

Date: December 31, 2024

QIP POLICY LETTER 24-011

To: All QIP Entities

Subject: FUX Measures Technical Specifications for QIP PY7 Reporting

Dear Quality Incentive Pool (QIP) Entities,

We wanted to provide you with additional information in preparation for QIP Program Year (PY) 7 (Calendar Year [CY] 2024) reporting and to provide further guidance related to the Follow-Up (FUX) measures including Follow-Up After Emergency Department Visit for Substance Use (FUA), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Follow-Up After High-Intensity Care for Substance Use Disorder (FUI).

For PY7 (CY 2024) reporting, the QIP entity will continue to follow PY7 Reporting Manual to produce rates for these three FUX measures. However, DHCS will instruct Managed Care Plan (MCP)s to use the native HEDIS logic denominator logic, which includes a 31-day exclusion period after *any* prior Emergency Department (ED) visit that meets denominator criteria. This approach for MCPs is different than the QIP specification manual denominator trigger (wherein QIP entity only looks at ED visits at their own facility when producing rates for QIP PY7 [CY 2024] performance). This means that for PY7 (CY 2024) reporting, the MCP-produced and QIP Entity-produced rates will be based on different methods of triggering a denominator count. Nonetheless, QIP Entities may use the "better of" the two rates to tie to payment in QIP.

For PY7, MCPs have been informed that they must submit FUA, FUM, and FUI data to their QIP entity's contact **by June 9, 2025**.

NOTE: To accommodate reporting "better of" the two rates (MCP-produced or QIP entity-produced), the QIP online reporting platform for these measures will be opened **until 11:59PM on June 23, 2025**.

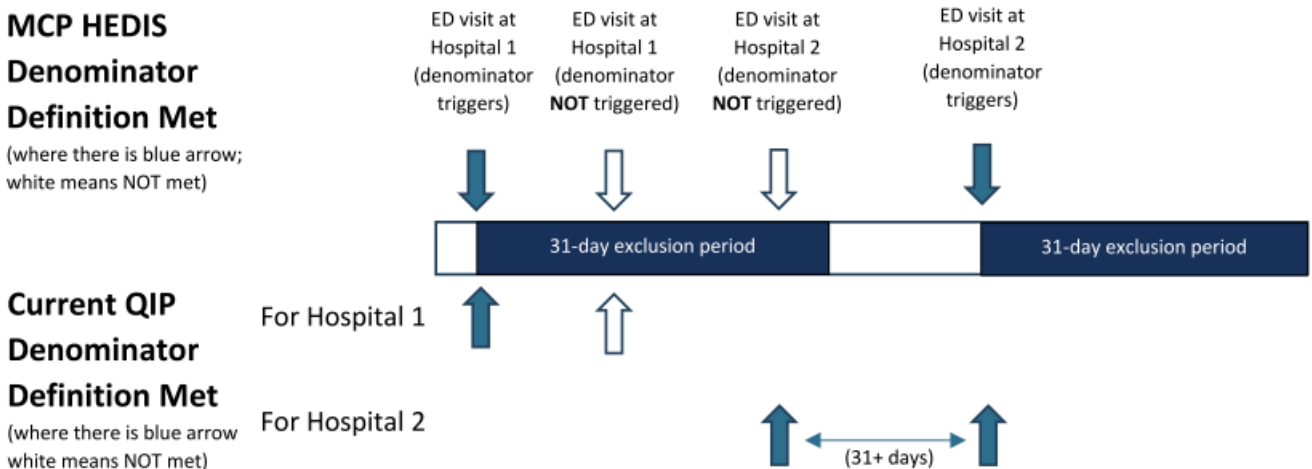
For PY8 (CY 2025) reporting and beyond, QIP Entities will adopt the HEDIS logic denominator trigger to be in alignment with the MCP produced rates. DHCS recognizes the challenges caused by data access limitations in this specification change and that entities can only leverage data they have access to. This will require DHCS to issue a



Policy Letter to QIP entities as the approach will deviate from the PY8 (CY 2025) QIP Reporting Manual that will be soon released. We expect to send that Policy Letter to QIP Entities in Q1 2025.

The approach MCPs must take will be incorporated into the forthcoming California Technical Specifications (CaTS) as soon as feasible. MCPs have been instructed to limit members with index ED visits at specific NPI(s) for each QIP entity/facility to mirror the QIP target population, as well as to provide numerator and denominator data along with total rates.

Below is an infographic of how HEDIS and QIP specifications currently differ and why a change is necessary to move to a consistent rate production methodology.



Below is a table to clarify:

	QIP Entity-Produced Rates	MCP-Produced Rates
PY7 (2024) Performance	Use current PY7 QIP spec (which triggers denominator regardless of ED visits at any outside hospitals; 31-day exclusion is only based on if there is a prior ED visit meeting denominator criteria at the <i>same</i> QIP hospital in the prior 31 days)	Use HEDIS spec to come to initial MCP level denominator (usual HEDIS steps), then subset to ED visits that trigger the denominator to only those at the specific QIP hospital regardless of assignment (to create a QIP-hospital specific rate; note the hospital might have multiple ED sites); only count follow-up, per HEDIS spec, that ties to that QIP-hospital specific denominator

	QIP Entity-Produced Rates	MCP-Produced Rates
PY8 (2025) Performance	Use HEDIS specification denominator, which means the QIP hospital will have to (with data they have available) exclude from the denominator any ED visits where that member was seen in another ED (regardless of which hospital) in the prior 31 days and met denominator criteria (i.e. the member falls into the 31-day exclusion period based on the HEDIS specification)	Same as above for PY7 (CY 2024)

Sincerely,

ORIGINAL SIGNED BY JEFFREY NORRIS

Jeffrey Norris, MD

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