Quality Incentive Pool (QIP) Program Evaluation Report

Program Year (PY) 7
January 1, 2024, to December 31, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Executive Summary

Beginning on July 1, 2017, the Department of Health Care Services (DHCS) implemented a managed care directed payment program, the Quality Incentive Pool (QIP) program. QIP advances the state's goal of enhancing quality in DHCS programs by incentivizing Designated Public Hospital (DPHs) and District and Municipal Public Hospitals (DMPHs) to expand Medi-Cal members' access to preventive services, screenings, and wellness programs. In QIP Program Year (PY) 7 (Calendar Year 2024), in alignment with the DHCS Comprehensive Quality Strategy, DHCS strengthened the requirements for DPHs and DMPHs to improve on both priority and elective measures. For CY 2024, the QIP program had a budget of $2.2 billion.

The purpose of this evaluation is to determine if QIP directed payments resulted in improvement in the quality of inpatient and outpatient services for Medi-Cal members assigned to or seen by DPHs and DMPHs. The state analyzed aggregate data reported by DPHs and DMPHs to DHCS pertaining to the performance measures.

DPHs showed collective improvement on 16 out of 20 measures (with the exception being decreases on childhood immunization measure), and DMPHs showed improvement on 14 measures (with the exception being decreases for the childhood immunization and prenatal and timeliness to prenatal care measures). Both DPHs and DMPHs showed improvement on many of the elective measures for 2023 compared to 2023. DPHs' overall improvement on priority measures ranged from 0.0 percent to 12.9 percent, and for DMPHs ranged from 0.9 percent to 14.1 percent.

The major goal of QIP is to improve disease prevention and primary care access and quality of clinical services for all Medi-Cal members at public health care systems. In CY 2024, QIP expanded the set of required priority measures; this decision was accompanied by fewer DPHs and DMPHs meeting their performance targets, but broad improvement in overall clinical quality. Falling childhood immunization and diabetes rates indicate a need to focus quality improvement efforts on these measures.

BACKGROUND

Beginning on July 1, 2017 (state fiscal year 2017-18), the Department of Health Care Services (DHCS) implemented a managed care directed payment program, the Quality Incentive Pool (QIP) program. QIP integrates supplemental payments that were previously made to public hospitals and provides quality targets for chronic disease management. It distributes these payments in compliance with the managed care final rule [42 Code of Federal Regulations (CFR) 438.6(c)] by linking payments to utilization and delivery of services under managed care plan (MCP) contracts. QIP advances the state's managed care quality strategy goal of enhancing quality in DHCS programs by supporting public hospitals and health systems to deliver effective, efficient, and affordable care. This program encourages preventive services, screenings, and wellness programs for Medi-Cal members. These efforts aim to promote early detection and disease prevention. The system also promotes Medi-Cal members' care coordination among healthcare providers ensuring seamless transitions between different levels and settings of care. The QIP program promotes access and value-based payment, increasing the amount of funding tied to quality outcomes, while at the same time further aligning state, managed care plan (MCP), and hospital system targets. The QIP program is authorized by California Welfare and Institutions Code section 14197.4(c).

For PY7, from January 1, 2024, to December 31, 2024, 17 Designated Public Hospitals (DPHs) and 31 District and Municipal Public Hospitals (DMPHs) participated; one DMPH (Palo Verde Hospital) did not report any data due to data unavailability, and one DMPH (Trinity Hospital) opted not to participate in CY 2024 reporting, so they are excluded from this report. There were 56 total performance measures across nine measure categories. QIP performance measures included process and outcome measures drawn from nationally vetted and endorsed measure sets (e.g., National Quality Forum, National Committee for Quality Assurance, the Joint Commission). Among these measures, the required priority measure sub-set were measures that were of high priority to the state and to Medi-Cal MCPs. The elective measures were additional measures chosen by QIP entities themselves to complete their required number of measures. QIP Program Policies contains more information on compliance requirements and payments. For calendar year (CY) 2024, the Centers for Medicaid and Medicare Services (CMS) approved the DPH and DMPH preprints on July 24, 2024, and August 5, 2024, respectively, with a budget of $2.2 billion. Annual QIP Evaluations are posted on DHCS' QIP website and shared with CMS.

Reporting for DPHs and DMPHs

DPH systems were required to report a total of 40 measures, 20 of which were from the priority measure sub-set. If a DPH did not report on at least the minimum number or measures required, the DPH did not receive any QIP payment for CY2024. DPH system allocation was based on proportion of Medi-Cal managed care members served in the given year.

Each DMPH was required to report on at least its minimum number of measures committed. Due to variance in size and services offered, DMPHs were grouped into two tiers determined by annual DMPH Medi-Cal revenue. Tier 1 was required to commit to a minimum of 2 and maximum of 12 measures, and Tier 2 was required to commit to a minimum of 10 and maximum of 20 measures. DMPHs with in-house primary care or those providing the relevant clinical services reported at least 50% of their committed measures from the priority measure sub-set. If a DMPH did not report on at least the minimum number of measures they attested to report, the DMPH did not receive any QIP payment for CY 2024. DMPH allocation was based on their Medi-Cal revenue and the number of selected measures chosen to report relative to all other participating DMPHs.

Data with denominators of at least 30 were reported since this is the minimum denominator for quality measures per NCQA standard to ensure mathematical reliability. Individual QIP entity performance targets were calculated according to the 10% gap closure between the QIP entity's prior calendar year performance (baseline) and the current calendar year high performance benchmark.

In CY2024, QIP introduced the three "better of" measures which are Q-FUA: Follow-Up After Emergency Department Visit for Substance Use (FUA), Q-FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI), and Q-FUM: Follow-Up After Emergency Department Visit for Mental Illness (FUM) where some QIP entities opted to report MCP-produced rates instead of QIP entity-produced rates. For these three measures, MCPs generally have more comprehensive access to data to determine follow-up rates. Additionally, the introduction of "better of" rates is part of a broader strategy to move away from entity-produced rates; this transition is occurring to reduce administrative burden, reduce duplicative audits across MCPs and QIP entities, encourage data sharing between entities and MCPs, and enable MCPs to have a more complete picture of their members' health and health care.

Quality: Improving Health Equity 1 (Q-IHE1) was a priority measure and *Quality: Improving Health Equity 2* (Q-IHE2) remained an elective measure designed to improve health equity for select populations in select measures having statewide disparities.[1] For CY 2024, since Q-IHE1 is a priority measure, only those Eligible Equity Measures that are also priority measures were able to be chosen by entities for Q-IHE1. Entities reporting on Q-IHE2 could choose the measure and any of its priority populations from the QIP Eligible Equity Measures listed in Appendix B. The priority populations could be the same, but Q-IHE1 and Q-IHE2 were required to have two different eligible equity measures, and the parent measure (total population) was required to be reported. An entity could choose a priority population from the QIP Eligible Equity measure list, subject to the following requirements:

- The priority population had to be less than 50 percent of the parent measure's total population. This requirement ensured efforts in IHE measures did not duplicate efforts in the parent measure.
- The priority population baseline rate had to have 3 percentage points or greater disparity compared to the total population baseline rate of the parent measure.
- The priority population baseline rate could not be at or above the measure's 90th percentile benchmark.[2]

Given this flexibility, there was wide variation in the measures and populations chosen. No more than three DPHs chose to report on the same Q-IHE1 or Q-IHE2 measure, and there was no overlap in the measures reported by DMPHs.

For *Q-GSD: Glycemic Status Assessment for Patients with Diabetes*, three P4P rates were reported, one for Total Population and two rates for sub-populations (Hispanic/Latino ethnicity and Black/African American race) to encourage improvement in these sub-populations as well as in the total population. Any sub-rate which had a denominator of less than 30 was excluded from the calculation of the Total Achievement Value (AV), which was the average of the three AVs of the sub-rates. The requirement of a denominator of at least 30 was designed to ensure that QIP entities were incentivized based on statistically stable performance rates, and DHCS acknowledges that this limits the ability to incentivize improvement for smaller patient populations.

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[1] DHCS Health Disparities Report, Preventive Services Report, Behavioral Risk Factor Surveillance System - BRFSS Survey 2018, and CA HIV/AIDS Health Disparities 2019

[2] QIP uses the Medicaid benchmarks where a Medicaid-specific benchmark exists for a measure.

Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) and *Q-PPC-Pst: Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)* were a pair of priority measures. Entities were required to report both measures if they selected either one. The requirement to report both did not apply if a denominator was below 30 or the relevant service (e.g., prenatal care or postpartum care) was not offered by the health system.

QIP CY 2024 Data Audit

To support data integrity and ensure accountability for the QIP funds, DHCS partnered with an external auditor, Health Services Advisory Group, Inc. (HSAG), to assess QIP reports as part of its review and oversight process. National Healthcare Safety Network (NHSN) measures (*Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections* and *Q-SSI: Surgical Site Infection*) and California Maternal Quality Care Collaborative (CMQCC) measures (*Q-PC02: Cesarean Birth* and *Q-PC05: Exclusive Breast Milk Feeding*) were exempt from the scope of audit due to reported rates being considered validated by the above-mentioned organizations. If an entity reported Q-IHE1 and Q-IHE2, HSAG validated and audited the total rate for the parent measure. Any MCP-produced rates used for pay-for-performance in QIP were not subject to QIP audit.

EVALUATION PURPOSE

The purpose of this and future program evaluations is to determine if QIP directed payments made through DHCS contracts with Medi-Cal MCPs to contracted DPHs and DMPHs result in improvement in the quality of inpatient and outpatient services for Medi-Cal members assigned to and/or seen by DPHs and DMPHs.

Evaluation Questions

Specifically, this evaluation was designed to determine:

- For each DPH or DMPH, the percentage of measures for which they met their quality performance targets.

- For each measure, the aggregate improvement seen across all DPHs or DMPHs who reported on the measure; and

- For each measure, of DPHs or DMPHs reporting on that measure, what percentage met their quality performance targets.

EVALUATION DESIGN AND METHODS

The state used aggregate data reported by DPHs and DMPHs to DHCS pertaining to the performance measures listed in the Addendum Table 1A of the DMPH and DPH preprints.

DPHs and DMPHs submitted their data to DHCS in accordance with the QIP CY 2024 Reporting Manual, using a secure online reporting system. DHCS analysts and HSAG auditors then reviewed the reported data for accuracy. They asked clarifying questions or requested corrections, when necessary, before deeming the data final. DHCS conducted its analysis on 100 percent of the data received. The full datasets for QIP CY 2024 can be located on the California Health and Human Services (CHHS) open data portal.

Performance rates were aggregated across all DPHs or all DMPHs by dividing the sum of all DPH or DMPH numerators for a given measure by the sum of all DPH or DMPH denominators for that same measure. This approach ensured that all individuals included in the numerators and denominators were given an equal weight in the aggregate rates. To avoid statistically unstable rates, rates were suppressed when the denominator was less than 30 (except for risk-adjusted measures). Aggregate rates for 2023 and 2024 only included data from hospitals that reported data for both years (so that the two years are comparing data for the same hospitals). Changes from 2023 to 2024 were calculated as the absolute difference between the rates in the two years, expressed as percentage points.

For each hospital system, measure performance was assessed based on the amount of progress made toward achieving the performance target, which was defined as closing 10% of the gap between the 2023 performance and the 2024 high-performance benchmark for that measure. Hospitals with 2023 performance at or above the high-performance benchmark were required to maintain or exceed that measure's high-performance benchmark in 2024. The progress made toward achieving the measure's

performance target was given an Achievement Value (AV) as specified in Section VI Payment of the QIP PY7 (CY2024) Program Policies. Hospitals received an AV of 1 if they achieved the minimum performance benchmark, had a denominator of at least 30 patients, and met the 10% gap closure performance target. Otherwise, they received an AV of 0.

To calculate each hospital's percentage of measures where performance targets were met, DHCS calculated the percent of measures with AVs of 1 for each hospital. See Appendix B: Technical notes for more details.

A draft of this report was shared with stakeholders (DPHs, DMPHs, California Association of Public Hospitals/California Health Care Safety Net Institute, the District Hospital Leadership Forum, California Association of Health Plans, Local Health Plans of California, and MCPs) in May 2026 and their input was incorporated into the final report.

Methodology Limitations

For some measures when numerators were summed to calculate the aggregate performance rate, the total numerators were low. While summed numerators less than 11 were suppressed, there were other low numbers; therefore, a symbol was added to the figures when the summed numerator was less than 75. Also, the actual change reflects the percentage-point difference between aggregate rates across comparison years. These values are descriptive and should not be interpreted as evidence of statistically significant change unless statistical testing is explicitly reported. Interpretation should consider the number of reporting entities, consistency of reporting across years, and the underlying numerator and denominator counts.

RESULTS

Priority Measures

In 2024, 17 DPHs and 31 DMPHs submitted aggregated data to DHCS, which was used for all analyses. Numerators, denominators, achievement rates, and achievement values for each measure can be located on the (CHHS) open data portal.

Table 1 shows how many DPHs met performance targets for the 20 priority measures (Appendix Table A1 shows similar information for elective measures). The percent of DPHs meeting their target for each measure ranged from 41.2 percent to 94.1 percent

(excluding sub-rates). DPHs' actual change in performance rates on priority measures from 2023 to 2024 ranged from -1.4 percent to 12.9 percent, with the *Developmental Screening in the First Three Years of Life* measure exhibiting the largest improvement. Rates for one measure worsened from 2023 to 2024**:** by 1.4 percentage for *Childhood Immunization Status*.

In 2024, for the Improving Health Equity Measure (IHE1), DPHs were able to pick any priority measure and any population in the Eligible Equity Measure list based on the disparities experienced by their patient populations. Generally, only one DPH reported on each measure and each targeted population. The performance rates for all populations showed improvement from 2023 to 2024.

Table 1: Rate of DPHs Meeting Quality Improvement Targets and the Actual Percentage Changes in Performance Rates for Priority Measures from 2023 to 2024

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Asthma Medication Ratio (AMR)	14	17	82.4%	62.2%	66.7%	4.5%
Breast Cancer Screening (BCS-E)	16	17	94.1%	58.9%	62.9%	4.0%
Cervical Cancer Screening (CCS)	8	17	47.1%	48.1%	51.1%	3.0%
Cesarean Birth (PC02)[↓]	8	17	47.1%	22.8%	23.7%	0.9%
Child and Adolescent Well Care Visits	11	17	64.7%	49.2%	53.8%	4.6%
Childhood Immunization Status (CIS 10)	8	17	47.1%	41.9%	40.5%	-1.4%
Chlamydia Screening in Women	14	17	82.4%	67.5%	68.5%	1.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Colorectal Cancer Screening	15	17	88.2%	53.7%	56.7%	3.0%
Controlling High Blood Pressure (CBP)	15	17	88.2%	64.0%	66.3%	2.3%
Developmental Screening in the First Three Years of Life	16	17	94.1%	55.9%	68.8%	12.9%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
30 Days	13	17	76.5%	28.4%	33.2%	4.8%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
30 Days	11	17	64.7%	30.5%	35.0%	4.5%
Glycemic Status Assessment for Patients With Diabetes (GSD)[↓]						
Black/African American	8	17	47.1%	33.8%	33.2%	-0.6%
Hispanic/Latino	14	17	82.4%	32.3%	31.1%	-1.2%
Total Population	16	17	94.1%	31.6%	30.4%	-1.2%
Immunizations for Adolescents	10	17	58.8%	44.8%	50.2%	5.4%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Improving Health Equity 1[a]						
Asthma Medication Ratio (AMR) - Hispanic/Latino	0	1	0.0%	55.3%[b]	69.2%	13.9%
Breast Cancer Screening (BCS-E) - American Indian/Alaskan Native	1	1	100.0%	43.4%[b]	51.1%	7.7%
Breast Cancer Screening (BCS-E) - Black/African American	2	3	66.7%	57.0%	58.3%	1.3%
Breast Cancer Screening (BCS-E) - White	1	1	100.0%	53.6%	56.5%	2.9%
Cervical Cancer Screening (CCS) - Black/African American	2	2	100.0%	56.1%	59.8%	3.7%
Cesarean Birth (PC02-CH)[↓] - Black/African American	1	1	100.0%	31.9%	23.7%	-8.2%
Child and Adolescent Well Care Visits (WCV) - American Indian/Alaskan Native	1	1	100.0%	43.6%	64.0%	20.4%
Childhood Immunization Status (CIS) - White	1	1	100.0%	41.7%	47.4%	5.7%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Colorectal Cancer Screening - Black/African American	1	1	100.0%	52.0%	54.8%	2.8%
Controlling High Blood Pressure (CBP) - Black/African American	1	1	100.0%	55.9%	60.3%	4.4%
Controlling High Blood Pressure (CBP) - White	1	1	100.0%	64.5%[b]	67.3%	2.8%
Immunizations for Adolescents (IMA) - White	1	1	100.0%	27.8%[b]	36.6%	8.8%
Prenatal and Postpartum Care: Postpartum Care (PPC-Pst) - Black/African American	1	1	100.0%	70.5%	77.2%	6.7%
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) - Black/African American	1	1	100.0%	85.0%	95.1%	10.1%
Prenatal and Postpartum Care (Postpartum Care)	14	17	82.4%	81.7%	85.6%	3.9%
Prenatal and Postpartum Care (Timeliness of Prenatal Care)	12	17	70.6%	83.5%	86.3%	2.8%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention[c]						
Rate 2	12	17	70.6%	67.3%	73.1%	5.8%
Rate 3	7	17	41.2%	89.7%	89.3%	-0.4%
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	9	17	52.9%	82.2%	82.2%	0.0%
Well-Child Visit in the First 30 Months of Life						
First 15 Months	11	17	64.7%	71.7%	72.2%	0.5%
15 Months – 30 Months	12	17	70.6%	69.7%	75.2%	5.5%

The last two columns were only reported for measures whose performance rates were available in both 2023 and 2024. These aggregate percentage rates were calculated by dividing the sum of all numerators for a given measure by the sum of all denominators for that same measure.

All DPHs reported on all 20 priority measures

If Achievement Value was N/A then not counted for sub-rates so number reporting might be lower since not including N/A. Also not counted in the next columns Therefore, more hospitals may have reported on these measures, but due to having denominators less than 30 this information was not tied to payment so not counted in these tables.

[1]For these measures lower achievement rates indicate better care

[a]For the Improving health equity 1 measure, DPHs were able to report data on any measure and any population in the Eligible Equity Measure list

[b]Indicates that the aggregate numerator was less than 75

[c]For the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure rate 2 is the percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention, while rate 3 is the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user

Table 2 shows how many DMPHs met performance targets for the 20 priority measures (Appendix Table A2 shows similar information for elective measures). The percent of DMPHs meeting their target ranged from 33.3 percent to 100 percent. DMPHs were more likely to report the following two measures, *Breast Cancer* Screening (15) and *Glycemic Status Assessment for Patients with Diabetes* (14). DMPHs were less likely to report the *Follow-Up After Emergency Department Visit for Mental Illness* (2), *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (3) and *Developmental Screening in the First Three Years of Life (*3). No DMPH reported on the *Asthma Medication Ratio* measure. DMPHs' actual change in performance rates on priority measures from 2023 to 2024 ranged from -4.3 percent to 14.2 percent, with the greatest improvement on the *sub-rate of 30 days for the Follow-up After Emergency Department Visit for Mental Illness (FUM)* measure. Rates for two measures worsened from 2023 to 2024 *(Childhood Immunization Status and Prenatal and Postpartum Care (Timeliness of Prenatal Care)).*

In 2024, for the Improving Health Equity Measure (IHE1), DMPHs were able to pick any priority measure and any population in the Eligible Equity Measure list based on the disparities they see in their population. Generally, only one DMPH reported on each measure and each targeted population. DMPHs only meet the target rate for one of the three IHE1 measures they reported. For this measure the performance rates for all populations showed improvement from 2023 to 2024.

Table 2: Rate of DMPHs Meeting Quality Improvement Targets and the Actual Percentage Changes in Performance Rates for Pay-For-Performance Priority Measures from 2023 to 2024

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Asthma Medication Ratio (AMR)	a	a	a	a	a	a
Breast Cancer Screening (BCS-E)	12	15	80.0%	61.6%	66.5%	4.9%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Cervical Cancer Screening (CCS)	7	10	70.0%	55.4%	58.6%	3.2%
Cesarean Birth (PC02)↓	5	9	55.6%	22.1%	19.9%	-2.2%
Child and Adolescent Well Care Visits	8	10	80.0%	46.6%	52.3%	5.7%
Childhood Immunization Status (CIS 10)	3	6	50.0%	31.4%	30.2%	-1.2%
Chlamydia Screening in Women	6	8	75.0%	57.0%	59.1%	2.1%
Colorectal Cancer Screening	11	12	91.7%	37.1%	42.9%	5.8%
Controlling High Blood Pressure (CBP)	12	12	100.0%	61.1%	63.8%	2.7%
Developmental Screening in the First Three Years of Life	3	3	100.0%	38.6%	52.7%	14.1%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
30 Days	2	3	66.7%	32.7%	40.0%	7.3%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
30 Days	2	2	100.0%	49.5%	63.7%	14.2%
Glycemic Status Assessment for Patients With Diabetes (GSD)[1]						
Black/African American	N/A	14	b	b	b	b
Hispanic/Latino	11	14	78.6%	28.3%	24.8%	-3.5%
Total Population	13	14	92.9%	29.0%	24.9%	-4.1%
Improving Health Equity 1						
Asthma Medication Ratio (AMR) - Hispanic/Latino	a	a	a	a	a	a
Breast Cancer Screening (BCS-E) - American Indian/Alaskan Native	a	a	a	a	a	a
Breast Cancer Screening (BCS-E) - Black/African American	a	a	a	a	a	a
Breast Cancer Screening (BCS-E) - White	0	1	0.0%	68.30%	75.9%	7.6%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Cervical Cancer Screening (CCS) - Black/African American	a	a	a	a	a	a
Cesarean Birth (PC02-CH)[↓] - Black/African American	0	1	0.0%	28.6%[d]	21.3%	-7.3%
Child and Adolescent Well Care Visits (WCV) - American Indian/Alaskan Native	a	a	a	a	a	a
Childhood Immunization Status (CIS) - White	a	a	a	a	a	a
Colorectal Cancer Screening - Black/African American	a	a	a	a	a	a
Controlling High Blood Pressure (CBP) - Black/African American	a	a	a	a	a	a
Controlling High Blood Pressure (CBP) - White	1	1	100.0%	56.1%	64.5%	8.4%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Immunizations for Adolescents (IMA) - White	a	a	a	a	a	a
Prenatal and Postpartum Care: Postpartum Care (PPC-Pst) - Black/African American	a	a	a	a	a	a
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) - Black/African American	a	a	a	a	a	a
Immunizations for Adolescents	5	5	100.0%	35.8%	41.6%	5.8%
Prenatal and Postpartum Care (Postpartum Care)	7	8	87.5%	86.2%	89.0%	2.8%
Prenatal and Postpartum Care (Timeliness of Prenatal Care)	5	7	71.4%	85.1%	80.8%	-4.3%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention						
Rate 2	8	9	88.9%	50.8%	62.5%	11.7%
Rate 3	8	9	88.9%	87.4%	91.9%	4.5%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
QIP Priority Performance Measures						
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	6	8	75.0%	67.2%	68.1%	0.9%
Well-Child Visit in the First 30 Months of Life						
First 15 Months	2	6	33.3%	82.6%	81.1%	-1.5%
15 Months – 30 Months	6	6	100.0%	74.5%	77.3%	2.8%

The last two columns were only reported for measures whose performance rates were available in both 2023 and 2024. These raw percentage rates were calculated by dividing the sum of all numerators for a given measure by the sum of all denominators for that same measure.
The number of DMPHs reporting on each priority measure varied
If Achievement Value was N/A then not counted for sub-rates so number reporting might be lower since not including N/A. Also not counted in the next columns Therefore, more hospitals may have reported on these measures, but due to having denominators less than 30 this information was not tied to payment so not counted in these tables.
[↓]For these measures lower achievement rates indicate better care
[a]Entity did not report this priority measure
[b]For DMPHs, the subrate of Black/African Americans for the GSD measure had an Achievement rate of N/A due to Denominator<30 so was not counted
[c]For the Improving Health Equity 1 measure, DMPHs were able to report data on any measure and any population in the Eligible Equity Measure list
[d]Indicates that the aggregate numerator was less than 75
[e]For the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure rate 2 is the percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention, while rate 3 is the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user

Elective Measures

Tables for the elective measures are in Appendix A. Of 35 elective performance measures (not including the Improving Health Equity Measure), DPHs showed aggregate improvement from 2023 to 2024 on 28 measures; however, two other measures were

100 percent in 2023 and 2024 (see Table A1). Among the 35 possible elective measures, DMPHs reported data on 25 and showed aggregate improvement on 17 measures (see Table A2).[3] For these measures there were 8 measures that were not reported by any DMPH. For DPHs, the largest improvement was in the subrate of *Follow-Up-PHQ-9 (Adults)* for the *Depression Remission or Response for Adolescents and Adults* measure, which increased by 10.0 percent. For DMPHs, the greatest improvement was in the *Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections* measure, which improved by 53.9 percentage. Compared to the mandatory priority measures, both DPHs and DMPHs were more likely to meet their performance targets for elective measures. All DPHs met the target for 16/35 elective measures, while DMPHs met the performance target for 10/25 measures. This difference between elective and priority measures for DPHs may be due to flexibility in choosing which elective measures to report. For DPHs, aggregate rates for 2024 compared to 2023 were worse for one elective measure *(Surgical Site Infection)* and two subrates *(Influenza* of the *Adult Immunization Status measure* and *Depression Screening* of the *Prenatal Depression Screening and Follow-up Plan measure)),* while for DPHMs it was worse for three measures *(Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older, Exclusive Breast Milk Feeding,* and *Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%))* and four subrates *(Influenza* of the *Adult Immunization Status* measure*, Depression Screening* of the *Prenatal Depression Screening and Follow-up* measure, *Patient Engagement after Inpatient Discharge* of the *Transitions of Care* measure, and *BMI Percentile Documentation* of the *Weight Assessment and Counseling for Nutrition Physical Activity for Children and Adolescents* measure*).*

In 2024, DPHs and DMPHs were also able to pick any measure with specific sub-population with disparity from the Eligible Equity Measure list for the Improving Health Equity Measure (IHE2). Generally, of the 14 DPHs that reported this measure, each chose a different measure with different sub-populations in IHE2. Only three DPHs and all DMPHs met their targets for their selected measure and sub-populations. Among DPHs, the performance rates for all IHE2 measures with both 2023 and 2024 data showed improvement from 2023 to 2024. For DMPHs that reported IHE2 data in both years, one

[3] DPHs also did not show performance improvement on three measure sub-rates, while DMPHs failed to demonstrate aggregate improvement on four sub-rates.

out of two showed improvements from 2023 to 2024. However, the *Breast Cancer Screening* rate for the White population declined.

Quality Performance Targets: DPHs

DPHs reported on 40 measures. Table 3 shows the number of measures and the percentage of measures with target met for each DPH. Nine DPHs reported meeting their target for 85 percent or more of their measures, but there was significant variation, with the percentage of measures with target met ranging from 47.5% to 95%.

Table 3: Number and Percentage of Pay-for-Performance Measures with Targets Met for Each DPH for 2024

DPH	No. Of Measures With Target Met	Number of Measures Reported	Percentage of Measures With Target Met
Alameda Health System	38	40	95.0%
Arrowhead Regional Medical Center	28	40	70.0%
Contra Costa Health Services	34	40	85.0%
Kern Medical	31	40	77.5%
Los Angeles County Department of Health Services	34	40	85.0%
Natividad Medical Center	36	40	90.0%
Riverside University Health System	36	40	90.0%
San Francisco Health Network	34	40	85.0%
San Joaquin General Hospital/ San Joaquin County Clinic	31	40	77.5%
San Mateo Medical Center	27	40	67.5%
Santa Clara Valley Medical Center	34	40	85.0%
UC Davis Health	33	40	82.5%
UC Irvine Health	29	40	72.5%

DPH	No. Of Measures With Target Met	Number of Measures Reported	Percentage of Measures With Target Met
UC Los Angeles Health	19	40	47.5%
UC San Diego Health	31	40	77.5%
UC San Francisco Health	34	40	85.0%
Ventura County Medical Center	34	40	85.0%

Quality Performance Targets: DMPHs

Table 4 shows the number and percentage of measures with target met for each of the 31 DMPHs. Percentages of measures with target met varied from 0 to 100 percent, with 12 DMPHs reporting meeting their target for 100 percent of their reported measures. Four DMPHs did not meet the target for any of the measures they reported, and three of those DMPHs reported only two measures (the fourth DMPH reported five measures). DMPHs reported fewer measures than DPHs (highest was 20 measures reported by 3 DMPHs); however, more DMPHs reported meeting their targets for the measures they reported.

Table 4: DMPH Number and Percentage of Pay-for-Performance Measures with Targets Met for 2024

DMPHs	No. Of Measures With Target Met	Number of Measures Reported	Percentage of Measures With Target Met
Antelope Valley Hospital	6	10	60.0%
Bear Valley Community Hospital	3	3	100.0%
Eastern Plumas Health Care	2	2	100.0%
El Camino Health	8	10	80.0%

DMPHs	No. Of Measures With Target Met	Number of Measures Reported	Percentage of Measures With Target Met
El Centro Regional Medical Center	15	15	100.0%
Hazel Hawkins Memorial Hospital	8	13	61.5%
John C. Fremont Healthcare District	2	2	100.0%
Kaweah Health	9	15	60.0%
Kern Valley Healthcare District	6	6	100.0%
Lompoc Valley Medical Center	19	20	95.0%
Mammoth Hospital	12	12	100.0%
Marin Health	7	10	70.0%
Mayers Memorial Hospital District	2	2	100.0%
Modoc Medical Center	0	2	0.0%
Northern Inyo Hospital	12	12	100.0%
Oak Valley Hospital District	20	20	100.0%
Palomar Medical Center	10	12	83.3%
Pioneers Memorial Healthcare District	8	10	80.0%
Plumas District Hospital, Quincy	2	2	100.0%
Salinas Valley Health	16	20	80.0%
San Bernardino Mountains Community Hospital	3	5	60.0%
San Gorgonio Memorial Hospital	0	5	0.0%
Seneca Healthcare District	2	2	100.0%
Sierra View Medical Center	8	10	80.0%
Sonoma Valley Hospital	0	2	0.0%

DMPHs	No. Of Measures With Target Met	Number of Measures Reported	Percentage of Measures With Target Met
Southern Humboldt Community Healthcare District (Jerold Phelps Community Hospital)	2	2	100.0%
Southern Inyo Healthcare District	0	2	0.0%
Surprise Valley Health Care District	1	2	50.0%
Tahoe Forest Hospital District	9	10	90.0%
Tri-City Medical Center	9	10	90.0%
Washington Hospital Healthcare System	17	20	85.0%

CONCLUSION

This report provides information regarding the quality of services provided to Medi-Cal members at DPHs and DMPHs during calendar year 2024 compared to calendar year 2023. All DPHs reported on 40 measures out of the list of 57 measures, twenty of which were required to be the priority measures. In contrast, the number of priority and elective measures reported by DMPHs varied depending on how many they attested to.

In this evaluation report, DHCS compared current achievement rates in 2024 for specific measures to achievement rates in 2023. In 2024, DHCS increased the number of priority measures from nine back to twenty. This reflected original program design and requirements, given that flexibilities permitted during the pandemic were being discontinued as ongoing impacts of COVID-19 were subsiding. While the numbers of DPHs and DMPHs meeting their performance targets varied, DPHs showed collective improvement on 16 out of 20 measures (and a decrease for childhood immunization), and DMPHs showed improvement on 14 measures (with the exception being decreases for the childhood immunization, and prenatal and timeliness to prenatal care measures).

DPHs met their performance target on 79.9 percent of reported measures in aggregate across all 17 DPHs in 2024, compared to 90.0 percent in 2023. In 2023, DPHs only had to report on nine priority measures which gave them flexibility to choose the other 31

required measures unlike in 2024, where they were required to report on the twenty priority measures which limited their choice. As in 2023, in 2024 none of the DPHs met the target for all measures; although nine DPHs reported meeting their target for at least 85 percent of their measures, which is an increase compared to 2023 when only six met the 85 percent threshold. From 2023 to 2024, seven DPHs increased the percent of measures for which they met their targets, three had no change, and seven experienced decreases. In 2024, 94 percent of DPHs, compared to 65 percent in 2023, obtained all their allocated funding through overperformance on measures that closed a gap of 15 percent or greater with achievement rate greater than or equal to the 50th percentile benchmark, which enabled DPHs to reclaim funding from some measures with missed targets.

A greater percentage of DMPHs than DPHs met at least 90 percent of their targets (48.4 percent vs. 17.7 percent). DPHs and DMPHs were both more likely to meet target rates for the elective measures – which DPHs and DMPHs had wide latitude in choosing – compared to the required priority measures. For elective measures, DPHs reported improvement in 28 of the 35 (excluding IHE2), while DMPHs reported improvement in 17 measures (varied by system). Both DPHs and DMPHs did not report any improvement for the subrates of *Influenza* for the *Adult Immunization Status* measure and *Depression Screening* of the *Prenatal Depression Screening and Follow-up Plan* measure. For the IHE1 and IHE2 measures, DPHs reported on a variety of measures and populations and were more likely to report meeting the performance targets than DMPHs.

This report and subsequent annual evaluation reports will be posted on the DHCS QIP website and shared with CMS, while the data itself is posted on the CHHS open data portal.

APPENDIX A: ADDITIONAL DATA TABLES

Table A1: Rate of DPHs Meeting Quality Improvement Targets and the Actual Change in Performance Rates for Elective Measures from 2023 to 2024

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Adult Immunization Status (AIS-E)						
Influenza	8	11	72.7%	25.5%	24.0%	-1.5%
Td/Tdap	11	11	100.0%	57.7%	59.5%	1.8%
Zoster	11	11	100.0%	33.6%	38.0%	4.4%
Advance Care Plan	2	2	100.0%	84.5%	88.6%	4.1%
Appropriate Treatment for Upper Respiratory Infection (URI)	13	14	92.9%	96.2%	96.2%	0.0%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	11	11	100.0%	84.1%	88.0%	3.9%
Concurrent Use of Opioids and Benzodiazepines (COB-AD)↓	12	12	100.0%	5.0%	4.7%	-0.3%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%)	4	6	66.7%	86.2%	87.1%	0.9%
Coronary Artery Disease (CAD): Antiplatelet Therapy	6	7	85.7%	88.4%	89.6%	1.2%
Depression Remission or Response for Adolescents and Adults (DRR-E)						
Follow-Up PHQ-9 (Adults)	6	8	75.0%	45.8%	55.8%	10.0%
Depression Remission (Adults)	8	8	100.0%	10.7%	13.7%	3.1%
Depression Response (Adults)	6	8	75.0%	17.2%	22.9%	5.7%
Discharged on Antithrombotic Therapy	9	9	100.0%	100.0%	100.0%	0.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	8	9	88.9%	93.1%	94.3%	1.2%
Exclusive Breast Milk Feeding (PC-05)	8	12	66.7%	67.0%	68.6%	1.6%
Eye Exam for Patients With Diabetes (EED)	14	15	93.3%	59.6%	66.5%	6.9%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
30 Days	4	6	66.7%	25.4%	28.0%	2.6%
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	14	14	100.0%	93.6%	94.2%	0.6%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
HIV Screening Measure	15	16	93.8%	70.3%	75.4%	5.1%
HIV Viral Suppression (HVL-AD)	10	12	83.3%	85.5%	85.6%	0.1%
Improving Health Equity 2[a]						
Breast Cancer Screening (BCS) - White	b	b	b	b	b	b
Child and Adolescent Well Care Visits (WCV) - American Indian/Alaskan Native	1	2	50.0%	56.7%	63.1%	6.5%
Childhood Immunization Status (CIS) - White	0	1	0.0%	39.6%[c]	d	d
Colorectal Cancer Screening - Black/African American	1	1	100.0%	46.3%	49.6%	3.4%
Controlling High Blood Pressure (CBP) - Black/African American	2	3	66.7%	56.6%	60.5%	3.9%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Exclusive Breast Milk Feeding (PC-05) - Black/African American	2	2	100.0%	65.2%	69.2%	3.9%
Exclusive Human Milk Feeding (PC-05) - Hispanic/Latino	1	1	100.0%	41.0%[c]	64.9%	24.0%
Immunizations for Adolescents (IMA) - Black/African American	2	2	100.0%	39.2%	43.9%	4.7%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 2 -Hispanic/Latino	b	b	b	b	b	b
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 3 -Hispanic/Latino	b	b	b	b	b	b
Kidney Health Evaluation for Patients with Diabetes	15	15	100.0%	58.4%	61.8%	3.4%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Lead Screening in Children	14	14	100.0%	69.3%	74.4%	5.1%
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	12	13	92.3%	95.2%	95.8%	0.6%
Pharmacotherapy for Opioid Use Disorder	1	1	100.0%	20.1%[c]	21.7%[c]	1.6%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Bronchodilator	2	2	100.0%	84.9%	91.0%	6.1%
Systemic Corticosteroid	2	2	100.0%	63.5%	73.1%	9.6%
Plan All-Cause Readmissions (PCR)↓	5	5	100.0%	72.9%	67.3%	-5.6%
Postpartum Depression Screening and Follow-Up (PDS-E)						
Depression Screening	11	11	100.0%	54.2%	57.2%	3.1%
Follow-Up on Positive Screen	5	11	45.5%	74.5%	76.3%	1.8%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Prenatal Depression Screening and Follow-Up (PND-E)						
Depression Screening	11	11	100.0%	79.4%	76.7%	-2.6%
Follow-Up on Positive Screen	6	11	54.5%	59.0%	65.0%	6.0%
Prenatal Immunization Status	10	10	100.0%	46.3%	48.2%	1.9%
Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	12	12	100.0%	77.9%	80.7%	2.8%
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	7	7	100.0%	67.4%	74.4%	7.0%
Preventive Care and Screening: Influenza Immunization	3	4	75.0%	41.4%	43.6%	2.1%
Reduction in Hospital Acquired Clostridium Difficile Infections↓	8	9	88.9%	40.5%	35.6%	-4.9%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	6	6	100.0%	80.5%	82.0%	1.5%
Surgical Site Infection (SSI)↓[e]	7	9	77.8%	63.9%	68.6%	4.7%
Transitions of Care (TRC)						
Medication Reconciliation Post-Discharge	7	7	100.0%	94.6%	97.9%	3.3%
Notification of Inpatient Admission	7	7	100.0%	100.0%	100.0%	0.0%
Patient Engagement after Inpatient Discharge	2	7	28.6%	79.6%	81.7%	2.0%
Receipt of Discharge Information	7	7	100.0%	100.0%	100.0%	0.0%
Use of Imaging Studies for Low Back Pain (LBP)	11	11	100.0%	82.3%	83.0%	0.7%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)↓	4	4	100.0%	1.4%[c]	[d]	[d]

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents						
BMI Percentile Documentation	14	15	93.3%	93.9%	94.7%	0.7%
Counseling for Nutrition	13	15	86.7%	84.1%	86.2%	2.2%
Counseling for Physical Activity	15	15	100.0%	82.4%	85.1%	2.7%

If Achievement Value was N/A then not counted for sub-rates so number reporting might be lower since not including N/A. Also not counted in the next columns Therefore, more hospitals may have reported on these measures, but due to having denominators less than 30 this information was not tied to payment so not counted in these tables.

The last two columns were only reported for measures whose performance rates were available in both 2023 and 2024. These raw percentage rates were calculated by dividing the sum of all numerators for a given measure by the sum of all denominators for that same measure.

[1]For these measures lower achievement rates indicate better care

[a]For the Improving health equity 2 measure, DPHs were able to report data on any measure and any population in the Eligible Equity Measure list

[b]Entity did not report this priority measure

[c]Indicates that the aggregate numerator was less than 75

[d]Rate suppressed because denominator less than 30

[e]Composite SIR is the sum of the observed number of SSIs across all 6 procedure categories divided by the sum of the expected number of SSIs across the 6 procedure categories. Observed and expected data from all 6 procedure categories are included.

Table A2: Rate of DMPHs Meeting Quality Improvement Targets and the Actual Changes in Performance Rates for Pay-For-Performance Elective Measures from 2023 to 2024

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Adult Immunization Status (AIS-E)						
Influenza	1	1	100.0%	32.2%	31.7%	-0.5%
Td/Tdap	1	1	100.0%	58.6%	59.6%	0.9%
Zoster	1	1	100.0%	28.2%	29.8%	1.7%
Advance Care Plan	5	7	71.4%	64.0%	71.9%	7.9%
Appropriate Treatment for Upper Respiratory Infection (URI)	a	a	a	a	a	a
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	1	1	100.0%	76.8%	89.3%	12.5%
Concurrent Use of Opioids and Benzodiazepines (COB-AD)↓	a	a	a	a	a	a

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%)	0	1	0.0%	94.4%[b]	0.0%[c]	-94.4%[c]
Coronary Artery Disease (CAD): Antiplatelet Therapy	4	4	100.0%	86.0%	87.4%	1.4%
Depression Remission or Response for Adolescents and Adults (DRR-E)						
Follow-Up PHQ-9 (Adults)	a	a	a	a	a	a
Depression Remission (Adults)	a	a	a	a	a	a
Depression Response (Adults)	a	a	a	a	a	a
Discharged on Antithrombotic Therapy	7	7	100.0%	99.6%	100.0%	0.4%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	6	7	85.7%	93.0%	92.7%	-0.3%
Exclusive Breast Milk Feeding (PC-05)	5	8	62.5%	64.6%	62.7%	-1.9%
Eye Exam for Patients With Diabetes (EED)	4	4	100.0%	44.7%	56.6%	11.9%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
30 Days	1	1	100.0%	42.1%[b]	58.8%[b]	16.7%
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	1	1	100.0%	94.9%[b]	96.3%[b]	1.4%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
HIV Screening Measure	7	7	100.0%	36.6%	42.7%	6.1%
HIV Viral Suppression (HVL-AD)	a	a	a	a	a	a
Improving Health Equity 2[d]						
Breast Cancer Screening (BCS) - White	1	1	100.0%	75.0%	66.1%	-8.9%
Child and Adolescent Well Care Visits (WCV) - American Indian/Alaskan Native	a	a	a	a	a	a
Childhood Immunization Status (CIS) - White	a	a	a	a	a	a
Colorectal Cancer Screening - Black/African American	a	a	a	a	a	a
Controlling High Blood Pressure (CBP) - Black/African American	a	a	a	a	a	a

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Exclusive Breast Milk Feeding (PC-05) - Black/African American	a	a	a	a	a	a
Exclusive Human Milk Feeding (PC-05) - Hispanic/Latino	a	a	a	a	a	a
Immunizations for Adolescents (IMA) - Black/African American	a	a	a	a	a	a
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 2 -Hispanic/Latino	1	1	100.0%	e	37.5%[b]	e
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 3 -Hispanic/Latino	1	1	100.0%	63.2%[b]	82.5%[b]	19.3%
Kidney Health Evaluation for Patients with Diabetes	9	9	100.0%	53.5%	57.1%	3.6%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Lead Screening in Children	6	7	85.7%	58.3%	72.3%	14.0%
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	4	5	80.0%	97.7%	98.5%	0.8%
Pharmacotherapy for Opioid Use Disorder	a	a	a	a	a	a
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Bronchodilator	a	a	a	a	a	a
Systemic Corticosteroid	a	a	a	a	a	a
Plan All-Cause Readmissions (PCR)↓	a	a	a	a	a	a
Postpartum Depression Screening and Follow-Up (PDS-E)						
Depression Screening	2	2	100.0%	84.6%	94.5%	9.9%
Follow-Up on Positive Screen	f	f	f	f	f	f

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Prenatal Depression Screening and Follow-Up (PND-E)						
Depression Screening	2	2	100.0%	96.2%	95.1%	-1.1%
Follow-Up on Positive Screen	[f]	[f]	[f]	[f]	[f]	[f]
Prenatal Immunization Status	1	1	100.0%	25.6%[b]	33.1%	7.5%
Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	4	4	100.0%	39.8%	93.7%	53.9%
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	5	6	83.3%	61.7%	79.7%	18.0%
Preventive Care and Screening: Influenza Immunization	3	4	75.0%	47.8%	51.5%	3.7%
Reduction in Hospital Acquired Clostridium Difficile Infections↓	7	11	63.6%	45.0%	37.1%	-7.9%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	3	3	100.0%	74.3%	77.0%	2.7%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Surgical Site Infection (SSI)↓[g]	0	2	0.0%	[h]	135.2%[i]	[h]
Transitions of Care (TRC)						
Medication Reconciliation Post-Discharge	2	2	100.0%	46.1%	82.0%	35.9%
Notification of Inpatient Admission	2	2	100.0%	61.5%	86.1%	24.6%
Patient Engagement after Inpatient Discharge	1	2	50.0%	78.3%	76.3%	-2.0%
Receipt of Discharge Information	2	2	100.0%	73.0%	86.9%	13.9%
Use of Imaging Studies for Low Back Pain (LBP)	[a]	[a]	[a]	[a]	[a]	[a]
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)↓	[a]	[a]	[a]	[a]	[a]	[a]

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2023 Aggregate Performance Rate	2024 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents						
BMI Percentile Documentation	4	5	80.0%	87.9%	87.6%	-0.4%
Counseling for Nutrition	5	5	100.0%	74.0%	79.1%	5.0%
Counseling for Physical Activity	5	5	100.0%	72.6%	78.8%	6.2%

If Achievement Value was N/A then not counted for sub-rates so number reporting might be lower since not including N/A. Also not counted in the next columns Therefore, more hospitals may have reported on these measures, but due to having denominators less than 30 this information was not tied to payment so not counted in these tables.

The last two columns were only reported for measures whose performance rates were available in both 2023 and 2024. These raw percentage rates were calculated by dividing the sum of all numerators for a given measure by the sum of all denominators for that same measure.

[↓]For these measures lower achievement rates indicate better care

[a]Entity did not report this priority measure

[b]Indicates that the aggregate numerator was less than 75

[c]The DMPH that reported misinterpreted measure specification and auditor requested hospital report zero for 2024

[d]For the Improving health equity 2 measure, DPHs were able to report data on any measure and any population in the Eligible Equity Measure list

[e]Rate suppressed because numerator less than 11

[f]All of the achievement values were N/A because the denominators were all less than 30

[g]Composite SIR is the sum of the observed number of SSIs across all 6 procedure categories divided by the sum of the expected number of SSIs across the 6 procedure categories. Observed and expected data from all 6 procedure categories are included.

[h]Rate suppressed because denominator less than 30

[i]This rate would generally be noted as a ratio with expected SSIs/observed SSIs so 135.2% would be 1.35, since there were only two DMPHs reporting this measure and the numbers for both hospitals were low this number may be unstable.

APPENDIX B: TECHNICAL NOTES

Measures

QIP performance measures included process and outcome measures drawn from nationally vetted and endorsed measure sets e.g. National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc. The priority measure sub-set represented measures that were of high priority to the state and to Medi-Cal MCPs. The sub-set was composed of measures from the Managed Care Accountability Set for which MCPs had Minimum Performance Levels plus several additional measures representing conditions with high priority, high prevalence, or high mortality in California. COVID-19 QIP program modifications ended and in CY2024, the required number of priority measures was back to 20 from 9. The elective measure sub-set are the other performance measures that hospitals report to complete the minimum measures required for QIP reporting. Performance measures must include known benchmarks applicable to the Medicaid population.

For all measures that have national Medicaid benchmarks, the minimum and high-performance benchmarks were the 25th and 90th percentiles respectively, except for Q-FUA, Q-FUI and Q-FUM where the Medicaid 10th, 25th, and 50th percentile benchmarks were used as the minimum, median, and high-performance benchmarks. The 50th percentile benchmark was also used when assessing risk-adjusted measures[4] as well as determining overperformance values. QIP performance targets were set to ten percent gap closure. The gap is the difference between the prior year's (2023) performance and the high-performance benchmark. Hospitals that achieved the QIP performance targets and performed at or above the 2024 minimum benchmark would receive incentive payments. Value-Based Payment, also known as Pay-for-Performance (P4P), tied payment to improvement in clinical quality measures, which encourages preventive care, better care coordination, and attention to health equity. Additionally, hospitals had the ability to earn additional funds through overperformance on measures that closed a gap of 15% or greater with achievement rate greater than or equal to the 50th percentile benchmark.

[4] The three risk-adjusted measures (Q-PCR: Plan All-Cause Readmissions, Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections, and Q-SSI: Surgical Site Infection) performance are measured by an observed to expected (O/E) ratio and not gap closure methodology.

For CY2024 new measures or if measures had not already been reported in prior year, CY2023 data had to be reported as baseline before hospitals could enter the CY2024 data. Trending break measures that had specification change between two CYs followed the same reporting process, which was to report a baseline (capturing 2023 data using 2024 specification manual) before entering the current CY data. Reporting two versions of the data would account for trending breaks that required modification of the following CY's target rate and enabled comparison of achievement rates. The most current sources of data were used in re-calculating baselines using the CY2024 measure specification.

The following policies applied to measures impacted by denominators of less than 30:

- A QIP entity could use a measure with a denominator of less than 30 to fulfill its minimum number of required measures for QIP reporting, however, the AV was equal to zero.
- A denominator of at least 30 for two consecutive CYs was required for a QIP measure to earn a nonzero AV, as determined by performance, and be eligible for payment.
- Measures containing accountable sub-rates with denominators less than 30 that were limited by patient demographic characteristics such age, race, or ethnicity and prevalence of a particular condition, risk factor, or patient behavior were excluded in the Total AV of the measure.

Eligible Health Equity Measures

Primary Care Access and Preventive Care

Q-BCS: Breast Cancer Screening (DHCS 2019 Health Disparities Report – HDR19)

- o American Indian/Alaskan Native
- o Black/African American
- o Native Hawaiian/Pacific Islander
- o White

Q-CCS: Cervical Cancer Screening (DHCS 2018 Health Disparities Report – HDR18)

- o American Indian/Alaskan Native
- o Asian
- o Black/African American
- o Native Hawaiian/Pacific Islander
- o White

Q-WCV: Child and Adolescent Well-Care Visits (DHCS 2020 Preventive Services Report - PSP20)
- o American Indian/Alaskan Native
- o Black/African American
- o Native Hawaiian/Pacific Islander
- o White

Q-CIS: Childhood Immunization Status (HDR18: CIS-3 data)
- o American Indian/Alaskan Native
- o Black/African American
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander
- o White

Q-CHL: Chlamydia Screening in Women (HDR19)
- o American Indian/Alaskan Native
- o Asian
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander
- o White

Q-CMS130: Colorectal Cancer Screening (Behavioral Risk Factor Surveillance System - BRFSS Survey 2018)
- o Asian
- o Black/African American
- o Native Hawaiian/Pacific Islander
- o White

Q-DEV: Developmental Screening in the First Three Years of Life (PSP20 & HDR19 – same data)
- o American Indian/Alaskan Native
- o Black/African American
- o Hispanic/Latino
- o White

Q-IMA: Immunizations for Adolescents: Combination 2 (HDR18)
- o American Indian/Alaskan Native
- o Black/African American
- o Native Hawaiian/Pacific Islander
- o White

Q-CMS147: Preventive Care and Screening: Influenza Immunization (CDC)
- o Black/African American
- o Hispanic/Latino

Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-up Plan (PSP20)
- o American Indian/Alaskan Native
- o White

Q-CMS138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (DHCS 2017 Health Disparities Report - HDR17)
- o Alaskan Native/American Indian
- o Asian
- o Black/African American
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander

Q-W30: Well-Child Visits in the First 30 Months of Life (PSP20)
- o American Indian/Alaskan Native
- o Black/African American
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander
- o White

Acute and Chronic Conditions

Q-AMR: Asthma Medication Ratio (HDR19)
- o American Indian/Alaskan Native
- o Black/African American
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander
- o White

Q-CBP: Controlling High Blood Pressure (HDR18)
- o American Indian/Alaskan Native
- o Asian
- o Black/African American
- o Hispanic/Latino
- o White

Q-CMS314: HIV Viral Suppression (CA HIV/AIDS Health Disparities 2019)
- o Black/African American
- o Hispanic/Latino
- o White

Maternal/Perinatal Health

Q-PC02: Cesarean Birth (CMQCC)
- o Black/African American

Q-PC05: Exclusive Breast Milk Feeding (CMQCC)

- o American Indian/Alaskan Native
- o Asian
- o Black/African American
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander

Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care (HDR18)

- o American Indian/Alaskan Native
- o Black/African American
- o Native Hawaiian/Pacific Islander

Q-PPC-Pst: Prenatal and Postpartum Care: Postpartum Care (HDR18)

- o American Indian/Alaskan Native
- o Black/African American
- o Hispanic/Latino
- o Native Hawaiian/Pacific Islander
- o White

The above measures were identified as having statewide race or ethnicity disparities in care as per data from the following sources:

- Behavioral Risk Factor Surveillance System - BRFSS Survey 2018
- CA HIV/AIDS Health Disparities 2019
- CDC Data Influenza Vaccination Coverage Estimates 2019-2020 Influenza Season (CDC)
- 2019 CMQCC Medicaid Births 2019 (CMQCC)
- DHCS 2017 Health Disparities Report (HDR17)
- DHCS 2018 Health Disparities Report (HDR18)
- DHCS 2019 Health Disparities Report (HDR19)
- DHCS 2020 Preventive Services Report (PSP20)

For reporting Q-IHE1 or Q-IHE2 based on Q-PC02: Cesarean Birth and Q-PC05: Exclusive Breast Milk Feeding, entities used the data for their selected Priority Population that was posted in the CMQCC Maternal Data Center.

DMPH Community Partners:

The DMPHs were allowed to use managed care data from contracted community clinics ("community partners") in QIP data reporting, if approved to do so by DHCS. For a select group of measures, DMPHs could use data from DHCS-approved contracted community partners' patients in their QIP reports. Only specific QIP measures where the DMPH had a demonstrated role in the coordination of care and achievement of the measure were considered for this allowance. These measures generally included patients who had an

emergency room or inpatient encounter at the DMPH and measured quality improvement activities that could be undertaken by the DMPH. In 2024, four hospitals had approved community partners: El Camino Hospital, Marin General Hospital, Palomar Health, and Tri-City Medical Center. For more information regarding community partners, including which QIP measures were selected for community partner data inclusion, please see the QPL 24-005 .

DMPHs

- For any required priority measure, if the entity was unable to report due to not providing the relevant clinical services, a denominator less than 30, or not receiving sufficient assigned lives data from Medi-Cal Managed Care plans that resulted in a denominator less than 30, the entity could substitute an alternative priority measure. If no other priority measure was applicable, the substitute measure could be any elective measure from the QIP Measure List.
- DMPHs had to report the number of attested measures with complete and accurate data in order to be eligible to receive payment for the year.

For more details on CY2024 reporting policies, please see QPL 25-002, QPL 24-006, QPL 24-007, QPL 24-011, QPL 25-001, PY7 Program Policies, and PY7 General Guidelines.