Quality Incentive Pool (QIP) Program Evaluation Report

Program Year (PY) 6
January 1, 2023, to December 31, 2023

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) 6 (Calendar Year 2023), in alignment with the DHCS Comprehensive Quality Strategy, DHCS reduced the number of priority clinical quality measures and strengthened the requirements for DPHs and DMPHs to improve on both these and additional elective measures. For CY 2023, the QIP program had a budget of $2.232 billion.

The purpose of this evaluation was 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 improvement on all but one (childhood immunization) of the nine priority measures, six of which were significant, compared with CY2022. DMPHs showed improvement on all but two (childhood immunization and child and adolescent well care visits) of the nine priority measures four of which were statistically significant. Both DPHs and DMPHs showed improvement on many of the elective measures for 2023 compared to 2022. DPHs' overall improvement on priority measures ranged from 0.1 percent to 12.1 percent, and for DMPHs it ranged from 1.1 percent to 15.2 percent

The major goal of QIP is to improve disease prevention and primary care access and quality for all Medi-Cal members at public health care systems. In CY 2023, QIP mostly returned to stringent pre-pandemic performance requirements and developed a focused set of priority measures; these decisions were accompanied by fewer DPHs and DMPHs meeting their performance targets, but broad improvement in overall clinical quality. Falling childhood immunization rates indicate a need to focus quality improvement efforts on this measure.

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, provides quality targets for chronic disease management, and distributes them 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 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 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 PY6, from January 1, 2023, to December 31, 2023, 17 Designated Public Hospitals (DPHs) and 32 District and Municipal Public Hospitals (DMPHs) participated and 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). Of these measures, the required priority measure sub-set represented measures which were of high priority to the state and to Medi-Cal MCPs. The Elective Measure sub-set represented 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) 2023, the Centers for Medicaid and Medicare Services (CMS) approved the DPH and DMPH preprints on December 27, 2023 with a budget of $2.232 billion. Annual QIP Evaluations are posted on DHCS' QIP website and shared with CMS.

The following reporting requirements, performance targets, and payment policies were updated for CY 2023 due to ongoing impacts of the COVID-19 public health emergency (PHE). The previously required 20 priority measures were decreased to 9 to strengthen

alignment of QIP goals with the DHCS Comprehensive Quality Strategy (CQS). All DPHs were required to report these 9 measures as Pay-for-Performance (P4P). Decreasing the priority measures also allowed hospitals more flexibility in choosing elective measures to report quality improvement efforts that occurred despite dispersing staff resources to address COVID-19 public health emergencies.

Reporting for DPHs and DMPHs

While the 9 priority measures were required to be reported by all DPHs, DMPHs were required to report 20% of their measures from the 9 priority measure sub-set. DPHs and DMPHs had different options for reporting additional measures. All additional measures were chosen from a list of elective measures, and P4P performance targets were calculated in the same way as the performance targets for priority measures. DPH systems could choose whether to report a total of 40 measures or a total of 30 measures. For DPHs reporting 40 total measures, the maximum earnable amount was 100% of each DPH system allocation, based on proportion of Medi-Cal managed care members served in the given year. DPHs reporting only 30 total measures could earn only 75% of this amount. No adjustment was made for DPH systems that reported greater than 30 but less than 40 total measures. These maximum earnable amounts included overperformance funds for exceeding performance targets.

In contrast, the smaller DMPHs did not report the same number of measures across all hospitals 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. Each system reported the number of measures to which it committed in advance (20% Priority Measures and 80% Elective Measures) and the Quality Score was based on these measures. DMPHs with in-house primary care or those providing the relevant clinical services reported at least 20% of their required measures from the 9 priority measures. Moreover, DMPHs with committed measures of 4 or more had the option to reduce their number of reported measures by 25%; however, their maximum earnable amount was reduced to 75%. 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. Performance targets of 10% gap closure between the QIP entity's end of prior calendar year performance (baseline) and the current calendar year high performance benchmark remained the same. DMPH payment amount was based on their Medi-Cal revenue and

the number of selected measures chosen to report relative to all other participating DMPHs. 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 2023.

Quality: Improving Health Equity 1 (Q-IHE1) and *Quality: Improving Health Equity 2* (Q-IHE2) were elective measures designed to improve health equity for select populations in select measures having statewide disparities.[1] For CY 2023 all entities reporting on Q-IHE1 and/or 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-HBD: Hemoglobin A1c Control for Patients with Diabetes*, three P4P sub-rates - Hispanic/Latino ethnicity, Black/African American race, and Total Population - were reported 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 AV, which was the average of the three AVs of the sub-rates. This 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

[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.

acknowledges that this limits the ability to incentivize improvement for smaller patient populations.

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 had to report both measures if selecting to report on either measure. 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 2023 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 aggregate rate for the parent measure.

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 Attachment 1 of the DMPH and DPH preprints.

DPHs and DMPHs submitted aggregated data collected in accordance with the QIP CY 2023 Reporting Manual to DHCS, using a secure online reporting system. DHCS analysts and the HSAG auditor reviewed the reported data for accuracy, asking questions of the entities and/or requesting corrected data when necessary, and then deemed the data final. DHCS conducted its analysis on 100 percent of the data received. The full datasets for QIP CY 2023 can be located on the California Health and Human Services (CHHS) open data portal.

DHCS created figures that display trends in the nine priority measures for DPHs. No figures were created for DMPHs because they either did not consistently report the measures or had low numerators leading to suppression of rates for the measures. The rate of each measure was also compared to the minimum (min) performance benchmark (national 25th percentile benchmark) and the high-performance benchmark (national 90th percentile benchmark) for the measure. T-tests of proportions were conducted on each priority measure (comparing each year) to determine if the difference between time points were significant.

For each of the nine priority measures, 95 percent confidence intervals were calculated by modifying NCQA methodology:

$$lower\ interval = rate - 1.96\sqrt{\frac{rate(1-rate)}{denominator}}$$

$$upper\ interval = rate + 1.96\sqrt{\frac{rate(1-rate)}{denominator}}$$

The achievement rate for each measure was calculated by dividing the numerator by the denominator, except for risk-adjusted measures, as reported by the DPH/DMPH. The aggregate performance rate for each measure was calculated only when DPHs/DMPHs reported data for both 2022 and 2023. For each year, this rate was calculated by dividing the sum of all numerators for a given measure by the sum of all denominators for that same measure. Rates were suppressed when the denominator was less than 30 (except for risk-adjusted measures), resulting in a statistically unstable rate. To examine the improvement seen across all DPHs/DMPHs who reported on each measure, DHCS then calculated the actual change in performance rates for each measure from 2022 to 2023. "Actual change" is the *absolute* difference in performance rates from 2022 to 2023 for each measure; the resulting difference was expressed in terms of percentage points. For DPHs rates for 2021 are also included in figures of the aggregate rates for the nine priority measures.

For each hospital system, measure performance was assessed based on the amount of progress made toward achieving the measure performance target. Measure performance targets were 10 percent gap closure between QIP entity's 2022 performance and the 2023 high-performance benchmark. QIP entities with baseline performance on a given measure at or above the high-performance benchmark were considered to be at 100 percent of their quality goal and were required to achieve performance that maintained or exceeded that measure's high-performance benchmark in 2023. The progress made toward achieving the measure performance target was given an Achievement Value (AV) as specified in the DPH QIP PY4-6 COVID-19 Amended preprint, Attachment 1 and DMPH QIP PY4-6 COVID-19 Amended preprint, Attachment 1. An AV would be zero if the DPH/DMPH did not achieve the minimum performance benchmark. An AV would also be zero if the denominator for the measure was less than 30. An AV of one represented the QIP entities who met their goal.

To examine the percentage of measures for which each DPH or DMPH met its quality performance targets, DHCS calculated the number of AVs that were one. 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 2025, and the final report incorporated stakeholder input.

RESULTS

Priority Measures

In 2023, 17 DPHs and 32 DMPHs submitted aggregated data to DHCS, which was used for all analyses. Numerators, denominators, achievement rates, and achievement values for each measure are posted on the Open Data Portal.

Figure 1 through 10 show the actual change in aggregate performance rates from 2021 to 2023 for each priority measure (see Appendix A for similar information on the much longer list of elective measures) for DPHs. For one subrate *First 15 Months of the Well-Child Visits in the First 30 Months of Life*, one hospital had a denominator of less than 30, so their data was not included in the results. For all but one measure (*Childhood Immunization Status, or CIS*), DPHs rates improved from 2021 to 2023. The CIS measure improved from 2021 to 2022 but then went down in 2023 lower than the rate in 2021. DHCS calculated confidence intervals, but these intervals are not displayed in the figures because they are less than 1 percent for all but one measure and are too small to be seen in any figure. When comparing years for the priority measures all but the Postpartum measure comparison of 2022 to 2023 were statistically different. No time trends were done for the DMPHs because there was no 2021 data and most DMPHs did not consistently report on all nine measures.

Figure 1: Performance Rates for Child and Adolescent Well Care Visits for DPHs from 2021 to 2023

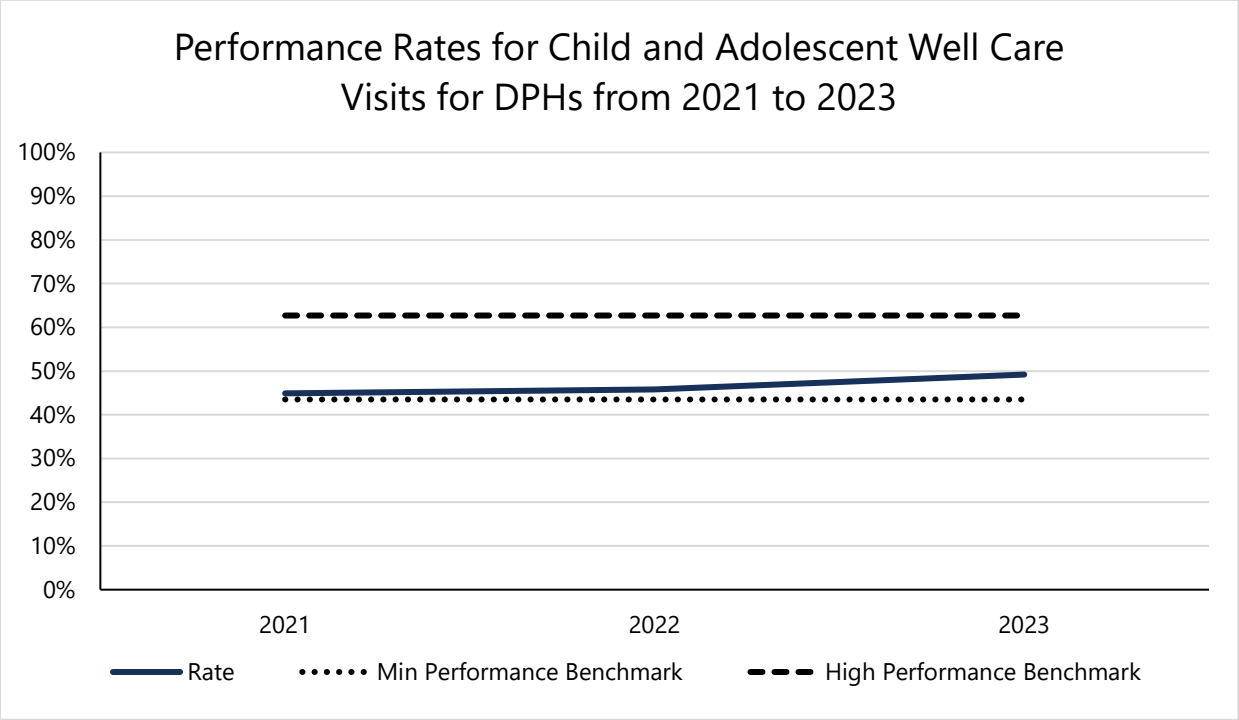

Figure 2: Performance Rates for Well-Child Visits in the First 30 Months of Life (First 15 Months) for DPHs from 2021 to 2023

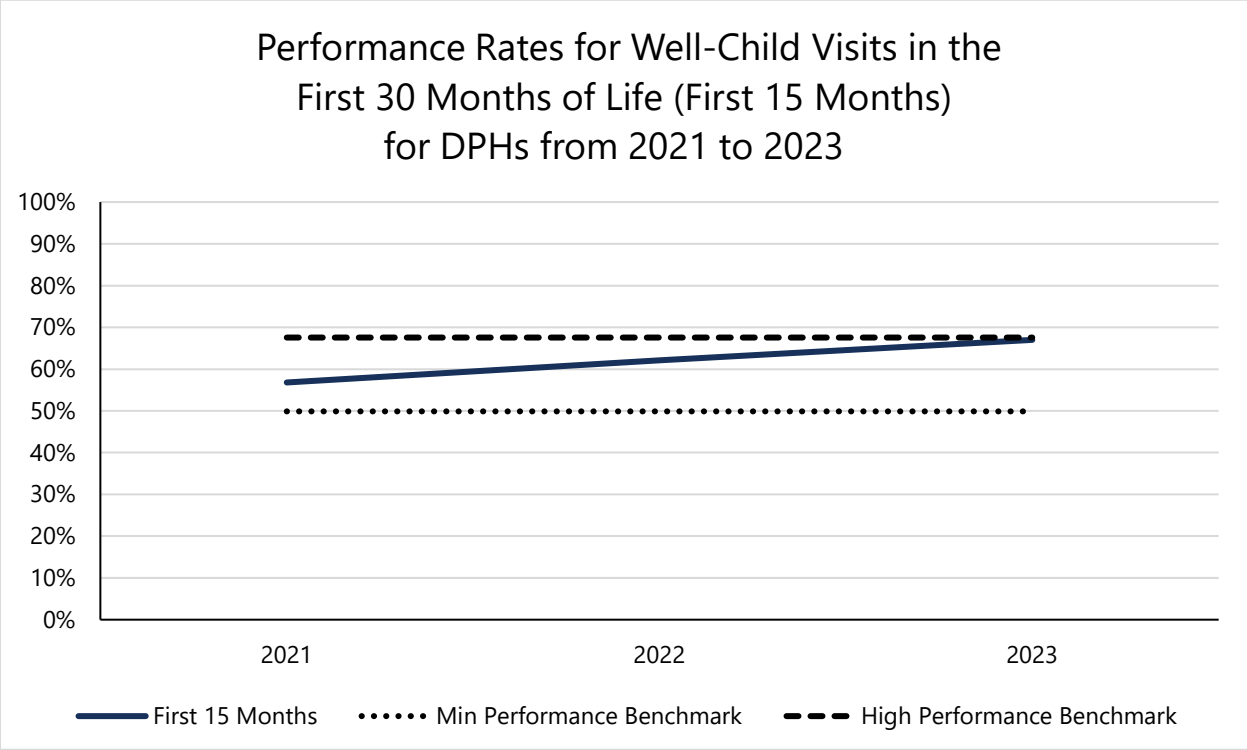

Figure 3: Performance Rates for Well-Child Visits in the First 30 Months of Life (15 to 30 Months) for DPHs from 2021 to 2023

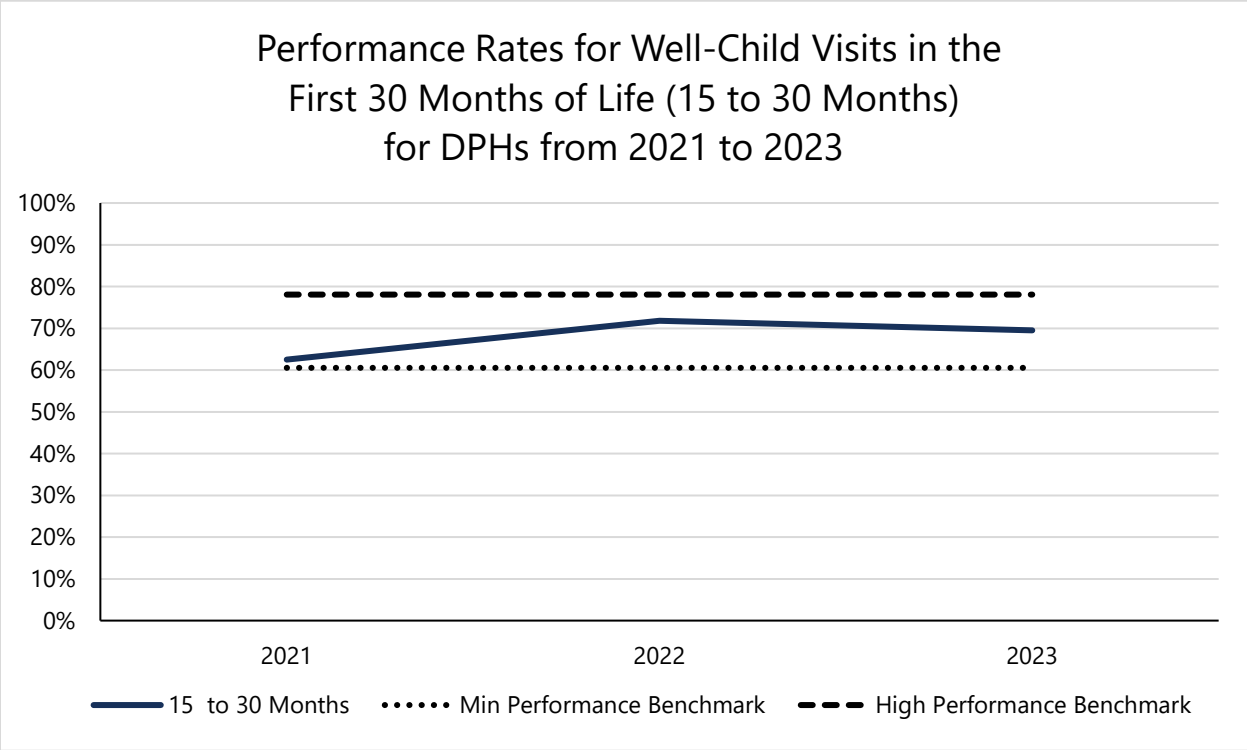

Figure 4: Performance Rates for Developmental Screening in the First Three Years of Life for DPHs from 2021 to 2023

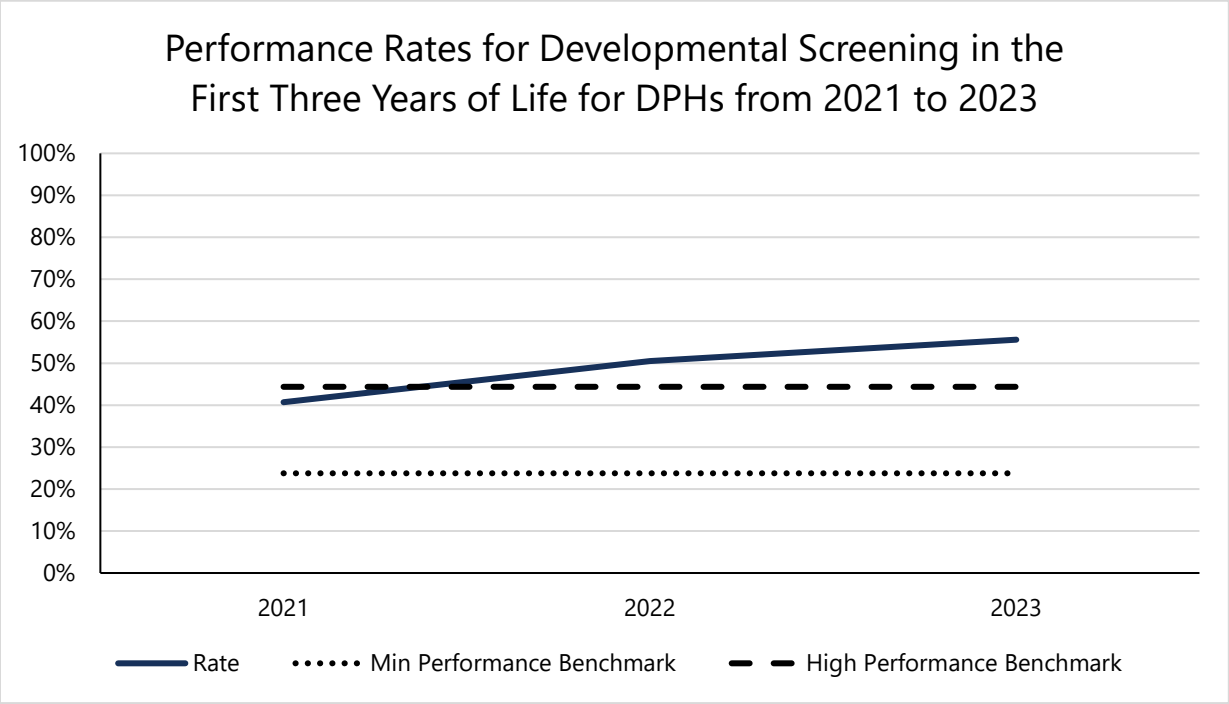

Figure 5: Performance Rates for Childhood Immunization Status (CIS 10) for DPHs from 2022 to 2023

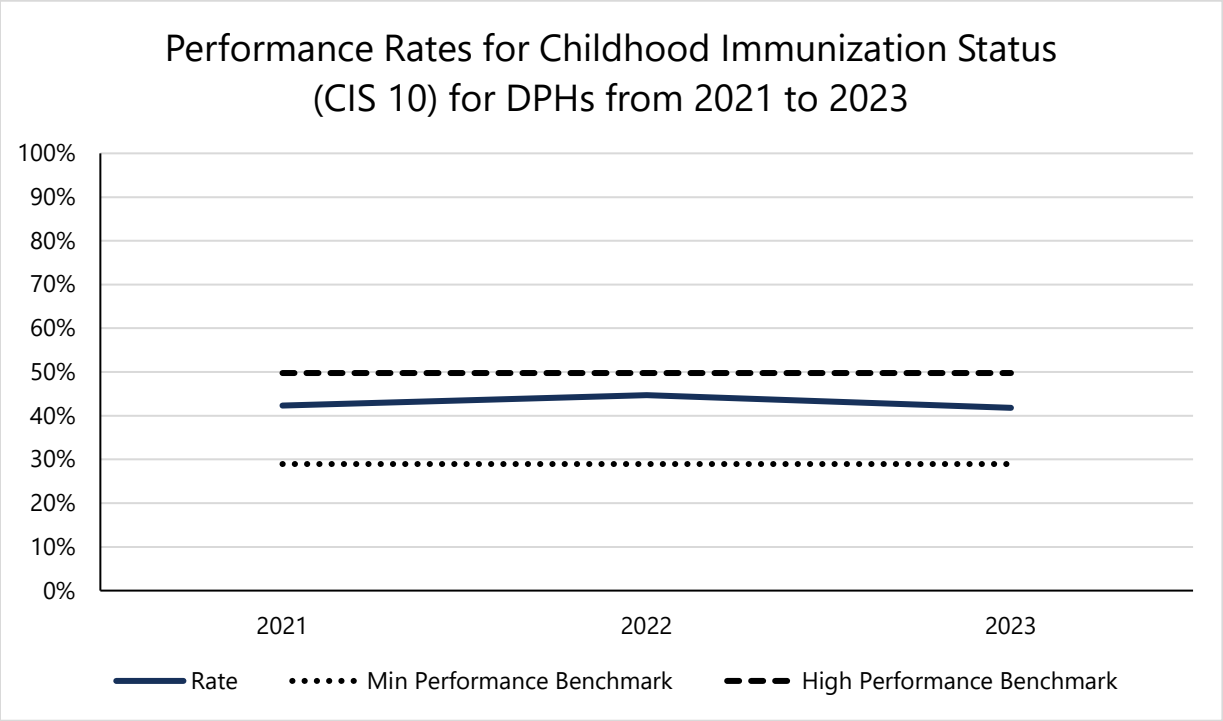

Figure 6: Performance Rates for Immunizations for Adolescents for DPHs from 2021 to 2023

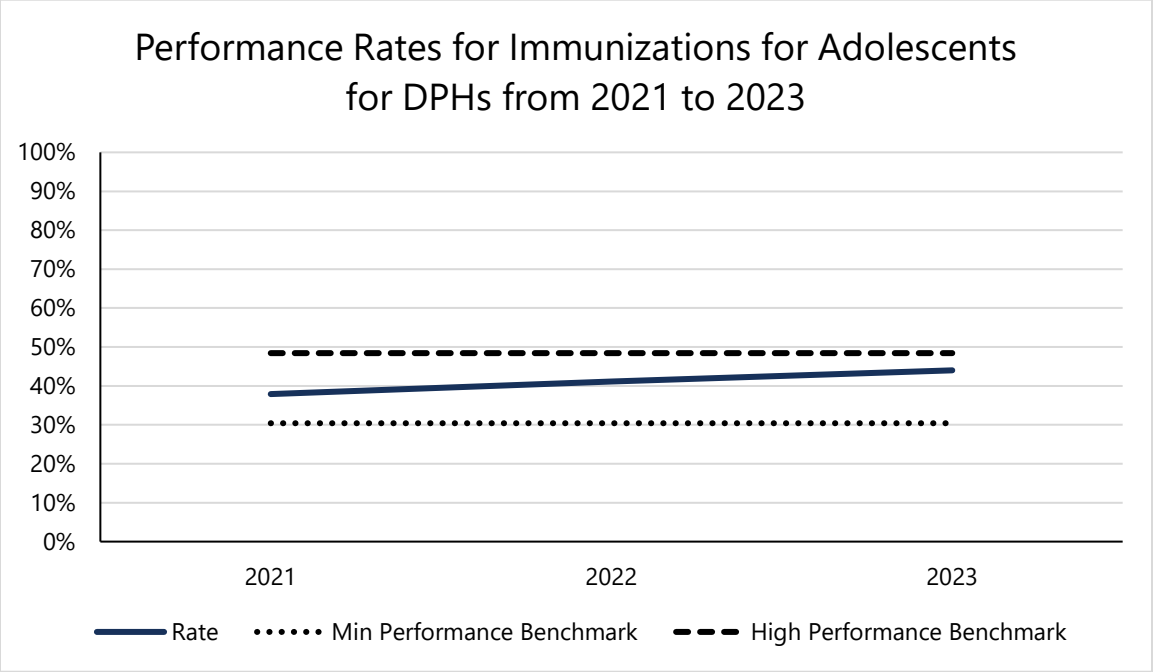

Figure 7: Performance Rates for Preventive Care and Screening: Screening for Depression and Follow-Up Plan for DPHs from 2021 to 2023

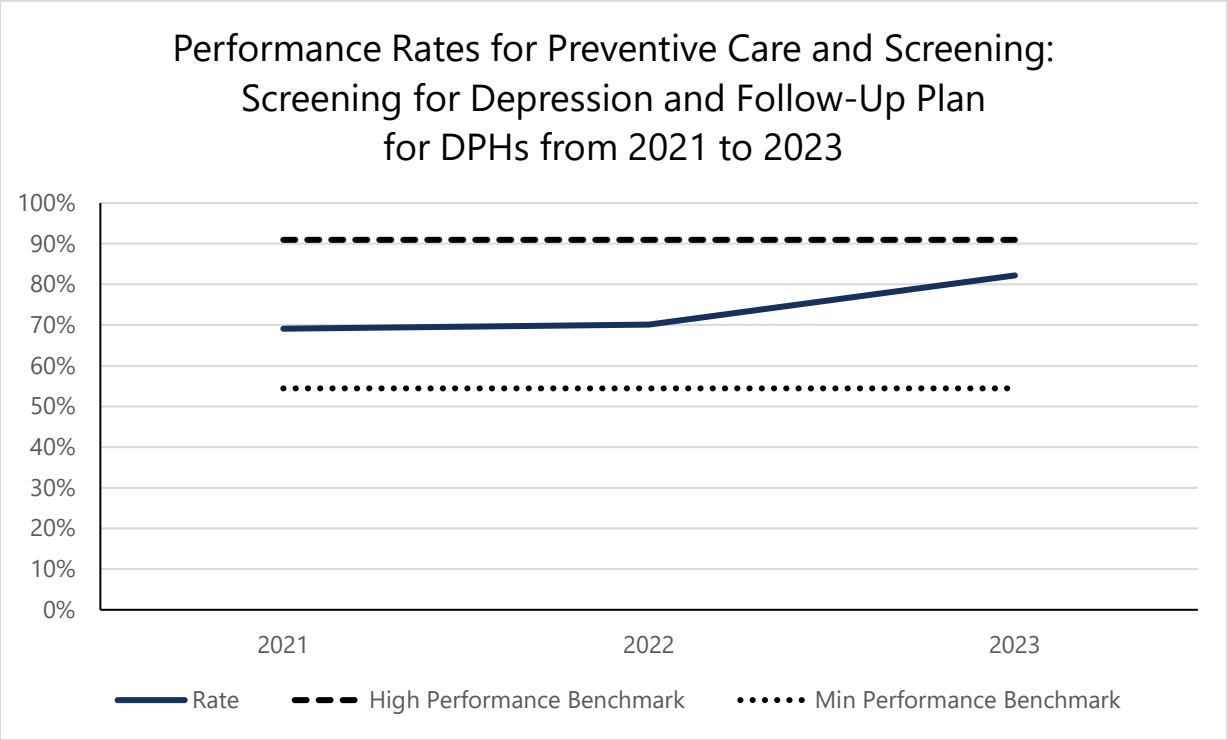

Figure 8: Performance Rates for Chlamydia Screening in Women (CHL) for DPHs from 2021 to 2023

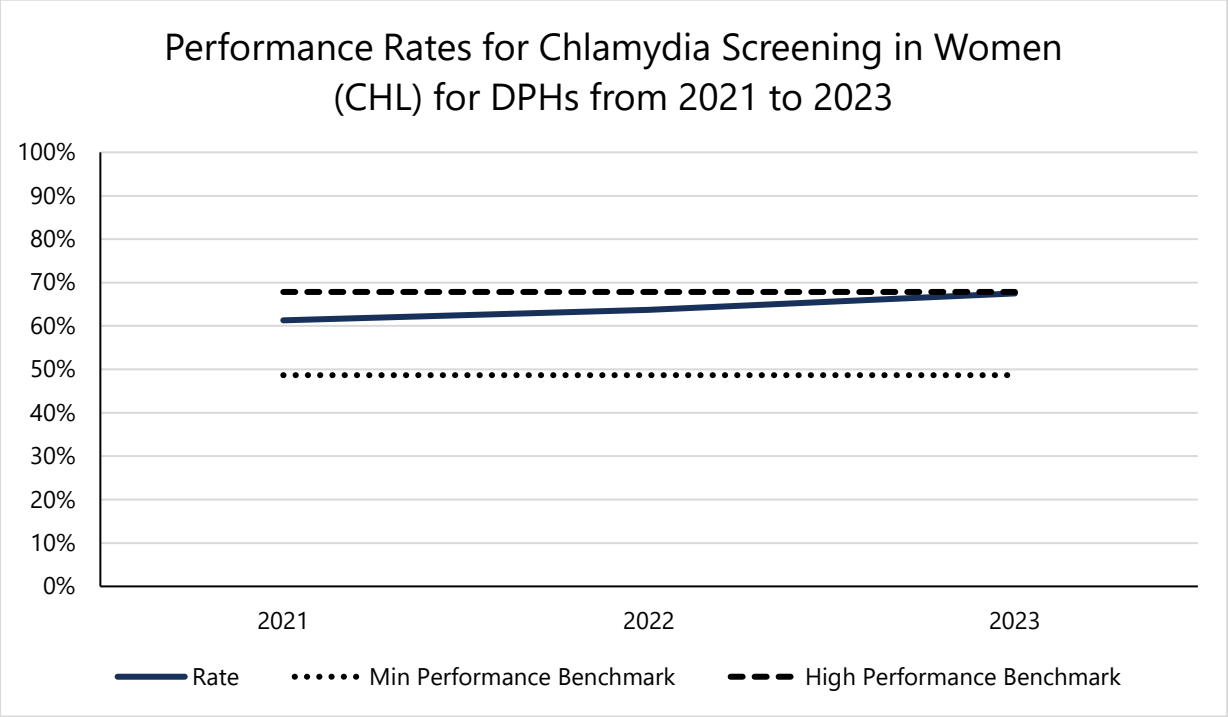

Figure 9: Figure 9: Performance Rates for Prenatal and Postpartum Care: Timeliness of Prenatal Care for DPHs from 2021 to 2023

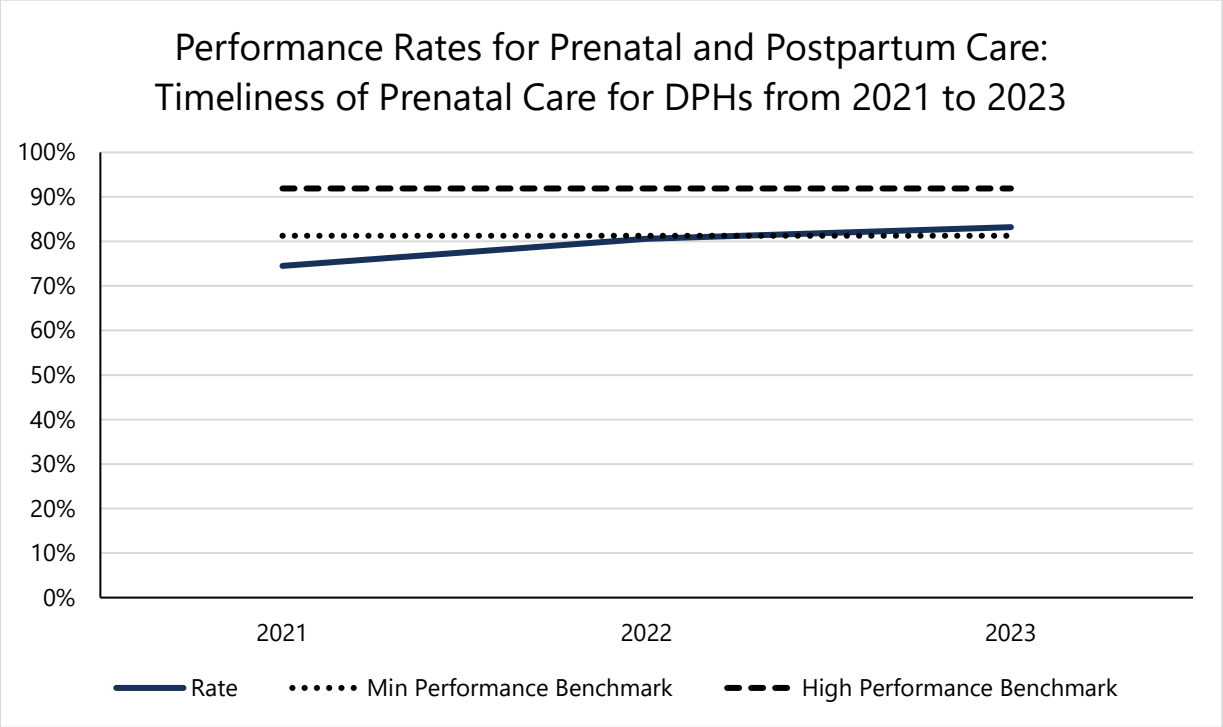

Figure 10: Performance Rates for Prenatal and Postpartum Care: Postpartum Care for DPHs from 2021 to 2023

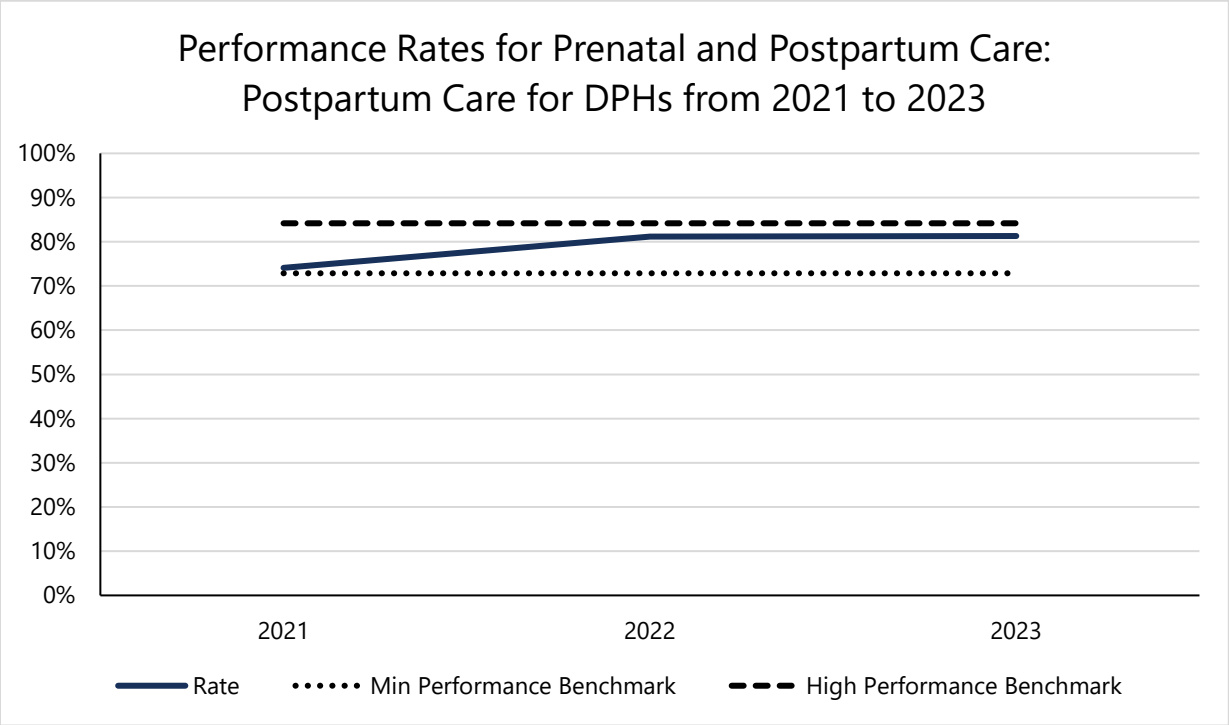

Table 1 shows how many DPHs and DMPHs met performance targets for the priority measures (Appendix Table A1 and Table A2 show similar information for elective measures). DPHs were less likely to meet their targets for the priority measures compared to the DMPHs (six out of nine measures) that chose to report those measures. CY 2022-2023 DPHs' aggregate improvement on priority measures from 2022 to 2023 ranged from -3.0 percent to 12.1 percent, with *Preventive Care and Screening: Screening for Depression and Follow-Up Plan* measure exhibiting the largest improvement compared to the rate in 2022. For DPHs all but the *Prenatal and Postpartum Care: Postpartum Care* and the childhood immunization measures showed statistically significant improvement from 2022 to 2023. DMPHs' aggregate improvement ranged from -2.0 percent to 15.2 percent, with the greatest improvement on the *Developmental Screening in the First Three Years of Life* measure. For DMPHs there was significant improvement from 2022 to 2023 for four measures (*Developmental Screening in the First Three Years of Life*, *Immunizations for Adolescents*, *Preventive Care and Screening: Screening for Depression and Follow-Up Plan*, and *Chlamydia Screening in Women*).

DMPHs' performance improvement exceeded DPHs' improvement for five of nine priority measures (see Table 1).

Table 1: Rate of DPHs and DMPHs Meeting Quality Improvement Targets and the Actual Percentage Changes in Performance Rates for Priority Measures from 2022 to 2023

Measure	Percentage of Entities Meeting Goal		2022 Aggregate Performance Rate		2023 Aggregate Performance Rate		Actual Change in Performance Rates	
	DPHs	DMPHs	DPHs	DMPHs	DPHs	DMPHs	DPHs	DMPHs
QIP Priority Performance Measures								
Child and Adolescent Well Care Visits	58.8%	70.0%	45.8%	51.2%	49.2%	51.1%	3.4%[a]	-0.1%
Childhood Immunization Status (CIS 10)	41.2%	80.0%	44.7%	37.3%	41.8%	35.3%	-3.0%[a]	-2.0%
Chlamydia Screening in Women	82.4%	75.0%	63.7%	51.9%	67.5%	62.4%	3.7%[a]	10.5%[a]
Developmental Screening in the First Three Years of Life	82.4%	100.0%	50.5%	36.0%	55.6%	51.2%	5.1%[a]	15.2%[a]
Immunizations for Adolescents	64.7%	75.0%	41.1%	31.5%	44.0%	39.5%	2.9%[a]	7.9%[a]
Prenatal and Postpartum Care (Postpartum Care)	76.5%	87.5%	81.2%	86.4%	81.3%	87.5%	0.1%	1.1%
Prenatal and Postpartum Care (Timeliness of Prenatal Care)	52.9%	71.4%	80.6%	83.0%	83.2%	84.4%	2.6%[a]	1.4%

Measure	Percentage of Entities Meeting Goal		2022 Aggregate Performance Rate		2023 Aggregate Performance Rate		Actual Change in Performance Rates	
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	88.2%	81.8%	70.1%	51.6%	82.2%	66.0%	12.1%[a]	14.4%[a]
Well-Child Visits in the First 30 Months of Life								
First 15 Months	68.8%	66.7%	62.1%	71.8%	71.8%	76.1%	9.7%[a]	4.2%
15 Months – 30 Months	52.9%	50.0%	67.0%	71.2%	69.5%	72.4%	2.5%[a]	1.3%

The last two columns were only reported for measures whose performance rates were available in both 2022 and 2023. 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.

All DPHs reported on all nine priority measures, while the number of DMPHs reporting on each priority measure varied

[a]Statistically different

Elective Measures

Tables for the elective measures are in Appendix A. Of 45 elective performance measures (not including the two Improving Health Equity Measures), DPHs showed aggregate improvement on 33 measures (see Table A1) and DMPHs showed aggregate improvement on 25 measures (see Table A2) from 2022 to 2023.[3] For DPHs, *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan* exhibited the largest improvement (increased by 20.9 percent) while for DMPHs, the measure on *Lead Screening in Children* showed the largest improvement (26.3 percent). For the elective measures there were 11 measures that were not reported by any DMPH. Compared to the mandatory priority measures, DPHs and DMPHs were more likely to meet their performance targets for elective measures, and on six elective measures all DPHs met

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

the performance target, while DMPHs did for 16 measures. This difference between elective and priority measures is quite possibly due to flexibility on choice of which elective measures to report.

Information about both Improving Health Equity Measures (IHE1 and IHE2) is also included in Table A1 and Table A2 in the appendix. In 2023, DPHs and DMPHs were able to pick any measure and any population in the Eligible Equity Measure list. For the IHE1 and IHE2 measures, generally only one DPH reported on each measure, with over 79 percent (75 percent for IHE1 and 86.6 percent for IHE2) of the hospitals meeting their target for these measures with the targeted populations. For these measures the performance rates for all measures showed improvement from 2022 to 2023. For DMPHs that reported on IHE1 and IHE2, 50.0 percent met the target for these measures for IHE1 and 33.3 percent for IHE2 with four out of five showing improvement from 2022 to 2023.

Quality Performance Targets: DPHs

DPHs reported on 40 measures and Table 2 shows the number of measures and the percentage of measures for which each DPH met the target. Six DPHs reported meeting their target for 85 percent or more of their measures, but there was significant variation, with two DPHs meeting their target for under 50 percent of their measures.

Table 2: Number and Percentage of Pay for Performance Measures with Targets Met for Each DPH for 2023

DPH	No. Of Measures With Target Met	Percentage of Measures With Target Met
Alameda Health System	36	90.0%
Arrowhead Regional Medical Center	17	42.5%
Contra Costa Regional Medical Center	36	90.0%
Kern Medical Center	31	77.5%
Los Angeles County Health System	33	82.5%
Natividad Medical Center	39	97.5%

DPH	No. Of Measures With Target Met	Percentage of Measures With Target Met
Riverside University Health System	33	82.5%
San Francisco General Hospital	38	95.0%
San Joaquin General Hospital	27	67.5%
San Mateo Medical Center	33	82.5%
Santa Clara Valley Medical Center	32	80.0%
UC Davis Medical Center	28	70.0%
UC Irvine Medical Center	29	72.5%
UC Los Angeles Medical Center	19	47.5%
UC San Diego Medical Center	33	82.5%
UC San Francisco Medical Center	36	90.0%
Ventura County Medical Center	36	90.0%

Quality Performance Targets: DMPHs

Table 3 shows the number and percentage of measures for which each DMPH met the target. Percentages of measures for which DMPHs met their target varied from 0 percent to 100 percent, with eight DMPHs reporting meeting their target for 100 percent of their reported measures. Five DMPHs did not meet the target for any of the measures they reported and those DMPHs reported only two measures. DMPHs reported fewer measures than DPHs (highest was 20 measures reported by 4 DMPHs); however, more DMPHs reported meeting their targets for the measures they reported. DMPHs were slightly more likely to report meeting the 2023 target for their measures. Lastly, one DMPH (Palo Verde Hospital) did not report any data before the reporting deadline, so they are excluded from this report.

Table 3: DMPH Number and Percentage of Pay for Performance Measures with Targets Met for 2023

DMPHs	No. Of Measures With Target Met	Percentage of Measures With Target Met
Antelope Valley Hospital	2	20.0%
Bear Valley Community Hospital	3	100.0%
Eastern Plumas Health Care	1	50.0%
El Camino Hospital	7	70.0%
El Centro Regional Medical Center	13	100.0%
Hazel Hawkins Memorial Hospital	10	100.0%
Jerold Phelps Community Hospital	0	0.0%
John C. Fremont Healthcare District	1	50.0%
Kaweah Delta Health Care District	6	60.0%
Kern Valley Healthcare District	5	83.3%
Lompoc Valley Medical Center	19	95.0%
Mammoth Hospital	12	100.0%
Marin General Hospital	6	60.0%
Mayers Memorial Hospital District	0	0.0%
Modoc Medical Center	1	50.0%
Northern Inyo Hospital	12	100.0%
Oak Valley Hospital District	19	95.0%
Palomar Medical Center	10	83.3%
Pioneers Memorial Healthcare District	7	70.0%
Plumas District Hospital, Quincy	1	50.0%
Salinas Valley Memorial Healthcare System	15	75.0%

DMPHs	No. Of Measures With Target Met	Percentage of Measures With Target Met
San Bernardino Mountains Community Hospital	5	100.0%
San Gorgonio Memorial Hospital	3	60.0%
Seneca Healthcare District	2	100.0%
Sierra View District Hospital	6	60.0%
Sonoma Valley Hospital	0	0.0%
Southern Inyo Hospital	0	0.0%
Surprise Valley	0	0.0%
Tahoe Forest Hospital District	8	100.0%
Tri-City Medical Center	5	50.0%
Trinity Hospital	1	50.0%
Washington Hospital Healthcare System	16	80.0%

CONCLUSION

This report provides information regarding the quality of services provided to Medi-Cal members at DPHs and DMPHs during calendar year 2023, a year in which the health care delivery system was still experiencing ongoing impacts from the COVID-19 pandemic. All DPHs reported on 40 measures out of the list of 56 measures, nine of which were required to be the priority measures. In contrast, the number of priority and elective measures reported by DMPHs varied.

In this evaluation report, DHCS compared current achievement rates in 2023 for specific measures to achievement rates in the previous year (2022). In 2022, DHCS reduced the number of priority measures to nine and strengthened the requirement to improve on these nine priority measures. DHCS made the strategic decision to continue this approach in 2023, keeping QIP entities focused on the same priority measures. While the numbers of DPHs and DMPHs meeting their performance targets varied, DPHs showed collective improvement on eight out of nine measures (with the exception being the lower rate on childhood immunization measure in 2023 compared to 2022), and

DMPHs showed improvement on seven compared with 2022. For all nine priority measures DPHs had rates higher than the 25th percentile national benchmark for all years except for the *timeliness of prenatal care measure*. Also, for DPHs in 2023, the aggregate rate for one measure (*Developmental Screening in the First Three Years of Life*) was above the 90th percentile benchmark, while three additional measures (*Immunization for Adolescents, Chlamydia Screening in Women, and Prenatal and Postpartum Care: Postpartum Care*) were within 2 to 4 percent of this national high-performance benchmark.

DPHs met their performance target on 90.0 percent of reported measures in aggregate across all 17 DPHs in 2023, compared to 72.7 percent in 2022. As in 2022, in 2023 none of the DPHs met the target for all measures, although six DPHs reported meeting their target for at least 85 percent of their measures. Comparing the number of measures for which hospitals hit their performance targets in 2023 compared with 2022, 14 DPHs did better and 3 did worse. In 2023, 65 percent of DPHs, compared to 71 percent in 2022, 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.

QIP entities did meet targets more frequently in 2023 compared to 2022, and a greater percentage of DPHs met at least 90 percent of their targets than DMPHs (35.3 percent and 31.3 percent, respectively). DPHs and DMPHs were 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. In 2023, QIP entities were given the option to report fewer measures, but the maximum earnable amount would have been reduced to 75 percent of their entity's funding allocation; no entities took this option.

DHCS also changed its approach to incentivizing disparity reductions through QIP in 2022 and this continued in 2023. For the IHE1 and IHE2 measures, DPHs reported on a variety of measures and populations and were more likely to report meeting the target measure, while DMPHs were less likely to meet the target for these IHE measures. For other elective measures, DPHs reported improvement in 33 of the 45 (excluding IHE1 and IHE2), while DMPHs reported improvement in 25 measures (varied by system) with both not reporting any improvement for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)* and *Cesarean Birth* measures.

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 2022 to 2023

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Adult Immunization Status (AIS-E)[a]						
Influenza	12	13	92.3%	21.1%	22.5%	1.4%
Td/Tdap	13	13	100.0%	47.5%	50.8%	3.3%
Zoster	13	13	100.0%	25.4%	31.6%	6.2%
Advance Care Plan	4	6	66.7%	36.9%	44.5%	7.6%
Appropriate Treatment for Upper Respiratory Infection (URI)	12	13	92.3%	98.2%	97.7%	-0.6%
Asthma Medication Ratio (AMR)	8	10	80.0%	62.6%	71.3%	8.7%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	9	10	90.0%	84.9%	83.5%	-1.4%
Breast Cancer Screening (BCS)	14	17	82.4%	57.1%	58.8%	1.7%
Cervical Cancer Screening (CCS)	6	9	66.7%	45.5%	49.0%	3.5%
Cesarean Birth (PC02-CH)↓	8	11	72.7%	20.5%	22.2%	1.7%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Colorectal Cancer Screening	16	17	94.1%	51.1%	53.7%	2.6%
Comprehensive Diabetes Care: Eye Exam (CDC-E)	13	15	86.7%	57.0%	59.0%	2.0%
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)↓						
Black/African American	12	14	85.7%	34.5%	33.1%	-1.4%
Hispanic/Latino	14	15	93.3%	36.1%	32.2%	-3.8%
Total Population	16	16	100.0%	34.2%	31.5%	-2.7%
Concurrent Use of Opioids and Benzodiazepines (COB-AD)↓	12	13	92.3%	5.3%	5.1%	-0.3%
Controlling High Blood Pressure (CBP)	17	17	100.0%	59.1%	63.7%	4.6%
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%)	9	11	81.8%	84.7%	86.6%	1.9%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Coronary Artery Disease (CAD): Antiplatelet Therapy	10	12	83.3%	87.8%	88.7%	0.9%
Depression Remission or Response for Adolescents and Adults (DRR-E)						
Follow-Up PHQ-9 (Adults)	5	8	62.5%	42.3%	41.6%	-0.7%
Depression Remission (Adults)	5	8	62.5%	12.8%	9.7%	-3.2%
Depression Response (Adults)	6	8	75.0%	18.8%	15.2%	-3.6%
Discharged on Antithrombotic Therapy	10	11	90.9%	98.2%	98.7%	0.5%
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	9	9	100.0%	89.9%	93.0%	3.1%
Exclusive Breast Milk Feeding (PC-05)	6	9	66.7%	70.3%	69.0%	-1.3%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence						
7 Days	6	7	85.7%	19.7%	23.0%	3.3%
30 Days	7	7	100.0%	31.9%	35.8%	3.9%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[a]						
7 Days	1	2	50.0%	53.6%	56.4%	2.9%
30 Days	2	2	100.0%	55.6%	59.7%	4.2%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
7 Days	2	3	66.7%	34.9%	43.3%	8.4%
30 Days	3	3	100.0%	48.0%	60.7%	12.6%
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)	13	13	100.0%	93.5%	93.6%	0.1%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
HIV Screening Measure	15	16	93.8%	65.0%	71.3%	6.3%
HIV Viral Suppression (HVL-AD)	10	15	66.7%	83.0%	84.3%	1.3%
Improving Health Equity 1[b]						
Asthma Medication Ratio (AMR) - - Black/African American	1	1	100.0%	50.0%	76.5%	26.5%
Breast Cancer Screening (BCS) - - Black/African American	1	2	50.0%	49.8%	57.0%	7.2%
Breast Cancer Screening (BCS) - - Native Hawaiian/Pacific Islander	1	1	100.0%	46.0%	60.0%	14.0%
Cervical Cancer Screening (CCS) - - Black/African American	2	2	100.0%	48.7%	56.1%	7.4%
Child and Adolescent Well Care Visits - - Black/African American	1	1	100.0%	44.2%	52.4%	8.2%
Chlamydia Screening in Women (CHL) - - White	1	1	100.0%	61.2%	65.9%	4.7%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Colorectal Cancer Screening - -Asian	1	1	100.0%	25.5%	64.2%	38.7%
Controlling High Blood Pressure (CBP) -Black/African American	3	3	100.0%	57.7%	64.2%	6.5%
Exclusive Breast Milk Feeding (PC-05) - -Black/African American	0	1	0.0%	[c]	72.9%	[c]
Immunizations for Adolescents - -Black/African American	1	1	100.0%	39.3%	51.5%	12.1%
Well-Child Visits in the First 30 Months of Life (W30) - 15 Months-30 Months -Black/African American	0	1	0.0%	0.0%	0.0%	0.0%
Well-Child Visits in the First 30 Months of Life (W30) - First 15 Months - Black/African American	0	1	0.0%	N/A	N/A	N/A
Improving Health Equity 2[b]						

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Breast Cancer Screening (BCS) - - Native Hawaiian/Pacific Islander	1	1	100.0%	49.0%	58.8%	9.8%
Child and Adolescent Well Care Visits - - Black/African American	1	1	100.0%	50.3%	52.8%	2.5%
Chlamydia Screening in Women (CHL) - - American Indian/Alaskan Native	1	1	100.0%	N/A	N/A	N/A
Chlamydia Screening in Women (CHL) - - White	1	1	100.0%	50.9%	75.2%	24.3%
Colorectal Cancer Screening - - Black/African American	1	1	100.0%	52.2%	54.8%	2.6%
Colorectal Cancer Screening - -Native Hawaiian/Pacific Islander	1	1	100.0%	43.5%	67.6%	24.1%
Controlling High Blood Pressure (CBP) - - Black/African American	1	1	100.0%	53.2%	56.8%	3.6%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Exclusive Breast Milk Feeding (PC-05) - -Black/African American	1	1	100.0%	60.9%	69.7%	8.8%
HIV Viral Suppression (HVL-AD) - -Black/African American	2	2	100.0%	67.6%	82.1%	14.5%
Prenatal and Postpartum Care: Postpartum Care (PPC-PST) - -Black/African American	1	1	100.0%	77.3%	80.0%	2.7%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 2 -Black/African American	0	1	0.0%	66.7%	72.2%	5.5%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 3 -Black/African American	1	1	100.0%	87.6%	88.7%	1.1%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Preventive Care and Screening: Screening for Depression and Follow-Up Plan - - White	0	1	0.0%	75.6%	81.1%	5.5%
Kidney Health Evaluation for Patients with Diabetes	16	16	100.0%	53.9%	58.0%	4.1%
Lead Screening in Children	9	11	81.8%	66.1%	71.9%	5.7%
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	14	15	93.3%	95.9%	95.0%	-0.9%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Bronchodilator	3	3	100%	87.3%	92.1%	4.7%
Systemic Corticosteroid	0	3	0.0%	65.5%	62.3%	-3.2%
Pharmacotherapy for Opioid Use Disorder	1	3	33.3%	25.8%	25.5%	-0.3%
Plan All-Cause Readmissions (PCR)↓	6	9	66.7%	14.5%	85.3%	70.9%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Postpartum Depression Screening and Follow-Up (PDS-E)[a]						
Depression Screening	11	11	100.0%	50.9%	53.9%	2.9%
Follow-Up on Positive Screen	3	7	42.9%	70.1%	71.9%	1.8%
Prenatal Depression Screening and Follow-Up (PND-E)[a]						
Depression Screening	12	12	100.0%	79.1%	80.7%	1.6%
Follow-Up on Positive Screen	3	7	42.9%	56.2%	54.0%	-2.2%
Prenatal Immunization Status	11	11	100.0%	42.9%	46.9%	4.0%
Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	10	12	83.3%	74.0%	75.7%	1.7%
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	8	9	88.9%	45.8%	66.6%	20.9%
Preventive Care and Screening: Influenza Immunization	1	6	16.7%	45.5%	42.2%	-3.3%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention[d]						
Rate 2	8	13	61.5%	64.5%	73.1%	8.7%
Rate 3	10	13	76.9%	91.5%	91.4%	-0.1%
Reduction in Hospital Acquired Clostridium Difficile Infections↓	5	7	71.4%	51.6%	40.5%	-11.1%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	11	12	91.7%	78.2%	81.3%	3.2%
Surgical Site Infection (SSI)↓[e]	11	13	84.6%	84.1%	65.3%	-18.8%
Transitions of Care (TRC)	16	16	100.0%	94.3%	96.0%	1.7%
Use of Imaging Studies for Low Back Pain (LBP)	10	11	90.9%	86.0%	86.6%	0.6%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)↓	9	11	81.8%	3.0%	2.2%	-0.8%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents						
BMI Percentile Documentation	13	14	92.9%	91.8%	93.7%	2.0%
Counseling for Nutrition	13	14	92.9%	81.4%	85.2%	3.8%
Counseling for Physical Activity	12	14	85.7%	79.6%	83.8%	4.2%

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.

Last column was only calculated for measures included in both 2022 and 2023

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

[a]New measure in 2023

[b]For the Improving health equity 1 and the Improving health equity 2 measures, DPHs were able to report data on any measure and any population in the Eligible Equity Measure list

[c]Rate suppressed because denominator less than 30

[d]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

[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 Elective Measures from 2022 to 2023

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Adult Immunization Status (AIS-E)[a]						
Influenza	2	2	100.0%	N/A	N/A	N/A
Td/Tdap	1	2	50.0%	N/A	N/A	N/A
Zoster	1	2	50.0%	N/A	N/A	N/A
Advance Care Plan	5	6	83.3%	55.1%	69.9%	14.8%
Appropriate Treatment for Upper Respiratory Infection (URI)	0	1	0.0%	92.6%	92.7%	0.1%
Asthma Medication Ratio (AMR)	b	b	b	b	b	b
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	1	1	100.0%	77.8%	76.8%	-1.0%
Breast Cancer Screening (BCS)	11	14	78.6%	63.2%	61.8%	-1.4%
Cervical Cancer Screening (CCS)	7	9	77.8%	57.4%	55.1%	-2.3%
Cesarean Birth (PC02-CH)↓	7	11	63.6%	20.0%	22.2%	2.2%
Colorectal Cancer Screening	9	9	100.0%	41.7%	42.7%	0.9%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Comprehensive Diabetes Care: Eye Exam (CDC-E)	3	4	75.0%	44.6%	44.6%	0.0%
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)↓						
Black/African American	0	2	0.0%	c	c	c
Hispanic/Latino	11	13	84.6%	32.4%	28.2%	-4.2%
Total Population	11	14	78.6%	32.6%	28.9%	-3.7%
Concurrent Use of Opioids and Benzodiazepines (COB-AD)↓	b	b	b	b	b	b
Controlling High Blood Pressure (CBP)	10	10	100.0%	56.5%	60.0%	3.5%
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%)	2	2	100.0%	93.4%	92.5%	-0.9%
Coronary Artery Disease (CAD): Antiplatelet Therapy	3	3	100.0%	82.8%	86.3%	3.5%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Depression Remission or Response for Adolescents and Adults (DRR-E)						
Follow-Up PHQ-9 (Adults)	b	b	b	b	b	b
Depression Remission (Adults)	b	b	b	b	b	b
Depression Response (Adults)	b	b	b	b	b	b
Discharged on Antithrombotic Therapy	4	6	66.7%	99.8%	99.6%	-0.2%
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	5	7	71.4%	87.1%	92.7%	5.6%
Exclusive Breast Milk Feeding (PC-05)	7	10	70.0%	60.0%	63.0%	3.0%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence						
7 Days	3	3	100.0%	10.2%	16.7%	6.5%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
30 Days	3	3	100.0%	18.8%	27.1%	8.3%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[c]						
7 Days	b	b	b	b	b	b
30 Days	b	b	b	b	b	b
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
7 Days	b	b	b	b	b	b
30 Days	b	b	b	b	b	b
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)	2	2	100.0%	91.6%	93.8%	2.2%
HIV Screening Measure	4	5	80.0%	30.8%	38.4%	7.6%
HIV Viral Suppression (HVL-AD)	b	b	b	b	b	b

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Improving Health Equity 1[d]						
Child and Adolescent Well Care Visits - - American Indian/Alaskan Native	1	1	100.0%	48.4%	58.3%	9.9%
Exclusive Breast Milk Feeding (PC-05) - -Black/African American	0	1	0.0%	58.8%	43.6%	-15.2%
Improving Health Equity 2[d]						
Breast Cancer Screening (BCS) - - White	0	1	0.0%	65.2%	74.0%	8.8%
Cesarean Birth (PC02-CH) - - Black/African American↓	0	1	0.0%	23.7%	28.6%	4.9%
Exclusive Breast Milk Feeding (PC-05) - -Asian	1	1	100.0%	45.7%	69.2%	23.6%
Kidney Health Evaluation for Patients with Diabetes	5	5	100.0%	35.6%	53.1%	17.5%
Lead Screening in Children	6	6	100.0%	36.2%	60.4%	24.3%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting Goal	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	4	4	100.0%	96.4%	98.5%	2.1%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Bronchodilator	b	b	b	b	b	b
Systemic Corticosteroid	b	b	b	b	b	b
Pharmacotherapy for Opioid Use Disorder	b	b	b	b	b	b
Plan All-Cause Readmissions (PCR)↓	b	b	b	b	b	b
Postpartum Depression Screening and Follow-Up (PDS-E)[a]						
Depression Screening	1	1	100.0%	58.1%	82.4%	24.3%
Follow-Up on Positive Screen	N/A	N/A	N/A	N/A	N/A	N/A
Prenatal Depression Screening and Follow-Up (PND-E)[a]						
Depression Screening	1	2	50.0%	80.0%	98.9%	18.9%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting Goal	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Follow-Up on Positive Screen	N/A	N/A	N/A	N/A	N/A	N/A
Prenatal Immunization Status	1	1	100.0%	34.3%	46.9%	12.6%
Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	2	5	40.0%	25.2%	38.5%	13.3%
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	6	6	100.0%	45.0%	62.1%	17.1%
Preventive Care and Screening: Influenza Immunization	1	2	50.0%	33.6%	41.1%	7.5%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention[e]						
Rate 2	3	6	50.0%	13.3%	35.8%	22.5%
Rate 3	3	6	50.0%	78.2%	78.5%	0.2%
Reduction in Hospital Acquired Clostridium Difficile Infections↓	8	13	61.5%	35.9%	54.3%	18.4%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	2022 Aggregate Performance Rate	2023 Aggregate Performance Rate	Actual Change in Performance Rates
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	2	2	100.0%	78.4%	78.5%	0.1%
Surgical Site Infection (SSI)↓[f]	1	5	20.0%	67.4%	91.6%	24.2%
Transitions of Care (TRC)	1	2	50.0%	64.0%	56.0%	-8.0%
Use of Imaging Studies for Low Back Pain (LBP)	b	b	b	b	b	b
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)↓	b	b	b	b	b	b
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents						
BMI Percentile Documentation	7	7	100.0%	84.9%	89.6%	4.6%
Counseling for Nutrition	7	7	100.0%	56.3%	74.6%	18.2%
Counseling for Physical Activity	7	7	100.0%	56.6%	73.1%	16.6%

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.
Last column was only calculated for measures included in both 2022 and 2023
[↓]For these measures lower achievement rates indicate better care
[a]New measure in 2022
[b]Hospitals did not report on the measure in 2023
[c]Rate suppressed because either total numerator or total denominator was less than 11.
[d]For the Improving Health Equity 1 and the Improving Health Equity 2 measures, DMPHs were able to report data on any measure and any population in the Eligible Equity Measure list
[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
[f]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.

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, which 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. In CY 2021 to 2023, the required number of priority measures was decreased from 20 to 9 to address ongoing impacts of the COVID-19 Public Health Emergency (PHE) putting more focus on QIP measures that aligns with the departmental Comprehensive Quality Strategy (CQS). 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. 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 from baseline period (2022) performance and the high-performance benchmark (90th percentile). Hospitals that achieve the QIP performance targets and perform at or above the 2023 minimum benchmark will receive incentive payments. This methodology is called Value-Based Payment also known as Pay-for-Performance (P4P). Additionally, QIP entities 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.

For new measures or if measures were not reported in prior calendar year 2022, baseline data was required to be reported in 2023, before an entity can enter the current PY data. Trending break measures that had specification change between two PYs, follows the

[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.

same reporting process which was to report a baseline (capturing 2022 data using 2023 specification manual) before entering the current PY data. Reporting two versions of the data will account for trending breaks that requires modification of the following PY's target rate and enable comparison of achievement rates.

DMPH Community Partners:

The 2023 DMPH preprint included a provision allowing DMPHs 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 2023, 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 23-003.

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 2023 QIP Measure List.
- For reporting measures (applicable to DMPH only), DMPHs had to report complete and accurate data to complete the number of attested measures to report in order to be eligible to receive payment for the year.

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 PYs was required for a QIP measure to earn a nonzero AV, as determined by performance, and be eligible for payment.

- Should that gap between the priority population baseline rate and total population baseline rate of the parent measure decrease to less than 3 percentage points by the end of the year, the entity was required to choose a new Priority Population and/or Eligible Equity Measure two years later.
- If an entity achieved ≥90th percentile in any one year, the entity had to choose a new measure and/or a different Priority Population two years later even if the performance on the Priority Population dropped below the 90th percentile in subsequent years (regardless of whether the entity reported on it or not).

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.

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

- Hispanic/Latino
- Native Hawaiian/Pacific Islander
- White

Acute and Chronic Conditions

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

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

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

Maternal/Perinatal Health

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

Q-PC05: Exclusive Breast Milk Feeding (CMQCC)
- American Indian/Alaskan Native
- Asian
- Black/African American
- Hispanic/Latino
- Native Hawaiian/Pacific Islander

Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care (HDR18)
- American Indian/Alaskan Native
- Black/African American
- 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 more details on 2023 reporting updates, please see QIP Policy Letter 24-001.