Quality Care Incentive Program (QCIP)
Frequently Asked Questions

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Financial

How often does program reporting occur?

The Quality Care Incentive Program portal reporting module is updated monthly reflecting the previous 12 months of care rendered. Financial reporting will be updated quarterly as payments are calculated and generated.

How are Quality Care Incentive Program measures calculated?

Quality Care Incentive Program measures are calculated using current NCQA HEDIS® Volume 2 Technical Specifications which reflect the most recent clinical recommendations and preventive health guidelines that apply to the measurement periods.

How are quality of care scores calculated?

Quality scores are based on performance for all measures combined. These are calculated by dividing the total number of a PCP's assigned members who received an aspect(s) of care, by the total number of assigned members who were due for an aspect(s) of care. Members are only included if they were covered by CenCal Health for sufficient time to receive recommended services.

How does a PCP earn the full withhold?

To earn the full PCP withhold, a PCP site needs to attain a 3-star level of performance. The QCIP algorithm is based on availability of the PCP withhold (40% for most) plus the CenCal Health contribution (approximately 50% of total capitation). So, earning only the PCP withhold without the CenCal Contribution is not directly tied to the number of stars earned. However, if a 3-star performance is achieved by any PCP site, those PCP sites will always earn 135% of their capitation withhold. A 2-star performance, on the other hand, will always earn 90% of their capitation withhold.

What is the frequency of Quality Care Incentive Program payments?

The Quality Care Incentive Program (QCIP) performance periods measured end each June, September, December, and March with incentive payments distributed quarterly in July, October, January, and April. Because four QCIP payments are made each 12 months, PCPs can earn the full annual withhold plus the CenCal Health contribution, within the rolling 12-month funding period.

Does the Quality Care Incentive Program promote withholding of services for members?

The Quality Care Incentive Program only includes quality measures that promote increased utilization of medically needed services.

What are all the data sources used to calculate Quality Care Incentive Program scores?

CenCal Health uses all claims, lab, and registry data available at the time of reporting is to calculate Quality Care
Incentive Program scores.

Why the gaps between the Quintiles?

The gaps between quintiles represent the difference in rate of performance achieved by the top performing PCP in the lower quintile and the lowest performing PCP in the next higher quintile. The quintiles are comprised of groups of PCPs, with each quintile including 20% of all participating PCPs. As such, the lowest performing PCP in one quintile will have a rate that is

higher than the top performing PCP in the next lower quintile. PCPs that achieve a equal rate of performance get grouped in the higher quintile.

Is the July payment based on just the Q2 numbers? Or rather, is it based on a 12-month rolling average?

The period of performance that is measured for QCIP performance calculation is a rolling period. The upcoming payment later this month is based on the period that ended June 30, 2022. The rolling period for most measures is 12 months, but it does differ for some measures to align with established preventive screening or clinical treatment guidelines. An exception, for example, is Breast Cancer Screening that has a performance period of 24 months to align with the USPSTF recommended screening periodicity.

How is the Total Funding* of the program calculated?

The funding is calculated for each PCP as a percentage of the total capitation that CenCal Health allocates for members assigned to the PCP. For most PCPs a percentage of 20% is withheld for QCIP funding purposes. PCPs may alternatively choose to allocate 40%. CenCal Health contributes an additional amount from its plan reserves that is not sourced from a capitation withhold. The total payment, per member per month, to all PCPs networkwide is roughly equal to that paid in prior years. Because the at-risk finding for the program is based on capitation, the total funding available is proportional to a PCP's total membership. The amounts at risk also reflect a PCPs mix of members, since capitation differs depending on member aid category, sex, age, and the corresponding capitation paid.

Claims

Medi-Cal claims must be received by CenCal Health within six months following the month in which services were rendered or the following payment reductions may apply. **Claims received during the 7th, 8th or 9th month** after the month of service will have final payment **reduced by 25%. Claims received during the 10th, 11th or 12th month** after the month of service will have final payment **reduced by 50%. Claims received after the 12th month following the month of service will be denied.**

There are exceptions to these billing limits. These can be found in the State of California's Medi-Cal Billing Manual and at the following links:
CMS-1500 Claim Timeliness Instructions
UB-04 Timeliness Instructions

Performance Measures

How often are quality measures updated?

Generally, quality measures remain in place for at least 2 years to reinforce improvement priorities, support program stability for PCPs, and increase the ability to achieve clinical excellence.

Why aren't some services or quality measures included in the Quality Care Incentive Program?

CenCal Health includes quality measures in the Quality Care Incentive Program that meet certain criteria such as needed clinical improvement, alignment with state-wide quality priorities, and the ability to measure quality of care accurately with available data. Quality of care measures that are not included in the Quality Care Incentive Program are measured through other processes. For example, annual MCAS auditing and Facility Site Reviews.

Members in QCIP

Which members are included in the Quality Care Incentive Program?

All CenCal Health Medi-Cal members are included in the Quality Care Incentive Program except those with Medicare as their primary insurance. Members also covered by Medicare are excluded because CenCal Health does not have access to complete claims data as evidence of their care.

Who receives credit for referrals?

PCPs are only included in the Quality Care Incentive Program and their quality-of-care score includes referrals to specialized providers.

What information will be necessary to remove a patient who has moved out of the county, is out of the country, has deceased, has insurance, the phone number is out of service, or has chosen a different provider?

If the provider has a list of members that are deceased, who have moved out of the area or chose a different provider, the list can be emailed to: emrodriguez@cencalhealth.org with the corresponding details (for example the date of death, new out of county address, etc.). This information is needed to report to the Department of Social Services, and they can confirm. CenCal Health cannot remove members from any provider list unless the member agrees to it.

How to receive credit for patients transitioning between payers and services were previously provided under the other payer?

CenCal Health's Quality Measurement team can assist in providing PCPs with an EMR extract for previously rendered services. Please email your request to: QCIP@cencalhealth.org

Pediatric Measure

How do you determine how many well-child visits are required for QCIP?

The amount of Well-Child visits are in alignment with the AAP periodicity schedule as required by DHCS contract. To improve well child visits, a report is made available on the provider portal that identified babies that are falling behind schedule.

How to receive credit for a sports physical?

If the visit is for a sport physical, to get credit for QCIP reimbursement of a well care exam, when billing for the sport physical use >> **CPT 99212**, with a diagnosis code of **Z02.5** = Encounter for examination for participation in sport. Now if the provider wants to schedule a comprehensive well care exam that isn't specific to a sport physical a different CPT code appropriate to that encounter would have to be used.

I see patients 18 years of age and older. Will I be affected by measures pertaining to adolescent immunizations?

For Immunizations for Adolescents, QCIP will only identify adolescents who turn 13 years of age during the measurement period. If your youngest patients are at least 18 years old, QCIP will not be assessing if they had the immunizations applicable to that measure.

Are there exclusions to the well-child measure?

Members in hospice are excluded from the eligible population.

Behavioral Health Measure

PHQ9 Codes

Medi-Cal reimburses screening adults and children ages 12 and older for depression as an outpatient service only. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment options including referral to mental health specialists, and appropriate follow-up. Modifier U1 is required for dyadic caregiver depression screening.

These should be the codes to bill when using that tool: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval.pdf (starting at page 44)

- G8431: Screening for depression is documented as positive and a follow-up plan is documented
- G8510: Screening for depression is documented as negatives, a follow-up plan is not required