DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: January 4, 2024

QIP POLICY LETTER 24–001

TO: ALL QUALITY INCENTIVE POOL (QIP) ENTITIES

SUBJECT: UPDATES TO PROGRAM YEAR (PY) 6 REPORTING

PURPOSE:

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

1. **Trending Break Measures**
2. **Anchor Date**
3. **Over-Performance for Elective Measures ≥90th percentile benchmark**
4. **Q-IHE: Improving Health Equity – Eligible Equity Measures**
5. **PY6 COVID-19 PHE-Related Modifications**
6. **Type of Medi-Cal**
7. **Clarification on Target Population E (Payer Agnostic)**
8. **Q-CMS130 and Q-HVL – Clarification on inclusion of individuals with other health coverage across both target populations**
9. **Clarification on How to Report Inverted Measures in the QIP Portal**
10. **Q-PCR: Plan All-Cause Readmissions Reporting Guidance**
11. **D<30 Policy for Q-W30, and Q-HBD sub-rates**
12. **Ratio-based Risk Adjusted Measures (Q-PCR, Q-SSI, and Q-CDI)**

BACKGROUND:

In June 2023, the Department of Health Care Services (DHCS) submitted an additional revision of Designated Public Hospital (DPH) and District/Municipal Public Hospital (DMPH) QIP preprints due to ongoing impacts of COVID-19 PHE in PY 5 and PY 6 to the Centers for Medicare and Medicaid Services (CMS) for approval. On December 27, 2023, CMS approved the revised preprints for both DPH and DMPH preprint. 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 6, as well as additional clarifications and modifications to reporting since the release of the PY 6 Reporting Manual on December 16, 2022, are outlined in this policy letter to provide additional guidance to entities for reporting of their QIP performance data by **11:59p.m. on June 14, 2024**.

POLICY:

1. Trending Break Measures

For PY 6, entities must re-report baseline data (PY 5 calendar year 2022 data, using PY 6 specifications) in the "Trending Break Data For PY 5 Reported In PY 6" field in the QIP reporting application for the six (6) measures listed below. Entities should use the most current sources of data available when re-calculating PY 5 baselines using PY 6 measure specifications.

i. Q-CMS130: Colorectal Cancer Screening
ii. Q-CMS147: Preventive Care and Screening: Influenza Immunization
iii. Q-CMS138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
iv. Q-CMS135: Heart Failure (HF): ACE Inhibitor or ARB or ARNI Therapy for LVSD
v. Q-CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
vi. Q-STK-2: Discharged on Antithrombotic Therapy

2. Anchor Date

The "Anchor Date" definition will be applicable starting in PY6 and NCQA has added it to the PY6 Reporting Manual as an update for PY6 (Appendix 5: HEDIS General Guidelines, Section D. HEDIS General Guideline 23: Anchor Dates).

> **D. HEDIS GENERAL GUIDELINE 23: ANCHOR DATES**
> If a measure requires an individual to be assigned and to have a benefit on a specific date, the allowable gap must not include that date; the individual must also have the benefit on that 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. Although she meets the continuous assignment criteria, she does not meet the anchor date criteria, which requires her to be assigned as of December 31 of the measurement year.

3. Over-Performance for Elective Measures ≥90th percentile benchmark

In PY 6, QIP entities will now be eligible to earn additional funds for Elective Measures through over-performance by Method 2 (as described in red):

Progress toward performance target	OV for Over-Performance on Priority Measures (Method 1)	OV for Over-Performance on Elective Measures (Method 2)
≥15% and <20% gap closure, and ≥50th percentile/median benchmark	0.50	0.25
≥20% gap closure and ≥50th percentile/median benchmark	1.00	0.50
≥90th percentile	1.00	a) If baseline is already ≥90th percentile/high-performance benchmark, **OV = 0.00** b) If baseline is below the 90th percentile/high benchmark and current PY Achievement Rate ≥90th percentile/high-performance benchmark, **OV = 0.50**

4. Q-IHE: Improving Health Equity – Eligible Equity Measures

Similar to PY 5 reporting, in PY 6, 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-E is chosen for Q-IHE1 then Q-BCS-E cannot be used for Q-IHE2.

5. PY 6 COVID-19 PHE-Related Modifications

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 6:

For PY 6, 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.

Nine (9) Required Priority Measures:

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

<u>For DPH systems</u>:

- 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 75%. No adjustment will be made for DPH systems that report greater than 30 but less than 40 total measures.

- 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:

For PY 6, the Quality Score will be based on 100% of the measures DMPHs will report in PY 6. However, the following changes will apply:

- DMPH systems with primary care or those providing the relevant clinical services must report at least 20% of their required reported measures from the required nine (9) Priority Measures set.

- DMPHs with committed measures of 4 or more will have the option to reduce their number of reported measures by 25% or report their full number of measures. However, if they do reduce this number, their maximum earnable amount will be reduced to 75%.

- 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.

6. Type of Medi-Cal

Further definitions for “enrolled in Medi-Cal Managed Care” and for “enrolled in Medi-Cal Fee for Service” in the manual are provided below in red font:

- *Enrolled in Medi-Cal Managed Care:* Services provided to a patient who is enrolled in a Medi-Cal Managed Care Plan. Managed Care Plan payments to providers may be fee for service payments or through capitation arrangements.

- *Enrolled in Medi-Cal Fee for Service:* Services provided to patients who are enrolled in Medi-Cal but not enrolled in a Medi-Cal Managed Care Plan.

Payments to providers for services under "Medi-Cal Fee for Service" are fee for service payments made by the state or the state's fiscal intermediary. Specifically, if a patient has both private coverage or Medicare coverage AND Medi-Cal Fee for Service, because Medi-Cal is always a payer of last resort, the provider will likely not receive Medi-Cal payments for services. However, these patients are still "enrolled in Medi-Cal Fee for Service" when determining eligibility for denominator inclusion.

7. Clarification on Target Population E (Payer Agnostic)

For PY 6 data submission in June 2024, Medicare and private insurance only patients should not be included in Target Population E.

Target Population E: On the date of the measure specified event (e.g., encounter, procedure) the individual was either (1) uninsured, (2) had Medi-Cal primary insurance (either Medi-Cal Fee for Service or Medi-Cal Managed Care Plan), or (3) had a non-Medi-Cal primary insurance (e.g., Medicare or private insurance) with Medi-Cal as a secondary payer (either Medi-Cal Fee for Service or Medi-Cal Managed Care Plan).

Note: The above will not apply to the true payer agnostic measures (i.e., Q-CDI and Q-SSI).

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

Similar to PY 5 reporting, both Q-CMS130 and Q-HVL require the inclusion of members/patients with other health coverage (i.e., individuals with a non-Medi-Cal primary insurance (e.g., Medicare or private insurance) with Medi-Cal as a secondary payer (either Medi-Cal Fee for Service or Medi-Cal Managed Care Plan). The member/patient should only be reported once in either category not both, to avoid duplication.

9. Clarification on How to Report Inverted Measures in the QIP Portal

The QIP portal does not automatically calculate the inverse rate for the following three (3) measures:

- Q-URI: Appropriate Treatment for Upper Respiratory Infection
- Q-AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Q-LBP: Use of Imaging Studies for Low Back Pain

Reporting entity needs to invert the rate using the instructed calculation **[(Aggregate denominator – Aggregate numerator)/Aggregate denominator)]** in the measure specification**.**
Example:
Aggregate numerator = 25
Aggregate denominator = 2252

To calculate the appropriate numerator, the entity would need to do the following:

(Aggregate denominator – Aggregate numerator)/Aggregate denominator
(2252 – 25)/2252
= 2227/2252

Report in the portal:
Inverted numerator = 2227
Denominator = 2252

The QIP portal calculates the Achievement Rate, Achievement Value and Next PY Target Rate. A higher rate indicates better performance or appropriate treatment for these three QIP measures.

10. 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

The minimum number of individuals or cases is higher for Q-PCR: Plan All-Cause Readmissions. To earn a nonzero AV, as determined by performance, on Q-PCR, the entity **must have a minimum of 150 Index Discharges for the PY**.

11. D<30 Policy for Q-W30 and Q-HBD sub-rates

For Q-W30 and Q-HBD measures which contain accountable sub-rates with non-identical denominators will have the total AV exclude any sub-rate containing a denominator of < 30 for either the current or baseline PY. The QIP liaison will manually adjust the sub-rate's AV to "N/A" in the QIP portal according to the D<30 policy.

12. Ratio-based Risk Adjusted Measures (Q-PCR, Q-SSI, and Q-CDI)

For all three risk-adjusted QIP measures (Q-PCR, Q-CDI, Q-SSI), where performance is measured by an observed to expected (O/E) ratio, the Achievement Value (AV) in the QIP portal will be manually adjusted by the QIP Liaison. Please refer to page 22 of 527, PY 6 Reporting Manual, Section D. Ratio-Based Risk Adjusted Measures for the performance target calculation using the Calibrated O/E methodology.

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

Jeffrey Norris, MD
Value-Based Payment (VBP) Branch Chief
Quality and Population Health Management
California Department of Health Care Services