Quality Incentive Pool (QIP) Program

Program Year 7 (PY7)
QIP Program Policies

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. 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.

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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DISTRICT HOSPITAL LEADERSHIP FORUM

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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 quality of DHCS programs by supporting DPH systems and DMPHs (hereafter "QIP entities") in delivery of 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. It 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 PY7 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 PY7 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 2024 outlining all corrections, policy changes, and clarifications from the MY 2024 HEDIS Technical Update and Joint Commission Version 2024B that apply to the QIP program; entities are responsible for applying all updates to the QIP PY7 Reporting Manual, as applicable.

A. NAVIGATION OF THE PY7 MANUAL

All key headings are available as bookmarks in the PY7 Manual. Use the PDF Navigation Pane in the left-hand column of the manual to view and use the bookmarks to navigate through the document.

Measures in the Measure Category Summary Tables are also linked to their location in the PY7 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. PY7 DOCUMENT CONTROL LOG: QIP PROGRAM POLICIES

Modifications from PY6 Manual
• Updated all dates and references to PYs. • Removed all references to PY6. • Removed prompts that are no longer relevant from Section V.B. Minimum Narrative Reporting Requirements. • Added new measures to Table 2: QIP Measures Allowable for Community Partner Data. • Updated Section VI. Payment with additional guidance on Q-FUA, Q-FUI, Q-FUM and Q-FUAH. • Added guidance for earning over-performance values for the ≥90th percentile benchmark for the Elective Measures in Section VI.F. Over-Performance.

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 PY7, 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:

- PY7 Annual Report Measurement Period: January 1–December 31, 2024.
- Annual Report due: June 16, 2025.
- Estimated date of QIP payment to each QIP entity by its MCP: No later than June 30, 2026.

A. PY7 REPORTING DATES

All QIP PY7 data are due by **11:59p.m. on June 16, 2025**. **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 16, 2025. Contact DHCS as soon as possible with questions or concerns, to ensure that you receive the necessary support.

IV. QIP MEASURES

There are 57 measures across all measure categories in QIP PY7. (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. All other measures are elective, and there is one informational measure.[1]

A. MEASURE SPECIFICATION TYPES

There are several different 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,* see the **Guide for Reading eCQMs** (PDF) and the **eCQI Resource Center's Eligible Professional / Eligible Clinical eCQMs** page.
- *MIPS CQMs,* download the **2023 Clinical Quality Measure Specifications and Supporting Documents** and view the PDF titled "**2023 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

Pursuant to the QIP PY7 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).

[1]For PY7, Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge is required to be reported as an informational-only measure.

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

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 2018 Medi-Cal Revenue and 2018 PRIME 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/6c6d350a-3de1-41ac-890e-874a61e1d997?inner_span=True

DMPHs will select a minimum number of measures to report for PY7 in a measure commitment survey that DHCS will conduct in the first quarter of PY7 (60 calendar days after the release of the PY7 Reporting Manual). This minimum measure commitment number will apply to PY7.

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 Priority 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 PY7, 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, risk factor, and/or patient behavior, such as tobacco use (i.e., for PY7, 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-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.

Note: 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)**. 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.

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, 2024. Managed care lives that did not have 12 months of continuous assignment to the QIP entity should not be included. 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.

In addition, state (1) if the QIP entity is not reporting on assigned lives measures, (2) the frequency and timing (e.g., monthly or by a specific date) the QIP entity received the MCP data, and (3) the type of clinical service data received (i.e., Encounter, Claim, Fee-for-Service, other Supplemental Data, etc.).

including (*Note:* Only include information that is not provided via the QIP audit)lata,

- Reporting and validation methodologies.
- Data system(s) employed.
- Ongoing or anticipated system-level changes in staffing, technology, analytics capacity, and partnerships that may impact reporting methods.
- Use of data to monitor performance improvement.
- Accessibility, frequency, and quality of data received from MCPs (regarding assignment data or other measure-specific data).

Describe any bidirectional data sharing, quality improvement, and alignment efforts with MCPs.

Measure Level:

Question 1: 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 is composed of measures from the Managed Care Accountability Set, 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 that have a denominator ≥30. QIP entities will 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 are unable to 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 with primary care services:* Required to report at least 50 percent of the required minimum number of 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), the DMPH must pick 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. QIP entities will use the QIP Reporting Application to communicate to DHCS that they cannot achieve a denominator ≥30 for a Priority Measure, or do not provide the relevant clinical services.
- *DMPH entities without primary care:* For each Priority Measure, the DMPH will demonstrate on the QIP Reporting Application that it does not provide the relevant clinical services.

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 21-003**, released April 19, 2021.

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** have 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: *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-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: *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

DHCS understands the importance of collecting, maintaining, and sharing data as one vehicle for maximizing health care value through QIP. In accordance with Welfare & Institutions Code section 14197.4(c)(1)(B), DHCS sets forth this QIP Data Integrity Policy specifying the data reporting requirements that QIP entities must follow through the duration of the QIP program.

For the purposes of these *QIP Program Policies*, 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 the QIP Data Integrity Policy.
2. Ensure that its data handling practices comply with the requirements outlined in the Policy.

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

Data Integrity Requirements
By participating in the QIP program and submitting QIP data, QIP entities agree and attest to compliance with the QIP Data Integrity Policy's requirements:

- The QIP entity's leadership, management, and staff, at all levels, must make a good faith effort to manage the risks that might undermine data integrity of the QIP program.
- QIP entities must facilitate data integrity through a process of self-governance, meaning that QIP entities have the lead responsibility for preventing, deterring, identifying, and rectifying any data integrity issues within their respective programs.
- QIP entities must ensure that QIP data meet the following standards:
  - *Attributable:* Establish who performed an action, and when.
  - *Legible:* Are recorded permanently in a durable medium, readable by others, with traceable changes.
  - *Contemporaneous:* Activities are recorded at the time they occur (when an activity is performed or information is obtained).
  - *Accurate:* Reflect true and correct information.

- QIP entities must retain applicable supporting documentation for ten years after submission of PY reports, and make such documentation available in case of an audit conducted by external parties. Retention of applicable supporting documentation includes maintenance of 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 ten years after submission of a PY report.
- QIP entities must report to DHCS, within ten 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 with a summary of the discovery inclusive of the following information:
    a) *Date of the discovery of the data breach?*
    b) *How was the discrepancy discovered?*
    c) *What measure(s) was impacted? Please provide a detailed list of the measure(s) and a description of the findings.*
    d) *How was the error(s) corrected?*
    e) *What kind of mitigation process is implemented to prevent any future incidents?*

  Further communication between DHCS and the reporting QIP entity will be determined on a case-by-case basis.

By submitting QIP data, QIP entities attest to compliance with this policy. Entities may not submit data without attesting to compliance with this policy.

Data Modification
Complete and accurate data meeting of the above data integrity requirements must be submitted to DHCS by the applicable reporting deadline. DHCS and/or external oversight entities evaluate reports for validity and accuracy. At its sole discretion, DHCS may request data corrections, if necessary. After entities have made requested corrections, data will be considered final, and all QIP payments, future target rates, and publicly reported data will be based on these final data. **QIP entities may not request data modifications after the reporting deadline.**

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 a QIP entity a reporting deadline extension if there has been unexpected or significant impact on data systems out of the QIP entity's control, such as incapacitation of data systems or natural disasters affecting operations. When 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.

G. SUPPORTING DATA/DOCUMENTATION

QIP entities should follow the guidelines on supporting documentation listed in the **QIP Data Integrity Policy** section above.

H. AUDIT GUIDANCE

State and federal officials reserve the right to require additional verification of any data, related documentation, and compliance with all QIP requirements, and to audit QIP entities at any time. QIP entities must, upon state or federal official request, provide any additional information or records related to QIP reporting, and, in the case of an audit, provide information and access deemed necessary by state or federal officials, or their auditors.

Additional details regarding QIP audit processes are included in **QPL-22-003-Data-Auditing**, released October 6, 2022.

I. 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, AND;
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.

J. UPDATING BENEFICIARY CONTACT INFORMATION VIA COUNTY SOCIAL SERVICES

In the event 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. At that point, the QIP entity should remove the patient from the denominator of the affected measure(s).

K. 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 containing 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**) requires compliance with the terms of each directed payment program approved by CMS under 42 CFR 438.6(c), as specified by DHCS through program policies and technical guidelines. All Medi-Cal MCPs are required to provide QIP entities with the Minimum Necessary Data set for QIP reporting, as defined by "**PY7 QIP Value Sets by Measure for MCPs for QIP Reporting**."

MCPs must assist QIP entities, including DMPHs seeking information related to DHCS-approved contracted DMPH community partners, in collecting any information that is 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. 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 QIP report narratives, QIP entities will provide the status of receipt and inclusion of MCP data in the calculations of their QIP performance data.

VI. PAYMENT

A. PAY-FOR-PERFORMANCE

Although most measures in this manual are reported on a pay-for-performance basis for PY7, 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 PY7, **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge** is reported on an informational basis. A QIP entity choosing to report on a performance measure for PY7 must also report data for Calendar Year (CY) 2023 (PY7 baseline), if not previously reported in PY6, according to specifications from the PY7 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 PY7 data until the QIP entity reports CY 2023 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 PY7 minimum, median, and high performance levels (i.e., 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 PY7, 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 PY7 are sent via email.

Benchmarking for PY7

The available benchmarks for the majority of QIP PY7 measures use data from Measurement Year (MY) 2022 (a few use data from MY 2021), as described below.

At the start of PY7, DHCS will release PY7 benchmarks generated from MY 2022 (or MY 2021) data.

For measures identified in early 2024 as having trending breaks by their national steward, there will be an MY 2023 benchmark. Of such measures, the PY7 benchmarks will be updated if the MY 2023 benchmark is released either by October 1, 2024, or by the release date of HEDIS Quality Compass® (QC) for Medicaid (in 2023, QC was released on September 29). For measures with trending breaks, these latter benchmarks will be the official benchmarks for PY7 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 PY6, entities must also re-report baseline (MY 2023) performance rates using PY7 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** below 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 10.0 percent gap closure, as described below.

QIP entities must perform at or above the established minimum performance benchmark, as 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 PY7 QIP measures:

- *Improvement:* Performance ≥25th percentile and <90th percentile.
  - 10% gap closure between CY 2023 performance and PY7 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%
    - PY7 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 PY7, 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 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 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, will use the following criteria:

1. The QIP entity will report separate numerators and denominators for each measure sub-rate, per the measure specifications.
2. Each sub-rate will be assessed for an AV using the methodology described in Table 4.
3. The total AV for each sub-rated measure will be 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). Priority 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-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.
2. **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.
3. **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.
4. **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.

5. **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.

6. **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 below 90th percentile and current PY AR ≥90th percentile benchmark. 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 PY7, 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. First, 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. Second, 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 PY7:

- 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 4 Priority Measures and 1 Elective Measure.
  - Its remaining Priority Measure AV is 4 and its remaining Elective Measure AV is 1.
- QIP entity A over-performs on 1 Priority Measure, worth 1 OV, and over-performs on 5 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 PY7, 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

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 it selected for reporting. Each QIP entity's maximum allowable payment amount would then be multiplied by the QIP entity's Quality

Score to determine the base payment. AVs will be 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 greater 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 the total Medi-Cal managed care members served in the given 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 the 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) 60 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 PY7 (60 calendar days after the release of the PY7 Reporting Manual) in order for DMPHs to commit to the minimum number of measures the DMPH will report on beginning in PY7.

40 percent by the most current annual Medi-Cal revenue, proportionate to other participating DMPHs.