Quality Incentive Pool (QIP) Program Evaluation Report

Program Year (PY) 5
January 1, 2022, to December 31, 2022

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) 5 (calendar year 2022), 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 PY5, the QIP had a budget of $1.897 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 and DMPHs showed improvement on all nine priority measures and many of the elective measures compared with PY4. DPHs' overall improvement on priority measures ranged from 0.8 percent to 9.8 percent, and for DMPHs it ranged from 3.2 percent to 10.7 percent. DMPHs' performance improvement exceeded DPHs' performance improvement on eight of nine priority measures. For DMPHs, most race/ethnicity data was suppressed because of low numbers, but in DPHs disparities were evident. The African American/Black population had the lowest rates for two immunization measures, indicating room for improvement. For the Child and Adolescent Well Care Visits and Postpartum Care measures, the Native Hawaiian/Other Pacific Islander (NH/OPI) population had the lowest rates.

The major goals of QIP are to improve disease prevention and primary care access for Medi-Cal members, and to reduce racial/ethnic disparities in clinical quality at public health care systems. In PY5, 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. Performance rates stratified by race/ethnicity show where to direct quality improvement efforts, including on low rates of child and adolescent immunization among African-American/Black populations who visit DPHs.

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 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. QIP integrates supplemental payments that were previously made to public hospitals, provides equity targets and 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. The QIP program is authorized by California Welfare and Institutions Code section 14197.4(c).

In QIP Program Year (PY) 5, 17 Designated Public Hospitals (DPHs) and 33 District and Municipal Public Hospitals (DMPHs) (including two newly joined - Bear Valley Community Hospital and Palo Verde Hospital) participated and there were 52 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 PY5, from January 1, 2022, to December 31, 2022, the Centers for Medicaid and Medicare (CMS) approved the DPH and DMPH preprints on December 27, 2023 with a budget of $1.897 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 PY5 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 participating entities – DPHs and DMPHs – 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

Beyond the 9 priority measures required to be reported by all QIP entities, 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 program year. DPHs reporting only 30 total measures could earn only 90% 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 of PY5. For payment purposes, DMPHs could choose to base their P4P performance on a subset of these measures, as few as 67 percent of the original number of measures (rounded to the nearest integer) but not less than 1 measure. The remaining 33 percent could be reported as pay-for-reporting (P4R) and were assigned an Achievement Value (AV) of Not Applicable (N/A). 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 would not receive any QIP payment for PY5. Two other specific requirements applied to DMPHs:

- DMPH systems reported at least 20 percent of their required reported measures from a modified Priority Measure set. However, DMPHs that did not offer primary care or other relevant services for a given priority measure were provided the flexibility to substitute an elective measure.
- Data with denominators of at least 30 must be reported. Performance targets remained the same.

Improving Health Equity (IHE) Measures

Quality: Improving Health Equity 1 (Q-IHE1) and Quality: Improving Health Equity 2 (Q-IHE2) were measures designed to improve health equity for select populations in select measures having statewide disparities[1]

For PY5, 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 was required to be reported. An entity could choose a priority population for a QIP Eligible Equity measure, 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.

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.

Stratification of Reported Data by Race and Ethnicity

To begin identifying hospital-level disparities that could be reduced through QIP, DHCS required informational reporting of race and ethnicity stratifications for five measures in

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

PY5. The required stratifications and protocols were outlined in QIP Policy Letter QPL 23-001. The specific measures stratified were:

- Q-WCV: Child and Adolescent Well-Care Visits
- Q-CIS: Childhood Immunization Status
- Q-IMA: Immunizations for Adolescents
- Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care
- Q-PPC-Pst: Prenatal and Postpartum Care: Postpartum Care

For Q-HBD: Hemoglobin A1c Control for Patients with Diabetes, three P4P sub-rates namely Hispanic/Latino ethnicity, Black/African American race, and Total Population were reported. Any sub-rate which had a denominator of less than 30 was excluded in the calculation of the AV. Although this requirement is designed to ensure that QIP entities are incentivized based on statistically-stable performance rates, DHCS acknowledges that this limits the ability to incentivize improvement or examine health disparities for patient populations with low numbers.

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 measures. Entities had to report both measures if selecting to report on any of these measures. 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 provided.

QIP PY5 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. For PY 5 only, all measures that counted towards the entities' Quality Score were in scope of review for the external auditor, HSAG.

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 or seen by DPHs and DMPHs.

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 encrypted aggregated data collected in accordance with the QIP PY5 Reporting Manual to DHCS, using a secure online reporting system. DHCS staff 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 PY5 can be located on the California Health and Human Services (CHHS) open data portal.

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. For each DPH/DMPH, measure performance was assessed by comparing each measure's PY5 achievement rate to the measure's minimum performance benchmark and

assigning an Achievement Value (AV) as specified in the QIP COVID-19 PHE Amended Preprint, Attachment I. 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. 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 PY4 performance and the PY5 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 PY5.

The aggregate performance rate for each measure was calculated only when DPHs/DMPHs reported data for both PY4 and PY5. 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 PY4 to PY5. "Actual change" is the *absolute* difference in performance rates from PY4 to PY5 for each measure; the resulting difference was expressed in terms of percentage points.

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 2024, and the final report incorporated stakeholder input.

RESULTS

Priority and Elective Measures

In PY5, 17 DPHs and 33 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.

Table 1 shows the actual change in aggregate performance rates from PY4 to PY5 for each priority measure (see appendix A for similar information on the much longer list of elective measures). For each measure, DPHs improved their aggregate performance

from PY4 to PY5, as did DMPHs. DPHs' aggregate improvement ranged from 0.8 percent to 9.8 percent, with Developmental Screening in the First Three Years of Life measure exhibiting the largest improvement compared to the rate in PY4. DMPHs' aggregate improvement ranged from 3.2 percent to 10.7 percent, with the greatest improvement on the Child and Adolescent Well Care Visits measure. DMPHs' performance improvement exceeded DPHs' improvement for eight of nine priority measures.

Table 1: Rate of DPHs and DMPHs Meeting Quality Improvement Targets and the Actual Percentage Changes in Performance Rates for Priority Measures from PY4 to PY5

Measure	Percentage of Entities Meeting Goal		PY4 Aggregate Performance Rate		PY5 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	41.2%	71.4%	44.9%	40.7%	45.8%	51.0%	0.8%	10.3%
Childhood Immunization Status (CIS 10)	58.8%	100.0%	42.3%	37.7%	44.7%	40.9%	2.4%	3.2%
Chlamydia Screening in Women	70.6%	50.0%	61.3%	33.8%	63.7%	41.4%	2.4%	7.6%
Developmental Screening in the First Three Years of Life	88.2%	80.0%	40.7%	35.9%	50.5%	43.4%	9.8%	7.4%
Immunizations for Adolescents	58.8%	100.0%	37.9%	31.1%	41.1%	39.1%	3.2%	8.0%
Prenatal and Postpartum Care (Postpartum Care)	76.5%	100.0%	74.1%	79.6%	81.2%	87.7%	7.1%	8.1%
Prenatal and Postpartum Care	58.8%	100.0%	74.5%	78.3%	80.6%	85.7%	6.1%	7.3%

Measure	Percentage of Entities Meeting Goal		PY4 Aggregate Performance Rate		PY5 Aggregate Performance Rate		Actual Change in Performance Rates	
(Timeliness of Prenatal Care)								
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	58.8%	80.0%	69.1%	66.6%	70.1%	77.3%	0.9%	10.7%
Well-Child Visits in the First 30 Months of Life	52.9%	100.0%						
First 15 Months	76.5%	100.0%	56.8%	50.9%	62.0%	61.0%	5.2%	10.1%
15 Months – 30 Months	52.9%	100.0%	62.5%	68.1%	67.0%	76.9%	4.5%	8.8%

Note: The last two columns were only reported for measures whose performance rates were available in both PY4 and PY5. 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.

Table 1 also shows how many DPHs and DMPHs met performance targets for the priority measures (Appendix Tables A.1 and A.2 show similar information for elective measures). DPHs were less likely to meet their targets for the priority measures compared to DMPHs, and compared to prior years in which performance targets were less stringent. For the priority measures, 100 percent of DMPHs who reported on five of the nine measures met the target.

Tables for the elective measures are in Appendix A. Of 33 elective performance measures, DPHs showed aggregate improvement on 29 measures and DMPHs showed aggregate improvement on 30 measures from PY4 to PY5.[2] For DPHs, Reduction in Hospital Acquired Clostridium Difficile Infections exhibited the largest improvement (decreased by 14.6 percent) while for DMPHs, the measure on Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan showed the largest improvement (22.5 percent). Compared to the mandatory priority measures, DPHs were

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

more likely to meet their performance targets for elective measures, and on six elective measures all DPHs met the performance target. In contrast, DMPHs were equally likely to meet their targets for the priority measures as for the elective measures. For 14 of the 33 elective measures, at least 80 percent of DMPHs reported meeting the target.

Improving Health Equity Measures (IHE1 and IHE2)

Information about both Improving Health Equity Measures (IHE1 and IHE2) is also included in Tables A.1 and A.2 in the appendix. In PY5, DPHs 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 80 percent (92.9 percent for IHE1) and (81.8 percent for IHE2) of the hospitals meeting their target for these measures with the targeted populations. For these measures the performance rates for all but one measure (Child and Adolescent Well Care Visits for the Black/African American population) showed improvement from PY4 to PY5. None of the DMPHs that reported on IHE1 and IHE2 met the target for these measures.

Race-Ethnicity Aggregate Rates

Table 2 shows the PY5 aggregate rates for the six measures that were stratified by race/ethnicity for DPHs and DMPHs. Race/ethnicity reporting standards were not consistent from PY4 to PY5,[3] so it was not possible to directly assess changes over time in racial/ethnic disparities on these measures. All 17 DPHs stratified five of the measures while 16 DPHs also stratified Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (Riverside University Health System did not report this measure). For DMPHs, twelve reported on the Child and Adolescent Well-Care Visits, seven on Childhood Immunization Status, eight on Immunizations for Adolescents, six on Prenatal and Postpartum Care: Timeliness of Prenatal Care, seven on Prenatal and Postpartum Care: Postpartum Care, and twelve on Comprehensive Diabetes Care: HbA1c Poor Control

[3] Specifically, the measures for which DPHs and DMPHs reported stratified race and ethnicity information in PY4 and PY5 were different. In addition, the stratification approach was different: in PY4, DPHs and DMPHs reported racial categories separately from their reporting of Hispanic/Non-Hispanic ethnicity, using a matrix approach. In PY4, individuals identifying as one or more race were counted multiple times, once for each applicable race category, while individuals of Hispanic ethnicity were included in at least one race category. In PY5, QIP entities reported each individual in only one mutually exclusive race/ethnicity category, with Hispanic being one of the categories. Each individual was counted only once, and a single "Two or More Races" category was added to capture multiracial individuals.

(>9.0%). The aggregate rates varied for the measures by race and ethnicity for DPHs and DMPHs.

DPHs

- The African American/Black population had the lowest aggregate rates for the two immunization measures.
- Among all groups, there was significant room for improvement on the Child and Adolescent Well Care Visits and the two immunization measures.
- For the Child and Adolescent Well Care Visits measure, the African American/Black, American Indian/Alaska Native (AI/AN), and Native Hawaiian/Other Pacific Islander (NH/OPI) populations had the lowest rates.
- For the Prenatal and Postpartum Care: Postpartum Care measure the Native Hawaiian/Other Pacific Islander (NH/OPI) population had the lowest rates.
- The Asian population had the most favorable rates for the Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) measure.

DMPHs

- Only the White and Hispanic/Latino populations had sample sizes large enough to summarize all the measures for PY5.
- For White and Hispanic/Latino patients, DMPHs' performance on the two immunization measures was substantially lower than DPHs' performance.

Table 2: DPH and DMPH Aggregate Rates for the QIP Measures Stratified by Race-Ethnicity

Race/Ethnicity	Child and Adolescent Well-Care Visits	Childhood Immunization Status (CIS 10)	Immunizations for Adolescents	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓
DPHs						
Hispanic/Latino	51.3%	50.9%	48.1%	83.8%	83.9%	36.3%
White	48.4%	49.4%	40.5%	82.7%	81.2%	35.0%
African American/Black	41.8%	25.4%	29.2%	83.6%	75.5%	35.3%

Race/Ethnicity	Child and Adolescent Well-Care Visits	Childhood Immunization Status (CIS 10)	Immunizations for Adolescents	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓
American Indian/Alaska Native	46.7%	60.0%	36.4%	80.7%	80.0%	35.6%
Asian	50.8%	63.4%	44.6%	87.7%	89.7%	20.9%
Native Hawaiian (NH)/Other PI	40.6%	41.9%	50.0%	83.1%	72.1%	37.6%
Other/Unknown /Declined	43.1%	41.2%	43.3%	77.0%	81.7%	37.7%
Non-Hispanic/Latino	46.4%	40.4%	35.2%	83.2%	79.2%	30.0%
Other/Unknown /Declined Ethnicity	15.8%	21.0%	16.3%	54.0%	71.4%	48.8%
DMPHs						
Hispanic/Latino	55.3%	27.5%	40.3%	83.9%	89.9%	31.4%
White	46.2%	27.8%	30.2%	86.0%	80.4%	33.0%
African American/Black	42.2%	*	*	*	a	30.0%
American Indian/Alaska Native	44.4%	a	*	*	*	a
Asian	43.1%	37.1%	34.8%	a	a	19.5%
Native Hawaiian (NH)/Other PI	36.5%	*	*	*	*	*
Other/Unknown /Declined	54.8%	26.5%	40.0%	79.7%	91.7%	29.0%

Race/Ethnicity	Child and Adolescent Well-Care Visits	Childhood Immunization Status (CIS 10)	Immunizations for Adolescents	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓
Non-Hispanic/Latino	39.9%	34.2%	22.5%	79.1%	73.5%	27.8%
Other/Unknown /Declined Ethnicity	43.1%	15.0%	18.1%	[a]	75.0%	34.7%

Notes: All rates are based on at least a numerator of 11 and a denominator of 30
Totals are not a sum of subsequent rows see QIP Policy Letter QPL 21-006 for details
↓For this measure lower rates indicate better care
*Rate suppressed because either total numerator or total denominator was less than 11.
[a] Rate suppressed because the denominator was less than 30, resulting in a statistically invalid rate

DPHs

Fourteen DPHs reported 40 pay-for-performance (P4P) measures and three DPHs reported 30 P4P measures (see table 3). Arrowhead Regional Medical Center, UC Davis Medical Center, and UC Los Angeles Medical Center did not receive all of their allotted funding, because these DPHs only reported 30 out of 40 measures.

Table 3 shows the number of measures, and the percentage of measures for which each DPH met the target. Also reported in this table is the number and percentage of measures for which DPHs improved from PY4 to PY5 or reported achievement rates in PY5 that were at or above the 90th percentile.

Six DPHs reported meeting their target for above 85 percent of their measures, but there was significant variation, with three DPHs meeting their target for 50 percent or fewer measures. This table shows that only three hospitals had at least 70 percent of their measures' performance rates showing improvement or residing at or above the 90th percentile. The other 14 DPHs had 47.4 percent to 68.4 percent of their measures' performance rates showing improvement or residing at or above the 90th percentile.

Table 3: Number and Percentage of Pay for Performance Measures with Targets Met for Each DPHs for PY5

DPH	No. Of Measures With Target Met	Percentage of Measures With Target Met	No. of Measures Hospitals Improved or ≥ 90th percentile**	Percentage of Measures Hospital Improved or ≥ 90th percentile***
Alameda Health System	34	85.0%	25	64.1%
Arrowhead Regional Medical Center*	13	43.3%	14	51.9%
Contra Costa Regional Medical Center	35	87.5%	29	72.5%
Kern Medical Center	30	75.0%	23	60.5%
Los Angeles County Health System	32	80.0%	22	57.9%
Natividad Medical Center	36	90.0%	29	74.4%
Riverside University Health System	35	87.5%	26	68.4%
San Francisco General Hospital	35	87.5%	27	67.5%
San Joaquin General Hospital	26	65.0%	22	59.5%
San Mateo Medical Center	31	77.5%	26	66.7%
Santa Clara Valley Medical Center	33	82.5%	22	57.9%
UC Davis Medical Center*	23	76.7%	18	62.1%
UC Irvine Medical Center	20	50.0%	18	47.4%
UC Los Angeles Medical Center*	14	46.7%	15	51.7%
UC San Diego Medical Center	31	77.5%	25	64.1%
UC San Francisco Medical Center	30	75.0%	22	57.9%
Ventura County Medical Center	35	87.5%	30	78.9%

Notes: *DPHs that only reported 30 measures

**3 measures did not have a 90th percentile.

***In the last column, the denominator is the number of measures that hospitals had both PY4 and PY5 data. Measures were only included in the counts for the last two columns if there was both PY4 and PY5 data.

DMPHs

Table 4 shows the number of measures, and the percentage of measures for which each DMPH met the target. Percentages of DMPHs meeting their target for measures varied from 25.0 percent to 100 percent, with sixteen DMPHs reporting meeting their target for 100 percent of their reported measures. Table 4 only included pay-for-performance measures. Five DMPHs did not meet the target for any of the measures they reported. Also reported in this table is the number and percentage of measures for which DMPHs improved from PY4 to PY5 or reported achievement rates in PY5 that were at or above the 90th percentile. Improvement was calculated only when DMPHs had data from both PY4 and PY5. This table shows that only 14 hospitals had at least 70 percent of their measures' performance rates showing improvement or residing at or above the 90th percentile, while 11 had 90 percent or higher and 10 had 100 percent. DMPHs reported fewer measures than DPHs (highest was 13 measures reported by 4 DMPHs); however, more DMPHs reported meeting their targets for the measures they reported and more DMPHs reported improvement from PY4 to PY5.

Table 4: DMPH Number and Percentage of Pay for Performance Measures with Targets Met for PY5

DMPHs	No. Of Measures With Target Met	Percentage of Measures With Target Met	No. of Measures Hospitals Improved or ≥ 90th percentile**	Percentage of Measures Hospital Improved or ≥ 90th percentile***
Antelope Valley Hospital	7	70.0%	7	70.0%
Bear Valley Community Hospital*	2	100.0%	2	100.0%
Eastern Plumas Health Care	1	100.0%	0	0.0%
El Camino Hospital	6	85.7%	5	71.4%
El Centro Regional Medical Center	13	100.0%	11	84.6%
Hazel Hawkins Memorial Hospital	6	100.0%	6	100.0%
Jerold Phelps Community Hospital	1	25.0%	1	25.0%
John C. Fremont Healthcare District	2	50.0%	3	75.0%
Kaweah Delta Health Care District	6	46.2%	5	38.5%

DMPHs	No. Of Measures With Target Met	Percentage of Measures With Target Met	No. of Measures Hospitals Improved or ≥ 90th percentile**	Percentage of Measures Hospital Improved or ≥ 90th percentile***
Kern Valley Healthcare District	3	75.0%	3	75.0%
Lompoc Valley Medical Center	13	100.0%	9	69.2%
Mammoth Hospital	8	100.0%	7	87.5%
Marin General Hospital	6	85.7%	3	42.9%
Mayers Memorial Hospital District	0	0.0%	0	0.0%
Modoc Medical Center	1	100.0%	1	100.0%
Northern Inyo Hospital	3	100.0%	3	100.0%
Oak Valley Hospital District	12	92.3%	9	69.2%
Palomar Medical Center	9	100.0%	7	77.8%
Palo Verde Hospital*	0	0.0%	2	66.7%
Pioneers Memorial Healthcare District	8	100.0%	8	100.0%
Plumas District Hospital, Quincy	1	100.0%	1	100.0%
Salinas Valley Memorial Healthcare System	13	100.0%	12	92.3%
San Bernardino Mountains Community Hospital	3	100.0%	3	100.0%
San Gorgonio Memorial Hospital	2	66.7%	2	66.7%
Seneca Healthcare District	1	100.0%	1	100.0%
Sierra View District Hospital	4	57.1%	4	57.1%
Sonoma Valley Hospital	1	100.0%	1	100.0%
Southern Inyo Hospital	0	0.0%	0	0.0%
Surprise Valley	0	0.0%	0	0.0%
Tahoe Forest Hospital District	5	71.4%	5	71.4%
Tri-City Medical Center	4	30.8%	7	53.8%

DMPHs	No. Of Measures With Target Met	Percentage of Measures With Target Met	No. of Measures Hospitals Improved or ≥ 90th percentile**	Percentage of Measures Hospital Improved or ≥ 90th percentile***
Trinity Hospital	0	0.0%	1	100.0%
Washington Hospital Healthcare System	13	100.0%	11	84.6%

Notes: *First time this DMPH participated in the QIP program
**3 measures did not have a 90th percentile.
***In the last column, the denominator is the number of measures that hospitals had both PY4 and PY5 data. Measures were only included in the counts for the last two columns if there was both PY4 and PY5 data.

CONCLUSION

This report provides information regarding the quality of services provided to Medi-Cal members at DPHs and DMPHs during calendar year 2022, a year in which the health care delivery system was still recovering from the influence of the COVID-19 pandemic. In PY5, as both DMPHs and DPHs reported measures for the QIP program, both were evaluated in this report. All but three DPHs (Arrowhead Regional Medical Center, UC Davis Medical Center, and UC Los Angeles Medical Center) reported on all 40 measures. Those three DPHs' funding allocations were reduced to 90% because they only reported 30 of the required 40 measures.

In this evaluation report, DHCS compared achievement rates (PY5) for specific measures to achievement rates in the previous year (PY4). In PY5, DHCS reduced the number of priority measures to nine and strengthened the requirements for all DPHs and DMPHs to improve on these nine priority measures. While the numbers of DPHs and DMPHs meeting their performance targets varied, DPHs and DMPHs showed collective improvement on all nine measures, compared with PY4.

DPHs met their performance target on 72.7 percent of reported measures in aggregate across all 17 DPHs in PY5. This was a notable change from PY4, when DPHs met their performance target on 100 percent of reported measures. Similarly, in PY5, none of the DPHs met the target for all measures, although six DPHs reporting meeting their target for at least 85 percent of their measures. Comparing the rates at which hospitals achieved their performance targets with rates at which hospitals improved or achieved

the 90th percentile rate demonstrated that performance targets were well-aligned with an independent indicator of high performance and quality improvement in most cases.

A number of factors may explain why QIP entities did not meet targets as frequently in PY5 vs. PY4. In PY4, due to the COVID-19 Public Health Emergency, DHCS made a number of programmatic changes to push hospitals to work on COVID-19 testing, vaccination, and surge planning and response efforts. Additionally, as part of accommodations related to COVID-19, DPHs only had to report on 10 pay-for-performance measures in PY4. In comparison, in PY5, as the public health emergency wound down, the QIP program reinstated most of its pre-pandemic requirements. The performance target in PY5 was also set higher (10% gap closure between the baseline and the 90th percentile benchmark) than PY4 (minimum benchmark of 25th percentile). DMPHs reported on less measures than DPHs (highest was 13 measures reported by 4 DMPHs); however, more DMPHs reported meeting their targets for the measures and more improvement from PY4 to PY5. DPHs were more likely to meet target rates for the elective measures compared to the priority measures, where for DMPHs there was no difference by type of measure. This may reflect the greater flexibility provided to DMPHs to report fewer priority measures and to continue reporting up to a third of their measures as P4R, a flexibility that did not exist prior to the pandemic and that was extended in PY5. DPHs also retained the option to reporting fewer than 40 P4P measures, although this resulted in a slightly reduced funding allocation for such DPHs.

DHCS also changed its approach to incentivizing disparity reductions through QIP in PY5. 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 did not meet the target for those two measures. For the other elective measures both DPHs and DMPHs reported improvement with all but four measures (varied by system) with both not reporting any improvement for the Kidney Evaluation measure.

Racial-ethnic differences in aggregate rates for the six stratified measures showed where DPHs and DMPHs should focus ongoing equity-related quality improvement efforts. For example, disparities for African Americans/Black populations on immunizations (child and adolescent) were evident in DPHs. Narrowing these disparities should be an area of continued emphasis, along with diabetes control, a measure for which African American/Black patients experienced lower rates in PY4, and where there is still room for improvement for many populations. Finally, the data showed that interventions to increase immunizations for adolescents and child and adolescent well care visits would benefit almost all populations.

It was not possible to compare these stratified performance rates to PY4 because of changes in quality measures and in the way DPHs/DMPHs were asked to report race/ethnicity categories. However, in PY6, DHCS will require that DPHs and DMPHs report the same measures in PY5 (plus additional measures) using the same stratification approach. Narrowing racial/ethnic disparities on these measures does not play a role in determining incentive payments, but it should be possible in next year's report to assess whether DPHs and DMPHs have been successful in narrowing the disparities shown here, which can provide information for the QIP program in future years.

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

Table A.1: Rate of DPHs Meeting Quality Improvement Targets and the Actual Change in Performance Rates for Elective Measures from PY4 to PY5

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Elective QIP Performance Measures						
Advance Care Plan	5	7	71.4%	72.3%	68.2%	-4.2%[a]
Appropriate Treatment for Upper Respiratory Infection	13	13	100.0%	98.0%	98.2%	0.1%
Asthma Medication Ratio	8	10	80.0%	61.7%	64.4%	2.8%
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	7	7	100.0%	81.8%	85.4%	3.6%
Breast Cancer Screening	14	16	87.5%	54.2%	57.6%	3.4%
Cervical Cancer Screening	6	11	54.5%	52.9%	54.2%	1.4%
Cesarean Birth (PC-02)↓	12	12	100.0%	19.9%	19.5%	-0.5%
Colorectal Cancer Screening	11	16	68.8%	54.3%	53.9%	-0.4%[a]
Comprehensive Diabetes Care: Eye Exam	12	15	80.0%	54.2%	57.2%	3.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓	11	16	68.8%			
Black/African American	11	16	68.8%	36.3%	35.2%	-1.1%
Hispanic/Latino	13	16	81.3%	37.2%	36.3%	-1.0%
Total Population	14	16	87.5%	-	34.2%	-
Concurrent Use of Opioids and Benzodiazepine↓	15	16	93.8%	6.8%	6.0%	-0.8%
Controlling High Blood Pressure	16	17	94.1%	55.5%	59.1%	3.6%
Coronary Artery Disease: Antiplatelet Therapy	10	13	76.9%	86.3%	87.1%	0.8%
Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	13	15	86.7%	84.2%	87.2%	3.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Depression Remission or Response for Adolescents and Adults	5	12	41.7%			
Follow-Up PHQ-9 (Adults)	7	12	58.3%	38.8%	45.4%	6.6%
Depression Remission (Adults)	7	12	58.3%	9.7%	13.1%	3.3%
Depression Response (Adults)	7	12	58.3%	14.9%	19.4%	4.5%
Discharged on Antithrombotic Therapy (STK-2)	9	10	90.0%	96.2%	99.0%	2.8%
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	7	8	87.5%	85.6%	89.9%	4.3%
Exclusive Breast Milk Feeding (PC-05)	10	14	71.4%	68.6%	70.8%	2.1%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	7	9	77.8%			
7 Days	7	9	77.8%	13.7%	18.3%	4.6%
30 Days	8	9	88.9%	23.5%	30.1%	6.6%
Follow-Up After High-Intensity Care for Substance Use Disorder[b]	1	3	33.3%			
7 Days	1	3	33.3%	29.1%	22.8%	-6.3%[a]
30 Days	1	3	33.3%	38.0%	43.0%	5.0%
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)	12	14	85.7%	87.8%	90.9%	3.1%
HIV Screening	15	17	88.2%	60.6%	64.3%	3.7%
HIV Viral Load Suppression	10	13	76.9%	82.1%	83.3%	1.2%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Improving Health Equity #1**	13	14	92.9%			
Asthma Medication Ratio – White	1	1	100.0%	51.2%	72.2%	21.0%
Breast Cancer Screening (BCS) – Black/African American	2	2	100.0%	44.2%	49.8%	5.6%
Child and Adolescent Well Care Visits – Black/African American	1	1	100.0%	36.1%	44.2%	8.1%
Childhood Immunization Status (CIS 10) – Black/African American	1	1	100.0%	36.1%	38.5%	2.4%
Chlamydia Screening in Women (CHL) – American Indian/Alaskan Native	1	1	100.0%	43.0%	50.4%	7.4%
Controlling High Blood Pressure (CBP) – Black/African American	3	3	100.0%	53.4%	59.8%	6.4%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Improving Health Equity #1**	13	14	92.9%			
Developmental Screening in the First Three Years of Life – Black/African American	1	1	100.0%	30.5%	38.6%	8.1%
Immunizations for Adolescents – Black/African American	1	1	100.0%	*	*	*
Prenatal and Postpartum Care: Postpartum Care (PPC-PST) – Black/African American	1	1	100.0%	66.1%	77.3%	11.2%
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention – Rate 2 -Native Hawaiian/Pacific Islander	1	1	100.0%	42.4%	93.5%	51.1%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Improving Health Equity #1**	13	14	92.9%			
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention – Rate 3 -Native Hawaiian/Pacific Islander	1	1	100.0%	76.2%	94.6%	18.4%
Improving Health Equity #2**	9	11	81.8%			
Child and Adolescent Well Care Visits – Black/African American	0	1	0.0%	47.7%	37.1%	-10.7%[a]
Colorectal Cancer Screening – Black/African American	1	1	100.0%	51.5%	54.9%	3.4%
Chlamydia Screening in Women (CHL) – Asian	1	1	100.0%	54.9%	65.9%	11.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Improving Health Equity #2**	9	11	81.8%			
Controlling High Blood Pressure (CBP) – Black/African American	1	1	100.0%	50.9%	53.2%	2.3%
Exclusive Breast Milk Feeding (PC-05) – Asian	1	1	100.0%	63.0%	66.1%	3.1%
Exclusive Breast Milk Feeding (PC-05) – Black/African American	2	2	100.0%	45.9%	56.2%	10.3%
HIV Viral Load Suppression – Hispanic/Latino	1	1	100.0%	76.9%	85.7%	8.8%
Prenatal and Postpartum Care: Postpartum Care (PPC-PST) – Black/African American	1	1	100.0%	50.0%	71.4%	21.4%
Preventive Care and Screening: Influenza Immunization – Black/African American	1	1	100.0%	45.1%	59.2%	14.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Kidney Evaluation for Diabetes[b]	14	15	93.3%	55.0%	53.9%	-1.1%[a]
Lead Screening in Children	8	13	61.5%	61.4%	69.1%	7.7%
Perioperative Care: Venous Thromboembolism (VTE)	14	14	100.0%	89.9%	95.9%	6.0%
Pharmacotherapy Management of COPD Exacerbation (PCE)	3	4	75.0%			
Systemic Corticosteroid	3	4	75.0%	58.1%	66.1%	8.0%
Bronchodilator	3	4	75.0%	81.1%	91.0%	9.9%
Pharmacotherapy for Opioid Use Disorder[b]	0	1	0.0%	*	*	*
Plan All-Cause Readmissions↓	5	9	55.6%	26.9%	14.5%	-12.4%
Prenatal Immunization Status[b]	6	8	75.0%	53.0%	51.9%	-1.0%[a]
Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections	11	11	100.0%	66.7%	78.8%	12.0%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	2	8	25.0%	48.8%	49.3%	0.6%
Preventive Care and Screening: Influenza Immunization	8	11	72.7%	58.1%	62.2%	4.1%
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention***	9	13	69.2%			
Rate 2	9	13	69.2%	50.1%	61.2%	11.1%
Rate 3	12	13	92.3%	88.8%	92.4%	3.6%
Reduction in Hospital Acquired Clostridium Difficile Infections↓	5	8	62.5%	66.1%	51.5%	-14.6%
Statin Therapy for The Prevention And Treatment Of Cardiovascular Disease	11	14	78.6%	72.9%	77.4%	4.4%
Surgical Site Infection (SSI)↓****	6	10	60.0%	88.6%	82.4%	-6.2%
Transitions of Care (TRC)	16	16	100.0%	99.4%	94.3%	-5.1%[a]
Use of Imaging Studies for Low Back Pain	11	12	91.7%	76.7%	86.9%	10.1%

Measure	Number of DPHs Meeting Goal	Number of DPHs Reporting	Percentage of DPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Use of Opioids at High Dosage in Persons Without Cancer↓	6	7	85.7%	2.2%	2.0%	-0.2%
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	11	14	78.6%			
BMI	14	14	100.0%	85.5%	91.9%	6.5%
Counseling for Nutrition	11	14	78.6%	72.1%	79.0%	6.9%
Counseling for Physical Activity	12	14	85.7%	66.4%	78.0%	11.5%

Note for the last column there needed to be both PY4 and PY5 data

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

*Rate suppressed because either total numerator or total denominator was less than 11.

**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

***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

****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.

[a]Red text indicates the performance between PY4 and PY5 did not show improvement

[b]new measure in PY5

Table A.2: Rate of DMPHs Meeting Quality Improvement Targets and the Actual Changes in Performance Rates for Elective Measures from PY4 to PY5

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Advance Care Plan	3	4	75.0%	77.0%	89.7%	12.7%
Appropriate Treatment for Upper Respiratory Infection	1	1	100.0%	92.2%	92.6%	0.4%
Asthma Medication Ratio	-----	-----	-----	-----	-----	-----
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	-----	-----	-----	-----	-----	-----
Breast Cancer Screening	10	13	76.9%	51.2%	62.4%	11.0%
Cervical Cancer Screening	7	9	77.8%	51.2%	60.5%	9.3%
Cesarean Birth (PC-02)↓	9	10	90.0%	22.0%	19.9%	-2.1%
Colorectal Cancer Screening	9	10	90.0%	34.5%	39.6	5.1%
Comprehensive Diabetes Care: Eye Exam	1	1	100.0%	0.0%	45.1%	45.1%
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓	10	10	100.0%			
Black/African American	0	1	0.0%			
Hispanic/Latino	9	9	100.0%	29.7%	27.9%	-1.8%
Total Population	10	10	100.0%		27.5%	

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Controlling High Blood Pressure	6	7	85.7%	64.3%	65.0%	0.7%
Concurrent Use of Opioids and Benzodiazepines↓	1	2	50.0%	13.8%	12.3%	-1.6%
Coronary Artery Disease: Antiplatelet Therapy	3	3	100.0%	81.3%	87.3%	6.0%
Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	2	2	100.0%	88.9%	93.4%	4.5%
Depression Remission or Response for Adolescents and Adults	5	12	41.7%			
Follow-Up PHQ-9 (Adults)	7	12	58.3%	38.8%	45.4%	6.6%
Depression Remission (Adults)	7	12	58.3%	9.7%	13.1%	3.3%
Depression Response (Adults)	7	12	58.3%	14.9%	19.4%	4.5%
Discharged on Antithrombotic Therapy (STK-2)	9	10	90.0%	96.2%	99.0%	2.8%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	7	8	87.5%	85.6%	89.9%	4.3%
Exclusive Breast Milk Feeding (PC-05)	9	10	90.0%	53.0%	60.0%	7.1%
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	0	2	0.0%	-	-	-
7 Days	0	2	0.0%	18.4%	*	*
30 Days	1	2	50.0%	19.4%	17.1%	-2.3%[a]
Follow-Up After High-Intensity Care for Substance Use Disorder[b]	-----	-----	-----	-----	-----	-----
7 Days	-----	-----	-----	-----	-----	-----
30 Days	-----	-----	-----	-----	-----	-----
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)	3	4	75.0%	84.3%	83.9%	-0.4%a

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
HIV Screening	3	3	100.0%	22.9%	31.7%	8.8%
HIV Viral Load Suppression	-----	-----	-----	-----	-----	-----
Improving Health Equity #1**	0	1	0.0%			
Exclusive Breast Milk Feeding (PC-05) - Black/African American	0	1	0.0%	*	*	*
Improving Health Equity #2**	0	2	0.0%			
Cesarean Birth (PC02-CH) - Black/African American↓	0	1	0.0%	25.7%	23.7%	-2.1%
Exclusive Breast Milk Feeding (PC-05) - Asian	0	1	0.0%	31.3%	45.7%	14.4%
Kidney Evaluation for Diabetes[b]	2	3	66.7%	58.8%	39.7%	-19.1%[a]
Lead Screening in Children	-----	-----	-----	-----	-----	-----
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	2	3	66.7%	89.2%	95.7%	6.5%

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Pharmacotherapy Management of COPD Exacerbation (PCE)	0	1	0.0%			
Systemic Corticosteroid	0	1	0.0%	*		
Bronchodilator	0	1	0.0%	*		
Pharmacotherapy for Opioid Use Disorder[b]	0	1	0.0%			
Plan All-Cause Readmissions↓	-----	-----	-----	-----	-----	-----
Prenatal Immunization Status[b]	-----	-----	-----	-----	-----	-----
Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections	2	5	40.0%	56.0%	25.2%	-30.9%[a]
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	4	5	80.0%	35.8%	58.3%	22.5%
Preventive Care and Screening: Influenza Immunization	2	4	50.0%	24.4%	31.7%	7.3%
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention***	2	5	40.0%			
Rate 2	3	5	60.0%	10.1%	13.9%	3.8%
Rate 3	2	5	40.0%	81.8%	80.3%	-1.4%[a]

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Reduction in Hospital Acquired Clostridium Difficile Infections↓	5	6	83.3%	43.1%	25.6%	-17.5%
Statin Therapy for The Prevention And Treatment Of Cardiovascular Disease	3	3	100.0%	67.8%	76.6%	8.9%
Surgical Site Infection (SSI)↓****	2	2	100.0%	51.6%	34.3%	-17.3%
Transitions of Care (TRC)	4	5	80.0%	40.5%	59.6%	19.1%
Use of Imaging Studies for Low Back Pain	-----	-----	-----	-----	-----	-----
Use of Opioids at High Dosage in Persons Without Cancer↓	0	1	0.0%			

Measure	Number of DMPHs Meeting Goal	Number of DMPHs Reporting	Percentage of DMPHs Meeting Goal	PY4 Aggregate Performance Rate	PY5 Aggregate Performance Rate	Actual Change in Performance Rates
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	3	4	75.0%			
BMI	4	4	100.0%	63.4%	85.0%	21.6%
Counseling for Nutrition	3	4	75.0%	34.5%	55.6%	21.1%
Counseling for Physical Activity	3	4	75.0%	31.0%	56.4%	25.4%

Note for the last column there needed to be both PY4 and PY5 data

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

*Rate suppressed because either total numerator or total denominator was less than 11.

**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

***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

****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.

[a]Red text indicates the performance between PY4 and PY5 did not show improvement

[b]new measure in PY5

----no DMPH reported on the measure

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. From PY4 to PY5, the required number of priority measures was decreased from 20 to 9 to strengthen alignment of QIP goals 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 will be 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 (PY4) performance and the high-performance benchmark (90th percentile). Hospitals that achieved QIP targets and perform at or above the PY5 minimum performance benchmark on their reported measures, the hospitals will receive incentive payments. This methodology is called Value-Based Purchasing model 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, PY4, baseline data was reported in PY5 before an entity can enter the current PY data. Trending break, measures that had specification change between two PYs, follows the same reporting

[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.

process which was to report a baseline (capturing PY4 data using PY5 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 PY5 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 PY5, 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 22-004.

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 PY5 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, even though excluded in the computation of the quality score, in order to be eligible to receive payment for the program 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.

IHE1 and IHE2

- 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 program year, the entity was required to choose a new Priority Population and/or Eligible Equity Measure two Program Years later.
- If an entity achieved ≥90th percentile in any one Program Year, the entity had to choose a new measure and/or a different Priority Population two Program 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. Please note that CMQCC stratified Hispanic-US Born and Hispanic Foreign Born as separate strata but that these numerators and denominators were combined when reporting a Hispanic/Latino sub-rate. Entities also note the MDC combined Asian and Pacific Islander in one category and lacked a category for American Indian/Alaska Native.

Eligible 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-HVL: 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 more details on PY5 reporting updates, please see QIP Policy Letter 23-002.