Quality Incentive Pool (QIP) Program

Program Year 6 (PY6)

General Guidelines for QIP Data Collection and Reporting

RELEASED DECEMBER 16, 2022

Applies to Measurement Period January 1 – December 31, 2023

DHCS has approved this QIP Reporting Manual for the sole purpose of facilitating the participation of qualified entities in the QIP program, pursuant to the applicable *Directed Payments QIP, Section 438.6(c) Preprint.* Note that guidelines in this Manual may change if required for CMS approvals applicable to this program. The continuation of this program is subject to, and contingent upon, CMS approval.

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GENERAL GUIDELINES FOR QIP DATA COLLECTION AND REPORTING

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

The *General Guidelines for QIP Data Collection and Reporting* is a user-friendly resource for QIP managers and reporting leads that highlights key information necessary for reporting QIP performance measures. Citations from DHCS policy documents not included in the Guidelines are in quotes, with the relevant policy document listed as the source. Text not in quotes paraphrases cited documents or is additional DHCS guidance.

A. PY6 DOCUMENT CONTROL LOG: QIP GENERAL GUIDELINES

Modifications from PY5 Manual

- Updated all dates and references to Program Years.
- Removed all references to PY5.
- Renamed Section VIII. E "Mapping Proprietary and Other Codes," and revised the section to clarify mapping guidance.
- Added specific guidance for the Q-PCR measure to Section X. QIP Target Populations.
- Updated Table 8: Inclusion of Non-Entity Service Data by Measure.
- Added Table 11: Hybrid Specifications Included in the QIP Measure Set to Section XIII. Sampling.
- Updated list of measures in Section XIV. B. Stratification of Reported Data by Race and Ethnicity.
- Revised Section XIV. B. Stratification of Reported Data by Race and Ethnicity.
- Added screenshot to Section XIV. C. Stratification of Reported Data by Medi-Cal Health Plan.

VIII. MEASURE CODING

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

A. HEDIS VALUE SETS AND MEDICATION LIST DIRECTORY

HEDIS specifications and value sets can be obtained at the **NCQA Store** under "HEDIS Volume 2: Technical Specifications for Health Plans." Refer to the HEDIS Volume 2 MY 2023 specifications and value sets (including the MY 2023 Technical Update, which includes updates that were incorporated into the PY6 Manual) for the PY6 version of the QIP Reporting Manual. Entities may also obtain HEDIS Volume 2 by purchasing the **QIP HEDIS MY 2023 Digital Measures for ECDS Reporting** package. It is the QIP entities' responsibility to obtain the appropriate HEDIS value sets for each QIP PY.

Entities that purchased HEDIS MY 2023 Volume 2 prior to March 31, 2023, must redownload the Value Set Directory file for MY 2023 after the MY 2023 Technical Update is released on March 31, 2023, via **https://my.ncqa.org/**.

The HEDIS MY 2023 MLD list will be available on **NCQA's MY 2023 MLD website** on March 31, 2023.

Identifying HEDIS Code and Value Set Changes

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

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

Table 6. Value Set Summary of Changes Elements

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change (Added to; Deleted from).
Description	Describes the affected measure or, for renamed value sets, the new value set name.
Revised	August 1 release changes are identified by a revised date of 2022-8-01.

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

Table 7. Code Summary of Changes Elements

Element Name	Element Description
Value Set	The name of the value set affected by the change.
Change	The change (Added; Deleted).
Code System	The code system for the code.
Code	The code.
Revised	October 1 release changes are identified by a revised date of 2022-8-01.

B. ECQM VALUE SETS

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

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

- Click the **Download** tab.
- Select the corresponding version of the value sets to the eCQM version being used in the QIP Manual. Because the PY6 version of the manual uses eCQM 2023, select: "2023 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets."
  Note: *For Q-CMS 138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, use the "2021 Reporting/Performance Period eCQM Value Sets."*
- Select the final version of value sets that align with eCQM 2023: "May 2022 Release eCQM & Hybrid Measure Value Sets Publication Date: May 05, 2022."
- A table of value sets to download will display, and QIP entities can download the Excel file listed under row: "eCQM Value Sets for Eligible Professionals and Eligible Clinicians Published May 05, 2022," and column: "Sorted by CMS ID" to view the value sets sorted by eCQM measure.

Identifying eCQM Value Set Changes

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

- Go to the **eCQI Resource Center website**.
- Locate the corresponding eCQM by clicking the **EC eCQMs** tab and then selecting "2023" from the Select Performance Period drop-down menu.

- Click the corresponding measure name, click the **Release Notes** tab, and scroll down to the "Value Set" section, which will indicate the detailed value set updates to the latest version of the eCQM. These updates will also be noted in the "Summary of Changes from PY5 Manual" section at the top of most eCQM measures in the Manual.

C. CMS CORE SET VALUE SETS

Value sets for the CMS Child Core Set measures can be found **here** *(email **MACQualityTA@cms.hhs.gov** for "2022 Child Core Set HEDIS Value Set Directory" and "2022 Child Core Set Non-HEDIS Value Set Directory" if the files are no longer available on the website).*

Value sets for the CMS Adult Core Set measures can be found **here** *(email **MACQualityTA@cms.hhs.gov** for "2022 Adult Core Set HEDIS Measures Value Set Directory" and "2022 Adult Core Set Non-HEDIS Measures Value Set Directory" if the files are no longer available on the website).*

Value sets for the **Q-HVL: *HIV Viral Suppression (HVL-AD)** eMeasure can be found **here** (the codes can be found by clicking the link to the **Value Set**). The individual value sets can also be found on the **VSAC website**.

D. OPIOID NDC LISTS

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

E. MAPPING PROPRIETARY AND OTHER CODES

Code Mapping Not Allowed

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

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

Code Mapping Allowed

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

- Health care services documented in the health record[2] matching the clinical specificity of the codes required for the measure.
- A medication in a patient's health record that is not represented by an NDC or RxNorm code in the HEDIS MLD or the VSAC for eCQM measures may only be mapped if its generic name (or brand name), strength/dose, and route documented in the health record match those of a code in the MLD.
- If a patient has been given an immunization that is represented by an NDC code or other (non-NDC code) documentation in the health record, and the immunization is the same (in all aspects) as an immunization represented by an NDC in a value set, the immunization in the health record may be mapped to the immunization in the value set.
- Performance codes that signify a quality outcome/numerator fulfillment (e.g., G-Codes for Patient Health Questionnaire (PHQ) results, CPT-II code 3017F signifying "Colorectal cancer screening results documented and reviewed"). These are not used for billing, but are used for reporting performance.
- Clinical outcomes that do not have specific codes (e.g., A1c<8 evidence, which requires a combination of lab code plus lab result, reporting of a point of service lab result).
- Proprietary, state-, or institution-specific codes used to determine compliance with the measures' numerator, denominator, and exclusions.

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

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

QIP entities must have auditable documentation of the mapping process in place. To support this auditable process, QIP entities should be prepared to submit, at a minimum, documentation that includes a crosswalk containing the relevant mapped codes, descriptions, and clinical information, if requested by DHCS. It is also

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

recommended that QIP entities document the policies and procedures and workflows used to map the institution-specific codes to the codes specified in the measure.

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

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

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

Measures with specific guidance are listed below.

- **Q-PCR: Plan All-Cause Readmissions.** When applying risk adjustment, include all services, whether or not the organization paid for them or expects to pay for them (include denied claims). Do not include denied services (only include paid services and services expected to be paid) when identifying all other events (e.g., the index hospital stay [IHS] in the Q-PCR measure).
- **Q-URI: Appropriate Treatment for Upper Respiratory Infection; Q-AAB: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis; Q-LBP: Use of Imaging Studies for Low Back Pain:** Denied claims are not included when identifying numerator events, but all claims (paid, suspended, pending, and denied) must be used to determine the eligible population (if applicable).
- **Q-COB: Concurrent Use of Opioids and Benzodiazepines; Q-OHD: Use of Opioids at High Dosage in Persons Without Cancer.** Include paid claims only.

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

G. TELEHEALTH ALLOWANCES AND GUIDANCE

Additional guidance related to telehealth is available for some measures used in QIP PY6, including HEDIS, eCQMs, and CMS Adult and Child Core Set measures. A summary of this guidance is below.

HEDIS

The following information can be found in HEDIS *General Guideline 43: Telehealth*.

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

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

A measure will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.

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

eCQMs

Find telehealth guidance for 2023 eCQMs on the **eCQI Resource Center website**.

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

All other 2023 eCQMs used in the QIP PY6 Manual are eligible for telehealth encounters. Entities are responsible for reviewing the measure specifications and adhering to the types of telehealth encounters that are eligible for each aspect of the measure (e.g., denominator, numerator, exclusions).

Q-CMS138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention is not eligible for telehealth encounters. The PY6 Manual uses CMS138v9, which is a 2021 eCQM and thus does not fall under the 2023 eCQM guidance.

CMS Adult and Child Core Set

Find telehealth guidance for 2022 CMS Adult and Child Core Set measures at **Medicaid.gov**.

There are no specific telehealth restrictions for any 2022 Adult and Child Core Set measures in QIP PY6. The document should be reviewed for further details on each measure.

IX. INCLUSION OF NON-CLINICIAN CARE TEAM MEMBER

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

X. QIP TARGET POPULATIONS

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

Definition of "Individuals with Other Health Coverage"
"Individuals with other health coverage" are defined as "individuals with coverage in addition to Medi-Cal, where Medi-Cal is not the primary payer (i.e., individuals with Medi-Cal that have either Medicare or Private Insurance as the primary payer)".

The following target populations are used in QIP.

- **Target Population A:** Medi-Cal Managed Care (MCMC) beneficiaries assigned to the QIP entity and meeting measure specific Continuous Assignment criteria: For a given contracted Medi-Cal Managed Care Plan, a beneficiary meets the measure-specific continuous assignment criteria. For DMPHs with DHCS approved community partners only, this must include patients who meet measure-specific continuous assignment criteria with community partners for allowable QIP community partner measures.
    - If reporting a MCMC assigned lives measure, the entity must choose to either include all or exclude all MCMC assigned individuals with other health coverage, which may include dually eligible enrollees as defined in state and federal law for at least one month of the PY. The entity's decision to include or exclude such individuals for each given measure will apply to all three PYs of PY4-PY6 (for any given measure, the entity may not include such individuals in one PY and exclude them in the next). There are no exceptions and the entity may not change its decision in future PYs.
    - For the Q-PCR measure, entities must exclude all MCMC assigned individuals with other health coverage for at least one month of the PY.
- **Target Population B:** MCMC beneficiaries with 12 months of continuous assignment to the QIP entity during the program year ***OR*** individuals enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of the QIP entity primary care denominator encounter (Q-CMS130 *Colorectal Cancer Screening*).

  - A QIP entity must include **all** individuals with other health coverage, which may include dually eligible enrollees as defined in state and federal law, **in both target populations** (i.e., such individuals must be included for both the "Assigned Lives" target population *AND* from the "Enrolled in Medi-Cal" target population).
    - Include continuously assigned individuals with other health coverage, which may include dually eligible enrollees as defined in state and federal law, for at least one month of the program year.
    - For the "Enrolled in Medi-Cal" part of the target population, include individuals with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, on the date of the denominator event.

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

which may include dually eligible enrollees, as defined in state and federal law; or was uninsured.

Type of Medi-Cal

The definitions for “enrolled in Medi-Cal Managed Care” and for “enrolled in Medi-Cal Fee for Service” are as follows:

- *Enrolled in Medi-Cal Managed Care:* Services provided to a patient for which the QIP entity receives payment from a Medi-Cal managed care plan. Those managed care plan payments may be fee for service payments or through capitation arrangements.
- *Enrolled in Medi-Cal Fee for Service:* Services provided to patients for which the QIP entity receives payment from the state or from the state’s fiscal intermediary.

XI. USE OF NON-ENTITY SERVICE DATA

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

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

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

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

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-QPP118	Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	No	No A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-QPP6	Coronary Artery Disease: Antiplatelet Therapy	No	No A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-DRR-E	Depression Remission or Response for Adolescents and Adults	Yes	Yes
Q-DEV	*Developmental Screening in the First Three Years of Life	No, because the denominator is only based on individual's age	Yes
Q-STK-2	Discharged on Antithrombotic Therapy (STK-2)	No	No
Q-QPP415	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	No	No
Q-PC05	Exclusive Breast Milk Feeding (PC-05)	No	No
Q-EED	*Eye Exam for Patients With Diabetes	Yes	Yes
Q-FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	No	Yes

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-FUM	Follow-Up After Emergency Department Visit for Mental Illness	No	Yes
Q-FUI	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	Yes
Q-CMS135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	No	No A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-HBD	*Hemoglobin A1c Control for Patients With Diabetes	Yes	Yes
Q-CMS349	HIV Screening	Yes	Yes
Q-HVL	*HIV Viral Suppression	Yes, but only for Assigned Lives	Yes
Q-IMA	*Immunizations for Adolescents	No, because the denominator is only based on individual's age	Yes
Q-IHE1	*Improving Equity #1	Refer to parent measure	Refer to parent measure
Q-IHE2	Improving Equity #2	Refer to parent measure	Refer to parent measure
Q-KED	Kidney Evaluation for Diabetes (KED)	Yes	Yes
Q-LSC	Lead Screening in Children	No, because the denominator is only based on individual's age	Yes
Q-QPP23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	No	No
Q-POD	Pharmacotherapy for Opioid Use Disorder (POD)	Yes	Yes

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-PCE	Pharmacotherapy Management of COPD Exacerbation	Only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	Yes
Q-PCR	Plan All-Cause Readmissions	Yes	Yes
Q-PPC-Pst	*Prenatal and Postpartum Care (Postpartum Care)	Yes	Yes
Q-PPC-Pre	*Prenatal and Postpartum Care (Timeliness of Prenatal Care)	Yes	Yes
Q-PND-E	Prenatal Depression Screening and Follow-Up	Yes	Yes
Q-PRS-E	Prenatal Immunization Status (PRS-E)	Yes	Yes
Q-PDS-E	Postpartum Depression Screening and Follow-Up	Yes	Yes
Q-QPP76	Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections	No	No
Q-CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Yes, but only for denominator exclusions	No
Q-CMS147	*Preventive Care and Screening: Influenza Immunization	No	Yes
Q-CMS2	*Preventive Care and Screening: Screening for Depression and Follow-Up Plan	No	No
Q-CMS138	*Preventive Care and Screening: Tobacco Assessment and Counseling	No	No
Q-CDI	Reduction in Hospital Acquired C Difficile Infections	No	No

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-CMS347	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Yes	Yes
Q-SSI	Surgical Site Infection	No	No
Q-TRC	Transitions of Care: Medication Reconciliation Post-Discharge	Only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	No
Q-LBP	Use of Imaging Studies for Low Back Pain	Only for Negative Diagnosis History	No
Q-OHD	Use of Opioids at High Dosage in Persons Without Cancer	Yes	Yes
Q-WCC	Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	Yes	Yes
Q-W30	*Well-Child Visits in the First 30 Months of Life	Yes	Yes

XII. ELIGIBLE POPULATION EXCLUSIONS

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

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

XIII. SAMPLING

This section contains guidelines for sampling based on measure type.

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

If the QIP entity is sampling, it must use the health records from the cases in the randomly identified sample. When a measure population size is less than the minimum

number of cases for the sample size, sampling may not be used, as determined by DHCS. Sampling must be done after the end of the PY.

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

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

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

HEDIS and CMS Adult and Child Core Set

HEDIS and CMS Adult and Child Core Set measures in the QIP PY6 Manual may include one or more of three data collection methods listed below.

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

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

eCQMs and eMeasures

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

MIPS CQMs

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

Other Measure Types

Table 10 includes guidance on sampling for the remaining measure types in the QIP PY6 Manual.

Table 10: Sampling Guidance for Other Measure Types

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

Table 11: Hybrid Specifications Included in the QIP Measure Set

Hybrid Specifications Included in the QIP Measure Set
Q-CCS: Cervical Cancer Screening (CCS)
Q-CIS: Childhood Immunization Status (CIS)
Q-DEV: Developmental Screening in the First Three Years of Life
Q-IMA: Immunizations for Adolescents (IMA)
Q-LSC: Lead Screening in Children (LSC)
Q-WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
Q-CBP: Controlling High Blood Pressure (CBP)
Q-EED: Eye Exam for Patients with Diabetes (EED)
Q-HBD: Hemoglobin A1c Control for Patients with Diabetes (>9.0%) (HBD)
Q-TRC: Transitions of Care (TRC)
Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-PRE)
Q-PPC-Pst: Prenatal and Postpartum Care: Postpartum Care (PPC-PST)
Q-PC05: Exclusive Breast Milk Feeding

A. SAMPLE SIZE

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

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

B. RANDOM SAMPLING

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

The participating QIP entity has the option of using either simple random sampling or systematic random sampling:

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

Table 12: Sample Sizes

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

C. PROPORTIONATE SAMPLING

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

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

XIV. QIP REPORTING MECHANISM

A. REPORTING MECHANISM

QIP entities will report data as specified by DHCS. The reporting mechanism and instructions will be released closer to the reporting deadline for PY6. QIP entities are expected to report data stratified by Medi-Cal managed care plans, as specified in **Section XIV. C. Stratification of Reported Data by Medi-Cal Health Plan**.

B. STRATIFICATION OF REPORTED DATA BY RACE AND ETHNICITY

Entities reporting on the following measures in PY6 must stratify reported data by race and ethnicity for informational purposes. Entities must report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately (detailed instructions on reporting these informational stratifications, and the stratifications for Q-HBD, Q-IHE1, and Q-IHE2, will be specified in a future QIP Policy Letter).

- **Q-BCS-E: Breast Cancer Screening**
- **Q-WCV: Child and Adolescent Well-Care Visits**
- **Q-CIS: Childhood Immunization Status**
- **Q-CMS130: Colorectal Cancer Screening**
- **Q-IMA: Immunizations for Adolescents**
- **Q-CMS147: Preventive Care and Screening: Influenza Immunization**
- **Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan**
- **Q-CBP: Controlling High Blood Pressure**
- **Q-PPC-Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care**
- **Q-PPC-Pst: Prenatal and Postpartum Care: Postpartum Care**

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

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

	Baseline	Target Rate	Numerator	Denominator	Achievement Rate	Achievement Value	Next PY Target Rate
Aggregate Rate	0	0.4761	180	385	0.4675	0	0.5128
MCP Generic Name 1			100	200	0.5000		
Other Medi-Cal MCP(s)			50	75	0.6667		
Medi-Cal Fee For Service			25	100	0.2500		
Beneficiaries continuously assigned to QIP Entity but not meeting continuous enrollment criteria for any MCP plan above.			5	10	0.5000		

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

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

If a beneficiary was continuously assigned to the QIP entity through Medi-Cal managed care for the entire measure specified continuous assignment period, but switched MCP mid-year, and thus did not meet the continuous enrollment criteria for any contracted MCP, the QIP entity must include the data for these beneficiaries in the "Beneficiaries continuously assigned to the QIP Entity but not meeting continuous enrollment criteria for any MCP plan above" row.

XV. MEASURE QUESTIONS PROCESS

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

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

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

For **non-measure** QIP questions, QIP participating entities may contact their QIP Liaison at **DHCS** as well as their respective association. DPH participating entities may contact SNI (Dr. David Lown, **dlown@caph.org**; Arlene Marmolejo, **amarmolejo@caph.org**); DMPH participating entities may contact DHLF (Charity Bracy, **cbracy@umich.edu**).

XVI. STANDARD QIP SUMMARY OF CHANGES FROM PY5 MANUAL

A. ALL SPECIFICATIONS

- Updated all dates to align with the QIP PY6 reporting period and native specifications.
- Removed references to PY5 reporting.
- Added a reference to **Section XIV.C. Stratification of Reported Data by Medi-Cal Health Plan**.

B. HEDIS SPECIFICATIONS

- Removed references to optional exclusions.
- Added a reference to Appendix 5: HEDIS General Guideline 16: Deceased Individuals.

C. MIPS ECQM SPECIFICATIONS

- Removed *"Transmission Format"* section because it is not relevant to QIP reporting.

D. MIPS CQM SPECIFICATIONS

- Updated measure flow narratives.
- Removed measurement year reference from measure flow charts and narratives.

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- None.

XVII. STANDARD QIP MODIFICATIONS FROM NATIVE SPECIFICATIONS

A. ALL SPECIFICATIONS

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

B. HEDIS SPECIFICATIONS

- Replaced all references to "member" with "individual".
- Removed "*Data Elements for Reporting*" section describing requirements for plans reporting to NCQA because it is not applicable to QIP.
- Removed "*Rules for Allowable Adjustments*" section describing rules for permissible modifications to the HEDIS measure.
- Added a reference to **Appendix 5: HEDIS General Guideline 16: Deceased Individuals.**
- Added a reference to **Appendix 5: HEDIS General Guideline 15: Individuals in Hospice**.
- Removed language regarding reducing sample size from HEDIS hybrid measures.

C. MIPS ECQM SPECIFICATIONS

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

D. MIPS CQM SPECIFICATIONS

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

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- Replaced references to “states” with “QIP entities.”

F. OTHER SPECIFICATIONS

- None.

XVIII. QIP MEASURE COPYRIGHT TABLE

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

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Table 13. QIP Measure Copyright Table

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