharge. Evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
  - Medication reconciliation post-discharge. Medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

  Measure description

  The percentage of discharges for members 18 and older who had each of the following:

  - *Patient engagement after inpatient discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge based on medical admissions only.
  - *Medication reconciliation post-discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

  The denominator for this measure is based on discharges, not members

  Note: The Act Now cards (i.e., Recently Discharged Patients, Currently Hospitalized Patients) found at the top of the PEAR AR homepage can assist practices with this measure.

Incentive payment

The Care Efficiency Management component is paid in a one-time lump sum payment annually via EFT in the year following the measurement year (e.g., measurement year 2021 performance; anticipated payment in October 2022). Primary care practices at or above the 25th percentile among their peers of the same specialty type will be paid on a fixed PAMPY/PMPY, based on the following:

- Current capitated and attributed membership on record as of the payment month;

- How well a practice performs in each of the Care Efficiency Management component incentives:
  - ED visits per 1,000
  - Transition of care metrics
- The tier corresponding to the percentile rank earned, as indicated in the chart on the next page for each measure component;
- HMO and PPO membership populations will be combined and reimbursed annually on the applicable payment cycle.
- Tandigm Health Practices, although measured on their entire membership population, will only receive payments on their specific member population (in accordance with their Tandigm Health Practices contract) on record at the beginning of the payment month in which the payment is made for the QIPS program components for which they are eligible.

The following chart outlines Care Efficiency Management payments for measurement year 2021:

Primary care practice percentile rank within specialty	Commercial HMO/POS/PPO	Medicare Advantage HMO/POS/PPO
	PAMPY/PMPY	PAMPY/PMPY
Tier 1 (75 – 100%)	$8.40	$9.60
Tier 2 (50 – 74.99%)	$7.20	$8.40
Tier 3 (25 – 49.99%)	$6.00	$7.20
Tier 4 (<25%)	$0.00	$0.00

Cost Management and Access to Care (Pediatric practices only)

Given the important role of the primary care practices in the overall management of the health of our members, Independence recognizes and rewards practices that deliver and maintain quality and cost-effective care. The Cost and Access to Care programs for pediatric practices are comprised of the following incentives:

- Pharmacy Cost
- Medical Cost Efficiency
- Urgent Care/emergency room/department (ED) utilization

Cost Management

Pharmacy Cost

Practice and member eligibility requirements

In addition to the QIPS program participation and eligibility requirements outlined on pages 2 – 4, the following practice and member eligibility requirements are specific to the Pharmacy Cost incentive:

- HMO/POS members must be with the practice for at least 11 months of the measurement year. PPO members must be continuously enrolled with Personal Choice, Personal Choice 65 PPO, or a National BlueCard PPO plan for at least 11 months of the measurement year.

- Practices who have an eligible vaccination population of at least 20 members and a vaccination rate below 15 percent for that population will not be eligible for Pharmacy Cost incentive payments.
- National BlueCard PPO members are excluded from this metric.

Measure calculation

The Pharmacy Cost incentive payment is based on each practice's pharmacy cost risk-adjusted PMPM.† The risk-adjusted PMPM will be compared and percentile-ranked among the pediatric practices. Each practice, based on the percentile rank, will be assigned to one of four tiers.

†Risk-adjustment is performed using Verisk DxCG Risk Scores. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's PMPM costs are then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on their PMPM costs, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their PMPM costs.

Member exclusions

Prior to evaluating the Pharmacy Cost, all specialty drugs will be excluded, and a high-cost threshold of $5,000 will be applied to pediatric practices.

Incentive payment

The incentive is paid in a one-time lump sum payment annually via EFT in the year following the measurement year (e.g., measurement year 2021 performance; anticipated payment in October 2022). This is paid on a fixed PMPY basis, based on the following:

- Your pharmacy costs in comparison to your peers. Pharmacy cost is calculated at a PMPM level and includes all prescriptions paid for by our pharmacy benefit for any member capitated or attributed to your practice. The prescription did not have to be written by a physician within your office.
- Capitated and current attributed membership on record as of the month during which the Pharmacy Cost incentive is paid;
- HMO and PPO membership populations will be combined and reimbursed annually on the applicable payment cycle.

The following chart outlines Pharmacy Cost payments for measurement year 2021:

Primary care practice percentile rank‡	Commercial HMO/POS/PPO (PAMPY/PMPY)
Tier 1 (≥75th)	$18.00
Tier 2 (50 – 74.99%)	$10.80
Tier 3 (25 – 49.99%)	$2.40
Tier 4 (<25%)	$0.00

‡Frozen offices are not eligible for Pharmacy Cost payments.

Medical Cost Efficiency

The Medical Cost Efficiency incentive assesses and rewards practices on the management of their total overall medical cost in comparison to their pediatric peers. Medical cost is defined as Independence's contractual allowed amount paid to the practice of member liability (e.g., copayment, coinsurance, deductible) and Coordination of Benefits funds.

The following costs and members are excluded from this incentive:

- prescription drugs paid through the pharmacy benefit;
- members younger than 2 as of the last day of the reporting;
- home health/hospice services;
- mental health/substance use disorder costs;
- vaccination costs (vaccine and administration);
- high-cost claimants:
  - Commercial HMO/POS members with greater than $25,000 in total annual medical costs.
  - Personal Choice and National Blue Care PPO members with greater than $28,750 in total annual medical costs.
- HMO/POS members must be with the practice for at least 11 months of the measurement year. PPO members must be continuously enrolled with Personal Choice, Personal Choice 65 PPO, or a National BlueCard PPO plan for at least 11 months of the measurement year.

Practice and member eligibility requirements

In addition to the QIPS program participation and eligibility requirements outlined on pages 2 – 4, the following practice and member eligibility requirements are specific to the Medical Cost Efficiency incentive:

- Practices who have an eligible vaccination population of at least 20 members and a vaccination rate below 15 percent for that population will not be eligible for cost incentive payments.
- Practices must have an average panel size of 200 commercial HMO/PPO/POS and National BlueCard PPO members for the measurement year to be eligible for the commercial Medical Cost Efficiency incentive.

Practice score calculation

The Medical Cost Efficiency incentive is based on each practice's total cost risk-adjusted PMPM.[§] The risk-adjusted PMPM will be used to percentile rank the pediatric practices. Each practice, based on the percentile rank, will be assigned to one of four tiers, as shown in the chart on the next page.

[§]*Risk-adjustment is performed using Verisk DxCG Risk Scores. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's PMPM costs are then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on their PMPM costs, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their PMPM costs.*

Incentive payment

The Medical Cost Efficiency incentive is paid in a one-time lump sum payment annually via EFT in the year following the measurement year (e.g., measurement year 2021; anticipated payment in October 2022). Practices whose total risk-adjusted medical costs fall within the first three of the four tiers will be paid on a fixed PMPY basis, based on the following:

- Total populations of capitated HMO/POS and current attributed PPO and National BlueCard PPO membership on record as of the month during which the Medical Cost Efficiency incentive is paid;
- The tier corresponding to the percentile rank earned, as indicated in the chart below.

The following chart outlines the Medical Cost Efficiency payments for measurement year 2021:

Primary care practice percentile rank	Commercial HMO/POS/PPO PAMPY/PMPY
Tier 1 (≥75th)	$18.00
Tier 2 (50 – 74.99%)	$10.80
Tier 3 (25 – 49.99%)	$2.40
Tier 4 (<25%)	$0.00

Access to Care

The Access to Care measure offers an incentive for avoiding Urgent Care/ED utilization. Members are using urgent care centers and the ED for services that their pediatrician already provides. This measure will evaluate and percentile rank pediatric practices on their members' utilization of Urgent Care Centers and the ED for avoidable services.

Practice and member eligibility requirements

In addition to the QIPS program participation and eligibility requirements outlined on pages 2 – 4, the following practice and member eligibility requirements are specific to the Urgent Care/ED utilization incentive:

- Practices who have an eligible vaccination population of at least 20 members and a vaccination rate below 15 percent for that population will not be eligible for cost incentive payments.
- Practices must have an average panel size of 200 commercial HMO/PPO/POS and National BlueCard PPO members for the measurement year to be eligible for the commercial Total Cost Efficiency incentive.

Performance calculation and incentive payment

A provider's performance in this incentive is calculated by combining potentially avoidable ED visits and urgent care events and computing as a risk-adjusted* rate per 100 eligible members to determine a practice's performance in this measure. That rate per 100 will then be compared and percentile-ranked among the pediatric practices. *Note:* ER visit that results in an admission or where a minor or ambulatory surgical procedure was required will be excluded.

**Risk-adjustment is performed using Verisk DxCG Risk Scores. The most recent risk scores of the measurement year for each practice's eligible member is taken, and a mean risk score is calculated based on that membership. These mean risk scores are normalized against a practice's specialty group peers who are also participating in QIPS. A practice's avoidable ED plus urgent care utilization rate is then adjusted according to its normalized mean risk score. Practices with a "higher risk" membership relative to their peers' memberships will see a diminishing effect on*

their utilization, while practices with a "lower risk" membership relative to their peers' memberships will see an inflationary effect on their utilization."

The program is paid in a one-time lump sum payment annually via EFT in the year following the measurement year (e.g., measurement year 2021; anticipated payment in October 2022). Practices whose risk-adjusted visit target fall within the 5 tiers will be paid on a fixed PMPY basis, based on the following:

- Total populations of capitated HMO/POS and current attributed PPO and National BlueCard PPO membership on record as of the month during which the Access to Care incentive is paid;
- The tier corresponding to the percentile rank earned, as indicated in the chart below.

The following chart outlines Access to Care payments for measurement year 2021:

Primary care practice percentile rank	Commercial HMO/POS/PPO PAMPY/PMPY
Tier 1 (≥95th)	$36.00
Tier 2 (85 – 94.99%)	$19.20
Tier 3 (75 – 84.99%)	$12.00
Tier 4 (50 – 74.99%)	$2.40
Tier 5 (<50%)	$0.00

Care Management Fee (For CPC+ practices only)

The Care Management Fee (CMF) is an additional PMPY (per member per year) payment based on the number of Independence members enrolled in a Medicare Advantage HMO/PPO plan who are assigned to the practice and is made for the purpose of supporting population health and care coordination activities for these members.

The following chart identifies the CPC+ tracks assigned by CMS, indicates the anticipated payment schedules, and explains how the CMF payment is calculated based on PMPY:

Care Management Fee payments			
CMS-assigned track	**PMPY**	**Payment cycle**	**Payment determination**
Track 1*	$12.00	Annually	PMPY X current month's Medicare Advantage HMO/PPO membership
Track 2*	$36.00	Annually	PMPY X current month's Medicare Advantage HMO/PPO membership

**Practices are assigned a track by CMS.*

Please note the following regarding CMF payments:

- CMF payments will be paid annually (December 2021) via EFT. *Note:* This date is a target and may vary depending on availability of data and other factors
- Practices will receive a CMF payment based on the track assigned to them by CMS.
- Rosters that support the CMF payments are available at a member level and can be viewed on PEAR AR.

Retroactivity will NOT apply to payments. Payment is based on panel size at the time of payment. A practice must be participating with Independence at the time of payment to be eligible to receive payment. If a practice merges with or is acquired by another practice, the surviving/acquiring practice will be eligible to receive the merged/acquired practice's QIPS program payment. Please review ***Appendix B: How changes to your practice composition affect your QIPS program eligibility and payment*****,** which outlines various scenarios and describes how each would affect your QIPS program eligibility and payments.

Practices that perform at or above the 40th percentile in the QPM score program in measurement year 2020 are eligible for CMF payments. If a practice has a QPM score program score below the 40th percentile, the practice is not eligible to receive CMF payments.

Note: This program is set to end in December 2021. There will not be a CMF payment in 2022.

QIPS program

Appendices

Appendix A: General information

Program recognition

The QIPS program has received recognition from the following BCBSA and CMS initiatives:

- **Total Care.** TC is an initiative of the BCBSA that integrates select value-based programs across the country and creates a comprehensive national solution for multi-state employers. TC identifies physicians and hospitals participating in these selected local value-based programs — programs that are designed to lower cost trends through better coordinated, patient-centered care and evaluate practice payments based on quality performance and cost outcomes. To be considered for TC designation, a practice must be part of a value-based program with a local Blue plan that has met BCBSA's nationally consistent selection criteria, such as Independence's QIPS program. Practices recognized as a TC practice are indicated as such within Independence's online Find a Doctor tool at www.ibx.com and on the BCBSA's National Doctor and Hospital Finder. In order to maximize attribution of National BlueCard® PPO members, practices should submit professional claims to Independence.
- **Total Care+.** TC+ recognizes TC practices that are delivering high-quality care at a lower cost. These practices are identified using a methodology that incorporates BCBSA's national selection criteria and a practice's performance in the QIPS program.
- **Comprehensive Primary Care Plus.** CPC+ is an alternative payment model led by CMS and private payer partners. CPC+ is the largest-ever initiative designed to:
  - transform how primary care is delivered and paid for in the United States;
  - give primary care practices greater flexibility and resources to invest in improving the quality and efficiency of care they provide patients;
  - reduce unnecessary health care utilization.

  CMS has selected Independence as a payer partner in the Greater Philadelphia region for Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

  Practices participating in the CPC+ program with CMS are eligible for a Care Management Fee (CMF).

  Note: This program is set to end in 2021.

Member attribution

The following methodology is used to determine your practice's attributed membership:

- Identify members for attribution:
  - Independence members who live in the following Pennsylvania counties: Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northampton, and Philadelphia;
  - National BlueCard PPO members who live in the five Pennsylvania counties identified above. These are members of other Blue Cross and/or Blue Shield plans, and the data for these members is provided by the BCBSA. In order to obtain credit for services provided to National BlueCard PPO members, practices should submit professional claims to Independence. Claims sent to plans other than Independence for processing will not result in credit for meeting the QIPS program measures.
- Using an 18-month history, identify the member's primary care utilization patterns.
- Attribute to primary care practices based on plurality of visits. The "most recent visit" determines the primary care practice assignment in the case of a tie of visit counts.

PEAR portal: Registration and reporting

The PEAR portal provides fast, secure web access to applications designed to help you manage your clinical and certain financial activities. In addition, it is a vehicle for you to obtain a variety of plan information specific to your organization as well as reports to assist you with providing care for Independence members. In 2019, PEAR AR, our provider reporting tool, was the first PEAR portal application introduced.

PEAR AR is an online, self-service, and on-demand reporting tool for providers in the Independence network. Through PEAR AR, providers have access to timely data, including clinical care gaps (e.g., colorectal cancer screening, mammography, diabetic care), and actionable incentive program reports, delivered through a secure web connection. This centralized site allows providers to review and compare their performance to their peers' and identify gaps in care and opportunities for improvement. PEAR AR also provides a variety of practice-level reports and dashboards to show a real-time view of data specific to your practice or entity.

PEAR AR is an essential tool for providers and access to this tool is a requirement for practices that participate in the QIPS program. It helps with analyzing and utilizing real time data to aid in QIPS performance. PEAR AR is the repository for preliminary QIPS reports supplied during the measurement year and year end QIPS final performance results.

If your practice has not registered for the PEAR portal, please review the registration instructions outlined in the PEAR portal section of the Provider News Center at www.ibx.com/pnc/pearportal. *Note:* If your practice is part of an Integrated Delivery System, you will need to contact your PEAR Organization Administrator for additional information.

Appendix B: How changes to your practice composition affect your QIPS program eligibility*

Practice scenario	Description	Scoring impact
Provider number transfer	A participating practice has a change to its tax ID or ownership. The practice requires a new provider number.	The practice's percentile rank and/or qualifying level will transfer with it to the new provider number.
Merge	Two practices merge or combine during the measurement year (2021) or after the measurement year.	If practices merge during the measurement year (2021) or after and individual program scores have not been finalized and it is prior to the payment month (i.e., August 2022), the information from the individual practices will be combined to create each measure target/percentile rank for the merged practice. The new targets/percentile rank will be used for the 2022 payment year. Before the incentive payment has been issued, if practices merge after the measurement year (2021) and individual program scores have been finalized and applied to the pre-merged practices, the targets for the newly formed practice will be based on combining the numerator/denominator of the two practices to determine the band level achieved for each measure. For those measures that are percentile ranked, the newly formed practice will acquire a new score by determining the percentage of membership each practice contributed to the total combined membership and applying that percentage to the scores that were created pre-merge. If practices merge after the payment is made, then payments will remain with the pre-merged entities. If a band level/percentile rank was not available to one of the two practices because that practice did not meet the eligibility requirements, the merged practice will be given the band level/percentile rank of the scored practice only.
Providers leave a practice	A physician or physicians leaves a practice. The original practice remains active.	Performance scoring (i.e., band level/percentile rank) will remain with the original practice and will not migrate with the departing physicians.

Practice scenario	Description	Scoring impact
Practice dissolution	Practices terminate out of the network; all providers in the practice retire and cease practicing immediately; or a sole practitioner is deceased and the practice dissolves.	If a practice is terminated or is otherwise dissolved, it will not qualify for the QIPS program payment. If a new practice is formed, it will qualify for the QIPS program once it meets the participation and eligibility requirements, but any payment eligible to the old practice will not transfer to the new practice.

**This information is intended as a guideline to be used when certain practice composition changes occur. Each practice's situation will be reviewed on an individual basis, and these guidelines will assist us in determining the impact to each QIPS program component.*

Note: Any changes in practice composition must comply with the practice's Independence provider participation agreement and Independence's policies and procedures in order to remain eligible for payment. A change in practice composition could result in a delay of payment (eligibility requirements and opt-in requirements still apply), and appropriate adjustments will need to be manually calculated.

Appendix C: Quality measures for measurement year 2021[a]

Measure	Description	Eligible members
Childhood immunizations[b] **(Pediatric practices only)**	Children who turned 2 during the measurement year (2021) and who were identified as having each of the following: • four DTap on or before the 2nd birthday; • three IPV on or before the 2nd birthday; • three H influenza type B (HiB) on or before the 2nd birthday; • MMR – one MMR vaccination on or between the child's 1st and 2nd birthday; AND – at least one measles and rubella vaccination on or between the child's 1st and 2nd birthday AND one of the following: – at least one measles vaccination administered between the child's 1st and 2nd birthdays or history of measles illness on or before the child's 2nd birthday; OR at least one mumps vaccination administered between the child's 1st and 2nd birthdays; OR history of mumps illness on or before the child's 2nd birthday; OR at least one rubella vaccination administered between the child's 1st and 2nd birthdays or history of rubella illness on or before the child's 2nd birthday; – any combination that indicates evidence of all three antigens (on the same or different date of service). • one varicella (VZV) on or between the child's 1st and 2nd birthdays; **or** a history of varicella zoster illness on or before the child's 2nd birthday; • four pneumococcal conjugate (PCV) on or before the 2nd birthday; • at least two influenza vaccinations on or before the 2nd birthday, but not prior to age six months (180 days after birth): – one of the two vaccinations can be a LAIV vaccination administered on the child's second birthday; • two or three rotavirus, depending on the vaccine type, on or before the 2nd birthday; – two doses of Rotarix®; OR – one dose of Rotarix® and two doses of RotaTeq®; OR – three doses of RotaTeq®. *Note:* For DTaP, IPV, HiB, VZV, and PCV, a vaccination administered from birth to age 42 days cannot be counted.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who turned 2 during the measurement year (2021).

Measure	Description	Eligible members
Adolescent immunizations[b] **(Pediatric practices only)**	**Meningococcal** Adolescents who turned 13 during the measurement year (2021) and who were identified as receiving one dose of the meningococcal vaccine on or between the member's 11th and 13th birthdays.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who turned 13 during the measurement year (2021).
	Tdap Adolescents who turned 13 during the measurement year (2021) and who were identified as receiving one dose of Tdap (tetanus, diphtheria toxoids, and acellular pertussis) on or between the member's 10th and 13th birthdays.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who turned 13 during the measurement year (2021).
	HPV Adolescents who turned 13 during the measurement year (2021) and who were identified as receiving at least two HPV (human papillomavirus) vaccines, with dates of service at least 146 days apart between the member's 9th and 13th birthdays or the member received three doses of the HPV (human papillomavirus) vaccine, with different dates of service on or between the member's 9th and 13th birthdays.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who turned 13 during the measurement year (2021).
Well-care visits[b]	**Well-child visits in the first 30 months of life[c] (Pediatric and adult practices)** Children who had the following number of well-child visits with a PCP during the last 15 months: • **Well-child visits in the first 15 months.** Six or more well-child visits that occur with a PCP on different dates of service *after 31-days after birth and on or before the child's 15-month birthday*. • **Well-child visits for 15 – 30 months.** Two or more well-child visits that occur with a PCP on different dates of service *between the child's 15-month birthday plus 1-day and the 30-month birthday*. Each well-child visit should include the following: physical exam, health history, physical developmental history, mental developmental history, and health education/anticipatory guidance.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and: • For well-child visits for the first 15 months of life, children who turn 15 months old during the measurement year (2021). Calculate the 15-month birthday as the child's 1st birthday plus 90 days. • For well-child visits 15 – 30 months, children who turn 30 months old during the measurement year (2021). Calculate the 30-month birthday as the 2nd birthday plus 180 days.

Measure	Description	Eligible members
Well-care visits[b] (continued)	**Child and adolescent well-care visits**[d] **(Pediatric and adult practices)** Children and adolescents who were 3 through 21 as of December 31 of the measurement year (2021) and have had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (2021).	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who were 3 through 21 as of December 31 of the measurement year (2021).
Cancer screenings[b] **(Adult practices only)**	**Breast cancer screening** Women 50 through 74 who had one or more mammograms any time on or between October 1 two years prior to the measurement year (October 1, 2019) and December 31 of the measurement year (December 31, 2021).	Women who were with a practice for 11 consecutive months within the measurement year (2021) and who were 52 through 74 as of December 31 of the measurement year (2021).
	Cervical cancer screening Women 21 through 64, during the measurement year (2021), who received one or more Pap tests during the measurement year (2021), or two years prior to the measurement year (2020 and 2019). Women 30 through 64, as of December 31 of the measurement year (2021) who had a high-risk human papillomavirus (hrHPV) test during the measurement year (2021) or the four years prior to the measurement year (2020, 2019, 2018, 2017). Women 30 through 64 as of December 31 of the measurement year (2021) who had a cervical cytology/high-risk human papillomavirus (hrHPV) test during the measurement year (2021), or the four years prior to the measurement year (2020, 2019, 2018, 2017).	Women who were with a practice for 11 consecutive months within the measurement year (2021) and who were 24 through 64 as of December 31 of the measurement year (2021).

Measure	Description	Eligible members
Cancer screenings[b] (continued)	**Colorectal cancer screening** Members 50 through 75 who had appropriate screening for colorectal cancer using any one of the following criteria: • fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year (2021) (CPT code 82270 or 82274 or HCPCS code G0328 only); OR • flexible sigmoidoscopy during the measurement year (2021) or four years prior (2020, 2019, 2018, 2017); OR • colonoscopy during the measurement year (2021) or nine years prior (2020, 2019, 2018, 2017, 2016, 2015, 2014, 2013, 2012). An FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening. *Note:* Cologuard (FIT-DNA) is considered a Tier 2 Test[e]; therefore, credit will not be given for completion of this test in QPM. Members who have a Cologuard test performed will be removed from the numerator and denominator when calculating performance for this measure.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who were 51 through 75 as of December 31 of the measurement year (2021).
Diabetes composite **(Adult practices only)**	Members who were 18 through 75 with diabetes (type 1 or type 2) and had each of the following performed: • HbA1c control (HbA1c < 8.0%) in the measurement year (2021); • Dilated retinal eye examination in the measurement year (2021) or a dilated retinal eye exam that is negative for retinopathy in the year prior to the measurement year (2020) by an ophthalmologist or optometrist; *Note:* CPT®II code 3072F, which reflects history of a dilated retinal exam negative for retinopathy the year prior (2020), should be submitted on claims for patients who have a diagnosis of diabetes in the measurement year (2021) but had a dilated retinal exam that was negative for retinopathy in the year prior to the measurement year (2020). Be sure to document in the patient's medical chart, using code 3072F, to indicate that he or she had a negative result in the year prior to the measurement year (2020).	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who were 18 through 75 as of December 31 of the measurement year (2021) who were identified as diabetics through pharmacy data and claims/encounter data in the measurement year (2021) or the year prior to the measurement year (2020).

Measure	Description	Eligible members
Diabetes composite (continued)	• nephropathy screening in the measurement year (2021) – documentation of any of the following: – urine for albumin or protein; OR – a visit to a nephrologist; OR – a renal transplant; OR – evidence of ACE/ARB therapy; OR – chart notes addressing any of the following: ○ diabetic nephropathy ○ renal insufficiency ○ proteinuria ○ albuminuria ○ end-stage renal disease ○ chronic kidney disease ○ chronic renal failure ○ acute renal failure ○ dialysis, hemodialysis, or peritoneal dialysis ○ renal dysfunction	
Acute care (Adult practices only) Other category	**Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis** Members 3 months of age and older who were identified as having a diagnosis of acute bronchitis through claims for outpatient or ED visits between July 1 of the year prior to the measurement year (2020) through June 30 of the measurement year (2021) and who were *not* dispensed an antibiotic.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who were 3 months of age and older, who were identified through outpatient and ED visit claims as having a diagnosis of acute bronchitis, who were continuously with a practice for one year prior to the diagnosis date through seven days after the diagnosis date, and who met all of the following criteria: • no active antibiotic prescription or any new antibiotic dispensed within the 30 days prior to the diagnosis date; • outpatient visit, telephone visit, online assessment, observation visit, or ED visit that resulted in the diagnosis of acute bronchitis/bronchiolitis. • No other upper respiratory or other infectious disease that required antibiotics within the 30 days prior to the diagnosis date through seven days after the diagnosis date;

Measure	Description	Eligible members
		• None of the following co-morbid conditions in the 12 months prior to the diagnosis date: – bronchiectasis – chronic bronchitis – COPD – cystic fibrosis – emphysema – extrinsic allergic alveolitis – HIV disease – HIV, asymptomatic – immunity disorders – malignant neoplasms – other respiratory system diseases – pneumoconiosis and other lung disease due to external agent – tuberculosis
Chronic care (Adult practices only) **Other category**	**Persistence of beta-blocker treatment after a heart attack** Members who were 18 and older who were hospitalized with a diagnosis of acute myocardial infarction (AMI), discharged alive on or between July 1 of the year prior to the measurement year (2020) and June 30 of the measurement year (2021) and who received persistent beta-blocker treatment for six months after discharge.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who were 18 and older as of December 31 of the measurement year (2021) who were discharged alive from an acute inpatient setting with an AMI on or between July 1 of the year prior to the measurement year (2020) and June 30 of the measurement year (2021) through 179 days after discharge. If there is more than one episode of AMI during the time frame, only the initial episode discharge date is used.
	Osteoporosis management in women who had a fracture Women who were 67 through 85 who had a diagnosis of a fracture on or between July 1 of the year prior to the measurement year (2020) and June 30 of the measurement year (2021) and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.	Members who were with a practice for 11 consecutive months within the measurement year (2021) and who were 67 through 85 as of December 31 of the measurement year (2021) who had a diagnosis of fracture (excluding pathological fractures or fractures of the fingers, toes, face, or skull) on or between July 1 of the year prior to the measurement year (2020) and June 30 of the measurement year (2021), who had no prior diagnosis of fracture in the two months prior to the fracture date, who did not

Measure	Description	Eligible members
		have a BMD test in the 24 months prior to the date of the fracture, and who did not receive any osteoporosis treatment during the 12 months prior to the date of the fracture.
Chronic care (continued)	**Statin therapy for patients with cardiovascular disease and/or diabetes – dispensed** Members with cardiovascular disease and/or diabetes eligible for statin therapy who had at least one dispensing event for a statin medication of the appropriate intensity during the measurement year (2021).	Members who were with a practice for 11 consecutive months within the measurement year (2021) and the year prior to the measurement year (2020) with a diagnosis of diabetes or a diagnosis of cardiovascular disease (history of MI with an inpatient admission, CABG, PCI, or a diagnosis of IVD) who were 21 through 75 as of December 31 of the measurement year (2021) and did not have the following in the measurement year (2021) or the year prior to the measurement year (2020): • diagnosis of pregnancy • in vitro fertilization • dispensed at least one prescription for clomiphene (Clomid®) • ESRD • Cirrhosis • Myalgia • Myositis • rhabdomyolysis
	Statin therapy for patients with cardiovascular disease and/or diabetes – adherence The number of eligible members with cardiovascular disease and/or diabetes compliant with statin therapy for at least 80 percent of their treatment.	

[a]*Quality measures are based on HEDIS and are used as the baseline measurement for performance measure frequency of preventive health services. Note, however, that 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.*

[b]*This measure also applies to National BlueCard PPO members.*

[c]*Fifteen months of life is defined as the patient's first birthday plus 90 days.*

[d]*A visit counts as an encounter if the documentation includes the proper CPT or ICD preventive care codes.*

[e]*US Multi-Society Task Force on Colorectal Cancer (MSTF); (American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], and American Society for Gastrointestinal Endoscopy [ASGE]) JAMA May 28, 2019 Volume 321, Number 20.*

Appendix D: Practice payment scenarios

The following are examples of how payments will be calculated for high- and low-performing practices in our quality, improvement, and engagement incentives:

Practice scenario	Description	Scoring calculation
Family/General Practice or Internal Medicine/Geriatrics practices (accepting all patients) *Note:* Example of QPM score program calculation.	• Practice earns a Band 1 in each of the following quality measures: – Breast cancer screening – Colorectal cancer screening – Cervical cancer screening – Statin therapy composite • Practice earns a Band 3 in the Diabetes and Other composite measures and earned no improvement component. • Practice is not eligible for the Engagement incentive component. • Membership: – Commercial HMO/PPO: 450 – Medicare Advantage HMO/PPO: 175	**Commercial** • PAMPY/PMPY: – $7.80 X 4 (Number of measures at Band 1) = **$31.20** PAMPY/PMPY – $3.00 PAMPY/PMPY x 2 Number (Number of measures at Band 3) = **$6.00** PAMPY/PMPY **Payment calculation – commercial** $37.20 (total of $31.20 and $6.00) X 450 commercial members = **$16,740 (annually)** **Medicare Advantage** • PMPY/PAMPY: – $13.20 X 4 (Number of measures at Band 1) = **$52.80** PMPY/PAMPY – $8.40 x 2 (Number of measures at Band 3) = **$16.80** **Payment calculation – Medicare Advantage** $69.60 (total of $52.80 and $16.80) X 175 Medicare Advantage members = **$12,180 (annually)**

Practice scenario	Description	Scoring calculation
Family/General Practice or Internal Medicine/Geriatrics practices (accepting all patients) *Note:* Example of QPM score program, Improvement incentive, and Engagement incentive calculation.	• For QPM score program, practice earns: – Band 1 – Statin therapy composite – Band 2 – Breast cancer screening – Band 3 – Colorectal and cervical cancer screening – Band 4 – Diabetes composite (earned Improvement incentive) – Band 5 – Other composite measure (earned Improvement incentive) • Practice also eligible for Engagement incentive (no payment interruption) • Membership: – Commercial HMO/PPO: 1,000 – Medicare Advantage HMO/PPO: 189	**Commercial** • PMPY/PAMPY: – $7.80 X 1 (Number of measures at Band 1) = **$7.80** PAMPY/PMPY – $6.60 x 1 (Number of measures at Band 2) = **$6.60** PAMPY/PMPY – $3.00 x 2 (Number of measures at Band 3) = **$6.00** PAMPY/PMPY – $1.80 x 1 (Number of measures at Band 4) = $1.80 +$1.20 (Improvement incentive) = **$3.00** PAMPY/PMPY – $0.00 x 1 (Number of measures at Band 5 = $0.00 +$1.20 (Improvement incentive) = **$1.20** **Payment calculation – Commercial** $24.60 (total PMPYs of band levels and improvement achieved) X 1,000 commercial members = **$24,600 (annually)** **Medicare Advantage** • PMPY/PAMPY: – $13.20 X 1 (Number of measures at Band 1) = **$13.20** PAMPY/PMPY – $12.00 x 1 (Number of measures at Band 2) = **$12.00** PAMPY/PMPY – $8.40 x 2 (Number of measures at Band 3) = **$16.80** PAMPY/PMPY – $7.20 x 1 (Number of measures at Band 4) = $7.20 +$1.20 (Improvement incentive) = **$8.40** PAMPY/PMPY – $0.00 x 1 (Number of measures at Band 5 = $0.00 +$1.20 (Improvement incentive) = **$1.20** **Payment calculation – Medicare Advantage** $51.60 (total PMPYs of band levels and improvement achieved) X 189 Medicare Advantage members = **$9,752.40 (annually)** **Engagement payment calculation – Commercial and Medicare Advantage** $0.60 PAMPM/PMPM x 1,189 (Commercial and Medicare Advantage members) = **$713.40** (monthly engagement payment without payment interruption.

Practice scenario	Description	Scoring calculation
Pediatric practices (accepting all patients) *Note:* Example of QPM score program calculation.	For the QPM score program, practice earns a Band 1 in both the Well-visit composite and Vaccination composite. Commercial HMO/PPO membership: 500	**Commercial** PAMPY/PMPY: $28.80 X 2 (composite measures at Band 1) = **$57.60** PAMPY/PMPY **Payment calculation – Commercial** $57.60 X 500 commercial members = **$28,800 (annually)**
Pediatric practices (accepting all patients) *Note:* Example of QPM score program calculation.	For the QPM score program, practice earns a Band 5 in the Well-visit composite and Band 2 in the Vaccination composite. Commercial HMO/PPO membership: 325	**Commercial** PAMPY/PMPY: • $0.00 X 1 (Well-visit composite at Band 5) = **$0** PAMPY/PMPY • $19.20 X 1 (Vaccination composite at Band 2) = **$19.20** **Payment calculation – Commercial** $19.20 X 325 commercial members = **$6,240 (annually)**