CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: March 13, 2023

QIP POLICY LETTER 23–002

TO: ALL QUALITY INCENTIVE POOL (QIP) ENTITIES

SUBJECT: UPDATES TO PROGRAM YEAR (PY) 5 REPORTING

PURPOSE:

This QIP Policy Letter (QPL) informs QIP entities of the following updates:

1. Removal of the 14-day requirement for counting numerator compliance for Q-CIS-10, Q-W30, and Q-IMA
2. Q-BCS: Breast Cancer Screening – removal of the requirement for an additional denominator qualifying encounter *(ONLY applicable to DMPHs with Community Partners)*
3. Q-PCR: Plan All-Cause Readmissions Reporting Guidance
4. Trending Break Measures
5. Q-IHE: Improving Health Equity – Eligible Equity Measures
6. PY5 COVID-19 PHE-Related Modifications *(pending CMS approval)*
7. PY 5 Audits and Measure Reporting Requirements

BACKGROUND:

On December 30, 2022, the Department of Health Care Services (DHCS) submitted the revised Designated Public Hospital (DPH) and District/Municipal Public Hospital (DMPH) QIP preprints with COVID-19 PHE-related modifications in PY5 and PY6 to the Centers for Medicare and Medicaid Services (CMS) for approval. Both revised preprints are currently pending CMS approval. The QIP program is authorized by Welfare and Institutions Code section 14197.4(c) and the prior PYs 4-6 DMPH and DPH preprints previously approved on January 20, 2022 and February 2, 2022 respectively.

Reporting requirements related to these COVID-related modifications for PY 5, as well as additional clarifications and modifications to reporting since the release of the PY 5 Manual in April 2022, are outlined in this policy letter to provide additional guidance to entities for reporting of their QIP performance data in June 2023.

POLICY:

1. ***Removal of the 14-day requirement for counting numerator compliance for Q-CIS-10, Q-W30, and Q-IMA***

   Entities are instructed to disregard reference to Appendix 5: HEDIS General Guideline 36: Collecting Data for Measures with Multiple Numerator Events for the following three measures listed in the PY5 Reporting Manual:

   - CIS-10 - Childhood Immunization Status
   - W30 - Well-Child Visits in the First 30 Months of Life
   - IMA - Immunizations for Adolescents

   This requirement states that when using administrative or a combination of administrative or medical record data for these three measures, numerator counts must be at least 14 days apart for each individual. The removal of this requirement will be retroactively applied for reporting in PY 5, so numerator counts no longer have to be at least 14 days apart for these three measures.

2. ***Q-BCS: Breast Cancer Screening – removal of the requirement for an additional denominator qualifying encounter*** *(**ONLY** applicable to DMPHs with Community Partners)*

   In Section V.D. DMPH Community Partner Eligible Measures, page 13, the manual states that for DMPHs reporting the Q-BCS measure, "the qualifying DMPH encounter(s) cannot be the same as the numerator-qualifying encounter(s)." Effective in PY 5, this additional requirement will be removed and entities are instructed to follow the Q-BCS measure specification as written in the QIP manual.

3. ***Q-PCR: Plan All-cause Readmissions Reporting Guidance***

   For Q-PCR, entities should enter the overall observed and expected counts in the discrete fields provided in the QIP Portal Reporting Application. The Medi-Cal managed care plan stratified observed counts and any other required reporting elements should be entered in the measure level data narrative.

   The following table summarizes where entities should be entering the respective data elements:

Data Element (no age strata, all elements reported on total population)	**Location in Reporting Application**
Observed Count	Observed Count Data Field
Observed Count stratified by Contracted MCP	Narrative
Expected Count	Expected Count Data Field
Number of Individuals in the QIP Entity Population	Narrative
Outlier Individual Count	Narrative
Outlier Rate	Narrative
Denominator	Narrative
Observed Rate	Narrative
Expected Rate	Narrative
Count Variance	Narrative
Observed Count/Expected Count Ratio	Calculated by Reporting Application

4. ***Trending Break Measures***

For PY5, entities must re-report baseline data (PY4 performance data derived from calendar year 2021 using PY5 specifications) in the "Trending Break Data For PY4 Reported In PY5" field in the QIP reporting application for the eight measures listed below:

i. Q-CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
ii. Q-CMS147: Preventive Care and Screening: Influenza Immunization
iii. Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
iv. Q-FUA: Follow-Up After Emergency Department Visit for Substance Use (FUA)
v. Q-QPP118: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVSD < 40%)
vi. Q-QPP6: Coronary Artery Disease (CAD): Antiplatelet Therapy
vii. 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)
viii. Q-LBP: Use of Imaging Studies for Low Back Pain (LBP)

5. ***Q-IHE: Improving Health Equity – Eligible Equity Measures***

In PY5, Q-IHE1 is no longer a Priority Measure due to the COVID-related modifications outlined in 6) below, thus any measure in the Eligible Equity Measure list may be chosen for reporting Q-IHE1. Please note that Q-IHE1 and Q-IHE2 must be based on two different Eligible Equity Measures.

6. ***PY5 COVID-19 PHE-Related Modifications*** *(pending CMS approval)*

To address the ongoing impacts of the COVID-19 PHE, the following changes will be made to the reporting requirements in the QIP program for PY 5:

The priority measure set will be reduced to 9 measures from the original set of 20 measures, selected based on their alignment with the DHCS Comprehensive Quality Strategy.

PY 5 Priority Measures:

- Q-WCV: Child and Adolescent Well Care Visits
- Q-CIS: Childhood Immunization Status (CIS 10)
- Q-CHL: Chlamydia Screening in Women
- Q-DEV: Developmental Screening in the First Three Years of Life
- Q-IMA: Immunizations for Adolescents
- Q-PPC-PRE: Prenatal and Postpartum Care (Postpartum Care)
- Q-PPC-PST: Prenatal and Postpartum Care (Timeliness of Prenatal Care)
- Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Q-W30: Well-Child Visits in the First 30 Months of Life

The remaining 11 measures from the original Priority set will be considered part of the Elective measures set for PY 5.

For DPH systems:

- Require reporting of nine (9) Priority Measures.
- Option to report 30 or 40 measures:
  - If reporting 40 total measures (Nine Priority Measures and 31 Elective Measures); Maximum earnable amount is 100%.
  - If reporting 30 measures (Nine Priority Measures and 21 Elective Measures); Maximum earnable amount will be reduced to 90%.
- Performance target for all measures will remain at 10% gap closure to the 90th percentile. At the minimum, entities will be required to perform at or above the minimum performance benchmark. If the baseline performance is at or above the high-performance benchmark, entities will be required to

maintain or exceed the high-performance benchmark.
- All data reported must have denominators of at least 30.

For DMPH systems:
- DMPH systems with primary care or those providing the relevant clinical services must report at least 20% of their required reported measures from the Priority Measure set.
- Report the PY5 attested number of measures but can designate their Quality Score to be calculated on a subset of these measures, as few as 67% of the original number of measures (rounded to the nearest integer) but not less than one measure.
- Performance target for all measures will remain at 10% gap closure to the 90th percentile. At the minimum, entities will be required to perform at or above the minimum performance benchmark. If the baseline performance is at or above the high-performance benchmark, entities will be required to maintain or exceed the high-performance benchmark.
- All data reported must have denominators of at least 30.

7. ***PY 5 Audits and Measure Reporting Requirements***

As stated in the QIP PY 5 Reporting Manual, 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. To support data integrity and ensure accountability for the QIP funds, DHCS will partner with an external auditor to assess QIP reports as part of its review and oversight process. **All entities must participate and provide any information, records, or access deemed necessary by DHCS auditors, who are HIPAA business associates of DHCS.**

For PY5 only, measures that are in scope of review for the external data auditor will be the measures that count towards the entities' Quality Score. For DPH systems, all reported measures will be under scope of review (30 or 40 measures). For DMPH systems, a minimum of 67% of their measures will be under scope of review. DMPH systems must indicate Pay-for-Performance (P4P) in the data methodology narrative's text box for measures that DMPH systems choose to count in the Quality Score.

For measures in scope of audit review, data methodology narrative will be optional. Entities may enter "Waived due to audit" in the data methodology narrative's text box in the QIP reporting application.

Please contact your QIP Liaison or email the QIP Mailbox at qip@dhcs.ca.gov if there are any questions concerning this QPL.

Sincerely,

ORIGINAL SIGNED BY PALAV BABARIA

Palav Babaria, MD, MHS
Deputy Director & Chief Quality Officer
Quality and Population Health Management