Section 3: QIPS resources and reports

The PEAR Analytics & Reporting (AR) application is essential to help manage your patient population and aid your performance in the QIPS program. Reports are accessible in PEAR AR throughout the year. You can print or download these reports as needed. When reports become available, we will notify you through various channels, such as an email to the address provided when you opted in, a message on our dedicated QIPS Resources page, or a PEAR notification.

The below section identifies the reports available to assist in QIPS, as well as the financial dashboard to monitor your financial progress.

Standard reports

These reports are published yearly and can be found in the "Output Manager" section of PEAR AR:

- **Preliminary Score Report.** Available in the 2nd quarter (typically around April), this report is a preview of your anticipated year-end QPM performance. It includes a measure-level summary of completed services for your eligible HMO/POS/PPO members, your preliminary band level, and year-over-year performance. *Note: Band levels may change after the QPM feedback process (outlined in sections 5 and 6) and additional claims data is taken into consideration. Therefore, it may not reflect final payment or performance.*
- **QIPS Final Report.** This report will be available in the 3rd quarter (typically around August). It provides your final performance in all QIPS program components. The report contains a summary of estimated earned incentives, band- and ranking-levels, and incentive-level supporting details.
- **QIPS Entity Report.** This report is available to practices with multiple offices. It is an Excel spreadsheet that summarizes the QIPS Final Reports for all offices associated with that practice.
- **Medication Reconciliation.** This report identifies Medicare Advantage members who were recently discharged from the hospital. You can review the medications listed on the report and take any additional steps to close open care gaps for the member.

Real-time reports

PEAR AR offers a variety of reports in the "Report Center" that are helpful to frequently download throughout the measurement year. Also, navigational videos associated with these reports are located on the PEAR Help Center to aid in your QIPS performance.

- **Attributed Member Snapshot.** This report lists your attributed Independence membership to help your practice target patients who need care and identify if they are eligible for additional services.
- **Gaps in Care report.** This report identifies your open care gaps on a real-time, monthly basis.
- **Pharmacy reports.** These reports help you identify the spend in utilization of all prescriptions prescribed to your patients, compare and evaluate if high-cost drugs are being prescribed, and provide detailed information on your patients who are on maintenance therapy drugs for Hypertension, Hyperlipidemia, or Diabetes and their

respective adherence to these medication regiments. These reports include Pharmacy Cost, RX Adherence and Usage Report, and High-Cost Drug Report.

- **Medical Cost and Utilization and Analytics reports.** These reports detail medical costs and utilization for your practice. You can access cost and total reimbursement for medical services incurred by your patients.
- **Emergency Department (ED) and Urgent Care (UC) Visit Analytics report.** This report identifies your patients who had an ED or UC visit in a specified period. It provides insight into those visits that potentially could have been avoided.
- **Payment Rosters.** These member-level reports support your financial payments that are issued with your incentive payments (yearly or monthly depending on the incentive).

Resources

- **Financial Dashboard.** The dashboard can be found under "Practice Financial Overview" on the PEAR AR home page. This real-time dashboard identifies your progress in reaching your QPM targets for each measure, the potential earnings opportunities available, and a detailed transaction check registry of all reimbursements made to your office.
- **ACT Now cards.** These action cards can be found at the top of the PEAR AR home page. They help identify your patients who have been recently hospitalized and need a follow-up visit.
- **Gap Closures Guide.** This guide provides measure-specific information on how to document the closure of gaps in care and is available in the PEAR Help Center.
- **QIPS Resources.** This page, on the Provider News Center, provides you with all the QIPS news you need to know, including deadlines, new measures, available resources, alerts, guides, manuals, etc. We encourage you to bookmark this page and check it frequently.

Reference

When it comes to attributing membership to your practice and for reporting purposes, members can be attributed in two ways.

1. For your patients with an HMO plan, they select their primary care practice (PCP). Based on that selection, that member is then 'capitated' to the practice of their choosing. The selected practice will be paid on that member, and that member will appear on all practice-specific reports.
2. For your patients with a PPO plan, they do not have to select a PCP; therefore, the following methodology is used to determine your practice's attributed PPO membership:
    a. Identify member for attribution:
        - Independence members who live in the following Pennsylvania counties: Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northampton, and Philadelphia.
        - National BlueCard® Commercial PPO members who live in the five-county Pennsylvania service area. These are members of other Blue Cross and/or Blue Shield plans, and the data for these members is provided by the BCBSA. To obtain credit for services provided to National BlueCard

Commercial 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.

b. Using an 18-month history, identify the member's primary care utilization patterns.

c. Attribute to PCPs based on plurality of visits. The "most recent visit" determines the primary care practice assignment in the case of a tie of visit counts.