

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

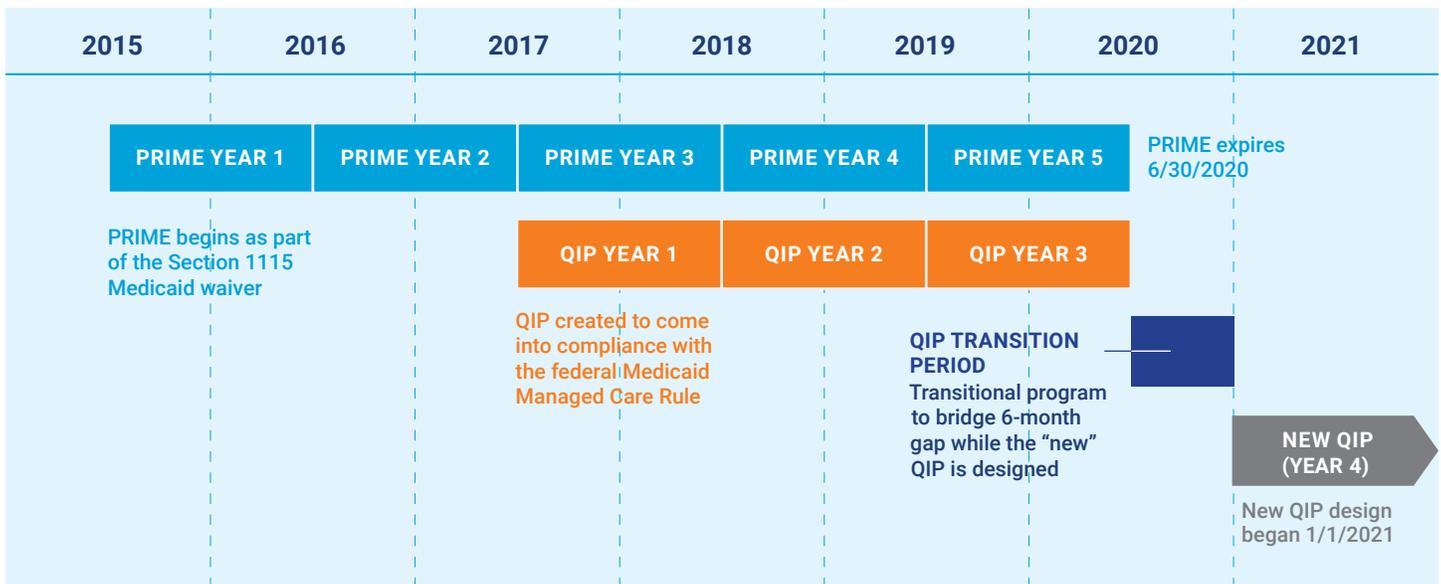
The QIP was implemented in 2017 as a result of [new requirements](#) in the federal Centers for Medicare & Medicaid Services’ (CMS) Medicaid and CHIP Managed Care Final Rule. QIP, a pay-for-performance program for [California’s public health care systems](#),* converts funding from previously existing 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.

PROGRAM OVERVIEW

The new QIP, which began January 1, 2021, continues to challenge public health care systems to improve quality via ambitious pay-for-performance targets in multiple domains of care. QIP payments are tied to the achievement of performance on a set of quality measures. By design, the measures in the new QIP closely align with the priorities of California's Department of Health Care Services (DHCS) and Medi-Cal managed care plans, including the State's [Managed Care Accountability Set \(MCAS\)](#).

If all public health care systems achieve their QIP performance targets, they would collectively receive approximately \$1.2 billion in federal funding annually, making QIP a very significant incentive for these systems to improve care.

MEASURES

Public health care systems are required to report each year on a total of 40 measures (see page 3 for a full list of measures). These measures are selected from:

- A **priority set of 20 measures** on which all public health care systems are required to report
- An **elective set of 31 measures** from which systems are required to choose at least 20

The program focuses on measures for conditions that represent leading causes of death in California, which align with the State's quality strategy and priorities, and that span the continuum of care provided by public hospitals and health care systems. Of the 51 measures in QIP, 24 (47%) are Healthcare Effectiveness Data and Information Set (HEDIS) measures, including all MCAS measures with a minimum performance level (to which Medi-Cal managed care plans are held accountable). Measures must also have known benchmarks applicable to the Medicaid population and meet at least one of the three following criteria: a National Quality Forum (NQF) endorsed measure, a national Medicaid performance measure, or have been used in a CMS pay-for-performance program.

The QIP is holistic and comprehensive with measures covering multiple domains of care:

- [Primary Care Access and Preventive Care](#)
- [Behavioral Health Care](#)
- [Care of Acute and Chronic Conditions](#)
- [Care Coordination](#)
- [Experience of Care](#)
- [Improving Health Equity \(see below\)](#)
- [Maternal and Perinatal Health](#)
- [Patient Safety](#)
- [Overuse/Appropriateness of Care](#)

PERFORMANCE TARGETS

As in PRIME and the first several years of QIP, performance targets are set based on a 10% gap closure methodology. For a given measure, the "gap" is the difference between the system's previous year performance and the 90th national percentile value for that measure. Systems with performance above the minimum performance threshold must "close the gap" by at least 10% each year in order to receive full funding. Systems that are already at or above the 90th percentile on a measure must maintain that level of performance in order to receive funding for that measure. Systems with performance below the minimum performance threshold at the end of the program year receive no funding for the given measure.

Improving Health Equity

QIP builds on [PRIME](#), which laid the foundation for data-driven health disparity reduction efforts. PRIME expanded the collection and use of detailed Race, Ethnicity and Language (REAL), and Sexual Orientation/Gender Identity (SOGI) data – known collectively as "REAL SO/GI" data. In QIP, public health care systems are required to reduce health disparities via one Improving Health Equity measure, which, in 2021, is focused on improving diabetes control in the Hispanic or Latinx and Black/African American populations. Systems may also choose a second Improving Health Equity measure from a sub-set of eligible QIP measures. Lastly, systems will be required to report stratified race and ethnicity data for five priority measures, which will lay the groundwork for and inform future expansion of health disparity reduction efforts in QIP.

CONCLUSION

Public health care systems are leading the way in developing and meeting the ambitious targets in pay-for-performance programs that shift payments from volume to value. The next few years will continue to challenge public health care systems to transform care and provide valuable lessons in the design of pay-for-performance programs, including the integration of health equity targets.

Priority Measures

1. Asthma Medication Ratio
2. Breast Cancer Screening*
3. Cervical Cancer Screening
4. Child and Adolescent Well-Care Visits
5. Childhood Immunization Status
6. Chlamydia Screening in Women
7. Colorectal Cancer Screening*
8. Comprehensive Diabetes Care: Eye Exam
9. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
10. Controlling High Blood Pressure*
11. Developmental Screening in the First Three Years of Life
12. HIV Viral Load Suppression
13. Immunizations for Adolescents
14. Improving Equity #1
15. Influenza Immunization*
16. Timeliness of Postpartum Care
17. Timeliness of Prenatal Care
18. Tobacco Assessment and Counseling
19. Screening for Depression and Follow-Up Plan*
20. Well-Child Visits in the First 30 Months of Life

*Systems required to report race and ethnicity data

Elective Measures

1. Advance Care Plan
2. Appropriate Treatment for Upper Respiratory Infection
3. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
4. BIRADS to Biopsy (% of mammograms that are suspicious for or highly suggestive of malignancy that result in a biopsy within two weeks)
5. Cesarean Birth
6. Comprehensive Diabetes Care: Medical Attention for Nephropathy
7. Concurrent Use of Opioids and Benzodiazepines
8. Contraceptive Care – All Women
9. Coronary Artery Disease: ACE Inhibitor or ARB Therapy for Diabetes or Left Ventricular Systolic Dysfunction
10. Coronary Artery Disease: Antiplatelet Therapy
11. Depression Remission or Response for Adolescents and Adults
12. Discharged on Antithrombotic Therapy
13. ED Utilization of CT for Minor Blunt Head Trauma for Patients Aged ≥18 years old
14. Exclusive Breast Milk Feeding
15. Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence
16. Heart Failure: ACE Inhibitor or ARB or ARNI Therapy for Left Ventricular Systolic Dysfunction
17. HIV Screening
18. Improving Equity #2
19. Lead Screening in Children
20. Transitions of Care: Medication Reconciliation Post-Discharge
21. Perioperative Care: Venous Thromboembolism Prophylaxis
22. Pharmacotherapy Management of COPD Exacerbation
23. Plan All-Cause Readmissions
24. Prevention of Central Venous Catheter Related Bloodstream Infections
25. BMI Screening and Follow-Up Plan
26. Reduction in Hospital Acquired C Difficile Infections
27. Statin Therapy for The Prevention and Treatment of Cardiovascular Disease
28. Surgical Site Infection
29. Use of Imaging Studies for Low Back Pain
30. Use of Opioids at High Dosage in Persons Without Cancer
31. Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents