Quality Incentive Pool (QIP) Program

Program Year 5 (PY5)
QIP Program Policies

RELEASED APRIL 15, 2022

Applies to Measurement Period January 1, 2022 – December 31, 2022

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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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 also includes District and Municipal Public Hospitals (DMPHs). The Department directs Medi-Cal managed care plans (MCPs) to make performance-based 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 (both entities herein after referred to as "QIP entities") in delivery of effective, efficient, and affordable care. This program also promotes access to care and value-based payment arrangements, increasing the amount of funding tied to quality outcomes, while at the same time 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.

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, prior to implementing the QIP PY5 measures. The *QIP Program Policies* and the *General Guidelines for QIP Data Collection and Reporting* apply to all QIP measures.

A. NAVIGATION OF THE PY5 MANUAL

All key headings are available as bookmarks in the PY5 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 hyperlinked to their location in the PY5 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 the PY5 measure set, compliance requirements, and payment information. Citations from DHCS policy documents not included in the *Program Policies* section are in quotes, with the relevant policy document listed as the source. Text not in quotations paraphrases cited documents or is additional DHCS guidance.

A. PY5 DOCUMENT CONTROL LOG – QIP PROGRAM POLICIES

Updated	Modifications from PY4 Manual
April 2022	• Updated all dates and references to PYs. • Removed all references to PY4. • Updated Section V.A. Minimum Data Reporting Requirements. • Updated Table 2: QIP Measures Allowable for Community Partner Data. • Updated Section V.K. Health Plan Data. • Updated Section VI.B. Benchmarks. • Updated Section VI.C. Trending Breaks. • Updated Section VI.D. Target Setting.

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, the calendar year (January–December) in this case, the QIP program year will adhere to the approved rate year between the plans and the state. Thus, each "QIP Program Year" is defined as the period starting January 1 and ending December 31.

For PY5, please 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:

- PY5 Annual Report Measurement Period: January 1, 2022 – December 31, 2022.
- Annual Report due: June 15, 2023.
- The estimated date of QIP payment to each QIP entity by its MCP is no later than June 30, 2024.

A. PY5 REPORTING DATES

All QIP PY5 data are due by **11:59p.m. on June 15, 2023**. **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. Please note that 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. on Thursday, June 15, 2023. Contact DHCS as soon as possible with questions or concerns to ensure that you receive the necessary support.

IV. QIP MEASURES

There are 52 measures across all measure categories in QIP PY5. (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 (*) at the beginning of the measure name in the Table of Contents and measure specifications.

A. MEASURE SPECIFICATION TYPES

There are several different types of QIP measure specifications, including but not limited to: HEDIS, MIPS CQM, eCQM, e-measure, and CMS Medicaid Adult and Child Core Set (hereinafter CMS Adult and Child Core Set).

For more information on:

- *eCQMs,* see **"Guide for Reading eCQMs"** (PDF), and the **eCQI Resource Center's Eligible Professional / Eligible Clinical eCQMs** page.
- *MIPS CQMs,* download the **2021 Clinical Quality Measure Specifications and Supporting Documents** and view the PDF titled, "**2021 MIPS Clinical Quality Measure Guide**".

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

IMPORTANT CLARIFICATION:

Outside of 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 PYs 4-6 Preprint, each DPH system must annually report at least 40 measures from the list of DHCS-approved performance measures (of which 20 are designated as Priority Performance Measures).

Each DMPH entity must annually report on at least its minimum number of measures committed. The DMPH's specific minimum commitment number must be selected within the range specified by the below 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 their minimum number of committed measures must be reported from the Priority Measure sub-set. DMPHs in Tier 2 who 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	Less than $30 million
2	10	20	$30 million and above

*https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/6c6d350a-3de1-41ac-890e-874a61e1d997?inner_span=True

DMPHs selected a specific minimum number of measures to report for PY4 in a measure commitment survey that DHCS conducted in July 2021. DHCS will administer a new DMPH measure commitment survey during the last quarter of PY5 and this minimum measure commitment number will apply to PY6 and beyond.

If a QIP entity does not report on at least their 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 less than 30:

1. A QIP entity may use a measure with a denominator of less than 30 to fulfill its minimum number of required measures for QIP reporting.
2. A denominator of at least 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 measures with 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 a 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 not meeting 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 less than 30 for either the current or baseline PY, if the following two 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 PY5, Q-W30, and Q-HBD). Additional requirements apply if both sub-rates for Q-HBD have denominators less than 30, but the total Q-HBD denominator is greater than 30. Refer to Q-HBD 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 PY5, Q-CMS-138)

If all sub-rates and the overall rate in a priority measure contain denominators of less than 30 for either the current or prior PYs, an AV of zero would apply to the measure.

The entity should consider a replacement measure, 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 that 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 sub-rates listed under **Section VI. E. Achievement Values – Sub-Rate Exceptions**, or to **Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections** or **Q-SSI: Surgical Site Infection (SSI)**. The minimum of 30 individuals or cases does not apply to 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 within 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 October 5, 2018 DHCS memo entitled **"Hospital Directed Payment Definition for SFY 2017-18 and SFY 2018-19"**.

For each MCP contract, report the number of assigned lives with 12 months of continuous assignment (with allowance for a 45-day gap) to your QIP entity for the period of January 1, 2022 through December 31, 2022. 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 can be included as long as this is indicated in the narrative. If an MCP does not provide the QIP entity with Primary Care assigned lives in time for QIP reporting, please provide a narrative explanation and rationale when submitting the report.

Question 2 – Describe data infrastructure used to report PY5 performance data, including:

- 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 bi-directional data sharing, quality improvement, and alignment efforts with MCPs.

Measure Level:

Question 1 – Describe the methods used to capture data for this measure. If applicable, provide details on sampling method(s) and local mapping. Also, identify challenges in capturing data for this measure and how those challenges will be addressed. If numerator is zero and/or denominator is less than 30 (includes zero), please explain why. DMPHs using data from DHCS-approved contracted community partners must state whether community partner data was used for this measure and indicate the numerator and denominator solely derived from community partner data.

Question 2 – Describe the quality improvement efforts for this measure. Provide details such as new policies and procedures, outreach efforts, and/or implementation of workflows, programs, and collaboratives. Describe any challenges in 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 which are of 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 several additional measures representing conditions with high priority, high prevalence, or high mortality in California. Priority measures are identified by an asterisk (*) before the measure name. QIP entities will have reporting requirements for these measures based on entity type and characteristics as follows:

- *DPH systems:* Required to report all Priority Measures that have denominator ≥30. The QIP Reporting Application will be used for QIP entities to demonstrate that they cannot achieve a denominator ≥30 for a Priority Measure or do not provide the relevant clinical services.
- *DMPH entities with primary care services:* Required to report at least 50 percent of their required minimum number of committed measures from the Priority Measure sub-set. In the event that the DMPH cannot achieve a denominator ≥30 for any of the required Priority Measures or it 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 will be allowed to substitute a measure from the remaining measure list. The QIP Reporting Application will be used for QIP entities to communicate to DHCS they cannot achieve a denominator ≥30 for a Priority Measure or do not provide the relevant clinical services.

- *DMPH entities without primary care:* The DMPH will demonstrate within the QIP Reporting Application for each priority measure 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 their role in these efforts. Additional guidance for the application and approval process is provided within **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.*

**Note, for the following measure, the qualifying DMPH encounter(s) cannot be the same as the numerator-qualifying encounter(s):*

- *Q-BCS: *Breast Cancer Screening (BCS) – mammogram encounter cannot be the only DMPH encounter.*

Table 2: QIP Measures Allowable for Community Partner Data

Q-AMR: *Asthma Medication Ratio (AMR)
Q-BCS: *Breast Cancer Screening (BCS)
Q-HBD: *Hemoglobin A1C Control for Patients with Diabetes (HBD)
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-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-PCE: Pharmacotherapy Management of COPD Exacerbation (PCE)
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, 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 the purposes of 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 of the vehicles for maximizing health care value through QIP. In accordance with Welfare & Institutions Code §14197.4(c)(1)(B), DHCS sets forth this QIP Data Integrity Policy specifying the data reporting requirements 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 this Policy.
2. Ensure that its data handling practices comply with the requirements outlined in this policy.

Scope
The QIP Data Integrity Policy applies to all QIP entities participating in the QIP program. This Policy constitutes a minimum viable standard for maintaining data quality and integrity under the QIP program. This document 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, which consists of the following 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:* Recorded permanently in a durable medium, readable by others, with traceable changes.
  - *Contemporaneous:* With activities 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 a period of ten years after submission of PY reports and make such documentation available in case of an audit conducted by external parties. This 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 a period of 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. 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 cannot submit data without attesting to compliance with this policy.

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

This 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 completely 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 the entity 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 will be released in a future policy letter.

I. UPDATING ENROLLMENT INFORMATION

If the QIP entity determines, through direct communication with a beneficiary (or beneficiary's authorized representative) that the beneficiary's assignment is incorrect, then the QIP entity should exclude the patient from the affected measure(s) if *BOTH* of 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 that 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 dis-enrolled from Medi-Cal managed care, and the dis-enrollment 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).

In the event that 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 the dis-enrollment of the beneficiary from Medi-Cal managed care, and the dis-enrollment occurs at some point 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 the "PY5 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 whom 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 specific 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 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 their QIP reports but may be included at the discretion of the individual QIP entity. 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

While all measures listed in this manual are reported on a Pay-for-Performance basis for PY5, several measures have sub-strata rates that are reported on an informational basis (refer to **Section VI. E. Achievement Values – Sub-Rate Exceptions**). A QIP entity choosing to report on a performance measure for PY5 must also report data for Calendar Year (CY) 2021 (PY5 baseline), if not previously reported in PY4, according to specifications from the PY5 Manual. A QIP entity will receive payment for achieving targets only, and there will be no payment given for reporting historical performance. **Please note the QIP Reporting Application will not allow QIP entities to report PY5 data until the QIP entity reports CY 2021 data.** Stratification by MCP is not required for historical data.

Pay-for-Performance: The achievement value of a measure will be determined by the amount of progress made toward achieving the measure performance target per **Table 3: Measure Performance Achievement Values (AVs)**.

B. BENCHMARKS

DHCS-approved QIP PY5 minimum, median, and high-performance levels, i.e., the 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 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 given measure, be it 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 respective 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 PY5 were sent via email.

Benchmarking for PY5

The available benchmarks for the majority of QIP PY5 measures use data from Measurement Year (MY) 2020 (a few use data from MY 2019) and will be as described below.

At the start of PY5, DHCS will release PY5 benchmarks generated from MY 2020 (or MY 2019) data.

Benchmarks will only be updated MY 2021 benchmarks for measures that are identified in early 2022 as having trending breaks by their national steward. Of such measures, the PY5 benchmarks will be updated if the MY 2021 benchmark is released either by October 1, 2022, or by the release date of HEDIS Quality Compass (QC) for Medicaid (in 2021, QC was released on September 24). These latter benchmarks will be the official benchmarks for PY5 target setting for measures with trending breaks.

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 measure specification between two PYs that usually requires a modification to the following the PY's target rate. When a trending break is identified for any measures QIP

entities reported in PY4, entities must also re-report baseline (MY 2021) performance rates using PY5 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 the section below on **Ratio Based Risk Adjusted Measures** for target setting 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-program year 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, at a minimum, will be required to perform at or above the established minimum performance benchmark, as described in **Table 3: Measure Performance Achievement Values (AVs)** in **Section VI. Payment**. QIP entities with performance on a given measure at or above the high performance benchmark for that measure will be considered to be at 100 percent of their quality goal and will be required to achieve performance that maintains or exceeds that measure's high performance benchmark for the subsequent PY.

An example of 10 percent Gap Closure Target Setting Methodology PY5 QIP measures is as follows:

- *Improvement:* performance ≥25th percentile and <90th percentile.
  - 10% gap closure between CY 2021 performance & PY5 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%
    - PY5 Target: 56.5%

Ratio Based Risk Adjusted Measures

For all three risk-adjusted QIP measures (Q-PCR, Q-CDI and 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 would be converted to a Calibrated O/E using the National or State Average O/E ratio as follows:

  Calibrated O/E = (Entity O/E) / (National Average O/E)

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

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 average O/E) = 0.8834 / 0.9980 = 0.8851
- **Outcome** → The entity's calibrated O/E <0.9 therefore, the entity would receive an Achievement Value of '1', indicating they performed better than expected (compared to the national average).

E. ACHIEVEMENT VALUES

For QIP PY5, the achievement value (AV) of a measure will be based on the amount of progress made toward achieving the measure performance target.

Table 3: Measure Performance Achievement Values (AVs)

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

Measure Performance in Prior PY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
< 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
< 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 specs:

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 3.
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 less than 30 if conditions described in **V. A. Minimum Data Reporting Requirements** are present.

Sub-Rate Exceptions

1. **Q-DRR-E: Depression Remission or Response for Adolescents and Adults - Follow Up (DRR-E)**
   - The Adolescent sub-strata (12-17 years old) will be required for reporting 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.

F. OVER-PERFORMANCE

QIP entities will be eligible to earn additional funds through over-performance 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.
- For measures with sub-rates, QIP entities must over-perform on all sub-rates to earn over-performance. If entities over-perform on all sub-rates and over-perform at different levels for each sub-rate, the entity will earn the OV corresponding with the lowest over-performance level.
- For measures with no gap closure or ≥90th percentile benchmark, over-performance is not possible.

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 OV of a measure will be based on the amount of 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 4 below.

Table 4: Over-Performance Values (OVs)

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	N/A

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 PY5 and PY6, OVs earned through over-performance on elective measures may be used to earn:

- ≤ 2 remaining priority measure AVs, and
- 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 PY5:

- QIP entity A reports full achievement on 16 priority measures and 19 elective measures.
  - QIP entity A achieves less than 5 percent gap closure, thus completely 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 the 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 PY5, QIP entity A can only use 2 of these OVs to earn 2 of the 3 remaining priority measure AVs and can use the balance of its 0.5 OV to earn 0.5 of the 1 remaining elective measure AV.
- After accounting for OVs, the QIP entity has earned a total of 3.5 remaining measure AVs and has a total of 1.5 remaining elective measure AVs that it cannot make-up via over-performance.

G. CALCULATING PAYMENTS

Final QIP payments: 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 Quality Score to determine the QIP entity's 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 together to determine the QIP entity's final QIP payment. The QIP entity's 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 amount of total funds available in the applicable QIP PY.

DPH Systems
The maximum allowable payment amount that may be earned by a specific DPH system (i.e., the amount earned if the DPH system attains all of its selected quality targets) will be equal to the amount of 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 specific DMPH is equal to a given DMPH's specific allocation. This includes a minimum allocation amount 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. Each DMPH completed a survey by July 15, 2021 committing to the minimum number of measures that they will report on for PY4 and PY5. DHCS will administer a new measure commitment survey during the last quarter of PY5 in order for DMPHs to commit to the minimum number of measures the DMPH will report on beginning in PY6.

(2) 40 percent by the most current annual Medi-Cal revenue, proportionate to other participating DMPHs.