

# Quality Incentive Pool (QIP) Program

## Program Year 4 (PY4) QIP Program Policies

**RELEASED MAY 28, 2021**

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**Applies to Measurement Period January 1, 2021 – December 31, 2021**

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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## I. BACKGROUND

The Department of Health Care Services (DHCS) 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 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 within DHCS programs by supporting DPH systems **and DMPHs (both entities herein after referred to as "QIP entities")** to deliver 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 prior to implementing the QIP PY4 measures. The **QIP Program Policies and the General Guidelines for QIP Data Collection and Reporting** apply to all QIP measures.

### A. NAVIGATION OF THE PY4 MANUAL

All key headings are available as bookmarks in the PY4 Manual. Use the PDF 'Navigation Pane' on the left-hand column of the Manual to view and use the bookmarks to navigate throughout the document.

Measures in the Measure Category Summary Tables are also hyperlinked to the measure's location within the PY4 Manual.

## II. ABOUT THE PROGRAM POLICIES SECTION

The **Program Policies** Section is meant to be a user-friendly resource for QIP managers and reporting leads. The **Program Policies Section provides information about participating in the QIP program, including the PY4 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. Texts not in quotations are a paraphrase of cited documents or are additional DHCS guidance.

## III. REPORTING CALENDAR

Since QIP payments are factored into Medi-Cal managed care rates and represent incentives for the quality of services provided during a specific rating period, which follows the calendar **year (January to December)**, the QIP program year will follow 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 PY4, please be aware of the following annual report measurement period, annual report due date, and estimated timing of payments to MCP:

- PY4 Annual Report Measurement Period: January 1, 2021 – December 31, 2021.
- Annual Report Due: June 15, 2022.
- The estimated date of QIP payment to each QIP entity by its MCP is no later than June 30, 2023.

#### **A. PY4 REPORTING DATES**

All QIP PY4 data is due by **11:59pm on June 15, 2022**. **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. **It is the sole responsibility of the QIP entity to ensure that it meets ALL QIP requirements and follows ALL DHCS guidance.**

Note: IT and technical support from DHCS will be available until 5:00pm on **Wednesday, June 15, 2022**. Please reach out to DHCS as soon as possible with any questions or concerns to ensure that you receive any necessary support.

### **IV. QIP MEASURES**

Across all **measure categories** in QIP, there are **50** total measures (see Table of Contents and Navigation pane) available. Each measure has a corresponding measure ID and measure name. **Priority measures** are denoted with 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 [2020 Clinical Quality Measure Specifications and Supporting Documents](#) and view the PDF titled, “2020\_MIPSClinicalQualityMeasure\_Guide”.
- Guidance on HEDIS, CMS Core Set, and other specification types can be found within 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 specifications types (e.g., eCQM) become available, they may be incorporated into the QIP Reporting Manual if appropriately aligned 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 Net 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](https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/6c6d350a-3de1-41ac-890e-874a61e1d997?inner_span=True)

DMPHs will select a specific minimum number of measures to report for PY4 and PY5 in a measure commitment survey that DHCS will conduct 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 for fulfilling 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.

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 does 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 to **Q-SSI: Surgical Site Infection (SSI)**.**

See Section X. QIP Target Populations in the General Guidelines 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, 2021 through December 31, 2021. 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 PY4 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.

Category Level:

Describe quality improvement efforts/grants/partnerships, whether pre-existing to PY4 or new in PY4, that support quality improvement of QIP measures. Copying and pasting the same information from the prior PY narrative is not sufficient for the current PY.

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.

**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  $\geq 30$ . The QIP Reporting Application will be used for QIP entities to demonstrate that they cannot achieve a denominator  $\geq 30$  for a Priority Measure or it does 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  $\geq 30$  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 portal will be used for QIP entities to communicate to DHCS they cannot achieve a denominator  $\geq 30$  for a Priority Measure or it does 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. 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 as part of the QIP program. 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):*

- *Breast Cancer Screening – 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-CDC-H9: *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)
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-CMS135: Heart Failure (HF): ACE/ARB/ARNI Therapy for LVSD
Q-IHE1: *Improving Health Equity (Q-IHE-1) <sup>1</sup>
Q-IHE2: Improving Health Equity (Q-IHE-2) <sup>1**</sup>
Q-PCE: Pharmacotherapy Management of COPD Exacerbation (PCE)
Q-PPC-Pre: *Prenatal and Postpartum Care (Timeliness of Prenatal Care) (PPC-PRE)
Q-PPC-Post: *Prenatal and Postpartum Care (Postpartum Care) (PPC-PST)
Q-TRC: Transitions of Care (TRC)
Q-OHD: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

*\*Priority measures*

<sup>1</sup>*QIP entities must report on the parent measure if reporting on a Q-IHE measure.*

<sup>\*\*</sup>*Q-IHE2 measure is allowable for community partner data only if the entity is engaging in improving equity for Q-AMR, Q-BCS, Q-PPC-Pre, and Q-PPC-Pst.*

## **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 their data handling practices comply with the requirements outlined within 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 — establishing 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 — reflecting 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.

## **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 or no longer correct (i.e., the initial MCP enrollment info provided to the QIP entity listed the beneficiary as assigned to the entity, but it is determined that the beneficiary was never assigned to the entity or has changed their assignment to a different entity), 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 (see [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 "PY4 QIP Value Sets by Measure for MCPs for **QIP** Reporting". MCPs must assist QIP entities in collecting information necessary to complete QIP reporting obligations for all years in which the QIP is in effect. This includes providing QIP entities with the minimum necessary information outlined by DHCS, which may include, but is not limited to, pharmaceutical and non-pharmaceutical claims data. DHCS will notify MCPs of the specific data elements required to be shared with QIP entities on a regular basis via guidance on the [DHCS QIP website](#), and of the deadline by which the necessary data should be provided to the QIP entities. DHCS will email MCP Medical Directors when the aforementioned updates are posted to the DHCS QIP website.

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 PY4, several measures have sub-strata rates that are reported on an informational basis (see [Section VI. E. Achievement Values – Sub-Rate Exceptions](#)). A QIP entity choosing to report on a performance measure for PY4 must also report baseline data for Calendar Year (CY) 2020 according to specifications from the PY4 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 PY4 data until the QIP entity reports Calendar Year 2020 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 \(AV\)](#).

### B. BENCHMARKS

DHCS-approved QIP PY4 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 25<sup>th</sup>, 50<sup>th</sup>, and 90<sup>th</sup> 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 PRIME 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-national benchmarked measures annually, as appropriate based on the most recently available state or QIP entity data. **Benchmarks for PY4 were sent via email.**

### Benchmarking for PY4

The available benchmarks for the majority of QIP PY4 measures use data from Measurement Year (MY) 2019 (a few use data from MY2018). Due to the impacts of the COVID pandemic on health care delivery during 2020 and related performance reporting, applicable benchmarks for CY 2021 will be as described below.

At the start of PY4, DHCS will release preliminary PY4 benchmarks that have been generated from MY2019 (or MY2018) data. Benchmarks will be updated with MY2020 benchmarks for any measure for which the MY2020 benchmarks is released either by October 1, or by the release date of HEDIS' Quality Compass (QC) for Medicaid (in 2020, QC was released on September 25). These latter benchmarks will be the official benchmarks for PY4 QIP target setting. The preliminary benchmark document will indicate which measures are expected to have MY2020 benchmarks released in the fall of 2021.

For measures that do not have MY2020 benchmarks released by the above cut-off dates, their benchmarks from the start of PY4 will be the official benchmarks used for PY4 QIP target setting.

### **C. TRENDING BREAKS**

DHCS will issue a policy letter to inform QIP entities of the correct procedure in the event of a measure trending break. This type of reporting results from a change in measure specification between two PYs that usually requires a modification to the following the PY's target rate. 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 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 10.0% 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](#) 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% 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% Gap Closure target setting methodology PY4 QIP measures is as follows:

- Improvement: performance  $\geq 25^{\text{th}}$  percentile and  $< 90^{\text{th}}$  percentile.
  - 10% gap closure between CY 2020 performance & PY4 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%
- **PY4 Target: 56.5%**

**E. ACHIEVEMENT VALUES**

For QIP PY4, 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 (AV)**

Measure Performance Achievement Values (AV)				
Measure Performance in Prior DCY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
> High Performance Benchmark	Performance < High Performance Benchmark	NA	NA	Performance ≥ High Performance Benchmark
≥ Minimum Performance Benchmark and <High Performance Benchmark	< 50% of the applicable 10% gap is closed	≥ 50% to <75% of the applicable 10% gap is closed	≥ 75% to <100% of the applicable 10% gap is closed	100% of the applicable 10% gap is closed
< Minimum Performance Benchmark <b>Track A:</b> 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 <b>Track B:</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 above 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).

#### Sub-Rate Exceptions

1. Q-DRR: Depression Remission or Response for Adolescents and Adults - Follow Up (DRR)
  - 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.

#### **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 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 over-performance values 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 over-performance value corresponding with the lowest over-performance level.

Through all claiming mechanisms, including over-performance, QIP entities can earn up to 100 percent of their maximum allowable payment amounts.

1. Over-Performance Values

a. Determining Over-performance Values (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	Over-performance Values (OV) for Over-performance on Priority Measures (Method 1)	Over-performance Values (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
≥90 <sup>th</sup> percentile	1.0	N/A

b. Using Over-Performance Values (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 PYs 4 and 5, OVs earned through over-performance on elective measures may be used to earn:
    - ≤ 2 remaining priority measure AVs, and
    - Any remaining elective measure AVs.
  - ii. In PY 6, OVs earned through over-performance on elective measures may be used to earn:
    - ≤1 remaining priority measure AV, 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 of 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 Over-Performance Values](#), until the QIP entity uses all of its OVs earned through over-performance on elective measures, or until the QIP entity has earned all of its remaining AVs.

Over-Performance Example for PY4:

- 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 of 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 PY 4, 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 will be made 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 (APLs), 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. 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 will complete 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.