Quality Incentive Pool (QIP) Program

Program Year 7 (PY7)

General Guidelines for QIP Data Collection and Reporting

RELEASED DECEMBER 15, 2023

Applies to Measurement Period January 1–December 31, 2024

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.

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GENERAL GUIDELINES FOR QIP DATA COLLECTION AND REPORTING

VII. ABOUT THE GENERAL GUIDELINES FOR QIP DATA COLLECTION AND REPORTING SECTION

The *General Guidelines for QIP Data Collection and Reporting* is a user-friendly resource for QIP managers and reporting leads that highlights key information necessary for reporting QIP performance measures. Citations from DHCS policy documents not included in the Guidelines 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. PY7 DOCUMENT CONTROL LOG: QIP GENERAL GUIDELINES

Modifications from PY6 Manual

- Updated all dates and references to Program Years.
- Removed all references to PY6.
- Updated Section X. QIP Target Populations.
- Updated Table 8: Inclusion of Non-Entity Service Data by Measure.
- Updated list of measures in Table 10: Hybrid Specifications Included in the QIP Measure Set.
- Updated Section XIV. B. Stratification of Reported Data by Race and Ethnicity.
- Updated screenshot in Section XIV.C. Stratification of Reported Data by Medi-Cal Health Plan.

VIII. MEASURE CODING

Specifications for QIP measures may refer to value sets, the Medication List Directory (MLD), and/or National Drug Code (NDC) lists, which are maintained by the measure steward. The source and instructions for obtaining these code sets is included in each applicable measure section below. Measures and/or measure types without external code sets are as follows.

A. HEDIS VALUE SETS AND MEDICATION LIST DIRECTORY

HEDIS specifications and value sets can be obtained at the **NCQA Store** under "HEDIS Volume 2: Technical Specifications for Health Plans." Refer to the HEDIS Volume 2 MY 2024 specifications and value sets (including the MY 2024 Technical Update, which includes updates that must be incorporated for PY7 reporting) for the PY7 version of the QIP Reporting Manual. Entities may also obtain HEDIS Volume 2 by purchasing the **QIP HEDIS MY 2024 Digital Measures for ECDS Reporting** package. QIP entities must obtain the appropriate HEDIS value sets for each QIP PY.

Entities that purchased HEDIS MY 2024 Volume 2 prior to March 29, 2024, must redownload the Value Set Directory file for MY 2024 after the MY 2024 Technical Update is released on March 29, 2024, via **https://my.ncqa.org/**.

The HEDIS MY 2024 MLD list will be available on **NCQA's MY 2024 MLD website** on March 29, 2024.

Identifying HEDIS Code and Value Set Changes

Changes to HEDIS codes and value sets can be found in the HEDIS Value Set Directory file under the following tabs: **Summary of Changes – Value Sets and Summary of Changes – Codes**.

The **Summary of Changes – Value Sets** tab lists HEDIS value set changes and includes the elements in Table 6.

Table 6. Value Set Summary of Changes Elements

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change (Added to; Deleted from).
Description	Describes the affected measure or, for renamed value sets, the new value set name.
Revised	August 1 release changes are identified by a revised date of 2023-8-01.

The **Summary of Changes – Codes** tab lists the HEDIS code changes by value set and includes the elements in Table 7.

Table 7. Code Summary of Changes Elements

Element Name	Element Description
Value Set	The name of the value set affected by the change.
Change	The change (Added; Deleted).
Code System	The code system for the code.
Code	The code.
Revised	October 1 release changes are identified by a revised date of 2023-8-01.

B. ECQM VALUE SETS

Value sets for eCQMs listed in this QIP Reporting Manual can be found at the **National Library of Medicine Value Set Authority Center (VSAC)**. To access the value sets, users must obtain a free **Unified Medical Language System® Metathesaurus License (UMLS)**.

To access the correct version of the value sets on the VSAC website:

- Click the **Download** tab.
- Select the corresponding version of the value sets to the eCQM version in the QIP Manual. Because the PY7 version of the manual uses eCQM 2024, select: "2024 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets."

  Note: *For Q-CMS 138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, use the "2023 Reporting/Performance Period eCQM Value Sets."*
- Select the final version of value sets that align with eCQM 2024: "May 2023 Release eCQM & Hybrid Measure Value Sets Publication Date: May 04, 2023."
- A table of value sets to download will display, and QIP entities can download the Excel file listed under rows: "eCQM Value Sets for Eligible Clinicians Published May 04, 2023," and "eCQM Value Sets for Eligible Hospitals Published May 04, 2023," and column: "Sorted by CMS ID" to view the value sets sorted by eCQM measure.

Identifying eCQM Value Set Changes

Follow these instructions to find a list of eCQM value set updates.

- Go to the **eCQI Resource Center website**.
- Locate the corresponding eCQM by clicking the **EC eCQMs** tab and then selecting "2024" from the Select Performance Period drop-down menu.
- Click the corresponding measure name, click the **Release Notes** tab, and scroll down to the "Value Set" section, which will indicate the detailed value set updates to the latest version of the eCQM. These updates will also be noted in the "Summary of Changes from PY6 Manual" section at the top of most eCQM measures in the Manual.

C. CMS CORE SET VALUE SETS

Value sets for the CMS Child Core Set measures can be found **here** *(email **MACQualityTA@cms.hhs.gov** for "2023 Child Core Set HEDIS Value Set Directory" and "2023 Child Core Set Non-HEDIS Value Set Directory" if the files are no longer available on the website).*

Value sets for the CMS Adult Core Set measures can be found **here** *(email **MACQualityTA@cms.hhs.gov** for "2023 Adult Core Set HEDIS Measures Value Set Directory" and "2023 Adult Core Set Non-HEDIS Measures Value Set Directory" if the files are no longer available on the website).*

D. OPIOID NDC LISTS

The Opioid NDC lists for **Q-COB** and **Q-OHD** are publicly available via links included in the measure specifications.

E. MAPPING PROPRIETARY AND OTHER CODES

Code Mapping Not Allowed

- ***Standard codes.*** Standard codes not used in a measure may not be mapped to standard codes used in a QIP measure. For example, if LOINC codes are not used in a measure, LOINC codes may not be mapped to CPT codes included in the measure. Similarly, if a specific CPT code is not used in a measure, that CPT code may not be mapped to a CPT code included in the measure. For QIP mapping, standard codes include any code in a measure specification's value sets; for example, POS, CPT, CVX, HCPCS, ICD-9-CM/PCS, ICD-10-CM/PCS, LOINC, SNOMED CT,[1] UBTOB, RxHCC.
- ***Deleted codes.*** Deleted codes (removed from a measure) may not be mapped to standard codes used in the QIP Manual measures.

Code Mapping Allowed

QIP entities may map the following categories for QIP reporting, as per instructions specified below:

- Health care services documented in the health record[2] matching the clinical specificity of the codes required for the measure.
- A medication in a patient's health record that is not represented by an NDC or RxNorm code in the HEDIS MLD or the VSAC for eCQM measures may only be

[1]SNOMED codes are considered supplemental data for HEDIS measures.

[2]Health record data refers to all information (records and documents), on paper or in electronic form, pertaining to the care of the patient, to which the QIP entity has access (i.e., stored and/or retrievable by the entity).

mapped if its generic name (or brand name), strength/dose, and route documented in the health record match those of a code in the MLD.

- If a patient has been given an immunization represented by an NDC code or other (non-NDC code) documentation in the health record, and the immunization is the same (in all aspects) as an immunization represented by an NDC in a value set, the immunization in the health record may be mapped to the immunization in the value set.
- Clinical outcomes that do not have specific codes (e.g., A1c<8 evidence, which requires a combination of lab code and lab result, reporting of a point of service lab result).
- Proprietary, state-, or institution-specific codes used to determine compliance with the measures' numerator, denominator, and exclusions.

If the QIP Manual measure-specified coding systems are not documented in the QIP entity health record, entities determine compliance with the measures' numerator, denominator, and exclusions, by "mapping" the institution-specific codes or workflows to the codes specified for the relevant measures.

Note: Codes must be mapped consistently across all measures. When mapping codes, it is important to match the clinical specificity required for the measure.

QIP entities must have auditable documentation of the mapping process. To support this auditable process, QIP entities should be prepared to submit documentation that includes a crosswalk containing the relevant mapped codes, descriptions, and clinical information, if requested by DHCS. It is also recommended that QIP entities document the policies and procedures and workflows used to map institution-specific codes to the codes specified in the measure.

QIP entities are strongly encouraged to review the DHCS document, **Quality Measures for Encounter Data** (August 8, 2018) to understand DHCS expectations for submission of encounter data.

F. PAID, SUSPENDED, PARTIAL, PENDING, AND DENIED CLAIMS

For most measures, the QIP entity must include all paid, suspended, pending, partial, and denied claims. The QIP entity is ultimately responsible for the quality of care it provides to individuals.

Measures with specific guidance are listed below.

- **Q-PCR: Plan All-Cause Readmissions.** When applying risk adjustment, include all services, whether or not the organization paid for them or expects to pay for them (include denied claims). Do not include denied services (only include paid services and services expected to be paid) when identifying all other events (e.g., the index hospital stay [IHS] in the Q-PCR measure).

- **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:** Do not include denied claims when identifying numerator events, but all claims (paid, suspended, pending, and denied) must be used to determine the eligible population (if applicable).
- **Q-COB: Concurrent Use of Opioids and Benzodiazepines; Q-OHD: Use of Opioids at High Dosage in Persons Without Cancer.** Include paid claims only.

Unless otherwise specified in the measure, entities may choose to include reversed claims when reporting services. If an entity includes reversals, it must include these claims in all measures, and avoid double-counting services (e.g., if a subsequent claim is filed, use only the corrected or adjudicated claim).

G. TELEHEALTH ALLOWANCES AND GUIDANCE

Additional guidance related to telehealth is available for some measures used in QIP PY7, including HEDIS, eCQMs, and CMS Adult and Child Core Set measures. A summary of this guidance is below.

HEDIS

Synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins) are considered separate modalities for HEDIS measures.

Synchronous telehealth requires real-time interactive audio and video telecommunication. A measure specification that is silent on telehealth includes synchronous telehealth because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth Place of Service (POS) code. Therefore, the CPT or HCPCS code in the value set meets criteria (regardless of the presence of a telehealth modifier or POS code). Measure specifications indicate when synchronous telehealth is not eligible for use and should be excluded.

Measures reference the Telephone Visits Value Set when telephone visits are eligible for use.

Asynchronous telehealth, sometimes referred to as an “e-visit” or “virtual check-in,” is not “real-time” but still requires two-way interaction between the individual and provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. Measures reference the Online Assessments Value Set when asynchronous telehealth visits are eligible for use.

eCQMs

Find telehealth guidance for 2024 eCQMs on the **eCQI Resource Center website**.

Q-CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan is not eligible for telehealth encounters, as described in this resource.

All other 2024 eCQMs used in the QIP PY7 Manual are eligible for telehealth encounters. Entities are responsible for reviewing measure specifications and adhering to the types of telehealth encounters that are eligible for each aspect of the measure (e.g., denominator, numerator, exclusions).

Q-CMS138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention is eligible for telehealth encounters. The PY7 Manual uses CMS138v11, which is a 2023 eCQM and falls under the **2023 eCQM guidance**.

CMS Adult and Child Core Set

Find telehealth guidance for 2023 CMS Adult and Child Core Set measures at **Medicaid.gov**.

There are no specific telehealth restrictions for any 2023 Adult and Child Core Set measures in QIP PY7. The document should be reviewed for further details on each measure.

IX. INCLUSION OF NON-CLINICIAN CARE TEAM MEMBER

Unless already delineated in the measure specifications, the QIP entity determines the appropriate care team member(s) to conduct a service measured by each QIP measure, including both in-person and virtual services. If selected care team members are not licensed to practice independently, the QIP entity ensures that they have had the appropriate supervision and training to provide the service and will maintain the appropriate level of documentation of services provided.

X. QIP TARGET POPULATIONS

QIP Target Populations describe the payer criterion that is the starting point for each measure, prior to applying denominator criteria. Each measure includes the Target Population in the measure header as well as in a separate section in the measure body.

Continuous Assignment and Continuous Enrollment Criteria

For QIP reporting, patients are attributed in the following ways, as specified by each measure:

- *Continuous assignment to a QIP entity:* Continuous assignment specifies the minimum amount of time a patient must be assigned to the QIP entity before becoming eligible for a measure, ***and***
- *Continuous enrollment to an MCP:* Continuous enrollment specifies the minimum amount of time a patient must be enrolled in the MCP before becoming eligible for a measure.

Refer to **Section XIV.C. Stratification of Reported Data by Medi-Cal Health Plan** for reporting patients based on MCP enrollment and QIP entity assignment.

Definition of "Individuals with Other Health Coverage"
"Individuals with other health coverage" are defined as "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 following target populations are used in QIP.

- **Target Population A:** Medi-Cal Managed Care (MCMC) beneficiaries assigned to the QIP entity and meeting measure specific Continuous Assignment criteria: For a given contracted Medi-Cal Managed Care Plan, a beneficiary meets the measure-specific continuous assignment criteria. For DMPHs with DHCS approved community partners only, this must include patients who meet measure-specific continuous assignment criteria with community partners for allowable QIP community partner measures.
  - If reporting an MCMC assigned lives measure, the entity must choose to either include all or exclude all MCMC assigned individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, for at least one month of the PY. If the entity's decision to include or exclude such individuals for each given measure deviates from PY6, the entity will need to re-report baseline performance rates in PY7.
  - For the Q-PCR measure, entities must exclude all MCMC assigned individuals with other health coverage for at least one month of the PY.
- **Target Population B:** MCMC beneficiaries with 12 months of continuous assignment to the QIP entity during the program year ***OR*** individuals enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of the QIP entity primary care denominator encounter (Q-CMS130 *Colorectal Cancer Screening*).
  - A QIP entity must include **all** individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, **in both target populations** (i.e., such individuals must be included for both the "Assigned Lives" target population ***AND*** from the "Enrolled in Medi-Cal" target population).
    - Include continuously assigned individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, for at least one month of the program year.
    - For the "Enrolled in Medi-Cal" part of the target population, include individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, on the date of the denominator event.

- **Target Population C:** MCMC beneficiaries with 12 months of continuous assignment to the QIP entity during the program year, ***OR*** individuals enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of a QIP entity primary care or HIV specialty care denominator encounter (Q-CMS314: *HIV Viral Suppression*).
  - A QIP entity must include **all** individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, **in both target populations** (i.e., such individuals must be included for both the "Assigned Lives" target population *AND* from the "Enrolled in Medi-Cal" target population).
    - Include continuously assigned MCMC individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, for at least one month of the program year.
    - For the "Enrolled in Medi-Cal" part of the target population, include individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, on the date of the denominator event.
- **Target Population D:** Enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of the QIP entity denominator event. The Beneficiary was enrolled in Medi-Cal Fee for Service or enrolled with a specific Managed Care Plan on the date of the measure specified event (e.g., encounter, procedure, ED visit), which must have occurred at the QIP entity.
  - Include all Medi-Cal beneficiaries with other health coverage, which may include dually eligible enrollees as defined in state and federal law, on the date of the denominator event.
- **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).
- **Target Population F:** Payer Agnostic. All individuals (regardless of payer, continuous assignment, or continuous enrollment) are included in this population.

Type of Medi-Cal

The definitions for “enrolled in Medi-Cal Managed Care” and for “enrolled in Medi-Cal Fee for Service” are below. Note that individuals with Medi-Cal Fee for Service cannot be enrolled in managed care because there is no managed care plan.

- *Enrolled in Medi-Cal Managed Care:* Services provided to a patient who is enrolled in a Medi-Cal managed care plan. Individuals enrolled in a D-SNP combined Medi-Cal and Medicare managed care plan are included in this definition. Those managed care plan payments 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 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.

XI. USE OF NON-ENTITY SERVICE DATA

For Q-AAB, Q-URI, and Q-LBP, numerator compliance and denominator inclusion should be calculated by QIP entities using data only from services and encounters that occurred at the QIP entity’s facilities, with the exception that QIP entities must use all data (including non-entity data) to which they have access in order to determine Negative Medication, Comorbid Condition, and Competing Diagnosis Histories.

For Q-PCE, Q-FUA, Q-FUI, Q-FUM, and Q-TRC, denominator inclusion should be calculated by QIP entities using data only from encounters that occurred at the QIP entity’s facilities, with the exception that for Q-PCE, Q-FUI, Q-FUM, and Q-TRC, QIP entities must use all data (including non-entity data) to which they have access in order to identify and exclude QIP entity discharges that resulted in direct transfers to non-entity facilities.

Table 8: Inclusion of Non-Entity Service Data by Measure

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-AIS-E	Adult Immunization Status	Yes, only for denominator exclusions	Yes
Q-QPP47	Advance Care Plan	No	No Advance Care Plans obtained from a non-QIP entity but are accessible in the QIP entity health record during the measurement year are allowed
Q-URI	Appropriate Treatment for Upper Respiratory Infection	Only for negative medication and comorbid condition history and competing diagnosis histories	No
Q-AMR	*Asthma Medication Ratio	Yes	Yes
Q-AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Only for negative medication and comorbid condition history, and competing diagnosis histories	No
Q-BCS-E	*Breast Cancer Screening	Yes, only for denominator exclusions	Yes
Q-CCS	*Cervical Cancer Screening	Yes, only for denominator exclusions	Yes
Q-PC02	*Cesarean Birth	No	No
Q-WCV	*Child and Adolescent Well-Care Visits	Yes, only for denominator exclusions	Yes
Q-CIS	*Childhood Immunization Status	Yes, only for denominator exclusions	Yes
Q-CHL	*Chlamydia Screening in Women	Yes	Yes
Q-CMS130	*Colorectal Cancer Screening	Yes, only for Assigned Lives	Yes
Q-COB	Concurrent Use of Opioids and Benzodiazepines	Yes	Yes
Q-CBP	*Controlling High Blood Pressure	Yes	Yes
Q-QPP118	Coronary Artery Disease: Angiotensin-Converting	No	No

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
	Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)		A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-QPP6	Coronary Artery Disease: Antiplatelet Therapy	No	No A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-DRR-E	Depression Remission or Response for Adolescents and Adults	Yes	Yes
Q-DSF-E	*Depression Screening and Follow-Up Plan	Yes, only for denominator exclusions	No
Q-DEV	*Developmental Screening in the First Three Years of Life	No, because the denominator is only based on individual's age	Yes
Q-STK-2	Discharged on Antithrombotic Therapy (STK-2)	No	No
Q-QPP415	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	No	No
Q-PC05	Exclusive Breast Milk Feeding (PC-05)	No	No
Q-EED	Eye Exam for Patients With Diabetes	Yes	Yes
Q-FUA	*Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Yes, only for denominator exclusions	Yes

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-FUM	*Follow-Up After Emergency Department Visit for Mental Illness	Yes, only for denominator exclusions	Yes
Q-FUI	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	Yes
Q-GSD	*Glycemic Status Assessment for Patients With Diabetes	Yes	Yes
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)	No	No A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-CMS349	HIV Screening	Yes	Yes
Q-CMS314	HIV Viral Suppression	Yes, only for Assigned Lives	Yes
Q-IMA	*Immunizations for Adolescents	Yes, only for denominator exclusions	Yes
Q-IHE1	*Improving Equity #1	Refer to parent measure	Refer to parent measure
Q-IHE2	Improving Equity #2	Refer to parent measure	Refer to parent measure
Q-KED	Kidney Evaluation for Diabetes (KED)	Yes	Yes
Q-LSC	Lead Screening in Children	Yes, only for denominator exclusions	Yes
Q-FUAH	Percentage of acute hospital stay discharges which had follow-up ambulatory visits within 7 days post hospital discharge	Yes,only for direct transfers and denominator exclusions	Yes
Q-QPP23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	No	No
Q-POD	Pharmacotherapy for Opioid Use Disorder (POD)	Yes	Yes

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-PCE	Pharmacotherapy Management of COPD Exacerbation	Only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	Yes
Q-PCR	Plan All-Cause Readmissions	Yes, only for direct transfers and outliers	Yes
Q-PPC-Pst	*Prenatal and Postpartum Care (Postpartum Care)	Yes	Yes
Q-PPC-Pre	*Prenatal and Postpartum Care (Timeliness of Prenatal Care)	Yes	Yes
Q-PND-E	Prenatal Depression Screening and Follow-Up	Yes	Yes
Q-PRS-E	Prenatal Immunization Status (PRS-E)	Yes	Yes
Q-PDS-E	Postpartum Depression Screening and Follow-Up	Yes	Yes
Q-QPP76	Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections	No	No
Q-CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Yes, only for denominator exclusions	No
Q-CMS147	Preventive Care and Screening: Influenza Immunization	No	Yes
Q-CMS138	*Preventive Care and Screening: Tobacco Assessment and Counseling	No	No
Q-CDI	Reduction in Hospital Acquired C Difficile Infections	No	No
Q-CMS347	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Yes	Yes
Q-SSI	Surgical Site Infection	No	No
Q-TRC	Transitions of Care	Only for identifying exclusions and excluding	No

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
		QIP entity discharges that result in direct transfers	
Q-LBP	Use of Imaging Studies for Low Back Pain	Only for Negative Diagnosis History and denominator exclusions	No
Q-OHD	Use of Opioids at High Dosage in Persons Without Cancer	Yes	Yes
Q-WCC	Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	Yes	Yes
Q-W30	*Well-Child Visits in the First 30 Months of Life	Yes, only for denominator exclusions	Yes

XII. ELIGIBLE POPULATION EXCLUSIONS

MCMC beneficiaries who fit in any category below may be excluded prior to determining a measure's QIP eligible population, for all measures with continuous assignment criteria. Exclusions must be applied consistently across all applicable measures.

Note: The exclusions below only apply to measures with Target Population A.

1. **Retroactive Eligibility.** Individuals for whom the retroactive eligibility period is greater than one month during the QIP PY should be excluded from measure denominators. The retroactive eligibility period is the elapsed time between the actual date when the eligibility organization became financially responsible for the Medi-Cal beneficiary and the date when it received notification of the new beneficiary.
2. **Non-Certified Eligible Individuals.** Medi-Cal managed care beneficiaries for whom non-certified enrollment is greater than one month during the QIP PY should be excluded from measure denominators. Non-certified enrollment months are months when the beneficiary did not receive Medi-Cal benefit coverage (e.g., from unmet share of cost).
3. **Deceased Patients.** Patients who died during a measure's applicable continuous assignment period should be excluded if the QIP entity is aware of the patient's death prior to reporting, unless additional guidance is provided in a measure specification. The QIP entity must also notify the patient's MCP of the death, and include in its data methodology narrative the number of patients who were removed from the measure denominator for this reason.
4. **Individuals with Other Health Coverage.** Medi-Cal beneficiaries for whom Medi-Cal is not the primary payer. Only some measures allow exclusion of these beneficiaries. Refer to **Section X. QIP Target Populations** for target population-specific exclusion criteria for these individuals.

XIII. SAMPLING

This section contains guidelines for sampling based on measure type.

If the QIP entity chooses to pursue the Hybrid/Medical Record Review Method for applicable measures, it should follow sampling guidelines in the individual measure specification. When reporting performance data for each measure with a Hybrid/ Medical Record Review method, participating QIP entities are required to indicate if sampling was used. Participating QIP entities are encouraged to submit as many cases as possible, up to the entire population of cases, if reasonably feasible. If raw data can be easily extracted from an existing electronic database, or if the abstraction burden is manageable, the QIP entity should submit the entire population of cases that meet the initial selection criteria; otherwise, a statistically valid sample may be selected.

If the QIP entity is sampling, it must use the health records from the cases in the randomly identified sample. If a measure population size is less than the minimum number of cases for the sample size, sampling may not be used, as determined by DHCS. Sampling must be done after the end of the PY.

If the QIP entity does not sample, it should use all health records identified in the population. Sampling is not allowed for measures reported only using the Administrative Method.

QIP entities should follow the guidelines on supporting documentation in **Section V. F. QIP Data Integrity Policy**. Documentation may be used to support an audit, as outlined in **Section V. H. Audit Guidance**.

Table 9 includes a summary of guidance on sampling by measure type.

HEDIS and CMS Adult and Child Core Set

HEDIS and CMS Adult and Child Core Set measures in the QIP PY7 Manual may include one or more of the three data collection methods listed in Table 9.

Table 9: HEDIS and CMS Adult and Child Core Set Sampling Guidance

Data Collection Method	Measure Type	Sample Guidance
Administrative Method	HEDIS and CMS Adult and Child Core Set	QIP entities must report denominators that are based on the entire eligible population; **sampling is not allowed**.
Hybrid Method	HEDIS and CMS Adult and Child Core Set	QIP entities may report denominators that are based on a systematic sample of individuals drawn from the eligible population; **sampling is allowed**. Table 10 lists the hybrid specifications included in the QIP measure set.
Electronic Clinical Data Systems (ECDS) Method	HEDIS	QIP entities must report denominators that are based on the entire eligible population; **sampling is not allowed**.

Table 10: Hybrid Specifications Included in the QIP Measure Set

Hybrid Specifications Included in the QIP Measure Set
Q-CCS: Cervical Cancer Screening (CCS)
Q-CIS: Childhood Immunization Status (CIS)
Q-DEV: Developmental Screening in the First Three Years of Life
Q-IMA: Immunizations for Adolescents (IMA)
Q-LSC: Lead Screening in Children (LSC)
Q-WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
Q-CBP: Controlling High Blood Pressure (CBP)
Q-EED: Eye Exam for Patients with Diabetes (EED)
Q-GSD: Glycemic Status Assessment for Patients with Diabetes (>9.0%) (HBD)
Q-TRC: Transitions of Care (TRC) • Notification of Inpatient Admission* • Receipt of Discharge Information* • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge
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-PC05: Exclusive Breast Milk Feeding

*Hybrid reporting only.

eCQMs

eCQMs use data electronically extracted from electronic health records (EHRs) and/or health information technology systems to measure the quality of health care provided. QIP entities reporting eCQM measures must report denominators that are based on the entire eligible population. **Sampling is not allowed**.

MIPS CQMs

MIPS CQMs use transaction data such as enrollment, claims, encounters, and supplemental. QIP entities reporting MIPS CQM measures must report denominators that are based on the entire eligible population. **Sampling is not allowed**.

Other Measure Types

Table 11 includes guidance on sampling for the remaining measure types in the QIP PY7 Manual.

Table 11: Sampling Guidance for Other Measure Types

Measure Name	Measure Type	Sample Guidance
Improving Health Equity 1	DHCS	Refer to the selected Eligible Equity measure's QIP specification for sampling guidance.
Improving Health Equity 2	DHCS	Refer to the selected Eligible Equity measure's QIP specification for sampling guidance.
Exclusive Breast Milk Feeding (PC-05)	The Joint Commission	Sampling is allowed; refer to guidelines in the specifications.
*Cesarean Birth (PC-02)	The Joint Commission	Entire eligible population; **sampling is not allowed**.
Reduction in Hospital Acquired Clostridium Difficile Infections	Centers for Disease Control and Prevention National Healthcare Safety Network	Entire eligible population as reported via NHSN; **sampling is not allowed**.
Surgical Site Infection (SSI)	National Healthcare Safety Network/CA Department of Public Health	Entire eligible population as reported via NHSN; **sampling is not allowed**.

A. SAMPLE SIZE

As a general rule, sample size requirements are based on commonly accepted sampling criteria:

- A 5 percent margin of error is recommended.
- The size of the population, also referred to as the "universe population," is the volume of eligible records from which the sample is drawn. Refer to **Table 12: Sample Sizes** for sample size requirements per population size.
- Because the number of cases in the sample could be further reduced during the analysis phase due to missing data in the health records and additional measure exclusion criteria, participating QIP entities are strongly advised to overestimate the sample size by 10 percent to 20 percent, or as much as possible.
- A quality check is recommended to ensure that the sampling methodology was applied correctly. Participating QIP entities should run a basic comparative analysis of common demographic variables (e.g., age, gender ratio, race, ethnicity) between the sampled set and the population of eligible patients. The relative frequency or distribution of these common variables should be very close.
- Participating QIP entities may choose to use a larger sample size than is required.

B. RANDOM SAMPLING

To obtain statistically valid sample data, sample cases should be randomly selected in such a way that individual cases in the population have an equal chance of being selected, and thus representing the whole population.

The participating QIP entity may use either simple random sampling or systematic random sampling:

- *Simple random sampling:* Select a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected.
- *Systematic random sampling:* Select every kth record from a population size (N) in such a way that a sample size (n) is obtained, where k = N/n is rounded to the lower digit. Before taking the kth record, the first sample record or starting point must be randomly selected by choosing a number between 1 and k, using a table of random numbers or a computer-generated random number.

Table 12: Sample Sizes

Annual Population Size (N)	Annual Sample Size (n)	Annual Population Size (N)	Annual Sample Size (n)
≤80	Use all cases	401-425	203
81-100	80	426-450	208
101-125	95	451-500	218
126-150	109	501-600	235
151-175	121	601-700	249
176-200	132	701-800	260
201-225	143	801-900	270
226-250	152	901-1,000	278
251-275	161	1,001-2,000	323
276-300	169	2,001-3,000	341
301-325	177	3,001-4,000	351
326-350	184	4,001-5,000	357
351-375	191	5,001-10,000	370
376-400	197	≥10,001	377

C. PROPORTIONATE SAMPLING

If a QIP entity chooses to sample, and data are available electronically for one part of the entity and available only in paper charts for another, the entity may use proportionate sampling. The sample should be based on the total population of qualifying cases from both electronic and paper sources across the entire QIP entity.

The proportion of cases to be sampled electronically is equal to the proportion of electronic cases in the total population. The same applies to paper charts.

For example, the total population is 10,000. 8,000 cases have an electronic data source. 2,000 cases have paper charts as the only data source. Per **Table 12**, the sample size should be at least 377. If the QIP entity oversamples for a sample of 450 patients, the entity can sample 360 cases from the electronic data source and 90 cases from the paper charts. Sampling should adhere to the random sampling principles specified above.

XIV. QIP REPORTING MECHANISM

A. REPORTING MECHANISM

QIP entities report data as specified by DHCS, and are expected to report data stratified by Medi-Cal managed care plans, as specified in **Section XIV. C. Stratification of Reported Data by Medi-Cal Health Plan**.

B. STRATIFICATION OF REPORTED DATA BY RACE AND ETHNICITY

Entities reporting on the following measures in PY7 must stratify reported data by race and ethnicity for informational purposes. Report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately.

- **Q-BCS-E: Breast Cancer Screening**
- **Q-WCV: Child and Adolescent Well-Care Visits**
- **Q-CIS: Childhood Immunization Status**
- **Q-CMS130: Colorectal Cancer Screening**
- **Q-IMA: Immunizations for Adolescents**
- **Q-DSF-E: Depression Screening and Follow-Up for Adolescents and Adults**
- **Q-CBP: Controlling High Blood Pressure**
- **Q-GSD: Glycemic Status Assessment for Patients with Diabetes**
- **Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care**
- **Q-PPC-Pst: Prenatal and Postpartum Care: Postpartum Care**

Reporting Format for Informational Race and Ethnicity Stratification

In the QIP Reporting Applications, entities will enter stratification data using the format in Tables 13 and 14.

Legend for Table 13: Race and Table 14: Ethnicity

"a" = Achievement Rate is auto calculated by the QIP Reporting Application.

* = Must match the aggregate numerator/denominator/rate reported for the measure.

Table 13: Race

	Numerator	Denominator	Achievement Rate
American Indian or Alaska Native			a
Asian			a
Black or African American			a
Native Hawaiian or Other Pacific Islander			a
White			a
Two or More Races[A]			a
Other/Declined/Unknown[B]			a
TOTAL	a*	a*	a*

[A] "Two or More Races" is people with any combination of races, including "Some Other Race."

[B] "Other," "Declined," and "Unknown" are considered distinct and separate categories when collecting race stratification data, but are combined for reporting. This category is defined as people whose race information has been collected but does not fit into any of the six race categories, people who are asked to identify race but declined to provide a response, or people for whom the entity did not obtain race information or receive a declined response (i.e., "Asked but No Answer").

Table 14: Ethnicity

	Numerator	Denominator	Achievement Rate
Hispanic or Latino			a
Not Hispanic or Latino			a
Declined/Unknown[C]			a
TOTAL	a*	a*	a*

[C] "Declined" and "Unknown" are considered distinct and separate categories when collecting ethnicity stratification data, but are combined for reporting. This category is defined as people who are asked to identify ethnicity but declined to provide a response, or people for whom the entity did not obtain ethnicity information or receive a declined response (i.e., "Asked but No Answer").

Refer to the crosswalk tables in **Appendix 7** for additional guidance on collected data that do not conform to categories outlined in Tables 13 and 14.

Race and Ethnicity Data from MCPs

If data reported by an MCP conflicts with the QIP entity's EHR regarding an individual's race(s) and ethnicity, the entity should use the most recent information for counting the individual. If the most recent information cannot be determined, the entity should use its own EHR data.

Sampling

For measures collected using the Hybrid Method, with race and ethnicity stratification, follow the guidelines for sampling outlined in **Section XIII. Sampling**. Race and ethnicity stratifications are applied to the eligible population and denominator after Hybrid sampling.

Measures with multiple P4P race and ethnicity rates

For **Q-GSD: Glycemic Status Assessment for Patients with Diabetes**, the achievement value will be based equally on performance on three accountable rates as outlined below:

1) The Total Population.
2) The Hispanic/Latino ethnicity sub-rate from **Table 14**.
3) The Black/African American sub-rate, which will include a.) individuals from the Black/ African American rate from **Table 13** and b.) individuals with "Two or More Races" who identify, in part, as Black or African American. For this reason, the informational stratification of Black or African American for Q-GSD may not match the accountable sub-rate, because the latter will include multi-racial individuals.
    - If either the Black/African American or Hispanic/Latino sub-rate has a denominator of < 30, the AV for Q-GSD will be based on the Total Population rate and the population sub-rate with the denominator ≥30.
    - If both the Black/African American and Hispanic/Latino sub-rates have a denominator < 30, the AV for Q-GSD will be based on the Total Population rate alone, contingent on the requirement that the entity also reports Q-IHE2.
      For DPHs only, a DPH must select a Priority Measure as the Eligible Equity Measure.
      For DMPHs only, a DMPH may choose any Eligible Equity Measure. Both DPHs and DMPHs may select the Priority Population.
    - Q-GSD also requires informational reporting of race and ethnicity stratification as specified in **Table 13: Race** and **Table 14: Ethnicity**.

Measures with a Single P4P Race or Ethnicity rate

For **Q-IHE1: Improving Health Equity 1** and/or **Q-IHE2: Improving Health Equity 2,** entities are only required to report the numerator and denominator for the Priority Population of their selected eligible equity measure. Multi-racial individuals identifying in part with the race/ethnicity category of the Priority Population should be counted in reporting of the equity measure (e.g., for entities that engage with the Asian Priority Population, the denominator and numerator [if applicable] of a Q-IHE Eligible Equity Measure should count multi-racial individuals who identify in part as Asian). Entities are not required to report any other race/ethnicity strata for these two measures.

For reporting Q-IHE1 or Q-IHE2 based on **Q-PC02: Cesarean Birth** and **Q- PC05: Exclusive Human Milk Feeding**, for the selected Priority Population, entities should use the data that is posted in the CMQCC Maternal Data Center (MDC) under "Comparisons: By Race/Ethnicity" in the left navigation bar under the QIP measure selected for reporting by the entity (refer to "step 5" in **Using CMQCC's Maternal Data Center (MDC) for the DHCS Quality Incentive Pool (QIP) Inpatient Perinatal Measures**). The numerators and denominators for each race/ethnicity are listed directly below the bar graphs. Note that CMQCC stratifies "Hispanic-US Born" and "Hispanic

Foreign Born" as separate strata; these numerators and denominators should be combined when reporting a Hispanic/Latino sub-rate. Entities should also note that the MDC combines "Asian" and "Pacific Islander" in one category, which should crosswalk to "Asian" race, per Table RES-A-1/2/3 in **Appendix 7**, and lacks a category for "American Indian/Alaska Native."

C. STRATIFICATION OF REPORTED DATA BY MEDI-CAL HEALTH PLAN

Report all QIP measures as a single QIP entity rate. Also report all measures (with the exceptions of *Q-CDI: Reduction in Hospital Acquired C Difficile Infections* and *Q-SSI: Surgical Site Infection*), stratified by enrollment in Medi-Cal MCP and by enrollment in Medi-Cal Fee for Service, according to the type of Medi-Cal in which each measure's denominator patients are enrolled in the QIP PY. Below is an example of a measure stratified by a Medi-Cal health plan in the QIP Reporting Application.

	Baseline	Target Rate	Numerator	Denominator	Achievement Rate	Achievement Value	Over Performance Value	Next PY Target Rate
Aggregate Rate	0	0.4807	180	385	0.4675	0	0	0.4820
MCP Generic Name 1			100	200	0.5000			
Other Medi-Cal MCP(s)			50	75	0.6667			
Medi-Cal Fee For Service			25	100	0.2500			
Beneficiaries continuously assigned to QIP Entity but switched MCP			5	10	0.5000			

Refer to **Section X. QIP Target Populations** for definitions of "Type of Medi-Cal."

When reporting each measure's Medi-Cal stratified denominator data, only include patients who meet each measure's payer population. Refer to **Section X. QIP Target Populations** for definitions.

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, 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.

XV. MEASURE QUESTIONS PROCESS

For questions regarding **QIP measure specifications** and **QIP reporting**, QIP entities should first review previously answered QIP measure specification and reporting questions by accessing the QIP Policy Clarification Support (PCS) Report on the DHCS QIP SharePoint site, **eQIP,** and for DPHs at **SNI Link/QIP**.

For **measure** questions that are not answered in the QIP PCS Report, QIP entities should submit questions directly to PCS (refer to **Appendix 2** for instructions).

Responses to measure questions are posted in **eQIP** (NCQA Measure Policy Guidance).

For **non-measure** QIP questions, QIP participating entities may contact their QIP Liaison at **QIP@dhcs.ca.gov** or their respective association. DPH participating entities may contact SNI (Dr. Ash Amarnath, **aamarnath@caph.org**; Arlene Marmolejo, **amarmolejo@caph.org**); DMPH participating entities may contact DHLF (Charity Bracy, **cbracy@umich.edu**).

XVI. STANDARD QIP SUMMARY OF CHANGES FROM PY6 MANUAL

A. ALL SPECIFICATIONS

- Updated all dates to align with the QIP PY7 reporting period and source specifications.
- Removed references to PY6 reporting.

B. HEDIS SPECIFICATIONS

- Removed reference to Appendix 5: HEDIS General Guideline: Individuals in Hospice, and updated the measure specifications with the applicable hospice exclusion language to align with the HEDIS source specifications.
- Removed reference to Appendix 5: HEDIS General Guideline: Deceased Individuals, and updated the measure specifications to align with the HEDIS source specifications.
- Moved all previously listed Exclusions to Required exclusions in all applicable HEDIS specifications.
- Revised the method for identifying advanced illness in all applicable HEDIS specifications.
- Removed the Benefits line because it does not apply to QIP reporting.

C. MIPS ECQM SPECIFICATIONS

- None.

D. MIPS CQM SPECIFICATIONS

- Updated measure flow narratives.

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- Removed the Benefits line because it does not apply to QIP reporting.

XVII. STANDARD QIP MODIFICATIONS FROM SOURCE SPECIFICATIONS

A. ALL SPECIFICATIONS

- Priority Measures are noted by an asterisk in front of the title. Refer to **Section V.C. Priority Measure Reporting** for directions on reporting Priority Measures by QIP entity characteristics.
- Removed all references to Commercial and/or Medicare product lines, except the Medicare Special Needs Plan (SNP) and "living long-term in an institution" exclusion.
- Included a reference to **Section XIV.C. Stratification of Reported Data by Medi-Cal Health Plan**.
- Removed copyright language because it is included in **Section XVIII. QIP Measure Copyright Table** of the *General Guidelines for QIP Data Collection and Reporting.*
- Replaced references to "Continuous Enrollment" with "Continuous Assignment to QIP Entity" (HEDIS & Core Set).
- Added QIP target population language for all measures, including new guidance on individuals with "other health coverage" (refer to **Section X. QIP Target Populations** for target population details).

B. HEDIS SPECIFICATIONS

- Replaced all references to "member" with "individual".
- Replaced all references to "organization" with "QIP entity".
- Removed "*Data Elements for Reporting*" section describing requirements for plans reporting to NCQA because it is not applicable to QIP.
- Removed "*Rules for Allowable Adjustments*" section describing rules for permissible modifications to the HEDIS measure.
- Removed Benefits line, because it does not apply to QIP reporting.
- Removed language regarding reducing sample size from HEDIS hybrid measures.

C. MIPS ECQM SPECIFICATIONS

- Replaced references to "eligible clinicians" with "QIP entities."
- Throughout, removed references to "Payer", "Race", "Ethnicity" and "Sex," because supplemental data elements are not used for reporting in QIP.
- Removed *"Transmission Format"* section because it is not relevant to QIP reporting.
- Removed "*References*" section from the specification and added a note to refer to the source specification for a full list of references.
- Removed "*Supplemental Data Elements"* from the measure header because they are not used for reporting in QIP.

D. MIPS CQM SPECIFICATIONS

- Replaced references to “eligible clinicians” with “QIP entities.”
- Replaced “submitted/submitting” with “reporting/reported” throughout the measure.
- Removed the following statements from the ‘*Measure Reporting*’ section, because they do not apply to QIP:
    - “Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries.”
    - “The quality-data codes listed do not need to be reported by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be reported for those registries that utilize claims data.”
    - “For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.”
- Removed measurement year reference from the measure flow charts and narratives.

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- Replaced references to “states” with “QIP entities.”
- Removed the Benefits line because it does not apply to QIP reporting.

F. OTHER SPECIFICATIONS

- None.

XVIII. QIP MEASURE COPYRIGHT TABLE

Refer to the list of measures and associated Measure ID in the document’s Navigation Pane and Table of Contents.

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Table 15: QIP Measure Copyright Table

Measure ID (Version)	Copyright Language
Q-AIS-E, Q-BCS-E, Q-CCS, Q-WCV, Q-CIS, Q-CHL, Q-IMA, Q-LSC, Q-DSF-E, Q-WCC, Q-W30 Q-DRR-E, Q-FUM, Q-FUI, Q-FUA, Q-POD Q-CBP Q-HBD, Q-EED, Q-KED Q-AMR, Q-PCE Q-TRC, Q-PCR Q-PDS-E, Q-PND-E, Q-PPC-Pre, Q-PPC-Pst, Q-PRS-E Q-URI, Q-AAB, Q-LBP (HEDIS)	HEDIS® is a registered trademark of the National Committee for Quality Assurance ("NCQA"). The HEDIS measures and specifications were developed by and are owned by NCQA. NCQA holds a copyright in the HEDIS measures and specifications and may rescind or alter these measures and specifications at any time. Users of the HEDIS measures and specifications shall not have the right to alter, enhance or otherwise modify the HEDIS measures and specifications, and shall not disassemble, recompile or reverse engineer the HEDIS measures and specifications. Use of the Rules for Allowable Adjustments of HEDIS to make permitted adjustments of the materials does not constitute a modification. No license is required for noncommercial use of the measures solely to report quality data for the Quality Incentive Pool (QIP) Program or for noncommercial, internal quality improvement activities. All other uses, including a commercial use, or any external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA. Any use of the materials to identify records or calculate measure results, for example, requires a custom license and may necessitate certification pursuant to NCQA's Measure Certification Program. HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications. **A rate from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called an "Adjusted HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be**

Measure ID (Version)	Copyright Language
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