CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 16, 2025

QIP POLICY LETTER 25-002
SUPERSEDES QPL 24-003

TO: ALL QUALITY INCENTIVE POOL (QIP) ENTITIES

SUBJECT: UPDATES TO CALENDAR YEAR (CY) 2024 REPORTING (FORMERLY KNOWN AS PROGRAM YEAR (PY) 7) REPORTING

PURPOSE:

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

1. **Q-AIS-E's Pneumococcal Sub-rate – Informational Only**
2. **New Measure: Q-TRC: Transitions of Care (TRC) – Updated Guidance**
3. **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge – Removed from CY 2024 (PY7)**
4. **Target Population A: OHC – Updated Guidance on Resubmission of Baseline**
5. **Q-CMS130: *Colorectal Cancer Screening and Q-CMS314: HIV Viral Suppression (formerly Q-HVL) – Clarification on Inclusion of Individuals with OHC Across Both Target Populations**
6. **Q-IHE1* and Q-IHE2: Improving Health Equity Measures Clarification**
7. **Allowable Gap and References to Continuous Enrollment: Q-W30: *Well-Child Visits in the First 30 Months of Life, Q- EED: Eye Exam for Patients with Diabetes (EED), and Q-GSD: *Glycemic Status Assessment for Patients with Diabetes (GSD)**
8. **Q-PC05 – Clarification on Birthweight**
9. **Trending Break Measures**
10. **Q-CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease - ASCVD Risk Score Calculation**

11. **Data Methodology Narrative (at Measure-level)**
12. **Inclusion or Exclusion of Individuals Enrolled in "Out-of-County" MCPs Reporting (please see QPL 24–007)**
13. **Q-PCR: Plan All-Cause Readmissions (PCR) Reporting Guidance**
14. **Reporting Q-CDI: Reduction in Hospital Acquired C Difficile Infections, Q-PCR, or Q-SSI: Surgical Site Infection (SSI) as a New Reported Measure for CY 2024 (PY7)**
15. **Clarification on How to Report Inverted Measures in the QIP Reporting Application**
16. **Manual Adjustments in the QIP Reporting Application During the Review**

Note: * *indicates Priority Measure*

BACKGROUND:

The QIP program is authorized by the Welfare and Institutions Code section 14197.4(c). The Centers for Medicare and Medicaid Services (CMS) approved the Designated Public Hospitals (DPHs) one-year QIP preprint for Calendar Year (CY) 2024 (PY7) on Wednesday, July 24, 2024, and District Municipal Public Hospitals (DMPHs) one-year QIP preprint for CY 2024 (PY7) on Monday, August 5, 2024. In addition, the PY7 Reporting Manual for CY 2024 was released on Friday, December 15, 2023, for the DPHs and Wednesday, January 3, 2024, for the DMPHs.

The reporting requirements related to CY 2024 (PY7), as well as additional clarifications and modifications to reporting since the release of the manual are outlined in this policy letter to provide further guidance to QIP entities for reporting their QIP CY 2024 (PY7) performance data. The deadline for the CY 2024 (PY7) report is on **Monday, June 16, 2025.** For the three "better of" Follow-Up (FUx) measures (refer to QPL 24-011), the reporting application will remain open until its reporting due date on **Monday, June 23, 2025**.

POLICY:

1. **1. Q-AIS-E's Pneumococcal Sub-rate – Informational Only**

   For Q-AIS-E: Adult Immunization Status (AIS-E), the pneumococcal sub-rate will be informational only.

2. **New Measure: Q-TRC: Transitions of Care (TRC) – Updated Guidance**

   Q-TRC added three (3) new sub-rates:
   - Rate 1: Notification of Inpatient Admission
   - Rate 2: Receipt of Discharge Information
   - Rate 3: Patient Engagement After Inpatient Discharge

   Hence, there are four (4) total sub-rates reported for Q-TRC, including the original Rate 4: Medication Reconciliation Post-Discharge.
   - For baseline reporting for CY 2024 (PY7), the entity must report CY 2023 (PY6) data, using the CY 2024 (PY7) measure specification in the "***Data For PY6 Reported In CY7***" field.
   - Rate 1 and Rate 2: If the entity has direct access to the EHR, it must report identical numerator and denominator (e.g., 125/125 (AR=100%)). In addition, it must enter "Our entity provides PCPs or ongoing care providers have direct access to the EHR." into the data methodology narrative field.
   - Rate 4: If the entity reported Q-TRC in CY 2023 (PY6), then it must copy and paste its CY 2023 (PY6) aggregate data as baseline in the "***Data For PY6 Reported In CY7***" field. For an entity that did not report Q-TRC in CY 2023 (PY6) or entity whose decision to include or exclude Other Health Coverage (OHC) deviates from CY 2023 (PY6), it must report baseline data (CY 2023 (PY6) data, using the CY 2024 (PY7) measure specification).

3. **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge** – **Removed from CY 2024 (PY7)**

   Q-FUAH is no longer required for informational reporting in CY 2024 (PY7). Thus, QIP Entities **must only** report their required or committed number of measures (avoid overreporting). Specifically, DPHs **must only** report 40 measures, and DMPHs **must only** report their measure commitment number for CY 2024 (PY7).

4. **Target Population A: OHC - Updated Guidance on Resubmission of Baseline**

   For the Target Population A measures listed in CY 2023 (PY6), if an entity chooses to deviate from CY 2023 (PY6) on including or excluding Medi-Cal Managed Care (MCMC) individuals with OHC, then it must answer "Yes" to the question, *"Did you deviate from PY6 on including or excluding OHC (Answer: Yes, No, or N/A)?"* and re-report baseline data (CY 2023 (PY6), using the CY 2024 (PY7) measure specifications) in the "***Data For PY6 Reported In CY7***" field in the QIP Reporting Application. Entities should use the most current sources of data available when re- calculating CY 2023 (PY6) baselines, using the CY 2024 (PY7) measure specifications.

   If an entity did not deviate from CY 2023 (PY6) on including or excluding MCMC individuals with OHC (answer "No"), then it must copy and paste its CY 2023 (PY6) aggregate data as baseline in the "***Data For PY6 Reported In CY7***" field.

5. **Q-CMS130: *Colorectal Cancer Screening and Q-CMS314: HIV Viral Suppression (formerly Q-HVL) – Clarification on Inclusion of** Individuals with OHC Across Both Target Populations

   Both Q-CMS130 and Q-CMS314 require the inclusion of members/patients with OHC (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 target population of these two measures has two criteria - continuous assignment and denominator encounter. Member/patient meeting these criteria should only be reported once in either category, not both, to avoid duplication.

6. **Q-IHE1* and Q-IHE2: Improving Health Equity Measures Clarification**

   For CY 2024 (PY7), Q-IHE1 reverts to Priority Measure and only those Eligible Equity Measures that are also Priority Measures are to be chosen for Q-IHE1. The following three (3) Elective Measures from the Eligible Equity Measure list will not qualify for Q-IHE1:

   - Q-CMS147: Preventive Care and Screening: Influenza Immunization
   - Q-CMS314: HIV Viral Suppression (formerly Q-HVL)
   - Q-PC05: Exclusive Human Milk Feeding (PC-05)

   The QIP Reporting Application will not auto-populate the baseline for the Eligible Equity Measure and Priority Population that were reported for CY

2023 (PY6) and continued for CY 2024 (PY7). Therefore, if an entity reports the same Eligible Equity Measure and Priority Population from CY 2023 (PY6) (if eligible), it must re-enter its Eligible Equity Measure, Priority Population, and CY 2023 (PY6) aggregate data for baseline reporting.

7. Allowable Gap and References to Continuous Enrollment: Q-W30: *Well-Child Visits in the First 30 Months of Life (W30), Q-EED: Eye Exam for Patients With Diabetes (EED), and Q-GSD: *Glycemic Status Assessment for Patients With Diabetes (GSD)

Per the National Committee for Quality Assurance (NCQA) Policy Clarification Support (PCS) response # 00471767, there is an error in the PY7 Reporting Manual for CY 2024. This language was inadvertently carried over from the HEDIS source specifications and affects Q-W30, Q-EED and Q-GSD for CY 2024 (PY7). The correct term used in the allowable gap section in QIP should be "continuous assignment" rather than "continuous enrollment" for all Target Population A measures and should read, "To determine continuous assignment for a Medicaid individual for whom assignment is verified monthly."

8. Q-PC05 – Clarification on Birthweight

Per NCQA PCS response # 00471799, there is an error in the PY7 Reporting Manual for CY 2024, and the Excluded Population on page 410 should state, "Patients whose term status or gestational age is missing and birthweight <3000 gm."

9. Trending Break Measures

For CY 2024 (PY7), entities must re-report baseline data (CY 2023 (PY6) data, using the CY 2024 (PY7) measure specifications) in the "***Trending Break Data For PY6 Reported In CY7***" 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 CY 2023 (PY6) baselines, using the CY 2024 (PY7) measure specifications.

i. Q-AMR: *Asthma Medication Ratio (AMR)
ii. Q-CMS314: HIV Viral Suppression (formerly Q-HVL)
iii. Q-CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Note: QPHM approved baseline recalculation using January 2024 ASCVD risk scores for the 2023 population to estimate the subpopulation.

iv. Q-FUA: *Follow-Up After Emergency Department Visit For Substance Use (FUA)
v. Q-FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
vi. Q-FUM: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)

10. Q-CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease - ASCVD Risk Score Calculation

The baseline recalculation can use January 2024 ASCVD risk scores for the 2023population to estimate the subpopulation. This would only apply to Population Criteria 4: Patients aged 40 to 75 at the beginning of the measurement period with a 10-year ASCVD risk score (i.e., 2013 ACC/AHA ASCVD Risk Estimator or the ACC Risk Estimator Plus) of >=20 percent during the measurement period.

11. Data Methodology Narrative (at Measure-level)

Similar to CY 2023 (PY6), the data methodology questions are looking for a high-level description that does not need to be as detailed or duplicative of the Information Systems Capabilities Assessment Tool (ISCAT) questions requested by the Health Services Advisory Group Inc. (HSAG). However, entities can include the detailed information in the ISCAT if they elect to do so in order to not create additional work in creating new high-level narratives for reporting. Measure-specific information requested in the manual or policy letter should also be entered in the measure level Data Methodology Narrative, i.e., PCR data elements, SSI prior year's predicted infection count, and measures with target population that has two criteria (CMS130 and CMS314) steps results (criteria 1, criteria 2, and de-duplication of criteria 1 & 2).

12. Inclusion or Exclusion of Individuals Enrolled in "Out-of-County" MCPs Reporting (please see QPL 24–007)

Per an entity's attestation on Wednesday, May 1, 2024, on including or excluding out-of-county Medi-Cal Managed Care patients to all three FUx measures (Q-FUA, Q- FUI, and Q-FUM) for CY 2024 (PY7), it must enter "Our entity included out of county Medi-Cal Managed Care patients." or "Our entity

excluded out of county Medi-Cal Managed Care patients." into the data methodology narrative field.

However, if an entity chooses to expand the denominator to be more inclusive from excluding to including out-of-county Medi-Cal Managed Care patients at the time of CY 2024 (PY7) reporting for all three FUx measures, it must enter "Our entity included Medi-Cal Managed Care patients in order to expand the denominator." into the data methodology narrative field.

For an entity that did not respond by Wednesday, May 1, 2024, the denominators for these three FUx measures will default to only including Medi-Cal Managed Care patients within the entity's county. Thus, the entity must enter "Our entity excluded out of county Medi-Cal Managed Care patients." into the data methodology narrative field.

13. Q-PCR: Plan All-Cause Readmissions (PCR) Reporting Guidance

For Q-PCR, entities must enter the overall observed and expected counts in the discrete fields provided in the QIP Reporting Application. The Medi-Cal managed care plan stratified observed counts and any other required reporting elements should be entered into the data methodology 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. To earn a nonzero AV, as determined by performance, on Q-PCR, the entity **must have a minimum of 150 Index Discharges for the CY (PY)**.

14. **Reporting Q-CDI: Reduction in Hospital Acquired C Difficile Infections, Q-PCR, or Q-SSI: Surgical Site Infection (SSI) as a New Reported Measure for CY 2024 (PY7)**

    When reporting Q-CDI, Q-PCR, or Q-SSI as a new reported measure for CY 2024 (PY7), entities do not need to submit a baseline. To bypass the baseline reporting in the reporting application, the entities must enter 0.0001 as the numerator and denominator. Also, they must enter "The baseline data entered are not real data and have been entered to bypass baseline data reporting as directed by DHCS." into the data methodology narrative.

15. **Clarification on How to Report Inverted Measures in the QIP Reporting Application**

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

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

    The entity must 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 reporting application:
    Inverted numerator = 2227
    Denominator = 2252

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

16. Manual Adjustments in the QIP Reporting Application During the Review

The QIP liaison will manually adjust the following items accordingly in the QIP Reporting Application during the review:

- For the measures containing accountable sub-rates with non-identical denominators (Q-CMS138: *Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention, Q-GSD, Q-PDS-E: Postpartum Depression Screening and Follow-Up (PDS-E), PND-E: Prenatal Depression Screening and Follow-Up (PND-E), and Q-W30), the AV and OV to "N/A" of sub-rate with D<30 according to the PY7 Reporting Manual for CY 2024 policy on a measure's sub-rate denominator population limited by a patient's demographic characteristics, prevalence of a particular condition, risk factor, and/or patient behavior.

- For the Ratio-Based Risk Adjusted Measures (Q-CDI, Q-PCR, and Q-SSI), the AV using the Calibrated O/E methodology per the PY7 Reporting Manual for CY 2024 and the OV to "0.0" because over-performance does not apply to these three calibrated measures.

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 SARAH LAHIDJI

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