DATE: January 2, 2025

QIP POLICY LETTER 24–010

TO: ALL DISTRICT MUNICIPAL PUBLIC HOSPITAL (DMPH) ENTITIES

SUBJECT: QIP POLICY INFORMATION RELEVANT TO THE DMPH MEASURE COMMITMENT SURVEY AND THE DMPH COMMUNITY PARTNER APPLICATION FOR PROGRAM YEAR (PY8)

SUPERSEDES: QIP POLICY LETTER (QPL) 24-004.

PURPOSE:
This QIP Policy Letter (QPL) informs DMPH QIP entities of QIP policies that are relevant for the accurate completion of the DMPH Measure Commitment Survey for PY8. It also contains information and a link to the PY8 application template for DMPHs seeking DHCS approval to use community partners for the QIP program.

BACKGROUND:
QIP policy information relevant to the DMPH Measure Commitment Survey and Community Partner Application is being released for PY8 to assess how these policies will impact commitment to the number of QIP measures and Community Partner(s). Additionally, DMPHs must refer to the QIP PY8 Reporting Manual that was released on January 1, 2025, which includes the full QIP Program Policies and General Guidelines where requirements are stated prior to committing to the number of measures and Community Partner(s). All information contained herein is contingent upon the Centers for Medicare and Medicaid Services (CMS) approval of the QIP PY8 DMPH Preprint.

POLICY:

1. ***DMPH Number of QIP Measures and Commitment Survey***

    For PY8 only, DHCS has modified the two tiered groupings of DMPHs based on the sum of DMPH Medi-Cal Managed Care Revenue from the most current audited year (Calendar Year [CY] 2023). Each DMPH must complete a survey committing to the number of QIP measures within its tier grouping that it will report on, 60 calendar days after the release of the PY8 Reporting Manual.

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DMPHs must submit their Measure Commitment Survey via email to their respective QIP liaison by **Monday, March 3, 2025**.

DMPHs must ensure that the person who signs the Measure Commitment Survey is the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an authorized official who has financial responsibility for the QIP entity.

For DMPHs wanting to see their specific tier, please see Attachment 1, *Specific DMPH QIP Tiers*. Each tier contains a range of measures – a required minimum and a maximum possible that a DMPH could commit to report. DMPHs in Tier 2 with rural hospital designation, as defined by CA Health & Safety Code section 124840, have the option to move to Tier 1. QIP Tiers and measure ranges are in Table 1. NOTE: A DMPH **must** report on the number of measures it commits to in order to receive **ANY** payment for a PY. If a DMPH does not report on the number of measures it commits to via the survey, it will not receive **ANY** payment for the PY.

Table 1: DMPH QIP Tiers and Measure Ranges

DMPH QIP Tier	Measure Range		Sum of Net Medi-Cal Managed Care Revenue
	Minimum	Maximum	
1	1	15*	Less than $30 million
2	7	20	*$30 million and above*

For PY8 only, DMPHs in Tier 1 may add up to three (3) measures for a maximum commitment of fifteen (15) measures only if they achieved a Quality Score of 100% for their performance in the previous two (2) PYs, i.e., PYs 5 and 6, for which completed and audited data is available. This maximum commitment of fifteen (15) measures policy only applies to DMPHs that previously committed to and reported on a maximum total of twelve (12) measures in PYs 5 and 6 in Tier 1.

When completing the Measure Commitment Survey, DMPHs should consider that the number of measures they report partially determines their allocation, except as noted below. Each DMPH's specific allocation is determined by a minimum allocation amount of at least 0.75 percent of the total DMPH QIP pool or the following methodology, whichever is greater:

1. 50 percent by the number of measures the DMPH commits to report for PY8, proportionate to other DMPHs.
2. 50 percent by the most current annual Medi-Cal Managed Care revenue proportionate to other participating DMPHs.

If a DMPH is allocated the minimum, this will proportionally adjust all other DMPH allocations.

For PY8 only, the minimum allocation for DMPHs in Tier 1 reporting one (1) measure will be set at $500,000.

For PY8 and beyond, the allocation threshold for DMPHs in Tier 1 reporting two (2) measures will be kept at $750,000.

Before committing to the specific required number of measures, the DMPH must consider a multitude of factors including, but not limited to, which QIP Tier it is in, the QIP allocation methodology, the clinical services it offers, the participation of community partners (see Section 2 below), and the likelihood of its measure data to be above 30 patients for the baseline period as well as the performance period. In addition, the DMPH should consider these additional QIP program requirements prior to committing to the number of measures for a PY:

a. QIP Priority Measure sub-set and 50 Percent DMPH Requirement
    1) DHCS has designated 20 QIP measures as the Priority Measure sub-set. For DMPHs with primary care, at least **50 percent** of reported measures must be from the Priority Measure sub-set unless:
        - The DMPH does not offer the clinical service line covered by the measure(s),
        - The DMPH does not have enough Priority Measures with a denominator of at least 30 for the PY, or
        - The DMPH is reporting only on one (1) measure wherein the DMPH can report on either a Priority or Elective Measure.

    2) If a DMPH demonstrates to DHCS that either of the first two aforementioned criteria applies for a given Priority Measure, it must pick a different Priority Measure on which to report on. If all Priority Measures have been exhausted due to either criterion, then the DMPH must demonstrate this within the QIP Reporting Application. At that point, the DMPH may select from the list of Elective Measures from PY8 to meet its minimum measure commitment, and it is no longer held to the 50 percent Priority Measure requirement.

b. One Medi-Cal Managed Care (MCMC) Life for each QIP measure
    1) Each reported QIP measure [except Q-CDI: Reduction In Hospital Acquired Clostridium Difficile Infections, Q-HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems, and Q-SSI: Surgical Site Infection (SSI)] must include data with at least one person enrolled in MCMC in the

denominator during the reporting PY in order for payment to be made. For sub-rated measures, at least one sub-rate must include data from at least one person enrolled in MCMC. An entity will earn an AV of zero and will not receive payment for a reported measure in which data does not include at least one MCMC life. However, the measure may still be used to fulfill the required number of measures for an entity's QIP reporting.

2) NOTE: Any MCMC life meets this reporting requirement; the MCMC life does not necessarily have to be assigned to the DMPH unless it is required by the measure-specific criteria.

c. QIP Target Populations
The QIP Target Population depends upon the specific QIP measure and can be identified in the PY8 Reporting Manual.

d. For PY8 only, DMPHs must report 30% of their total measures from PY7, rounded to the nearest integer. DMPHs that have attested to one (1) measure or two (2) measures in PY8 will be exempt from this requirement. Below is a list of additional exemptions to the rule. Any other exemptions are on a case-by-case basis and will require a request in writing to DHCS for consideration.
   - The entity no longer offers the clinical service(s) line(s) required to report on the measure (e.g., the entity has closed its maternity unit).
   - The entity no longer has a community partnership in place to be able to use the community partner's data to report on the measure(s) (e.g., community partner agreement has been discontinued in PY8).
   - The entity's community partner no longer offers the clinical service(s) required to report on the measure(s).
   - The entity's community partner can no longer and/or will no longer provide the necessary data for to be able to report on the measure(s).
   - The entity or the entity's community partner does not have a denominator of 30 or greater required to be able to report on the measure(s).

2. ***DMPH Community Partner Applications***

The PY8 DMPH Preprint that is contingent upon CMS approval includes a provision allowing DMPHs to use community partner data in QIP data reporting, if approved to do so by DHCS. If approved, DMPHs must apply a consistent,

identical method for including all eligible community partner patient data for each measure selected within their application(s). Measures may be selected from the list outlined in *QIP Measures Allowable for Community Partner Data* within the PY8 Reporting Manual. For each approved measure, the DMPH **must** include all patients from the community partner who meet measure denominator criteria **and** have had at least one encounter with the DMPH during the measurement period.

DMPHs seeking approval to use community partners in QIP will have the opportunity to apply for approval 60 calendar days after the release of the PY8 Reporting Manual. DMPHs must submit the completed application to their QIP liaison by **Monday, March 3, 2025**. DMPHs must ensure that the person who signs the Community Partner Application form is the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an authorized official who has financial responsibility for the QIP entity.

Applications will be approved or denied no later than 45 calendar days upon receipt of application and on a case-by-case basis for DMPH-reported changes that affect the information within its application on which the approval is based, in accordance with criteria that the partnership must meet in order to be approved for this allowance. DHCS' approval will be valid for PY8.

Furthermore, DMPHs seeking to use community partner data must apply to DHCS using the PY8 application template available on **eQIP** and provide all supplemental documentation outlined in Attachment 2, *DMPH Community Partner Application Materials*. If a DMPH is seeking approval to use multiple community partners, one application per community partner is required. In addition, a minimum of one-year written agreement such as a Memorandum of Understanding (MOU) or Contract for PY8 for each community partner is required.

DMPHs with Community Partners are required to re-report baseline data if they choose to continue reporting the same measure(s) in the current PY and the following scenario(s) apply:
   a. *Change in Community Partnership:*
      In the prior PY, the DMPH had a community partnership with *Clinic A* and used *Clinic A*'s data to report an approved community partner measure. In the current PY, the DMPH discontinued the partnership with *Clinic A* and established a new partnership with *Clinic B.* Therefore, *Clinic B's* data shall be used to report the same measure.
   b. *Change in Data Source:*
      In the prior PY, the DMPH used both its own entity's data and its community partner's data to report an approved community partner measure. However, the DMPH and its community partner discontinued their

community partnership in the current PY. The DMPH chooses to only use its own entity's data to report the same measure in the current PY.

QIP entities should contact their QIP liaison or email the QIP Mailbox at QIP@dhcs.ca.gov if there are any questions concerning this QPL.

Sincerely,

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

Attachment 1 – Specific DMPH QIP Tiers

Tier 1 (Measure Range 1-15) ✶✶	Tier 2 (Measure Range 7-20)
Bear Valley Community Hospital, Big Bear Lake	Antelope Valley Medical Center, Lancaster
Eastern Plumas Health Care, Portola	El Camino Health, Mountain View
Southern Humboldt Community Healthcare District, Garberville (Jerold Phelps Community Hospital)	El Centro Regional Medical Center, El Centro
John C. Fremont Healthcare District, Mariposa	Hazel Hawkins Memorial Hospital, Hollister✶
Kern Valley Healthcare District, Lake Isabella	Kaweah Health, Visalia
Mammoth Hospital, Mammoth Lakes	Lompoc Valley Medical Center, Lompoc✶
Mayers Memorial Hospital District, Fall River Mills	Marin Health, Greenbrae
Modoc Medical Center, Alturas	Oak Valley Hospital District, Oakdale✶
Northern Inyo Hospital, Bishop	Palomar Health, Escondido
Palo Verde Hospital, Blythe	Pioneers Memorial Healthcare District, Brawley
Plumas District Hospital, Quincy	Salinas Valley Health, Salinas
Mountains Community Hospital, Lake Arrowhead (San Bernardino Mountains Community Hospital)	San Gorgonio Memorial Hospital, Banning✶
Seneca Healthcare District, Chester	Sierra View Medical Center, Porterville
Sonoma Valley Hospital, Sonoma	Tri-City Medical Center, Oceanside
Southern Inyo Healthcare District, Lone Pine	Washington Hospital Healthcare System, Fremont
Surprise Valley Health Care District, Cedarville	
Tahoe Forest Hospital District, Truckee	
Trinity Hospital, Weaverville (Mountain Communities Healthcare District)	✶DMPHs in Tier 2 with rural hospital designation, defined by CA Health & Safety Code section 124840, have the option to move to Tier 1.

✶✶***Note:*** *For PY8 only, DMPHs in Tier 1 may add up to three (3) measures for a maximum commitment of fifteen (15) measures only if they achieved a Quality Score of 100% for their performance in the previous two (2) PYs, i.e., PYs 5 and 6, for which completed and audited data is available. This maximum commitment of fifteen (15) measures policy only applies to DMPHs that previously committed to and reported on a maximum total of twelve (12) measures in PYs 5 and 6 in Tier 1.*

Attachment 2 – DMPH Community Partner Application Materials

The application materials are located on eQIP. The below table outlines the items that must be submitted as part of the DMPH Community Partner Application, which are due to the QIP liaison by **Monday, March 3, 2025**.

	Description	Source Document
1	Completed Application	One per community partner
2	Written Contract Agreement[1] that includes a Data Sharing/Data Use Agreement	One per community partner
3	Section 3 Responses Attachment that includes a Data Sharing Schedule	One per selected measure per community partner

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[1] Written contract agreements submitted to DHCS in draft form (i.e., not yet finalized/executed) can only receive conditional approval, with final approval contingent upon the written agreement being finalized and sent to the QIP liaison no later than 45 calendar days upon receipt of application on **Thursday, April 17, 2025**.