DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
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DATE: June 6, 2023

QIP POLICY LETTER 23–002

TO: ALL QUALITY INCENTIVE POOL (QIP) ENTITIES

SUBJECT: UPDATES TO PROGRAM YEAR (PY) 5 REPORTING

PURPOSE:

This QIP Policy Letter (QPL) informs QIP entities of the following updates:

1. Removal of the 14-day requirement for counting numerator compliance for Q-CIS-10, Q-W30, and Q-IMA
2. Q-BCS: Breast Cancer Screening – removal of the requirement for an additional denominator qualifying encounter *(ONLY applicable to DMPHs with Community Partners)*
3. Q-PCR: Plan All-Cause Readmissions Reporting Guidance
4. Trending Break Measures – Baseline Reporting
5. Q-IHE: Improving Health Equity – Eligible Equity Measures
6. PY5 COVID-19 PHE-Related Modifications (pending CMS approval)
7. PY 5 Audits and Measure Reporting Requirements – *Simplify question 2 of report-level narrative*
8. Q-PPC-Pre and Q-PPC-Pst are a Pair of Measures – *Adding clarification for DMPHs*
9. 13-month calculation which counts the month of birth applies to QIP measures with birthday-based anchor dates *(ref: NCQA PCS Response to Case #00424518)* – *Adding NCQA Correction for Q-W30 (ref: NCQA PCS Responses to Cases #00439170 and #00439610)*
10. Q-HBD Baseline (formerly Q-CDC-H9 and Q-IHE1 rates) – *Need to re-enter PY4 aggregate data in the portal*
11. Q-CMS130 and Q-HVL – *Clarification on inclusion of individuals with other health coverage across both target populations*
12. Anchor Date Measure Criteria
13. Entering information on *"Beneficiaries continuously assigned to QIP Entity but not meeting continuous enrollment criteria for any MCP plan above"* box in the QIP portal

BACKGROUND:

On December 30, 2022, the Department of Health Care Services (DHCS) submitted the revised Designated Public Hospital (DPH) and District/Municipal Public Hospital (DMPH) QIP preprints with COVID-19 PHE-related modifications in PY 5 and PY 6 to the Centers for Medicare and Medicaid Services (CMS) for approval. Both revised preprints are currently pending CMS approval. The QIP program is authorized by Welfare and Institutions Code section 14197.4(c) and the prior PYs 4-6 DMPH and DPH preprints previously approved on January 20, 2022, and February 2, 2022, respectively.

Reporting requirements related to these COVID-related modifications for PY 5, as well as additional clarifications and modifications to reporting since the release of the PY 5 Manual in April 2022, are outlined in this policy letter to provide additional guidance to entities for reporting of their QIP performance data in June 2023.

POLICY:

1. ***Removal of the 14-day requirement for counting numerator compliance for Q-CIS-10, Q-W30, and Q-IMA***

   Entities are instructed to disregard reference to Appendix 5: HEDIS General Guideline 36: Collecting Data for Measures with Multiple Numerator Events for the following three measures listed in the PY 5 Reporting Manual:

   - Q-CIS-10: Childhood Immunization Status
   - Q-W30: Well-Child Visits in the First 30 Months of Life
   - Q-IMA: Immunizations for Adolescents

   This requirement states that when using administrative or a combination of administrative or medical record data for these three measures, numerator counts must be at least 14 days apart for each individual. The removal of this requirement will be retroactively applied for reporting in PY 5, so numerator counts no longer have to be at least 14 days apart for these three measures.

2. ***Q-BCS: Breast Cancer Screening – removal of the requirement for an additional denominator qualifying encounter*** *(**ONLY** applicable to DMPHs with Community Partners)*

   In Section V.D. DMPH Community Partner Eligible Measures, page 13, the manual states that for DMPHs reporting the Q-BCS measure, “the qualifying DMPH encounter(s) cannot be the same as the numerator-qualifying encounter(s).” Effective in PY 5, this additional (non-mammogram) entity visit requirement will be removed, and entities are instructed to follow the Q-BCS measure

specification as written in the applicable QIP PY Reporting Manual.

3. ***Q-PCR: Plan All-cause Readmissions Reporting Guidance***

For Q-PCR, entities should enter the overall observed and expected counts in the discrete fields provided in the QIP Portal Reporting Application. The Medi-Cal managed care plan stratified observed counts and any other required reporting elements should be entered in the measure level data narrative.

The following table summarizes where entities should be entering the respective data elements:

Data Element (no age strata, all elements reported on total population)	**Location in Reporting Application**
Observed Count	Observed Count Data Field
Observed Count stratified by Contracted MCP	Narrative
Expected Count	Expected Count Data Field
Number of Individuals in the QIP Entity Population	Narrative
Outlier Individual Count	Narrative
Outlier Rate	Narrative
Denominator	Narrative
Observed Rate	Narrative
Expected Rate	Narrative
Count Variance	Narrative
Observed Count/Expected Count Ratio	Calculated by Reporting Application

4. ***Trending Break Measures – Baseline Reporting***

For PY 5, entities must re-report baseline data (PY 4 calendar year 2021 data, using PY 5 specifications) in the "Trending Break Data For PY4 Reported In PY5" field in the QIP reporting application for the eight (8) measures listed below. Entities should use the most current sources of data available when re-calculating PY 4 baselines using PY 5 measure specifications.

i. Q-CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
ii. Q-CMS147: Preventive Care and Screening: Influenza Immunization
iii. Q-CMS2: Preventive Care and Screening: Screening for Depression

and Follow-Up Plan

iv. Q-FUA: Follow-Up After Emergency Department Visit for Substance Use (FUA)
v. Q-QPP118: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%)
vi. Q-QPP6: Coronary Artery Disease (CAD): Antiplatelet Therapy
vii. Q-CMS135: 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)
viii. Q-LBP: Use of Imaging Studies for Low Back Pain (LBP)

5. ***Q-IHE: Improving Health Equity – Eligible Equity Measures***

In PY 5, any measure in the Eligible Equity Measure list may be chosen for reporting Q-IHE1. Please note that Q-IHE1 and Q-IHE2 must be based on two different Eligible Equity Measures. For example, if Q-BCS is chosen for Q-IHE1, then Q-BCS should not be used for Q-IHE2.

6. ***PY5 COVID-19 PHE-Related Modifications*** *(pending CMS approval)*

To address the ongoing impacts of the COVID-19 PHE, the following changes will be made to the reporting requirements in the QIP program for PY 5:

For PY 5, the required Priority Measure set will be reduced to nine (9) measures from the original set of 20 measures, selected based on their alignment with the DHCS Comprehensive Quality Strategy.

<u>Nine (9) Required Priority Measures</u>:

- Q-WCV: Child and Adolescent Well Care Visits
- Q-CIS: Childhood Immunization Status (CIS 10)
- Q-CHL: Chlamydia Screening in Women
- Q-DEV: Developmental Screening in the First Three Years of Life
- Q-IMA: Immunizations for Adolescents
- Q-PPC-PRE: Prenatal and Postpartum Care (Postpartum Care)
- Q-PPC-PST: Prenatal and Postpartum Care (Timeliness of Prenatal Care)
- Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Q-W30: Well-Child Visits in the First 30 Months of Life

For DPH systems:

- Require reporting of nine (9) Priority Measures
- Option to report 30 or 40 measures:
  - If reporting 40 total measures (Nine (9) Priority Measures and 31 Elective Measures); the Maximum earnable amount is 100%.
  - If reporting 30 measures (Nine (9) Priority Measures and 21 Elective Measures); the Maximum earnable amount will be reduced to 90%.
- Performance target for all measures will remain at 10% gap closure to the 90th percentile except for three (3) risk-adjusted measures *(Q-PCR, Q-SSI, and Q-CDI). At the minimum, entities will be required to perform at or above the minimum performance benchmark. If the baseline performance is at or above the high-performance benchmark, entities will be required to maintain or exceed the high-performance benchmark.
- All data reported must have denominators of at least 30 except for Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections, Q-SSI: Surgical Site Infection, Q-PCR: Plan All-Cause Readmissions, and Sub-rate Exceptions which are Adolescent sub-strata of Q-DRR-E: Depression Remission or Response for Adolescents and Adults – Follow Up, and Rate 1 (screening) of Q-CMS138: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention. A QIP entity may use a measure with a denominator of less than 30 to fulfill its minimum number of required measures for QIP reporting, but the measure will earn an achievement value of zero.

For DMPH systems:

- DMPH systems with primary care or those providing the relevant clinical services must report at least 20% of the required nine (9) Priority Measures set listed above.
- Report the PY 5 attested number of measures but can designate their Quality Score to be calculated on a subset of these measures, as few as 67% of the original number of measures (rounded to the nearest integer) but not less than one measure.
- Performance target for all measures will remain at 10% gap closure to the 90th percentile except for three (3) risk-adjusted measures *(Q-PCR, Q-SSI, and Q-CDI). At the minimum, entities will be required to perform at or above the minimum performance benchmark. If the baseline performance is at or above the high-performance benchmark, entities will be required to maintain or exceed the high-performance benchmark.
- All data reported must have denominators of at least 30 except for Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections, Q-SSI: Surgical Site Infection, Q-PCR: Plan All-Cause Readmissions, and Sub-rate Exceptions which are Adolescent sub-strata of Q-DRR-E: Depression

Remission or Response for Adolescents and Adults – Follow Up, and Rate 1 (screening) of Q-CMS138: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention. A QIP entity may use a measure with a denominator of less than 30 to fulfill its minimum number of required measures for QIP reporting, but the measure will earn an achievement value of zero.

7. ***PY 5 Audits and Measure Reporting Requirements*** *– Simplify question 2 of report-level narrative*

As stated in the QIP PY 5 Reporting Manual, State and Federal officials reserve the right to require additional verification of any data, related documentation, and compliance with all QIP requirements and to audit QIP entities at any time. To support data integrity and ensure accountability for the QIP funds, DHCS will partner with an external auditor to assess QIP reports as part of its review and oversight process. **All entities must participate and provide any information, records, or access deemed necessary by DHCS auditors, who are HIPAA business associates of DHCS.**

For PY 5 only, measures that are in scope of review for the external data auditor will be the measures that count towards the entities' Quality Score. For DPH systems, all reported measures will be under scope of review (30 or 40 measures). For DMPH systems, a minimum of 67% of their measures will be under scope of review. DMPH systems must indicate Pay-for-Performance (P4P) in the data methodology narrative's text box for measures that DMPH systems choose to count in the Quality Score. CMQCC data (Q-PC02 Cesarean Birth and Q-PC05 Exclusive Breast Milk Feeding) and NHSN data (Q-CDI and Q-SSI) will be categorized as verified data, thus, will not be audited.

For measures in scope of audit review, the data methodology narrative will be optional. Entities may enter "Waived due to audit" in the data methodology narrative's text box in the QIP reporting application.

Due to overlap in information contained within the Information Systems Capabilities Assessment Tool (ISCAT) obtained from entities during the audit process, the second report level narrative question (starting with, "Describe data infrastructure used to report PY5 performance data…") will now be optional for entities to complete. In lieu of this, entities will now complete the following supplementary narrative as part of the first report level narrative question (starting with "List each MCP contract…").

In addition, if data was received in time for reporting**, please state the frequency and timing (e.g., monthly or by a specific date) the QIP entity received the

following data from their MCP(s)*:

a) Eligibility (Enrollment and Assigned Lives)
b) Clinical Service (Encounter, Claim, Fee for Service, other Supplemental Data, etc.)

*Please state N/A if entity is not reporting on assigned lives measures
**If data was received after April 30th deadline and not used for reporting, this supplemental narrative is not required

8. ***Q-PPC-Pre and Q-PPC-Pst are a Pair of Measures*** *– Adding clarification for DMPHs only*

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) are a pair of measures. Entities must report both measures if selecting to report on any of these measures.

Per PY5 Reporting Manual section C. Priority Measure Reporting (page 12-13): *"In the event that the DMPH cannot achieve a denominator ≥30 for any of the required Priority Measures or it does not provide the relevant clinical service (e.g., prenatal or postpartum care), the DMPH must pick another Priority Measure(s) on which to report. If no other Priority Measure is applicable, the DMPH will be allowed to substitute a measure from the remaining measure list."* Thus, the requirement to report both does not apply if a denominator is below 30 or the service is not provided.

9. **13-month calculation which counts the month of birth applies to QIP measures with birthday-based anchor dates *(ref: NCQA PCS Response to Case #00424518)*** *– Adding NCQA Correction for Q-W30 (ref: NCQA PCS Responses to Cases #00439170 and #00439610)*

NCQA and OHSU provided further clarification to PCS Case #00424518 that the 13-month calculation which counts the month of birth applies to four (4) measures with birthday-based anchor dates for QIP entities who obtain patient assignment data monthly where the assignment date is not provided. Effective in PY 5, this logic for calculating continuous QIP entity assignment should be based on each measure's eligible population section within the applicable QIP PY Reporting Manual for the four (4) measures listed below. For example, for Q-DEV, for a child with a March 12, 2021 birthday, the continuous assignment period (the 12 months prior to the individual's 2nd birthday) would be March 1, 2021 through March 31, 2022. In other words, the continuous eligibility period would include a 13-month period with one allowed gap month not occurring the month they turn one, two, or three years old.

The following four (4) measures are impacted:

i. Q-DEV: Developmental Screening in the First Three Years of Life
ii. Q-CIS10: Childhood Immunization Status (CIS 10)
iii. Q-IMA: Immunizations for Adolescents
iv. Q-LSC: Lead Screening in Children

In addition, NCQA clarified that for age-based measures, where the anchor date is based on an individual's age (such as 15 months for Rate 1 of Q-W30), there may not be a gap on that date. For Rate 1 of the Q-W30 measure, when assignments are verified monthly, the child MUST be enrolled the entire month that they turn 15 months (because the anchor date is the date the child turns 15 months old). For example, for PY5, if the child turns 15 months old on March 12, 2022, and they were continuously assigned from January 1, 2021 - March 31, 2022 with no more than one month gap in assignment (gap in assignment cannot fall in the month of the date the child turns 15 months), then March 2022 can count towards the monthly verification. In other words, the continuous eligibility period would include a 15-month period with one allowed gap month not occurring the month they turn 15 months.

As a reminder, the above references to a "13-month continuous assignment" as well as references to "1 month gap" (including for Q-W30) only applies to QIP entities who obtain patient assignment data monthly where the assignment date is not provided. If the QIP entity receives patient assignment data with the exact assignment date must use the 12-month continuous assignment for Q-DEV, Q-CIS10, Q-IMA, and Q-LSC) and a 45 day gap for all 4 of those measures plus Q-W30.

10. **Q-HBD Baseline (formerly Q-CDC-H9 and Q-IHE1 rates)** – *Need to re-enter PY4 aggregate data in the portal*

Due to measure rename, the QIP portal will not auto-populate baseline for Q-HBD. For entities that reported this measure in PY4 and continue reporting it in PY5 must re-enter PY4 Q-CDC-H9 and IHE1 aggregate data in the portal under *"Data for PY4 Reported in PY5"* to show the baseline. For QIP entity who is reporting Q-HBD in PY5 but did not report either one of Q-CDC-H9 or Q-IHE1 in PY4, then the QIP entity should re-report baseline data (PY 4 calendar year 2021 data, using PY 5 specifications) in "Data for PY4 Reported in PY5".

Note: The QIP portal showed inaccurate information for PY4 Q-IHE1 "Next PY Target Rate". However, this has been corrected in PY5. When the PY4 Q-CDC-H9 and Q-IHE1 aggregate data are re-entered in PY5 as baseline, the "Next PY

Target Rate" should be populated correctly, as well as the Target Rate for Data For PY5.

11. **Q-CMS130 and Q-HVL** – *Clarification on inclusion of individuals with other health coverage across both target populations*.

Both Q-CMS130 and Q-HVL require the inclusion of members/patients with other health coverage (i.e., individuals with Managed Care or Fee for Service as either primary or secondary in the payer status). The member/patient should only be reported once in either category not both to avoid duplication.

12. **Anchor Date Measure Criteria**

To satisfy the anchor date criteria, a member must be assigned and have a benefit on the required anchor date e.g. December 31. The allowable gap in member beneficiary assignment must not include that anchor date. For example, a 30-year-old woman who has only one gap in assignment from November 30 of the measurement year throughout the remainder of the year is not eligible for the Cervical Cancer Screening measure that require anchor date on December 31. Although she meets the continuous assignment criteria, she does not meet the anchor date criteria. Thus, she cannot be included in the reported data.

13. **Entering information on *"Beneficiaries continuously assigned to QIP Entity but not meeting continuous enrollment criteria for any MCP plan above"* box in the QIP portal**

If a beneficiary was continuously assigned to the QIP entity through Medi-Cal managed care for the entire measure specified continuous assignment period, but switched MCP mid-year, and thus did not meet the continuous enrollment criteria for any contracted MCP, the QIP entity must include the data for these beneficiaries in the "Beneficiaries continuously assigned to the QIP Entity but not meeting continuous enrollment criteria for any MCP plan above" row. If the QIP entity doesn't receive the MCP beneficiary enrollment information and is unable to verify the switching of MCPs then the beneficiary must not be placed in the *"Beneficiaries continuously assigned to QIP Entity but not meeting continuous enrollment criteria for any MCP plan above"* box. The member/patient should only be reported once to avoid duplication.

	Baseline	Target Rate	Numerator	Denominator
Aggregate Rate				
MCP A				
MCP B				
Beneficiaries continuously assigned to QIP Entity but not meeting continuous enrollment criteria for any MCP plan above.				

Please contact your QIP Liaison or email the QIP Mailbox at qip@dhcs.ca.gov if there are any questions concerning this QPL.

Sincerely,

ORIGINAL SIGNED BY JEFFREY NORRIS

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