CALIFORNIA HEALTH CARE
SAFETY NET INSTITUTE

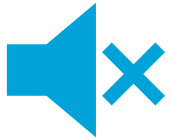
QIP Leads Monthly Forum

Monday, June 13, 12-1PM

Recording Link

Presenter: David Lown dlown@caph.org
Recordings of the webinar and slide deck posted on SNI Link/QIP/Webinars

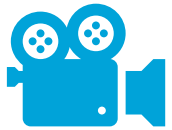
Housekeeping



Please mute locally. Lines are also muted on entry. Please don't use a speakerphone in order to prevent an audio feedback loop or an echo.

At any time, feel free to chat your question or raise your hand.

Please update your Zoom accounts – helps to fix issues/glitches.



The webinar will be recorded and saved on SNI Link: QIP Webinars

Program Updates

Updated QPL 22-002 – June 6, 2022

Section 1. d) PY 4 Measure Reporting Requirements:

As noted in sections a-b, QIP entities will still be required to report a minimum number of measures (40 measures for DPHs, variable for DMPHs depending on their specific number of committed measures). Per the approved PY 4-6 preprints, 50% of reported measures must be priority measures. Before substituting a priority measure for an elective measure as described below, entities must attempt to exhaust the priority measure list options.

For any required priority measure that they~~y~~ QIP entity~~are reporting~~ selects to reports~~for~~ on a **pay-for-performance** basis**, if** the entity is unable to report ~~on a required priority measure~~ due to not providing the relevant clinical services, a denominator less than 30, or not receiving sufficient assigned lives data from Medi-Cal Managed Care plans that result in a denominator less than 30, the entity~~y~~ may substitute an alternative measure from the PY 4 QIP Measure List. ~~Entities should attempt to exhaust the priority measure list options before substituting a measure from the elective list.~~

For measures for **reporting** only, denominators ≥ 30 are not required. However, entities should not report measures for which they do not provide the relevant clinical services. Entities should also be aware that measures that are planned to be reported in PY 5 must have statistically significant data from PY 4 (ie. d ≥ 30).

Updated QPL 22-002 – track change vs clean version of middle paragraph

For any required priority measure that they QIP entityare reporting selects to reportsfor on a **pay-for-performance** basis, if the entity is unable to report on a required priority measure due to not providing the relevant clinical services, a denominator less than 30, or not receiving sufficient assigned lives data from Medi-Cal Managed Care plans that result in a denominator less than 30, the entityy may substitute an alternative measure from the PY 4 QIP Measure List. Entities should attempt to exhaust the priority measure list options before substituting a measure from the elective list.

For any required priority measure that the QIP entity selects to report on a **pay-for-performance** basis, if the entity is unable to report due to not providing the relevant clinical services, a denominator less than 30, or not receiving sufficient assigned lives data from Medi-Cal Managed Care plans that result in a denominator less than 30, the entity may substitute an alternative measure from the PY 4 QIP Measure List.

Updated QPL 22-002: Q-PCR Table (p 6)

Removed duplicative element: “Observed Count stratified by MCP”

Data Element (no age strata, all elements reported on total population)	Location in Reporting App
Observed Count	Observed Count data Field
~~Observed Count stratified by 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 Count stratified by Contracted MCP	Narrative
Observed Rate	Narrative
Expected Rate	Narrative
Count Variance	Narrative
Observed Count/Expected Count Ratio	Calculated by Reporting App

← June 2 version

Remaining: “Observed Count stratified by Contracted MCP”

Data Element (no age strata, all elements reported on total population)	Location in Reporting App
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

← June 7 version

Q-PCR: Number of Individuals in QIP Entity Population (PCS 00393753)

Data Element (no age strata, all elements reported on total population)	Location in Reporting App
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

Inquiry: Is it correct that the "Number of Individuals in the Entity Population" is the total number of people in the Eligible Population? That term is not specifically linked to the Eligible Population nor well defined in both the PY4 (pg 321) and PY5 (pg 373) manuals.

Response: Per the Definitions section in the measure specification, for the Q-PCR measure in both PY4 and PY5 reporting, the Entity Population includes individuals in the eligible population prior to exclusion of outliers. The "Entity Population" is not the same as the eligible population. The Entity Population calculation is meant to be a distinct calculation. The Entity Population is ONLY used as a denominator for the "Outlier Rate" to determine how many individuals out of the entity's population met the criteria to be excluded as outliers.

Page 315 of PY4 Manual, Definitions:

Entity population Individuals in the eligible population prior to exclusion of outliers (denominator steps 1–5). The entity population is only used as a denominator for the Outlier Rate.

"Assigned Lives" = Assigned Primary Care Lives

(pg 10 PY4 Manual)

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.

Q-IHE1 and stratified reporting of R/E

QUESTION:
In submitting totals for our IHE1 A1c Latinx & African American/Black stratifications, we wanted to know if you would like us to fill out the full matrix with all of the race/ethnicity line items for the DM A1c metric or if you only want us to enter numbers for 1) Black or African American and 2) Hispanic or Latino?

ANSWER:

On page 336 of the PY4 Manual (under the IHE Specs) it says:
If reporting Q-IHE1, entities will be required to report sub-rates for all Q-CDC-H9 race/ethnicity groups (as specified by DHCS). The accountable sub-rates will be as outlined above. The other sub-rates will be for informational purposes only.

Of note: This only applies to PY4 IHE1. For PY4 IHE2 and future PY reporting of both IHE1 and IHE2, entities only have to report performance for the measure's Priority Population.

PY4 – send submitted reports to SNI

Just a reminder that once you have submitted your report, remember to download both the report and the spreadsheet of your submitted data and send both **via encrypted email** to Arlene (amarmolejo@caph.org)

PCS: mapping to SNOMED Codes (applies to PY5)

Measure: CMS2v10 Screening for Depression and Follow-up Plan

PCS Inquiry #00386094 Posted on 6/9/22 (edited):
Can CPT codes (used to represent positive depression screen) 96156, 96158 or 90834 (not in the measure's value sets) be mapped to any of the SNOMED codes in the measure's value sets?

Response:

- **SNOMED codes <u>are</u> standard codes**. Any code included in a measure's value set is considered "standard". Non-standard codes include proprietary or state-specific codes.
- Per GG Section VIII.E Local Mapping, **QIP entities may not map standard codes (e.g., CPT, SNOMED) not used in a given measure to standard codes used in the QIP Manual measures**
- In this example, the **entity should map just the medical record documentation that matches the clinical specificity of the SNOMED codes in the measure's value sets**. QIP entities must have some form of auditable documentation of the mapping process in place.

Key Takeaways:

- Any code included in a measure's value set is considered "standard", including SNOMED.
- Medical record documentation can be mapped to any standard code in a measure's value set, as long as the documentation matches the clinical specificity of the standard code in the value set.

PY5

- FYI: PRS-E Logic Error found by HEDIS (not QIP specific)
  - Updated digital package released Friday 5/13/22). QIP entities who had downloaded the package prior to 5/13 were notified

Resources

In Case You Missed it…

eVisit Transformation: Billable Medical Advice through EHR Messaging.

May 26, 11am-12pm

In response to an unprecedented surge in EHR messages, UCSF Health implemented a new model of billable Medical Advice Messages (or "eVisits"), which are reimbursable by Medi-Cal for non-FQHC providers. In doing so, UCSF Health is combating provider burnout by acknowledging the unpaid, after-hours time spent responding to messages. In this webinar, an expert from UCSF Health will share how they implemented Medical Advice Messages in Epic, updated their provider workflows, educated patients and staff on the change, and monitored for disparities.

View our Webinar Slides & Recording. Webinar Recap Pending

Other Related Materials posted on SNI Link:

- Provider Education Tip Sheet: MyChart Medical Advice e-Visit FAQs & Common Scenarios (UCSD Health)
- Provider Education Tip Sheet: MyChart Medical Advice e-Visit Billing Tip Sheet (UCSD Health)
- MyChart Medical Advice e-Visit Billing Tip Sheet (UCSD Health)

In Case You Missed it…

Reframing the Pandemic Response: UCSD Health's Framework for Endemic COVID-19 Operating Procedures

April 13, 1-2pm

Motivated by the need to transition from a "perpetual state of emergency" to a proactive approach that recognizes COVID-19 as one of many endemic viruses, UCSD Health recently developed "new normal" COVID-19 guidelines that inform patient and staff testing, PPE, telehealth, surge planning, return to office, and other health system operations. In this webinar, UCSD Health leaders will describe how they defined and operationalized three tiers of COVID-19 prevalence based on data-informed wastewater thresholds. Strategic, operational, clinical, and informatics leads are encouraged to attend. View our Webinar Recap and Webinar Slides & Recording.

Integrating Navigation and Virtual Care: How to Improve Patient Access and Sustain Virtual Care Teams

April 14, 12-1pm

The Center for Innovation in Access and Quality at the Zuckerberg San Francisco General Hospital will share their experiences and strategies for developing their Tech Navigator Program using a volunteer-based model to ensure smooth daily operations and implementation of virtual care services, including onboarding new clinical services, developing resources and tools to screen patients for Zoom video visits, and providing staff trainings across the San Francisco Health Network. Public health care system leaders will discuss early lessons from the field, including successes, challenges, and opportunities for designing various Tech Navigator approaches to advance equity and improve patient access and adoption of virtual care. View Webinar Slides & Recording Link.

Questions?