Quality Incentive Pool
Program Year 1
Reporting Manual

RELEASED 9/17/2018

Applies to Measurement Period 7/1/17 – 6/30/18

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 *SFY 17-18 Directed Payments DPH QIP, Section 438.6(c) Preprint.*

QIP entities should review the entire QIP Reporting Manual, including the General Guidance and all applicable measure specifications, prior to implementing the QIP PY1 measures. The General Guidance applies to all QIP measures.

NOTE: This document only includes the General Guidance Section.

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GENERAL GUIDANCE

I. ABOUT THE GENERAL GUIDANCE SECTION

The General Guidance Section is meant to be a user-friendly resource for QIP managers and reporting leads. The Guide does not cover all QIP reporting aspects, but serves to highlight key points of guidance necessary for Designated Public Hospital system (hereon in to be referred to as "DPH") reporting of QIP performance measures. Citations from DHCS policy documents 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.

Document Control Log – Modifications from PY1 Reporting Manual released 9/1/2018

Version		
PY1 Year End	8/1/2018	N/A as this is the first QIP Reporting Guide
PY1 Year End v2	9/17/2018	• Added General Guidance and Q-PC6 specifications • Throughout, corrected remaining references to "Continuous Enrollment" to "Continuous Assignment"

II. REPORTING CALENDAR

A. PROGRAM YEAR

Since QIP payments are factored into Medi-Cal Managed Care rates and represent incentives for the quality of services provided during a specific rate year, which follows the fiscal calendar (July to June), 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 July 1 and ending the subsequent June 30.

B. RECEIPT OF PLAN DATA

Year End Plan Data

Health Plan data must be received by the DPH by October 30 following the end of the Program Year to be included by the DPH in in the December 15 Year End QIP report. Plan data received by the DPH after October 30 following the end of the Program Year are not required to be included by the DPH in their Year End QIP reports, but may be included at the discretion of the individual DPH.

DPH QIP reports are due to DHCS December 15 following the end of the Program Year (6 weeks following the deadline for Plan data) as shown in C. Reporting Dates.

C. REPORTING DATES

Notes: Added columns clarifying timing of estimated payment

Program Year (PY)	Annual Report Measurement Period	Annual Report Due	Est. Payment
PY1	7/1/17 – 6/30/18	12/15/18	Summer 2019
PY2	7/1/18 - 6/30/19	12/15/19	Summer 2020
PY3	7/1/19 - 6/30/20	12/15/20	Summer 2022
PY4	7/1/20 - 6/30/21	12/15/21	Summer 2022
PY5	7/1/21 - 6/30/22	12/15/22	Summer 2023

For PY1 Year End reporting please be cognizant of the following reporting deadlines:

Deadline	Report
By 12/15/2108, 11:59pm (Note: IT support from DHCS will not be available after 5:00pm on Friday, 12/14/2018.)	All QIP PY1 Year End reporting data is due 12/15/2018 Please review all QIP Policy Letters posted on *(TBD)* prior to reporting. 1. *XXXXX*
XX/XX/XXXX	DHCS review: ♦ Details TBD
XX/XX/XXXX	DHCS payment to MCPs

III. MEASURES

A. MEASURES AND MINIMUM/MAXIMUM REPORTING REQUIREMENTS

Across all projects in QIP, there are 26 total measures without duplication. Each measure has a corresponding measure ID and measure name.

Each DPH is required to report on a minimum of 20 and no more than 25 measures each program year. Each of the reported measures must have a minimum denominator size of ≥30, with the exception of Program Year 1, as described in IV. E. Measure Exclusions.

For any DPH reporting performance for <20 measures in a given reporting year, that DPH's eligible DPH funding pool will be reduced in proportion to the number of measures for which that DPH does report performance for that year.

B. MEASURE SPECIFICATION TYPES

There are several different types of QIP measure specifications: HEDIS, eCQM, Registry, Claims or those that don't fit in the former categories. For a measure with multiple specification types, DPHs should select one of the specification types for reporting on that measure. See the table below for specification types available for QIP reporting of each measure.

IMPORTANT CLARIFICATIONS:

- Outside of QIP, not all specifications for measures of the same name are completely clinically aligned. As such, DPHs may only use the specifications listed in this QIP Reporting Manual. As new specifications types (e.g., eCQM) become available, they will be incorporated into the QIP Reporting Manual if appropriately aligned with existing QIP measures.

PRIMARY CARE

Measure	Specification Type
Q-PC1: Comprehensive Diabetes Care: A1C control (<8%) (CDC-H8)	HEDIS
Q-PC2: Comprehensive Diabetes Care: Eye Exam (CDC-E)	HEDIS
Q-PC3: Comprehensive Diabetes Care: BP control (CDC-BP)	HEDIS
Q-PC4: Asthma Medication Ratio (AMR)	HEDIS
Q-PC5: Medication Reconciliation Post Discharge (MRP)	HEDIS
Q-PC6: 7 Day Post-Discharge F/U for High Risk Beneficiaries	Other
Q-PC7: Children and Adolescent Access to PCP (CAP)	HEDIS
Q-PC8: Childhood Immunization Status (CIS) Combo 3	HEDIS
Q-PC9: Immunizations for Adolescents (IMA)	HEDIS

SPECIALTY CARE

Measure	Specification Type
Q-SC1: Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (NQF 1525, Quality ID # 326)	Registry, Claims
Q-SC2: Coronary Artery Disease (CAD): Antiplatelet Therapy (NQF 0067, Quality ID #006)	Registry
Q-SC3: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin-Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)(NQF 0066, Quality ID #118)	Registry
Q-SC4: CAD: Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)(eMeasure ID: CMS145v6, NQF 0070, Quality ID #007)	Registry, eCQM
Q-SC5: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin-Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (NQF: 0081, eMeasure NQF 2907, Quality ID #005, eMeasure ID: CMS135v6)	Registry, eCQM
Q-SC6: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (NQF 0083, , eMeasure NQF 2908, Quality ID #008 eMeasure ID CMS144v6)	Registry, eCQM

INPATIENT

Measure	Specification Type
Q-IP1: Surgical Site Infection (SSI)	Other
Q-IP2: Perioperative Care: Selection of Prophylactic Antibiotic – 1st OR 2nd Generation Cephalosporin (NQF 268, Quality ID #21)	Registry, Claims
Q-IP3: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) (NQF 239, Quality ID #23)	Registry, Claims
Q-IP4: Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections (Quality ID #76)	Registry, Claims
Q-IP5: Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia (Quality ID #407)	Registry, Claims
Q-IP6: Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy (STK-2)	Other

RESOURCE UTILIZATION

Measure	Specification Type
Q-RU1: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients (Quality ID #322)	Registry
Q-RU2: ED Utilization of CT for Minor Blunt Head Trauma for Patients 18 years and older (Quality ID #415)	Registry, Claims
Q-RU3: ED Utilization of CT for Minor Blunt Head Trauma for Patients 2-17 years old (Quality ID #416)	Registry, Claims
Q-RU4: Unplanned Reoperation within the 30 Day Postoperative Period (Quality ID #355)	Registry
Q-RU5: Concurrent Use of Opioids and Benzodiazepines	Other

C. MEASURE VALUE SETS

Specifications for QIP measures may refer to value sets and/or NDC lists, which are maintained by the measure's steward. The source and instructions for obtaining these code sets is included in each applicable measure, in the "Value Sets for this measure" section. A summary of all of the code set source locations is listed in this "Value Sets for this measure" section; if no external code sets are needed that is indicated in the measure specification.

- HEDIS specs and value sets can also be obtained at the NCQA Store. Refer to the Technical Specifications for Health Plans. It is the DPHs' responsibility to purchase the appropriate HEDIS value sets for each QIP Program Year.
- The most current HEDIS NDC list can be found on NCQA's website.
    - Please note the specific HEDIS year referenced in each measure spec, as this may differ from measure to measure.
- Value sets for eCQM measures 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.
- Value Sets from PQI measures referenced in this QIP Reporting Manual (i.e., for PC 5: 7 Day Post-Discharge Follow-up Encounters for High Risk Beneficiaries) can be found at (https://safetynetinstitute.org/wp-content/uploads/2018/05/pqi-v7.0-excel_locked-1.zip)

Identifying Value Set and Code Changes:

HEDIS:
Changes to HEDIS codes and Value Sets can be found in the in the HEDIS Value Set Directory file under the following tabs:

- *Summary of Changes – Codes*
- *Summary of Changes – Value Sets*

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

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 release changes are identified by a revised date of YYYY-MM-DD.

The *Summary of Changes – Value Sets* spreadsheet lists the HEDIS changes to value sets and includes the elements in the table below.

Element Name	Element Description
HEDIS 2017	The name of the value set in HEDIS 2017 (value sets that did not exist in 2017 are labeled NA).
Change	The change.
HEDIS 2018	The name of the value set in HEDIS 2018

eCQM:
To find a comparison of version-to-version eCQM code updates, please follow the below instructions:
Visit the eCQI Resource Center website: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms to access a comparison tool that will help identify coding differences in eCQM measure versions.

1. Under the column labeled "USHIK Version Links," click on the 'Version Compare' link for the corresponding measure.
2. The user will need to have a UMLS username / password to access specific code differences between versions. (Follow the link to create an account with UMLS).
3. Once you have acquired a username / password for UMLS, use it to sign into the 'Version Compare'.
4. Then click on the two versions of the eCQM you'd like to compare, and click on the 'QDM Data Elements & Codes' tab to view the specific coding differences.

D. LOCAL MAPPING

Four categories of measure specified codes have been identified for use when reporting QIP performance measures, as specified below. DPHs may locally map categories 2, 3 and 4 as per instructions specified below. The 4 categories are:

1. Billable encounters codes. For the purposes of QIP reporting, "billable encounters codes" are defined as encounter codes used to report traditional in-person clinic based outpatient primary and specialty encounters with a provider, as well as inpatient stays.
2. Other health care services that may be represented by CPT or other alphanumeric codes.
3. Performance codes that signify some kind of 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.
4. Clinical outcomes that do not have specific codes, e.g., A1c<8 evidence of which requires a combination of a lab code plus the lab result; or reporting of a point of service lab result).

If the category 2, 3 and 4 QIP manual measure-specified coding systems are not documented in the DPH medical record, DPHs must "map" the institution specific codes or workflows they use to determine compliance with the measures' numerator, denominator, and exclusions, to the codes specified for the relevant measures.
Institution-specific DPH codes may be mapped to codes in the QIP manual used to determine compliance with measures' numerator, denominator, and exclusion criteria. Please note that if codes are mapped, they must be mapped consistently across all measures. Standard codes not used in a given measure (i.e., CPT, HCPCS, ICD-10-CM/PCS, LOINC, NDC, etc.) or 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. When mapping codes, it is important to match the clinical specificity required for the measure.
DPHs may not use local mapping for QIP measure-specified billable encounter codes (Category 1 above). These codes must be recorded in the patient's medical record and associated billing system.
The DPHs must have some form of auditable documentation of the mapping process in place. To support this auditable process, it is recommended (although not required to be reported for QIP unless requested to do so by DHCS) that DPHs have, at a minimum, documentation that includes a crosswalk containing the relevant mapped codes, descriptions and clinical information. It is also recommended that DPHs document the policies and procedures and workflows used to map the institution specific codes to the codes specified in the measure. Documentation must be made available to DHCS upon request.
DPHs are strongly encouraged to review the January 2015 DHCS document, Quality Measures for Encounter Data, in order fully understand what DHCS' expectations are for submission of encounter data.

E. INCLUSION OF NON-CLINICIAN CARE TEAM MEMBERS

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

F. MEASURE QUESTIONS PROCESS

For questions regarding QIP measure specifications or reporting, DPHs should first review previously asked and answered QIP measure spec and reporting questions, by accessing the QIP Policy Clarification (PCS) report, located at SNI Link/QIP.
For questions that are not answered in the QIP PCS report: contact Dana Pong or the DHCS QIP team.

IV. QIP ELIGIBLE POPULATION

For any given measure, refer to that measure's category eligible population following the measure category summary table and to the measure specific denominator. All but one QIP measure (Q-PC7: Children and Adolescent Access to PCP (CAP)) includes DPH engagement criteria (encounters, source of prescriptions, discharges, other services).

Plan Specific QIP Measure Rates
All QIP measures are to be reported as a single DPH rate. All DPHs will also report all measures stratified by each Medi-Cal Managed Care Plan (MCP) for which the DPH had a contract for assigned Medi-Cal managed care lives within the QIP Program Year.

A. MEASURE EXCLUSIONS

1. Minimum Denominator Case Number
   A DPH must have a minimum of 30 individuals or cases in a measure denominator in order to be eligible to report on that measure. If a DPH meets this minimum, for a measure they have selected to report in a given year, then the DPH must report performance for the measure. If a DPH has fewer than 30 cases, then the DPH is not eligible to report on the measure for the program year, with the exception of QIP Program Year 1, for which the DPH may report measures with denominators of <30, including denominators of zero. The performance rate of any measure reported in Program Year 1 with a denominator <30 will not be used as baseline for that measure.
2. Minimum Numerator Case Number
   There is no minimum numerator case number. Numerators of zero may always be reported, however will impact achievement value for any measure reported under pay for performance status.
3. Duals
   a. Medi-Cal beneficiaries that also have Medicare Parts A and B coverage for greater than one month during the QIP program year, should be excluded prior to determining a measure's QIP eligible population:
   b. Medi-Cal beneficiaries that have only Medicare Part A coverage, should be excluded from measure denominators when Medi-Cal is not the primary payer for measure specific denominator eligible services.
   c. Medi-Cal beneficiaries that have only Medicare Part B coverage, should be excluded from measure denominators when Medi-Cal is not the primary payer for measure specific denominator eligible services,
4. Other Health Coverage (OHC), Retroactive Eligibility and Non-Certified Eligible Members
   a. Consistent with HEDIS reporting, Managed Care Medi-Cal beneficiaries who fit in any of these three coverage categories may be excluded prior to determining a measure's QIP eligible population for all measures with Continuous Assignment criteria, namely all Primary Care, measures and the Concurrent Opioids and Benzodiazepines measure in the Resource Utilization category. DPHs that apply these exclusions should do so consistently across all applicable measures.
      i. Managed Care Medi-Cal beneficiaries identified as also having private insurance for greater than one month during the QIP program year.
   b. Retroactive Eligibility:
      i. Individuals for whom the retroactive eligibility period is greater than one month during the QIP program year 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.
   c. Non-Certified Eligible Members

i. Managed Care Medi-Cal beneficiaries for whom non-certified enrollment is greater than one month during the QIP program year should be excluded from measure denominators. Non-certified enrollment months are those months in which the beneficiary did not receive Medi-Cal benefit coverage (perhaps from unmet share of cost).

B. OTHER MODIFICATIONS

QIP Data Modification Policy (TBD)

V. PAY-FOR-REPORTING / PAY-FOR-PERFORMANCE

Summary of Measure Progression from P4R to P4P

First year reporting, all measures will be reported on a Pay-for-Reporting basis. For subsequent years, all measures listed in this manual will be reported on a Pay-for-Performance basis, unless determined otherwise by DHCS for one of those subsequent years.

Pay-for-Performance: The achievement value of a measure will be based on the amount of progress made toward achieving the measure performance target.

VI. PAYMENT

A. CALCULATING PAYMENTS AND ACHIEVEMENT VALUES

Final QIP Payments: Payments will be made based on a Quality Score that measures the sum of the achievement values for all measures selected for reporting by the DPH system divided by the number of measures it selected for reporting. Each maximum DPH allocation would then be multiplied by the DPH Quality Score to determine the Final QIP payment. Full achievement will be given for each measure upon submission of the baseline data in Program Year 1 in the annual report. For subsequent QIP Program Years, achievement value will be based on performance and associated Achievement Values as to be determined by DHCS and will be included in future Program Year Reporting Manuals..

B. TIMING OF PAYMENTS

To be determined. Refer to Reporting Calendar section for estimates

VII. SAMPLING

Certain QIP measure specifications (e.g., Q-PC1-3, Q-PC5, Q-PC8, Q-PC9) describe administrative, hybrid, or medical record review methods. If the DPH chooses to pursue the hybrid or medical record review method and if that specification includes guidance on sampling, the DPH should follow the individual measure specification's guidance on sampling. If the measure specification does not include guidance on sampling, and if the DPH chooses to sample, the DPH should follow the sampling guidance below.

For each measure, the DPH has the option to either report on the entire measure population or on a sample, adhering closely to sampling criteria published and maintained in the CMS

Hospital Outpatient Quality Reporting Specifications Manual. For each measure, 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 DPH should submit the entire population of cases that meet the initial selection criteria. Otherwise, a statistically valid sample can be selected.
If the DPH is not sampling, the entity should use all medical records identified in the population.
If the DPH is sampling, the entity should use the medical records from the cases in the identified sample.
When a measure population size is less than the minimum number of cases for the sample size, sampling cannot be used, as determined by DHCS.
When a measure population size is less than the minimum number of cases for the sample size, sampling cannot be used.
Sampling must be done after the end of the program year.

A. SAMPLE SIZE

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

- A 5% 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. See the table below for sample size requirements per population size.
- Given that the number of cases in the sample could further be reduced during the analysis phase due to missing data in the medical records and additional measure exclusion criteria, it is strongly advised to overestimate their sample size by 10 to 20 percent, or as much as possible.
- A quality check is recommended to ensure that sampling methodology was applied correctly. The participating 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 theses common variables should be very close.
- The participating 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 entity has the option of using either simple random sampling or systematic random sampling:

1. 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.
2. Systematic random sampling is selecting every kth record from a population size (N) in such a way that sample size (n) is obtained, where k=N/n 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.

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

5,001-10,000	370
≥ 10,001	377

C. PROPORTIONATE SAMPLING

If a DPH chooses to sample and the data is available electronically for one part of the DPH and only available by paper charts in another, the DPH may choose to sample using proportionate sampling. The sample should be based on the total population of qualifying cases from both electronic and paper sources across the entire DPH. The proportion of cases to be sampled electronically is equal to the proportion of electronic cases of the total population. The same applies for paper charts. For example: 8,000 cases have an electronic data source. 2,000 cases have paper charts only as the data source. The total population is 10,000. Per sample size table, the sample size should be at least 377. If the DPH oversamples for a sample of 450 patients, the DPH 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.

VIII. COMPLIANCE REQUIREMENTS

A. SUPPORTING DATA/DOCUMENTATION

DPHs should follow the guidance on supporting documentation listed in the QIP Data Integrity Policy.

B. DATA INTEGRITY POLICY

For QIP, DPHs are required to follow the data integrity guidance in the QIP Data Integrity Policy (to be released by DHCS) The QIP Data Integrity Policy matches the guidance in the PRIME Data Integrity Policy.

C. 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 entities at any time. DPHs must, upon State or Federal official request, provide any additional information or records related to the QIP, and, in the case of an audit, provide information and access deemed necessary by State or federal officials, or their auditors.

D. HEALTH PLAN DATA

See Section II.B. RECEIPT OF PLAN DATA above for plan data inclusion requirements for annual reporting and for denominator inclusion requirements in relation to timely receipt of denominator specific plan data.

IX. QIP REPORTING MECHANISM

A. REPORTING MECHANISM

TBD

B. USER GUIDE

The QIP Reports will be submitted via the above referenced reporting mechanism.
This User Guide section (TBD) will describe how DPHs will use the QIP reporting mechanism.

C. ACCESS

This Access section (TBD) will describe how DPHs will access the QIP reporting mechanism.

X. QIP MEASURE COPYRIGHT TABLE

See list of measures and associated Measure ID in Section III. B. Measure Specification Types

Current Procedural Terminology (CPT®)
The five character codes included in the "QIP Reporting Manual PY 1 for Year End Reporting" are obtained from Current Procedural Terminology (CPT®), copyright 2016 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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CPT is a registered trademark of the American Medical Association.

Measure ID	Copyright Language
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