CALIFORNIA HEALTH CARE
SAFETY NET INSTITUTE

QIP Leads Monthly Forum

Mon, Aug 23, 2021, 12-1PM

Recording Link

Presenters: David Lown dlown@caph.org, Dana Pong dpong@caph.org
Recordings of the webinar and slide deck posted on SNI Link/QIP/Webinars

Housekeeping

Please mute locally. Lines are also muted on entry.

Please don't use a speakerphone in order to prevent an audio feedback loop, an echo.

At any time, feel free to chat your question & we will read out

Webinar will be recorded and saved on SNI Link: QIP Webinars

Program Year 3.5

PY3.5 Reports

Aug 31:	DHCS closes out all PY3.5 report reviews
September:	DHCS communicates PY3.5 Immunization Sub-Pool winners
March 2022:	DHCS to pay Health Plans (original date was January 2022)

Reminder: send Dana the final, DHCS-approved version of
1) QIP PY3.5 PRIME Transition Metrics Report
2) QIP PY3.5 Immunization Sub Pool Metrics Report

Program Year 4

PY4 Policy Updates

Updated from slide in 7/26 QIP Leads Webinar

Pending:

- CMS approval of original PY4 Pre-print. Through PY6 or PY9?
- DHCS release of "PY4 Value Sets for Managed Care Plans"
- DHCS Policy Letter: R/E stratification structure for 5 priority measures.
  - Update: There will be no stratification for the overall MCMC population.
  - See slide 9-10 from 6/28 QIP Leads Webinar
- DHCS Policy Letter: Non-Entity Data
  - See slide 11 from 6/28 QIP Leads Webinar. See later slide today.
- DHCS planning on audits for PY4
  - MTAC discussing initial high level DHCS proposal. Will bring to QIP leads at future date.

QPL-21-00X Non-Entity Data

- Policy still being reviewed/edited by DHCS
- High level concepts of the pending policy:
  - Q-LBP, URI, AAB & PCE will be limited to entity data for all aspects of the measure
  - Q-FUA will be limited to entity data for the denominator but will include non-entity data for the numerator
- High level concepts of other measures
  - Q-PCR: limited to entity data for both numerator and denominator. Almost certainly PY5 will expand numerator to include non-entity readmissions
  - For all other measures, unless the specs specifically limits both the numerator and denominator to entity services, the numerator services can have occurred anywhere (i.e. by a non-entity provider)

PY4 Measure Matrix Corrections

The lastest version was just posted on August 21

Column M "Must include Non-Entity Encounters or other services when calculating Denominator"

- Q-PCE, Q-FUA, Q-LBP, Q-URI, Q-AAB: Corrected to "No"
- Q-COB: Correction to "Yes (Rxs")" from "Yes for Rxs"

Column P "Must include Non-Entity Data in Numerator"

- Q-PPC-Pst, Q-PPC-Pre: Corrected to "Yes"
- Q-PCE & Q-PCR: Corrected to "No"
- Q-CMS130 (CRC), Q-CMS147 (Flu), Q-CMS2 (Depression): changed to "You should for all, even though only required for Assigned Lives"

Revised Matrix can be downloaded from SNI Link.

If you see any errors or have questions, email David dlown@caph.org

Local Mapping for NDC: PCS#00347076

"Package size" and "unit" versions are required to calculate units of medication to report the AMR measure. NCQA uses the RxNorm database to produce lists for the Medication List Directory (MLD), which does not include "package size" or "unit" as data elements.

Therefore, NCQA searches for this information in drug label and drug information sheets; if the information is not found from these sources, the code is not included. If these values are not available for a particular NDC code, or if they do not match the requirements of the measure, they are not included in the AMR measure medication lists in the HEDIS Medication List Directory.

If a patient has been given a medication that is represented by an NDC code or other (non-NDC code) documentation in their medical record, and that medication is the same (in all aspects) to a medication represented by an NDC in a value set, then the medication in the medical record can be mapped to the medication in the value set.

RxNorm → NDC Mapping

- eCQM value sets can consist solely of, or a mix of SNOMED, CPT, CPTII, RxNorm, and ICD-10 which are included in the value set data that MCPs are instructed to share with QIP entities.
- Common reality: Medi-Cal Managed Care Plans provide NDC, not RxNorm codes.
- QIP Entities need to map RxNorm → NDC codes.
- Santa Clara is willing to share with other CAPH members their code for mapping RxNorm → NDC in EPIC's Clarity. Contact Bob Sheridan bob.sheridan@hhs.sccgov.org

Program Year 5

Changes for PY5

Mainly same slide as in 7/26 QIP Leads Webinar (updates in red)

Deletions

- Comprehensive Diabetes Care: Medical Attention for Nephropathy (CDC-MN)
- Contraceptive Care - All Women Ages 15-44 (CCW-AD)

Additions

- Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Prenatal Immunization Status (PRS-E)
- Kidney Evaluation for Diabetes (KED)
  - only if HEDIS announces in October that KED is moving to Public Reporting for 2021

~~54~~52 PY5 Measures in Total

Includes 2 IHE measures

See QIP PY5 Measures Set 2021.07.22_FINAL (posted on SNI Link) for details on versions and benchmarks ~~(doesn't list the two IHE measures but those are definitely part of PY5)~~.

Name changes for DM measures in PY5

- HEDIS has separated out the Comprehensive Diabetes Care (CDC) measure into individual measures (mostly), each with its own name. DHCS has confirmed that QIP will update the measure names accordingly.
  - Q-CDC-H9 will become:
    - Q-HBD: Hemoglobin A1c Control for Patients With Diabetes (HBD)
      - The HEDIS version includes both "Control" (A1c<8) and "Poor Control (A1c>9), but QIP will still only use the Poor Control rate.
  - Q-CDC-E will become:
    - Q-EED: Eye Exam for Patients With Diabetes (EED)

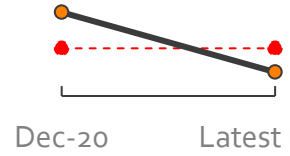
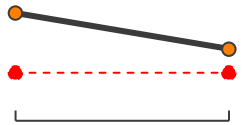
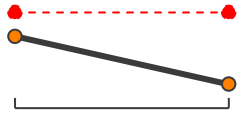
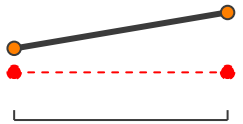
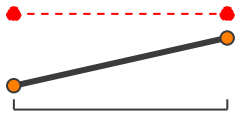
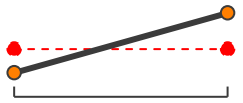
PY4 COVID Modification Proposal

PY4 Preliminary Data Analysis

- For the 50 QIP PY4 measures, there are 56 possible measure rates (due to sub-rates).
- # of All Possible Rates = 762 = 56 measure rates x (40 of 50 possible measures/DPH) x17 DPHs.
- 341 reported rates (44.7%) had either a baseline rate (12/31/2020) or at least 1 "current/2021" rate
  - 239 (31% of 762) have baseline and ≥1 2021 rate
  - 225 (30%) have baseline, 2021 rate and a benchmark
    - Graphs in slides 17 & 18: Quadrant totals sum to 225

- 10% gap closure:
  - 134 measure rates did not hit 10% gap closure targets (60% of received rates, only 17.6% of 762)
  - 91 rates hit PY4 targets(40% of received rates; only 12% of 762)
    - 63 met 10% gap closure PY4 target
    - 28 were ≥90th %ile PY4 target
- Too little data to base a proposal on without significant financial risk

Latest Data is….

		< 25th	>= 25th
< Dec 2020	Dec 2020 >= 25th	*Quadrant A*  **Total 4** Priority 2 Elective 2	*Quadrant B*  **Total 79** Priority 41 Elective 38
	Dec 2020 < 25th	*Quadrant C*  **Total 35** Priority 13 Elective 22	
>= Dec 2020	Dec 2020 >= 25th		*Quadrant D*  **Total 71** Priority 34 Elective 37
	Dec 2020 < 25th	*Quadrant E*  **Total 28** Priority 10 Elective 18	*Quadrant F*  **Total 8** Priority 5 Elective 3

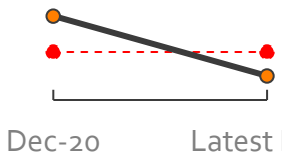
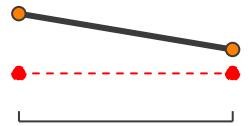
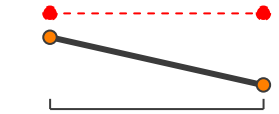
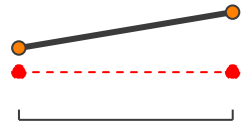
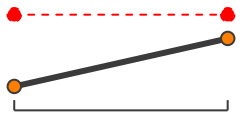
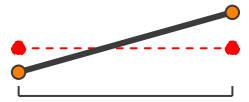
Of the 79 in Quadrant B:
28: Latest data was ≥90th %ile PY4 Target
51: Latest data was <90th %ile PY4 Target

Of the 71 in Quadrant D:
55: Met 10% gap closure PY4 Target
16: Didn't meet 19% gap closure PY4 Target

All 8: Met 10% gap closure PY4 Target

Where 5th or 10th %ile was unavailable, 25th used. PY4 benchmarks (based on MY2020) to be updated in the fall, likely to be lower than those based on MY2019.

Latest Data is….

		< 10th	>= 10th
< Dec 2020	Dec 2020 >= 10th	*Quadrant A*  **Total 5** Priority 3 Elective 2	*Quadrant B*  **Total 92** Priority 46 Elective 46
	Dec 2020 < 10th	*Quadrant C*  **Total 21** Priority 7 Elective 14	
>= Dec 2020	Dec 2020 >= 10th		*Quadrant D*  **Total 83** Priority 40 Elective 43
	Dec 2020 < 10th	*Quadrant E*  **Total 15** Priority 4 Elective 11	*Quadrant F*  **Total 9** Priority 5 Elective 4

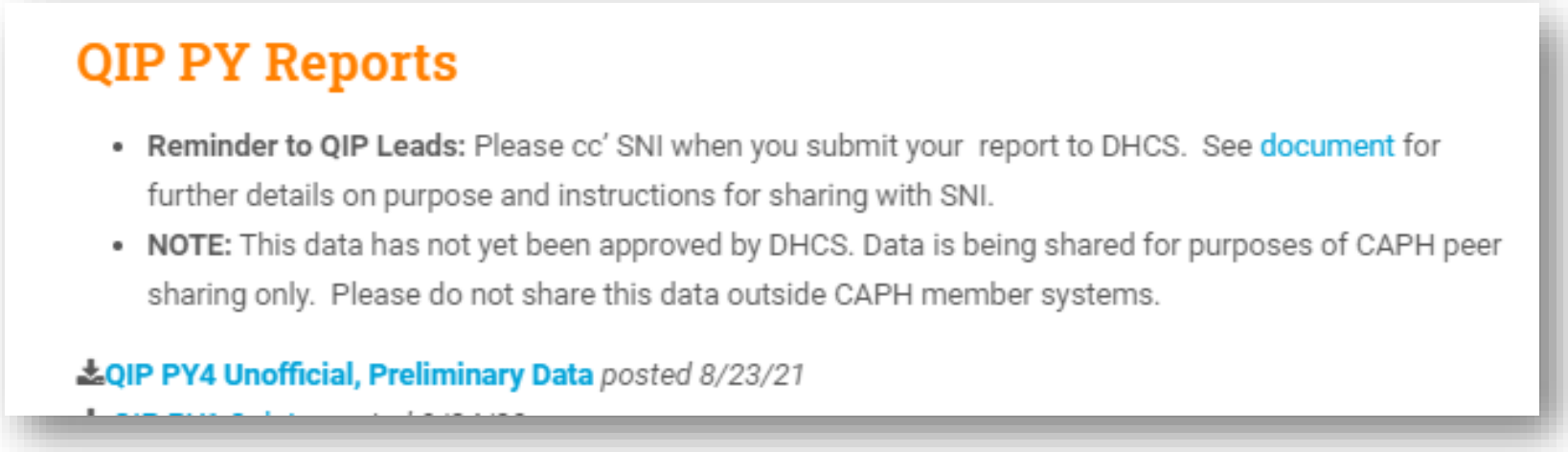
Where 5th or 10th %ile was unavailable, 25th used. PY4 benchmarks (based on MY2020) to be updated in the fall, likely to be lower than those based on MY2019.

PY4 Preliminary Data: How do you compare?

Compare your performance to others. PY4 preliminary data is posted on SNI Link:

Please note

- Data is preliminary, unofficial, and likely to change as systems validate &incorporate data.
- Some rates may still be based on PY3.5 spec.
- There may be other caveats to the data which may result rates not reflecting true performance.
- As with all performance data shared on SNI Link, please do not share outside your health system.
- If you're interested in connecting with another health system, see list of QIP Leads.



PY4 COVID Mitigation Proposal

- See slides 5-13 of 7/26 QIP Leads webinar for proposal options

For now, if you happen to easily have any updated data (not previously shared with SNI), please send to dpong@caph.org via encrypted email at any time.
At minimum, for as many measures as you have available data, send performance (per PY4 specs but with look-back anchored to below dates):

- as of Dec 31, 2020
- as of March 31, 2021, AND
- your most current performance.

Round Robin Q:

What are the **current** impacts of the pandemic on your ambulatory care services?

Resources & Events

SNI Webinar: Mixed Model Approach

Designing a Mixed Model Approach:

Finding Balance Between In-Person & Virtual Care

Leaders from Contra Costa Health Services and the San Francisco Department of Public Health shared their experiences and strategies developing, piloting, and adapting workflows and operations for a mixed model approach to balance in-person and virtual care to meet patient needs.

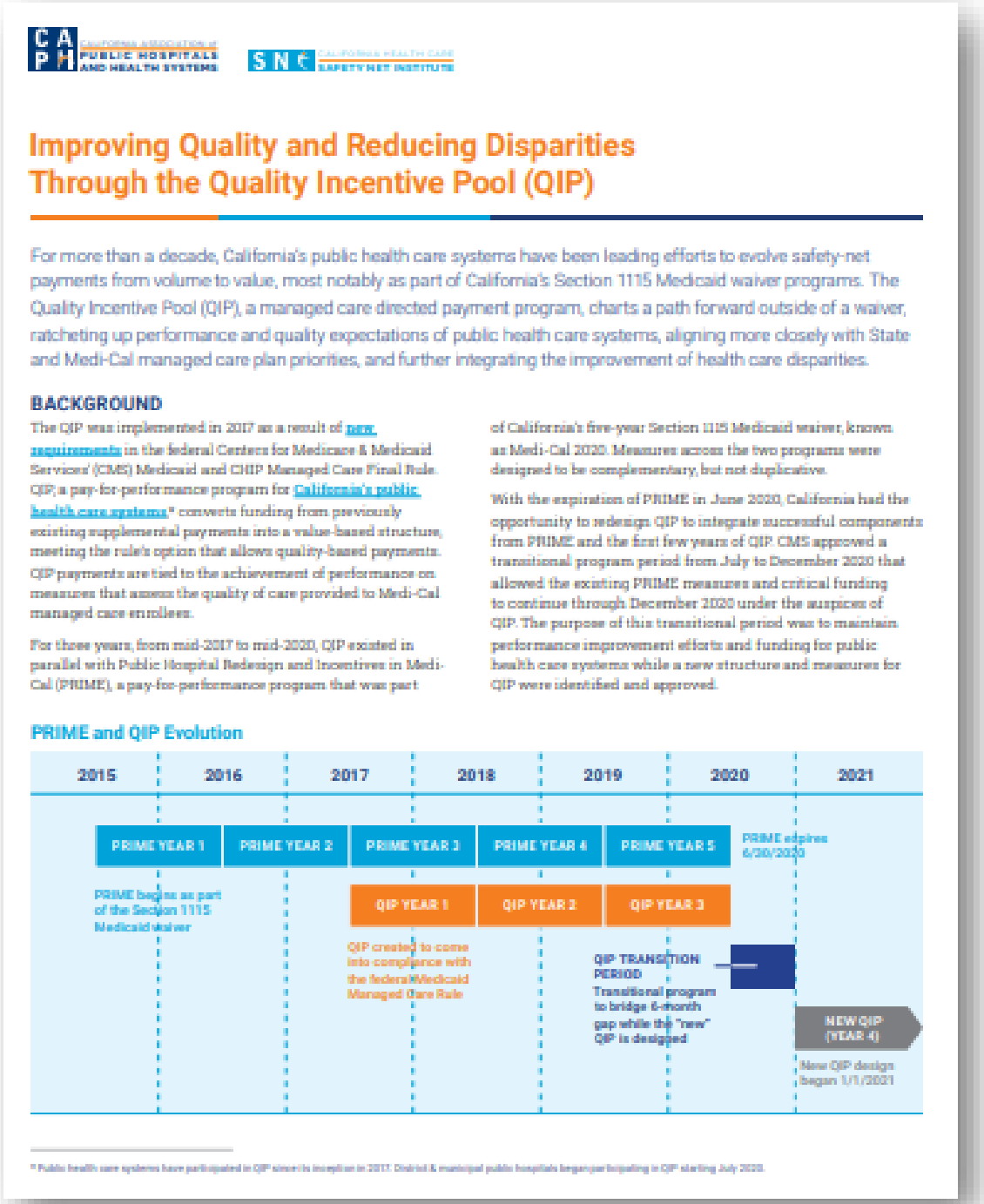
Public health care system leaders also discussed early lessons from the field, including successes, challenges, and opportunities for designing a mixed model approach during a time of constant change.

Link to slides and recording from Aug 16th are posted on SNI Link

QIP Brief

Share internally or externally to help educate about QIP and Program Year 4 changes.

Download Link is posted on the CAPH Publications webpage and on the QIP landing page



Improving Quality and Reducing Disparities Through the Quality Incentive Pool (QIP)

For more than a decade, California's public health care systems have been leading efforts to evolve safety-net payments from volume to value, most notably as part of California's Section 1115 Medicaid waiver programs. The Quality Incentive Pool (QIP), a managed care directed payment program, charts a path forward outside of a waiver, ratcheting up performance and quality expectations of public health care systems, aligning more closely with State and Medi-Cal managed care plan priorities, and further integrating the improvement of health care disparities.

BACKGROUND

The QIP was implemented in 2017 as a result of new requirements in the federal Centers for Medicare & Medicaid Services' (CMS) Medicaid and CHIP Managed Care Final Rule. QIP, a pay-for-performance program for California's public health care systems* converts funding from previously existing supplemental payments into a value-based structure, meeting the rule's option that allows quality-based payments. QIP payments are tied to the achievement of performance on measures that assess the quality of care provided to Medi-Cal managed care enrollees.

For three years, from mid-2017 to mid-2020, QIP existed in parallel with Public Hospital Redesign and Incentives in Medi-Cal (PRIME), a pay-for-performance program that was part of California's five-year Section 1115 Medicaid waiver, known as Medi-Cal 2020. Measures across the two programs were designed to be complementary, but not duplicative.

With the expiration of PRIME in June 2020, California had the opportunity to redesign QIP to integrate successful components from PRIME and the first few years of QIP. CMS approved a transitional program period from July to December 2020 that allowed the existing PRIME measures and critical funding to continue through December 2020 under the auspices of QIP. The purpose of this transitional period was to maintain performance improvement efforts and funding for public health care systems while a new structure and measures for QIP were identified and approved.

PRIME and QIP Evolution

* Public health care systems have participated in QIP since its inception in 2017. District & municipal public hospitals began participating in QIP starting July 2020.


CAPH
SNC
MEETING
THE
MOMENT
ANNUAL CONFERENCE 2021
Save the Date!
December 1-3, 2021

Quality Leaders Awards (QLAs)

Applications are open for the 2021 QLAs!

This year, the QLAs feature new award categories that recognize an outstanding effort to…

- Promote ***health equity*** and reduce disparities
- Improve ***population health*** by using data-driven approaches to identify and address multiple drivers of health outcomes
- Implement ***care redesign*** processes in a way that increases efficiencies, advances clinical quality, and enhances the patient experience
- Demonstrate ***innovation*** in technology, models of care, and/or system transformation that improves health outcomes and care delivery

This year's QLAs will be celebrated during our Annual Conference, which will take place on December 1-3. Applications can be found at www.safetynetinstitute.com/

Applications are due Friday, August 27, to Zoe So (zso@caph.org).

IHI Scholarship Opportunities

Through Kaiser Permanente Community Benefit's Institute for Healthcare Improvement (IHI) Endowment, SNI offers a limited number of scholarships to members to cover the cost of registration fees for select IHI programs.

Sep 7 **Redesigning Event Review w/ Root Cause Analyses & Actions**
Sep 14 **Finding and Creating Joy in Work**
Sep 28 **Moving Quality Improvement from Theory to Action**
Dec 5-8 **IHI Forum 2021**

On the first page of the application, select SNI (Manager: Abby Gonzalez)

Infant Well-Child Visit Learning Collaborative

Webinar Series by CMS Medicaid:

- Aug 26 12pm Using Payment, Policy & Partnerships to Improve Infant Well-Child Care
- Sep 10th 11:30pm Improving Quality and Utilization of Infant Well-Child Visits
- Sep 22nd 10am Models of Care that Drive Improvement in Infant Well-Child Visits

Target Audience:

- All interested state Medicaid and CHIP programs, managed care plans, providers, state health departments, and other public health entities

Register here.

Additional details here: Infant Well-Child Visit Learning Collaborative.

CAPH Demographic Data

THANK YOU
for helping to get the data in April!

Facts about California's Public Health Care Systems

California's 21 public health care systems provide a range of comprehensive services including primary care, outpatient specialty care, emergency and inpatient services, rehabilitative services, and in some instances, long-term care.

Public health care systems care for a diverse patient population:

- Nearly 60% of patients identify as persons of color
- 37% of patients identify as Hispanic or Latino
- One in five patients report a primary language other than English

Though accounting for just 6% of hospitals in the state, these public health care systems:

- Serve more than 3.7 million patients annually, a 30% increase since 2014
- Operate in 15 counties where more than 80% of the State's population lives
- Provide nearly 40% of all hospital care to the remaining uninsured in California
- Provide over 35% of all hospital care to Medicaid (Medi-Cal) beneficiaries in the communities they serve
- Operate over half of all California's top-level trauma and burn centers
- Provide over 10 million outpatient visits each year
- Operate more than 200 outpatient clinic facilities
- Train half of all new doctors in hospitals across the state
- Employ more than 85,000 individuals

https://caph.org/memberdirectory/facts/

Questions?