Quality Incentive Pool (QIP) Program

Program Year 8 (PY8)
QIP Program Policies

RELEASED DECEMBER 13, 2024

Applies to Measurement Period January 1–December 31, 2025

DHCS has approved this QIP Reporting Manual for the sole purpose of facilitating the participation of qualified entities in the QIP program, pursuant to the applicable *Directed Payments QIP, Section 438.6(c) Preprint.* Note that guidelines in this Manual may change if required for CMS approvals applicable to this program. The continuation of this program is subject to, and contingent upon, CMS approval. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, except for the purposes of reporting quality data for the QIP program or for internal quality improvement activities.

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QIP PROGRAM POLICIES

I. BACKGROUND

The Department of Health Care Services (DHCS) has implemented a Medi-Cal managed care Designated Public Hospital (DPH) Quality Incentive Pool (QIP) program; starting in Program Year 4 (PY4), the program includes District and Municipal Public Hospitals (DMPHs). The Department directs Medi-Cal managed care plans (MCPs) to make quality incentive payments to QIP entities based on their performance on quality measures specified in the QIP Reporting Manual. The QIP advances the State's Quality Strategy goal of enhancing the quality of DHCS programs by supporting DPH systems and DMPHs (hereafter "QIP entities") in delivering effective, efficient, affordable care. The QIP program also promotes access to care and value-based payment arrangements, increasing funding tied to quality outcomes while further aligning state, MCP, and hospital system goals. The program integrates historical supplemental payments, 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.

Prior to implementing the QIP PY8 measures, QIP entities should review the entire QIP Reporting Manual, including the *QIP Program Policies* section, the *General Guidelines for QIP Data Collection and Reporting,* and all applicable measure specifications and appendices, as well as all relevant Inquiries and Responses to PY8 measures from NCQA's Policy Clarification Support Report (aka "PCS Report") posted on eQIP. The *QIP Program Policies* and the *General Guidelines for QIP Data Collection and Reporting* apply to all QIP measures.

A memorandum will be released in spring 2025, outlining all corrections, policy changes, and clarifications from the MY 2025 HEDIS Technical Update and Joint Commission Version 2025B that apply to the QIP program; entities are responsible for applying all updates to the QIP PY8 Reporting Manual, as applicable.

A. NAVIGATING THE PY8 MANUAL

All key headings are available as bookmarks in the PY8 Manual. Use the PDF Navigation Pane in the left-hand column of the manual to view and use them to navigate through the document.

Measures in the Measure Category Summary Tables are also linked to their location in the PY8 Manual.

II. ABOUT THE QIP PROGRAM POLICIES SECTION

The *QIP Program Policies* section is a user-friendly resource for QIP managers and reporting leads. It provides information about participating in the QIP program, including compliance requirements and payment information. Citations from DHCS policy documents not included in the *Program Policies* are in quotes, with the relevant policy document listed as the source. Text that is not in quotes paraphrases cited documents or is additional DHCS guidance.

A. PY8 DOCUMENT CONTROL LOG: QIP PROGRAM POLICIES

Modifications from PY7 Manual
• Updated all dates and references to PYs. • Removed all references to PY7. • Updated report level and measure level questions in section V. B. Minimum Narrative Reporting Requirements. • Added Q-FUAH to Table 2 in section V.D. DMPH Community Partner Eligible Measures. • Updated section V. F. QIP Data Integrity Policy with language from QPL 24-002. • Removed sections V. G. Supporting Data/Documentation and V. H. Audit Guidance, as they are now covered under section V. F. • Added Q-AIS-E Rate 5, Q-FUI Rate 2, Q-ECM and Q-COMS to the measure and sub-rate exceptions list in section VI. E. Achievement Values. • Added information about interim payment to section VI. G. Calculating Payments.

III. REPORTING CALENDAR

Because QIP payments are factored into Medi-Cal managed care rates, and represent incentives for the quality of services provided during a specific rating period (calendar year [January–December], in this case), the QIP program year will adhere to the approved rate year between plans and the State. Thus, each "QIP Program Year" is defined as the period starting January 1 and ending December 31.

For PY8, be aware of the following annual report measurement period, annual report due date, and estimated timing of payments to each QIP entity by its MCP:

- PY8 Annual Report Measurement Period: January 1–December 31, 2025.
- Annual Report due: June 15, 2026.
- For eligible QIP entities, DHCS will release an interim payment in September 2026 (for more information, refer to **Section VI. G. Calculating Payments**).
- Estimated date of QIP payment to each QIP entity by its MCP: No later than June 30, 2027.

A. PY8 REPORTING DATES

All QIP PY8 data are due by **11:59 p.m. on June 15, 2026**. **No extensions will be granted.** The QIP Reporting Application will automatically lock all data submitted by this deadline, and will not allow further data entry or modifications. QIP entities must follow **ALL** guidance for **QIP** issued by DHCS, including, but not limited to, emails, QIP Policy Letters, and this QIP Reporting Manual. Entities must also follow all measure guidance provided by the measure stewards in the PCS Report, unless otherwise directed by DHCS. **It is the sole responsibility of the QIP entity to ensure that it meets ALL QIP requirements and follows ALL DHCS guidance.**

Note: Technical assistance from DHCS will be available until 5 p.m. Monday, June 15, 2026. Contact DHCS as soon as possible with questions or concerns, to ensure that you receive the necessary support.

IV. QIP MEASURES

There are 60 measures across all measure categories in QIP PY8. (Refer to the Table of Contents and the Navigation Pane.) Each measure has a corresponding measure ID and measure name. Priority Measures have an asterisk (*) in front of the measure title in the Table of Contents and the measure specifications. Outside the Priority Measures, there are three informational measures, and all other measures are elective.[1]

A. MEASURE SPECIFICATION TYPES

There are several types of QIP measure specifications, including, but not limited to, HEDIS®,[2] MIPS CQM, eCQM, and CMS Medicaid Adult and Child Core Set (hereafter "CMS Adult and Child Core Set").

For more information on:

- *eCQMs,* refer to the **Guide for Reading eCQMs** (PDF) and the **eCQI Resource Center's Eligible Professional / Eligible Clinical eCQMs** page.
- *MIPS CQMs,* download the **2024 Clinical Quality Measure Specifications and Supporting Documents** and view the PDF titled "**2024 MIPS Clinical Quality Measure Guide.**"

Guidance on HEDIS, the CMS Adult and Child Core Set, and other specification types can be found in the corresponding source specification manuals, as applicable.

IMPORTANT CLARIFICATION:

Outside QIP, not all specifications for measures of the same name are completely clinically aligned. As such, QIP entities must only use the specifications listed in this QIP Reporting Manual. As new specification types (e.g., eCQM) become available, they may be incorporated into the QIP Reporting Manual if they align appropriately with existing QIP measures.

V. COMPLIANCE REQUIREMENTS

A. MINIMUM DATA REPORTING REQUIREMENTS

[1]For PY8, Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge, Q-ECM: Number of Individuals Enrolled in ECM, and Q-COMS: Number of and Percentage of Eligible Individuals Receiving Community Supports, and Number of Unique Community Supports Received by Individuals are required to be reported as informational-only measures.

[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Pursuant to the QIP PY8 Preprint, each DPH system must annually report at least 40 measures from the list of DHCS-approved performance measures (20 measures are designated as Priority Performance Measures).

Each DMPH entity must annually report on at least its minimum number of measures committed. The DMPH's specific minimum commitment number must be selected within the range specified by the tiers in **Table 1**, determined by annual DMPH Medi-Cal Revenue. For DMPHs that offer the relevant clinical service lines, at least 50 percent of the minimum number of committed measures must be reported from the Priority Measure sub-set. DMPHs in Tier 2 that have "rural hospital" designation, defined by CA Health & Safety Code section 124840, have the option to move to Tier 1.

Table 1: DMPH QIP Tiers

DMPH QIP Tier	Measure Range Minimum	Measure Range Maximum	Sum of Net Medi-Cal Revenue*
1	2	12	<$30 million
2	10	20	≥$30 million

*https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/e6a7cc46-836f-4437-8ad1-e485d6ea0514

DMPHs will select a minimum number of measures to report for PY8 in a measure commitment survey DHCS will conduct in the first quarter of PY8 (60 calendar days after the release of the PY8 Reporting Manual). This minimum measure commitment number will apply to PY8.

If a QIP entity does not report on at least the minimum number of measures required, the entity will not receive **ANY** QIP payment for that PY.

The following policies apply to measures impacted by denominators of <30:

1. A QIP entity may use a measure with a denominator of <30 to fulfill its minimum number of required measures for QIP reporting.
2. A denominator of ≥30 for two consecutive PYs is required for a QIP measure to earn a nonzero achievement value (AV), as determined by performance, and be eligible for payment. This policy also applies to Elective Measures with identical denominator sub-rates, such as measure **Q-WCC: Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents**. A QIP entity will earn an AV of zero, and will not earn funding for this type of sub-rate that does not meet this requirement. The measure's total AV will be an average of the individual sub-rate AVs. An individual sub-rate that does not meet this requirement will decrease the total AV and funding for the measure.
3. A measure containing 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, if the conditions described in a. or b. are present.

a) The measure's sub-rate denominator population is limited by patient demographic characteristics such as age, race, or ethnicity (i.e., for PY8, Q-PND-E, Q-PDS-E, Q-W30, and Q-GSD). Additional requirements apply if both sub-rates for Q-GSD have denominators <30 but the total Q-GSD denominator is >30. Refer to Q-GSD for complete information.

b) The measure's sub-rate denominator population is limited by the prevalence of a particular condition or risk factor, and/or patient behavior, such as tobacco use (i.e., for PY8, Q-CMS138).

If all sub-rates and the overall rate in a Priority Measure contain denominators <30 for either the current or prior PYs, an AV of zero applies to the measure. The entity should consider a replacement Priority Measure (for DMPHs) or Elective Measure (for DPHs or for DMPHs that have exhausted the Priority Measure list), in accordance with **Section V. C. Priority Measure Reporting**.

Furthermore, each reported measure (except **Q-HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems**, **Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections** and **Q-SSI: Surgical Site Infection (SSI)**) must include data from at least one person enrolled in Medi-Cal managed care during the reporting PY in order for payment to be made for the measure for that PY. For reported sub-rated measures, at least one sub-rate must include data from at least one person enrolled in Medi-Cal managed care. A QIP entity will earn an AV of zero, and will not receive payment for a reported measure in which data do not include at least one Medi-Cal managed care life. However, the measure may still be used to fulfill the required number of measures for a QIP entity's reporting.

Exceptions to the Minimum Reporting Requirements:

a) The minimum of 30 individuals or cases and the minimum Medi-Cal managed care lives requirement do not apply to the informational-only measure or sub-rates listed in **Section VI. E. Achievement Values: Measure and Sub-Rate Exceptions**, or to **Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections** and **Q-SSI: Surgical Site Infection (SSI)**.

b) 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.

c) The minimum number of surveys for the **Q-HCAHPS** measure reporting is 300 surveys per QIP entity facility per PY. For example, if the entity has three facilities and only one of those facilities meet the reporting requirements then only that one facility will be included when the entity reports the measure.

Refer to **Section X. QIP Target Populations** for the definition of "enrolled in Medi-Cal managed care."

B. MINIMUM NARRATIVE REPORTING REQUIREMENTS

QIP entities must report narratives in QIP reports, based on the following prompts.

Report Level:

Question 1: List each MCP contract, effective date, number of assigned lives, as defined below, and how each contract meets the minimum criteria outlined in the DHCS memo titled **"Hospital Directed Payment Definition for SFY 2017-18 and SFY 2018-19"** (October 5, 2018). For each MCP contract, report the number of lives assigned to the entity for primary care with 12 months of continuous assignment (allowing for a 45-day gap) to the QIP entity for the period January 1–December 31, 2025. Do not include managed care lives that did not have 12 months of continuous assignment to the QIP entity. Assigned lives continuously enrolled in managed care who switch between MCPs may be included if this is indicated in the narrative. If an MCP does not provide the QIP entity with Primary Care assigned lives data (eligibility data or service data, or both) in time for QIP reporting, provide a narrative explanation and rationale when submitting the report.

Question 2: If data were received in time for reporting, state the frequency and timing (e.g., monthly or by a specific date) the QIP entity received the following data from its MCP(s)*. State whether the data were received after the April 30th deadline and were not used for reporting:

a) Eligibility (Enrollment and Assigned Lives).

b) Clinical Service (e.g., Encounter, Claim, Fee for Service, other Supplemental Data).

* Indicate N/A if the entity is not reporting on assigned lives measures.

Measure Level:

Question 1:

a) Describe data sources that inform measure calculation for each measure. Provide a high-level description of data sources that are integrated in the QIP entity's calculation and reporting of performance measures. List all sources of data used to identify the specified denominator population as well as numerator compliance, and any exclusions for each performance measure. Data sources include internal source data (e.g., EMR, eligibility data) and external source data (e.g., Meditech lab, California Immunization Registry (CAIR), MCP claims, Care Everywhere, …).

b) Describe how measures were calculated (e.g., using source code programming, manual workflow and data extraction, mixed methodology). Provide a high-level description on which methodology (e.g., source code programming or manual workflow and data extraction, or a mixed methodology) are used to calculate the denominator and numerator for the reported measures.

Notes:

- If using Sampling: include information on the number of individuals in the Total Population before sampling.
- If reporting numerator zero and/or the denominator is less than 30 (including zero), explain why.

Question 2:

Describe the quality improvement efforts for this measure. Provide details such as new policies and procedures, outreach efforts, and/or implementation of workflows, programs, and collaboratives. Describe any challenges to improvements on this measure, and how these challenges will be addressed. Copying and pasting the same information from the prior PY narrative is not sufficient for the current PY.

C. PRIORITY MEASURE REPORTING

The Priority Measure sub-set represents measures that are high priority to the State and to Medi-Cal MCPs. The sub-set comprises measures from the **Managed Care Accountability Sets** (MCAS), for which MCPs have Minimum Performance Levels, plus measures representing conditions with high priority, high prevalence, or high mortality in California. Priority Measures are identified by an asterisk (*) before the measure title. QIP entities' reporting requirements for these measures are based on entity type and characteristics, as follows:

- *DPH systems:* Required to report all Priority Measures with a denominator ≥30. QIP entities use the QIP Reporting Application to demonstrate that they cannot achieve a denominator ≥30 for a Priority Measure, or do not provide the relevant clinical services. DPHs that cannot report a Priority Measure due to either of these circumstances must report one or more additional Elective Measures, as needed to report a total of 40 measures for the PY.
- *DMPH entities*: Required to report at least 50 percent of the required minimum committed measures from the Priority Measure sub-set. If the DMPH cannot achieve a denominator ≥30 for any required Priority Measure, or does not provide the relevant clinical service (e.g., prenatal or postpartum care), it must choose another Priority Measure(s) on which to report. If no other Priority Measure is applicable, the DMPH may substitute a measure from the Elective Measure list. A DMPH can only select "Not Reporting Reason: Not required (DMPH Only)" if it already met and satisfied its required number of Priority Measures to report.

D. DMPH COMMUNITY PARTNER ELIGIBLE MEASURES

DHCS may approve a DMPH to use contracted community partner data for specified allowable measures for the QIP program. As part of the QIP program, participating DMPHs and their approved contracted community partners must engage in shared quality improvement efforts to improve the coordination and quality of care, as well as health outcomes, for their shared Medi-Cal beneficiaries. To participate, the DMPH

must clearly demonstrate its role in these efforts. Additional guidance for the application and approval process is provided in **QPL 24-004**, released February 26, 2024.

DMPHs approved to include data from community partner patients in their QIP reports must apply a consistent, identical method for including all eligible contracted community partner patient data in the allowable QIP measures on which they select to report. All DMPHs with approval **must** include all patients from the contracted community partner who meet measure denominator criteria **and** had at least one encounter with the DMPH during the measurement period.

Table 2: QIP Measures Allowable for Community Partner Data

QIP Measures Allowable for Community Partner Data
Q-AMR: *Asthma Medication Ratio (AMR)
Q-BCS-E: *Breast Cancer Screening (BCS-E)
Q-GSD: *Glycemic Status Assessment for Patients with Diabetes (GSD)
Q-CIS-E: *Childhood Immunization Status
Q-CMS147: Preventive Care and Screening: Influenza Immunization
Q-CMS130: *Colorectal Cancer Screening
Q-COB: Concurrent Use of Opioids and Benzodiazepines (COB-AD)
Q-FUA: *Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge
Q-FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
Q-FUM: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Q-POD: Pharmacotherapy for Opioid Use Disorder (POD)
Q-CMS135: Heart Failure (HF): ACE/ARB/ARNI Therapy for LVSD
Q-IHE1: *Improving Health Equity (Q-IHE-1)**[1]
Q-IHE2: Improving Health Equity (Q-IHE-2)**[1]
Q-IMA-E: *Immunization for Adolescents
Q-PCE: Pharmacotherapy Management of COPD Exacerbation (PCE)
Q-PND-E: Prenatal Depression Screening and Follow-Up (PND-E)
Q-PDS-E: Postpartum Depression Screening and Follow-Up (PDS-E)
Q-PPC-Pre: *Prenatal and Postpartum Care (Timeliness of Prenatal Care) (PPC-Pre)
Q-PPC-Pst: *Prenatal and Postpartum Care (Postpartum Care) (PPC-Pst)
Q-PRS-E: Prenatal Immunization Status (PRS-E)
Q-TRC: Transitions of Care (TRC)
Q-OHD: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

**Priority Measures.*

***Q-IHE measures are allowable for community partner data only if the entity engages in improving equity for Q-AMR, Q-BCS-E, Q-PPC-Pre, and Q-PPC-Pst.*
[1]QIP entities must report on the parent measure if reporting on a Q-IHE measure.

E. MULTIPLE HOSPITAL QIP ENTITIES

QIP entities with multiple hospitals operating under common ownership will be considered a single entity for QIP reporting, and must report on QIP measures accordingly.

F. QIP DATA INTEGRITY POLICY

This QIP Data Integrity Policy (added from **QPL 24-002 Data Integrity Policy**) provides guidance on collecting, maintaining, and sharing data as a vehicle for maximizing health care value through the QIP program.

In accordance with **Welfare & Institutions Code §14197.4(c)(1)(B)**, this section sets forth data reporting requirements QIP entities must follow throughout the duration of the QIP program.

For the purposes of this section, data integrity is defined as the quality, consistency, reliability, accuracy, and completeness of data collected and reported under the QIP program.

QIP Entity Responsibilities

Each QIP entity must:

1) Review this Policy.
2) Ensure that their data handling practices comply with the requirements outlined in this section.

Scope

The QIP Data Integrity Policy applies to all entities participating in the QIP program. This Policy constitutes a minimum viable standard for maintaining data quality and integrity under the QIP program. This section is not intended to interfere with any legal, privacy, regulatory, and/or security-related procedures and requirements that permit entities to conduct their regular business.

Data Integrity Requirements

As a requirement for participating in the QIP program, by submitting its QIP data, QIP entities agree and attest that they comply with the following QIP Data Integrity Policy requirements:

- The QIP entity's leadership, management, and all levels of staff, must make a good-faith effort to manage risks that might undermine the data integrity of the QIP program.

- QIP entities must have adequate documentation governing the rate production process. Except for MCP-reported rates, QIP entities must be able to show access to source data and show the detailed process to produce rates. When requested, QIP entities must provide DHCS with supporting documentation of the change and its impact on the numerator, denominator, and rate for DHCS review and determination. This could include summary of the identified error, the correction applied, screenshots of the code change and/or revised documentation (correction), count differences before/after, the rationale for the correction, and a plan to mitigate future discrepancy.
- QIP entities must facilitate data integrity through self-governance; they have the lead responsibility for preventing, deterring, identifying, and rectifying data integrity issues in their respective programs.
- QIP entities must host and maintain policies and procedures defining the data governance process, which outlines how the entity ensures data integrity and prevents data integrity issues.
- QIP entities must ensure that QIP data meet the following standards:
    - Attributable – establishing who performed an action and when.
    - Legible – recorded permanently in a durable medium, readable by others, with traceable changes.
    - Contemporaneous – with activities recorded when they occur (when an activity is performed, or information is obtained).
    - Accurate – reflecting the true information.
- For the purpose of data corrections in the QIP portal, QIP entities must distinguish between current PY data, prior PY data, measures in scope of audit, and measures not in scope of audit:
    - For measures in scope of audit, current PY quantitative data may be corrected in the portal if the auditor concurs with the corrections and validates the data during the audit period. Current PY qualitative (e.g., narrative) data may also be corrected in the portal, at the discretion of DHCS during the review period.
    - For measures not in scope of audit, current PY quantitative and qualitative data may be corrected in the portal, at the sole discretion of DHCS, during the review period. The QIP entity must provide written justification and supporting documentation (e.g., summary of identified error, correction applied, screenshots of the code change and/or revised documentation [correction], count differences before/after, rationale for the correction, and plan to mitigate future discrepancy) to DHCS for review and approval.
    - For prior PY data (baseline data reported in a previous PY) for all measures, the reporting QIP entity may not make any data corrections to the affected measure in the portal. However, for awareness and tracking purposes, the QIP entity must:

        - Inform the QIP Liaison and/or assigned auditor (depending on the measure). *Example: For Q-SSI and Q-CDI measures, the QIP entity must contact the QIP Liaison*.
        - Report the corrected data, issues that required corrections, their impact on the reported rate, and any action plans taken to mitigate them in the current PY measure's narrative. Refer to "Data Modification" for limitations on calculating targets (e.g., for gap closure).

- QIP entities must retain applicable supporting documentation for 10 years after submitting PY reports, and must make such documentation available for an audit conducted by external parties. Retention of documentation includes maintaining all patient-level data used to create submitted QIP Reports.
- QIP entities must document and retain records of all incentive payment amounts earned under QIP, as well as clinical and quality improvement data for QIP reports for 10 years after submitting PY reports.
- Until DHCS sends an official notification that PY reporting is officially approved and closed, QIP entities must retain copies of files and databases used for performance measure reporting, in the event results need to be reproduced and/or re-calculated based on identified need for corrections. QIP entities must ensure no new data, post submission period, are introduced into re-calculation and/or re-produced rates.
- QIP entities must report to DHCS and the auditor within 10 business days of discovery, any breach of these QIP data integrity requirements that results in discrepancies from submitted QIP quantitative or qualitative reports.
    - QIP entities must report the breach by emailing their QIP Liaison (and auditor, if an audit is ongoing and the measure is under audit) with a summary of the discovery that includes the following information:
        - Date of the discovery of the data breach.
        - How the discrepancy was discovered.
        - The affected measure(s). Provide a detailed measure list and a description of the findings.
        - How the error(s) corrected.
        - The mitigation process implemented to prevent future incidents.

As requested and directed by DHCS, the QIP entity must participate in further communication with DHCS.

PCS Responses

As QIP entities, auditors, and DHCS evaluate measures and related data, the most recent NCQA Policy Clarification Support (PCS) system response will supersede prior PCS responses (when there are conflicts or discrepancies in PCS). PCS responses will

only be included in the audit process if a PCS question is submitted within 30 calendar days of the QIP PY reporting submission deadline. After that date, no additional PCS responses may be considered when evaluating or auditing measures and related data, and entities and auditors should use only previously released measure specifications, PCS responses (recognizing that those submitted by the deadline will come back after the deadline), prior QIP policies, and prior DHCS communications. Exceptions to the scope of audit must be reviewed and approved by DHCS. Additionally, any exception approved by DHCS must be implemented within the time frame decided by DHCS. Refer to “Dispute Resolution” if these documents result in a dispute between parties.

Data Modification

QIP entities must submit complete and accurate data in accordance with all requirements set forth in this section to DHCS by the applicable reporting deadline. QIP entities may not request data modifications after the reporting deadline unless they obtain prior approval from DHCS and/or the DHCS external auditor. DHCS and/or the DHCS external auditor evaluate reports for validity and accuracy. DHCS, at its sole discretion, may request data corrections if data fail to meet necessary requirements. Submitted data will be considered final, and all QIP payments, future target rates, and publicly reported data will be based on the final data. For example, if a data integrity issue is recognized in a future PY, and the issue would have changed the measure rate, no changes to the prior finalized rates will be allowed.

The prohibition on data modifications after the reporting deadline does not relieve QIP entities of their duty to report any breach of QIP data integrity requirements, nor does it prohibit DHCS and/or external oversight entities from evaluating the data submitted for data errors resulting from data breaches, fraud, willful negligence, or unintentional errors.

DHCS may grant an entity a reporting deadline extension if there has been an unexpected significant impact on data systems out of the QIP entity’s control such as incapacitation of data systems or natural disasters affecting operations. If system incapacitation events affect reporting to the point of a delay beyond the reporting deadline, the QIP entity must notify DHCS in writing as soon as it is aware of the delay.

Dispute Resolution

DHCS and external auditors will partner with QIP entities to make a best effort to resolve disputes prior to escalation. If significant audit disputes arise between auditor and entity, the QIP entity should immediately notify DHCS, via an email to its QIP Liaison, and provide the following information:

- The exact issue encountered.
- Specific measure(s) affected and disputed.

- Auditor concerns with the metric specification interpretation, timeline, code review, and/or other audit tasks.

For measure-related issues not addressed in the measure specifications, DHCS and the external auditor will determine if a PCS question should be submitted. DHCS, auditors, and entities should accept and follow the most recent PCS response.

DHCS has the sole authority to resolve disputes when current QIP policies, measure specifications, PCS responses, or other formal QIP documents do not give clear guidance.

G. UPDATING ENROLLMENT INFORMATION

If the QIP entity determines, through direct communication with a beneficiary (or the beneficiary's authorized representative), that the beneficiary's assignment is incorrect, the QIP entity should exclude the patient from the affected measure(s) if *BOTH* the following are true:

1) The QIP entity has confirmed with the original MCP that the beneficiary's assignment is no longer correct.

2) Correcting this assignment information results in the beneficiary no longer meeting the continuous assignment criteria of the affected QIP measure(s).

- The QIP entity should retain documentation that substantiates the MCP's confirmation that the beneficiary does not meet continuous assignment criteria.

H. UPDATING BENEFICIARY CONTACT INFORMATION VIA COUNTY SOCIAL SERVICES

If a QIP entity is unable to contact a Medi-Cal beneficiary using the contact information provided by the MCP in the monthly eligibility file (i.e., returned QIP entity mail to that beneficiary), the entity may choose to report this to the MCP and/or the County Social Services Eligibility Department. If the Social Services Eligibility Department provides confirmation that the patient was disenrolled from Medi-Cal managed care, and disenrollment means the patient no longer meets continuous assignment criteria for the measurement period, the QIP entity should remove the patient from the denominator of the affected measure(s).

If a QIP entity determines, through direct communication with the beneficiary (or the beneficiary's authorized representative), that the beneficiary's contact information provided by the MCP in the monthly eligibility file is no longer correct, the QIP entity may choose to report changes or updates to the MCP and/or the County Social Services Eligibility Department. When updated beneficiary contact information is provided to the county, the county is responsible for following regulations in accordance with **All County Welfare Directors Letter No. 15-30, dated September 22, 2015**.
If the change or update results in disenrollment of the beneficiary from Medi-Cal managed care, and the disenrollment occurs during the measurement period, the

patient no longer meets continuous assignment criteria for the measurement period and the QIP entity should remove the patient from the denominator of the affected measure(s).

I. HEALTH PLAN DATA

The QIP program allows participating DPH and DMPH systems to earn performance-based quality incentive payments, as directed by DHCS, from MCPs with which they contract as Network Providers. QIP entities must submit reports directly to DHCS with any information necessary for DHCS to evaluate achievement of applicable performance measures and calculate the amount of QIP-directed payments earned.

MCPs' contracts with DHCS (refer to **Medi-Cal Managed Care Boilerplate Contracts**) require compliance with the terms of each directed payment program approved by CMS under 42 CFR 438.6(c), as specified by DHCS through APLs or other technical guidance. All Medi-Cal MCPs are required to provide QIP entities with the Minimum Necessary Dataset for QIP reporting.

MCPs must assist QIP entities, including DMPHs seeking information related to DHCS-approved contracted DMPH community partners, in collecting information necessary to complete QIP quality improvement efforts and reporting obligations for all years in which the QIP program is in effect. This includes providing QIP entities with the Minimum Necessary Data outlined by DHCS, which may include, but is not limited to, Medi-Cal member eligibility, lab tests and results (to the extent allowed by applicable laws and regulations), pharmaceutical and non-pharmaceutical claims data, and data for individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law.

DHCS will regularly notify MCPs of the specific DMPH community partners with which data must be shared, the specific data elements that must be shared with QIP entities and community partners, and any associated deadlines for the data, via guidance on the **DHCS QIP webpage**. DHCS will email MCP Medical Directors when the data elements required are posted on the DHCS QIP webpage.

MCP data must be received by the QIP entity by April 30, following the end of the PY, in order to be included in the QIP entity's report (except for MCP-reported numerators, denominators, and rates for measures that are "better of" either MCP-reported or QIP entity-reported rates[3]. DHCS will release expectations on the timeline for MCP data at a later date). MCP data received by the QIP entity after April 30, following the end of the PY, are not required to be included by the QIP entity in its QIP report, but may be included at the QIP entity's discretion. In the Report Level Question 2 in the QIP

[3] For PY8, Q-CCS, Q-CIS, Q-IMA, and Q-CHL are designated for optional MCP reporting.

Reporting Application, QIP entities provide the status of receipt and inclusion of MCP data in calculations of their performance data.

VI. PAYMENT

A. PAY-FOR-PERFORMANCE

Although most measures in this manual are reported on a pay-for-performance basis for PY8, several have sub-strata rates that are reported on an informational basis (refer to Section VI. E. Achievement Values–Measure and Sub-Rate Exceptions). For PY8, **Q-ECM: Number of Individuals Enrolled in ECM**, **Q-COMS: Number of and Percentage of Eligible Individuals Receiving Community Supports, Number of Unique Community Supports Received by Individuals**, and **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge** are reported on an informational basis.

A QIP entity choosing to report on a performance measure for PY8 must also report data for Calendar Year (CY) 2024 (PY8 baseline), if not previously reported in PY7, according to specifications from the PY8 Manual. A QIP entity will receive payment for achieving targets only; no payment will be given for reporting historical performance. **The QIP Reporting Application will not allow QIP entities to report PY8 data until the QIP entity reports CY 2024 data.** Stratification by MCP is not required for historical data.

Pay-for-performance: The measure's AV will be determined by the progress made toward achieving the measure performance target, per Table 4: Measure Performance Achievement Values.

B. BENCHMARKS

DHCS-approved QIP PY8 minimum, median, and high performance levels (performance benchmarks) are determined for each QIP measure using national benchmarks, where available. DHCS prioritized the use of Medicaid 25th, 50th, and 90th percentile benchmarks as the minimum, median, and high performance benchmarks, where available. For Q-FUA, Q-FUI and Q-FUM in PY8, the Medicaid 10th, 25th, and 50th percentile benchmarks will be used as the minimum, median, and high performance benchmarks.

For QIP measures without available Medicaid benchmarks, DHCS will establish appropriate minimum, median, and high performance benchmarks by using processes and criteria approved for identifying benchmarks for non-Medicaid benchmarked measures in the QIP program. These processes take into account all available performance data on a measure (national, state, or QIP entity-specific data), as well as known variances between the populations measured by the available performance data and the Medi-Cal managed care populations measured by QIP.

DHCS will adjust benchmarks for each QIP PY according to updates made by the national measure stewards. DHCS may also update non-Medicaid benchmarked measures annually, as appropriate, based on the most recently available State or QIP entity data. Benchmarks for PY8 are sent via email.

Benchmarking for PY8

The available benchmarks for the majority of QIP PY8 measures use data from Measurement Year (MY) 2023 (a few use data from MY 2022), as described below.

At the start of PY8, DHCS will release PY8 benchmarks generated from MY 2023 (or MY 2022) data.

There will be an MY 2024 benchmark for measures identified by their national steward in early 2025 as having trending breaks PY8 benchmarks will be updated for these measures if the MY 2024 benchmark is released either by October 1, 2025, or by the release date of HEDIS Quality Compass® (QC) for Medicaid (in 2024, QC was released on September 27). For measures with trending breaks, these latter benchmarks will be the official benchmarks for PY8 target setting.

C. TRENDING BREAKS

DHCS will issue a policy letter to inform QIP entities of the correct procedure in the event of a measure trending break. This type of reporting results from a change in a measure specification between two PYs that usually requires modification to the following PY's target rate. When a trending break is identified for any measure QIP entities reported in PY7, entities must also re-report baseline (MY 2024) performance rates using PY8 specifications. Reporting two versions of the data, as per the applicable DHCS trending break policy, will account for trending breaks and enable comparison of achievement rates.

D. TARGET SETTING

Individual QIP entity performance targets (except Q-PCR, Q-CDI, and Q-SSI; refer to **Ratio Based Risk Adjusted Measures** for setting targets for those measures) will be calculated according to the following Gap Closure methodology, with the QIP entity's performance rate and final target rounded to the same number of decimal places as the measure's benchmark.

The "Gap" is defined as the difference between the QIP entity's end of prior PY performance and the current PY's high performance benchmark. The target setting methodology for QIP is a 10 percent gap closure, as described below.

QIP entities must perform at or above the established minimum performance benchmark described in **Table 4: Measure Performance Achievement Values** in **Section VI. Payment**. QIP entities with performance at or above the high performance benchmark for a measure will be considered to be at 100 percent of their quality goal,

and will be required to achieve performance that maintains or exceeds the measure's high performance benchmark for the subsequent PY.

The following is an example of 10 percent Gap Closure Target Setting Methodology for PY8 QIP measures:

- *Improvement:* Performance ≥25th percentile and <90th percentile
  - 10% gap closure between CY 2024 performance and PY8 high performance benchmark:
    - Example: Behavioral Health Performance Measure X
      - High Performance Benchmark: 70.0%
      - Baseline: 55.0%
    - Gap: 70% − 55% = 15%
    - 10% of 15% = 1.5%
    - 55% + 1.5% = 56.5%
    - PY8 Target: 56.5%

***Note**:* Sub-rate 1 for Q-FUA, Q-FUI, and Q-FUM will utilize the Gap Closure Methodology with the following adjusted benchmarks: Medicaid 10th, 25th, and 50th percentile benchmarks as the minimum, median, and high performance benchmarks.

Ratio-Based Risk Adjusted Measures

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, individual QIP entity performance targets will be calculated using the following Calibrated O/E Threshold methodology:

- For each measure, the QIP entity's O/E ratio is converted to a Calibrated O/E using the National or State Median O/E ratio, as follows:

  Calibrated O/E = (Entity O/E) / (National/State Median O/E)

All QIP entity performance targets for these three measures are set using the Calibrated O/E, as follows.

Table 3: QIP Entity Calibrated O/E

Achievement Value	QIP Entity Calibrated O/E
AV = 1.0	<0.9
AV = 0	≥0.9

Example

- QIP entity's Q-PCR O/E ratio = 0.8834
- HEDIS PCR National Average O/E = 0.9880
- Entity's Calibrated O/E ratio = (Entity's O/E / National Median O/E) = 0.8834 / 0.9980 = 0.8851
- **Outcome** → The entity's calibrated O/E <0.9. The entity would therefore receive an AV of 1, indicating that it performed better than expected (compared to the national average).

E. ACHIEVEMENT VALUES

For QIP PY8, a measure's AV will be based on the progress made toward achieving the measure performance target.

Table 4: Measure Performance Achievement Values

Measure Performance in Prior PY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
≥ High performance benchmark	Performance < high performance benchmark	NA	NA	Performance ≥ high performance benchmark
≥ Minimum performance benchmark and < high performance benchmark	<50% of the applicable 10% gap is closed	≥50% to <75% of the applicable 10% gap is closed	≥75% to <100% of the applicable 10% gap is closed	100% of the applicable 10% gap is closed
< Minimum performance benchmark **Track A:** If the gap between performance and minimum performance benchmark is ≥10% gap between performance and the high performance benchmark	Performance < minimum performance benchmark	NA	NA	Performance ≥ minimum performance benchmark

Measure Performance in Prior PY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
< Minimum performance benchmark **Track B:** If the gap between performance and minimum performance benchmark is <10% gap between performance and high performance benchmark	Performance < minimum performance benchmark, or Performance ≥ minimum performance benchmark and <50% of the 10% gap is closed	Performance ≥ minimum performance benchmark and ≥50% to <75% of the 10% gap is closed	Performance ≥ minimum performance benchmark and ≥75% to <100% of the 10% gap is closed	100% of the 10% gap is closed

AVs for measures with sub-rates, unless otherwise specified in the measure specifications, use the following criteria:

1. The QIP entity reports separate numerators and denominators for each measure sub-rate, per the measure specifications.
2. Each sub-rate is assessed for an AV using the methodology described in Table 4.
3. The total AV for each sub-rated measure is an average of the individual sub-rate AVs. As such, the total AV will be a unique percentage (i.e., not necessarily 0.0, 0.5, 0.75, or 1.0). Measures with sub-rates will have the total AV exclude an accountable sub-rate with a denominator of <30 if conditions described in **V.A. Minimum Data Reporting Requirements** are present.

Measure and Sub-Rate Exceptions

1. **Q-AIS-E: Adult Immunization Status (AIS-E)**
   - Rate 5 (Immunization Status: Hepatitis B) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
2. **Q-DRR-E: Depression Remission or Response for Adolescents and Adults (DRR-E)**
   - The Adolescent sub-strata (12–17 years old) will be required for informational purposes only and will not contribute to the AV for this measure.
   - The Adult sub-strata (≥18 years old) will be reported as Pay-for-Performance and will be the only determinant of the AV for this measure.
3. **Q-CMS138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**
   - Rate 1 (screening) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.

- Rate 2 (tobacco users who received tobacco cessation intervention) and Rate 3 (screening and received tobacco cessation intervention if identified as a tobacco user) will be reported as Pay-for-Performance and will determine the AV for this measure. Refer to **V.A. Minimum Data Reporting Requirements** for an additional exception for any PY in which this measure is reported as a Priority Measure.

4. **Q-FUM: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)**
   - Rate 2 (percentage of ED visits at a QIP entity facility for which the individual received follow-up within 7 days) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
5. **Q-FUA: *Follow-Up After Emergency Department Visit for Substance Use (FUA)**
   - Rate 2 (percentage of ED visits at a QIP entity facility for which the individual received follow-up within 7 days) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
6. **Q-FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)**
   - Rate 2 (percentage of visits or discharges for which the individual received follow-up within 7 days) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
7. **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge**

   This measure will be required for informational purposes only and will not have an AV.
8. **Q-ECM: Number of Individuals Enrolled in ECM**

   This measure will be required for informational purposes only and will not have an AV.
9. **Q-COMS: Number of and Percentage of Eligible Individuals Receiving Community Supports, and Number of Unique Community Supports Received by Individuals**

   This measure will be required for information purposes only and will not have an AV.

F. OVER-PERFORMANCE

QIP entities will be eligible to earn additional funds through over-performing on measures that meet the following criteria:

- For Priority Measures, to earn over-performance values (OVs) by Method 1 (as described below):
  i. ≥15% and <20% gap closure, and ≥50th percentile/median benchmark, or

ii. ≥20% gap closure and ≥50th percentile/median benchmark, or
iii. ≥90th percentile benchmark.

- For Elective Measures, to earn OVs by Method 2 (as described below):
  i. ≥15% and <20% gap closure, and ≥50th percentile/median benchmark, or
  ii. ≥20% gap closure and ≥50th percentile/median benchmark, or
  iii. ≥90th percentile benchmark, if baseline achievement rate (AR) is below the 90th percentile benchmark.
- For measures with sub-rates, QIP entities must over-perform on all sub-rates to earn OVs. Entities that over-perform on all sub-rates and over-perform at different levels for each sub-rate will earn the OV corresponding with the lowest over-performance level.
- For measures for which gap closure cannot be calculated, and/or a ≥90th percentile benchmark does not exist, over-performance is not possible because it cannot be calculated according to the methods in this section (i.e., Q-PCR, Q-CDI, and Q-SSI).

QIP entities can earn up to 100 percent of their maximum allowable payment amounts through all claiming mechanisms, including over-performance.

1. Over-Performance Values
   a. Determining OVs:
      - The measure's OV will be based on the progress made toward the measure's performance target. Based on the progress reported, and using the target setting methodologies for over-performance described in this section, the OV will be determined as outlined in Table 5.

Table 5: Over-Performance Values

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	0.5	0.25
≥20% gap closure and ≥50th percentile/median benchmark	1.0	0.50
≥90th percentile	1.0	a) 0.5 if baseline AR is < 90th percentile and current PY AR ≥90th percentile benchmark.

Progress Toward Performance Target	OV for Over-Performance on Priority Measures (Method 1)	OV for Over-Performance on Elective Measures (Method 2)
		b) 0 (indicates is not possible) if baseline AR is already ≥90th percentile.

b. Using OVs:

1) OVs earned through over-performance on Priority Measures via Method 1 may be used to earn remaining Priority Measure AVs and/or remaining Elective Measure AVs. “Remaining AV” equals the number of reported measures minus total AVs.

2) OVs earned through over-performance on Elective Measures via Method 2 may be used to earn remaining Priority Measure AVs and/or remaining Elective Measures AVs, with the following limitations:

i. In PY8, OVs earned through over-performance on Elective Measures may be used to earn both:

- ≤2 remaining Priority Measure AVs.
- Any remaining Elective Measure AVs.

2. Over-Performance Incentive Process

Each QIP entity may earn additional funds through over-performance, as described in **Section VI. F. Over-Performance** and in accordance with the following process. A QIP entity can earn up to 100 percent of its maximum allowable payment amount through all claiming mechanisms, including over-performance.

a. Calculate the QIP entity’s reported total AVs and total remaining measure AVs separately for Priority Measures and Elective Measures.

b. Calculate the QIP entity’s reported total OVs separately for Priority Measures and Elective Measures.

c. Apply OVs earned through over-performance on Priority Measures by Method 1 to earn the QIP entity’s remaining Priority Measure AVs first, as available, and then to earn the QIP entity’s remaining Elective Measure AVs, until the QIP entity exhausts its remaining OVs earned through over-performance on Priority Measures, or until the QIP entity has earned all its remaining AVs.

d. Apply OVs earned through over-performance on Elective Measures via Method 2 to earn the QIP entity’s remaining Priority Measure AVs and/or remaining Elective Measure AVs, under the limitations described in **Section VI. F. 1. b. Using OVs**, until the QIP entity uses all its OVs earned through over-performance on Elective Measures, or until the QIP entity has earned all its remaining AVs.

Over-Performance Example for PY8:

- QIP entity A reports full achievement on 16 Priority Measures and 19 Elective Measures.
  - QIP entity A achieves <5 percent gap closure and thus misses targets on four Priority Measures and one Elective Measure.
  - Its remaining Priority Measure AV is 4 and its remaining Elective Measure AV is 1.
- QIP entity A over-performs on one Priority Measure, worth 1 OV, and over-performs on five Elective Measures, worth 2.5 OVs.
- First, QIP entity A applies its 1 OV from over-performance on Priority Measures via Method 1 to earn 1 of 4 remaining Priority Measure AVs.
  - QIP entity A has now used all its OVs earned through over-performance on Priority Measures.
  - QIP entity A still has 3 remaining Priority Measure AVs and 1 remaining Elective Measure AV.
- Second, QIP entity A has 2.5 OVs from over-performance on Elective Measures via Method 2.
  - In PY8, QIP entity A can only use 2 of these OVs to earn 2 of 3 remaining Priority Measure AVs, and can use the balance of its 0.5 OV to earn 0.5 of 1 remaining Elective Measure AV.
- After accounting for OVs, the QIP entity has earned 3.5 remaining measure AVs and has 1.5 remaining Elective Measure AVs that it cannot make-up via over-performance.

G. CALCULATING PAYMENTS

PY8 Payment Release

DHCS will release two payments to QIP entities that are eligible and elect to receive interim payment. The interim payment will be based on the entity's prior PY's Quality Score and 50 percent of the prior PY's earnable payment will be made to the MCPs in September, a year after the PY. Then, the total balance of earnable payment will be reconciled with current PY Quality Score and paid to MCPs in March, two years after the PY.

If a QIP entity has a zero quality score in the prior three years, it is not eligible for the interim payment. A zero score refers to overall performance, not performance on a single measure.

Final QIP payments are based on two elements:

1. *Base payment determined by a Quality Score:* A Quality Score that measures the sum of the AVs for all measures reported on by the QIP entity system, divided by the number of measures selected for reporting. Each QIP entity's maximum allowable payment amount is multiplied by the QIP entity's Quality Score to

determine the base payment. AVs are based on performance per **Section VI. E. Achievement Values**.

2. *Over-performance payments via Methods 1 and 2,* as described in **Section VI. F. Over-Performance**.

Each QIP entity's base payment and over-performance payment amounts will be added to determine the QIP entity's final QIP payment. The final QIP payment must not be more than 100 percent of the QIP entity's maximum allowable payment amount.

The State will require MCPs, via its contracts, All-Plan-Letters, or similar instructions, to make final QIP payments to contracted QIP entities. The State will identify the amount of final QIP payments each MCP must make to each contracted QIP entity, with the sum of these amounts not to exceed the total funds available in the applicable QIP PY.

DPH Systems
The maximum allowable payment amount that may be earned by a DPH system (i.e., the amount earned if the DPH system attains all selected quality targets) will be equal to the total funds available in the applicable QIP PY, multiplied by the DPH system's proportion of total Medi-Cal managed care members served in the PY, relative to all other participating DPH systems. If there is more than one MCP in the specific DPH system's service area, the final QIP payment to the DPH system will be allocated proportionally among MCPs.

DMPHs
The maximum allowable payment amount that may be earned by a DMPH is equal to its specific allocation. This includes a minimum allocation of at least 0.75 percent of the total amount available to all DMPHs for a specific PY. If a DMPH is allocated the minimum, this will proportionally adjust all other DMPH allocations. The allocation for all other DMPHs will be determined by two factors:

(1) 50 percent by the number of measures the DMPH commits to report, proportionate to other DMPHs. DHCS will administer a new measure commitment survey during the first quarter of PY8 (60 calendar days after the release of the PY8 Reporting Manual) in order for DMPHs to commit to the minimum number of measures the DMPH will report on beginning in PY8.

(2) 50 percent by the most current annual Medi-Cal revenue, proportionate to other participating DMPH