

Quality Care Incentive Program (QCIP)

Frequently Asked Questions

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Financial Performance- General

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 in January, April, July, and October. Projected payment reporting is available for non-payment months and can be accessed in the Provider Portal.

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 assigned members (as of the end of the reporting period) 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 Primary Care Provider (PCP) earn the full withhold?

To earn the full PCP withhold, a PCP site needs to attain at least a 3-star level of performance. The program's algorithm is based on availability of the PCP withhold plus the CenCal Health contribution (approximately 50% of total capitation). To maximize reimbursement, PCPs that attain 5 stars can earn 100% of the total pool.

PCPs earn incentives according to the number of stars earned:

- Quintile 5 = 5 stars = 100% of total pool
- Quintile 4 = 4 stars = 80% of total pool
- Quintile 3 = 3 stars = 60% of total pool
- Quintile 2 = 2 stars = 40% of total pool
- Quintile 1 = 1 star = 20% of total pool

What is the frequency of Quality Care Incentive Program payments?

The frequency of incentive payments is quarterly. The performance periods tied to each quarterly incentive payment end June 30th, September 30th, December 31st, and March 31st. Incentive payments are distributed at the end of January, April, July, and October. Because four QCIP payments are made each 12 months, PCPs have the opportunity to earn the full annual withhold plus the CenCal Health contribution within the rolling 12-month funding period. QCIP incentive payments reflect a rolling performance window and not just care delivered in the immediate quarter.

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 in alignment with established, evidence-based standards of care.

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

CenCal Health uses all claims, laboratory, pharmacy, and immunization registry data available at the time of reporting to calculate Quality Care Incentive Program **clinical** quality measure scores. Additionally, CenCal Health incorporates monthly supplemental data provided by the Department of Health Care Services (DHCS). CenCal Health uses member survey results to calculate Quality Care Incentive Program **operational** quality measure scores.

Why are there gaps between Quintiles?

Each quintile includes 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. 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. PCPs that achieve an equal rate of performance are grouped in the higher quintile.

Why does the percentage between quintiles vary from month to month? For example, in July, the minimum 2-star performance target rate was 50%, while in August it shifted to 51%.

Because the quintiles are based on performance relative to other participating PCPs, the cutoff points (thresholds) for each star ranking can change based on the performance of participating PCPs. Each quintile (Star Rank) represents 20% of participating PCPs.

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 performance calculation is a rolling period and not just care delivered in the immediate quarter (e.g. April-June). The rolling period for most measures is 12 months, though it does differ for some measures to align with established preventive screening or clinical treatment guidelines. See illustration below for a few examples.

Quality Measure	Lookback period for Evidence Service Rendered
Child and Adolescent Well-Care Visits	12 months
Cervical Cancer Screening	Depending on the test and the member's age, the lookback period varies from 3 years or 5 years
Chlamydia Screening in Women	12 months
Diabetes Care – Retinal Eye Exams	12 months
Immunizations for Adolescents – HPV Testing	Between the member's 9 th and 13 th birthday for adolescents who turned 13 years of age

How is the total funding of the program calculated?

Total funding includes all lines of business (Medi-Cal and Medicare) and is calculated monthly. The Quintile group is based on performance sorted in descending order for all eligible* providers for the quarter and divided into 5 even groups with 5 stars being the highest rating. Percentage is to the hundredth percent.

- Quintile 5 = 5 stars = 100% of total pool
- Quintile 4 = 4 stars = 80% of total pool
- Quintile 3 = 3 stars = 60% of total pool
- Quintile 2 = 2 stars = 40% of total pool
- Quintile 1 = 1 star = 20% of total pool

*eligible Medi-Cal providers include those who are capitated and have a denominator greater or equal to 30.

*eligible D-SNP PCP have a denominator greater or equal to 30.

How is “at-risk” funding determined?

For **Medi-Cal Members**: QCIP “at-risk” funding corresponding to Member’s with CenCal Health Medi-Cal eligibility is calculated as a percentage of Total Capitation paid to Provider for the twelve (12) months preceding each QCIP Payment Month.

For **D-SNP Members**: QCIP “at-risk” funding corresponding to Member’s with CenCal Health D-SNP eligibility is calculated as a percentage of CenCal Health’s monthly premium received for each Member assigned to the Provider.

My practice is closing one of its locations. What impact will this have on QCIP payment?

Our system identifies capitated PCPs as of the month preceding each incentive payment run. To be payment eligible, a practice must have 30 members in the eligible population at the time of payment run.

If you anticipate changes to your practice (e.g. location closure, ownership change, NPI change, etc.) please email qcip@cencalhealth.org and contact your Provider Relations Representative.

What is the timing of claims submission for inclusion in a payment month?

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 Department of Health Care Services Medi-Cal Billing Manual and at the following links:

- [Workbook_CMS-1500 Claim Form \(cms1500_bb\) \(ca.gov\)](#)
- [UB-04 Submission and Timeliness Instructions \(ub sub\) \(ca.gov\)](#)

Performance Measures- General

How are Quality Care Incentive Program measure criteria calculated?

Quality Care Incentive Program clinical measure criteria is 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. Operational measure criteria are calculated using CAHPS (Consumer Assessment of Healthcare Providers and Systems)-based member experience survey methodology.

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. Measures may change periodically to align with DHCS, NCQA, and/or CMS standards. All measures included in the program encourage increased utilization of treatment, screening and preventive health services which will improve the health status of CenCal Health members.

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 Review**.

Who do we contact or how do we let CenCal know if a patient declined services after multiple attempts?

Please document in the patient's chart that the member has refused or declined services. For pediatric blood lead testing, a refusal form is available [here](#). Since the program uses industry standard quality measurement methodology to determine whether a member received a clinically recommended service or not, members who have declined services cannot be removed from the measure criteria.

Members in QCIP

Which members are included in the Quality Care Incentive Program?

All CenCal Health members are included in the Quality Care Incentive Program. Different aspects of care are reviewed to determine if a member meets the criteria for being in the eligible population for any measure included in the incentive program.

How do you determine the number of members in the measure?

CenCal Health utilizes industry standard quality measurement methodology to aid in determining the eligible population size, which varies. Different aspects of care are reviewed to determine if a

member meets the criteria for being in the eligible population. These aspects of care range from continuous enrollment in the plan, age, diagnosis, sex, etcetera.

What information will be necessary to remove a patient?

To remove members who have moved out of the area and/or have chosen a different PCP:

The PCP should email Member Services at memberservices@cencalhealth.org. The CenCal Health Members Services Team can update this information or determine how the Department of Social Services (DSS) should be notified.

To remove members who have other health coverages:

CenCal Health utilizes enrollment provided by the Department of Health Care Services. The PCP should email Member Services at memberservices@cencalhealth.org.

To remove members who are deceased and this information has not been updated with DSS yet:

In the circumstances that a member was identified as deceased during the period of performance, the PCP should send CenCal Health evidence of the member being deceased to the following secured drop folder: <https://gateway.cencalhealth.org/form/hedis>. Evidence includes medical record screenshots from the PCP's EMR system that includes the member's date of death. Please email the CenCal Health Quality Measurement Team at QMGRP@cencalhealth.org to notify CenCal Health that this information has been provided. Please do not include protected health information in this email notification unless sent in an encrypted format.

To remove members who are transgender and this information has not been updated with DSS yet:

The PCP should send CenCal Health evidence of the member being transgender to the secured drop: <https://gateway.cencalhealth.org/form/hedis>. Evidence includes medical record screenshots from the PCP's EMR system that captures the member's gender at birth. Please email the CenCal Health Quality Measurement Team at QMGRP@cencalhealth.org to notify CenCal Health that the PCP sent this information. Please do not include protected health information in this email notification unless sent in an encrypted format.

For additional questions about removing patients, please contact your Provider Relations Representative.

How do I receive credit for patients transitioning between payers if 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

Clinical Measures

Staying Healthy - Pediatric Measures

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

The quality measures included within the program align with industry standard methodology. CenCal Health promotes adherence to the [American Academy of Pediatrics Periodicity Schedule](#). To increase the rate of well-child visits in the first thirty months of life, an Opportunity Report is available on the provider portal that identifies infants that are falling behind schedule based on claims received to date.

How do I receive credit for a sports physical?

If the visit is for a sport physical, to get credit for the program, bill the sports physical using the following >> **CPT 99212**, with a diagnosis code of Z02.5 = Encounter for examination for participation in sport. Billing requirements differ for comprehensive well-care exams that are not specific to a sports physical. Billing and benefit information for all PCPs can be accessed on the DHCS Medi-Cal Home Page here: [Publications](#) | [Medi-Cal Providers](#).

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

If your youngest patients are at least 18 years old, the program will not be assessing if the member received immunizations applicable to that measure. Measures pertaining to immunizations only identify children/ adolescents who turn the appropriate age during the measurement period. If your patients are outside of the age range for the measurement period, they will not be included in the measure.

Are there exclusions to the well-child measure?

Members in hospice are excluded from the eligible population.

How do I use the Lead Testing Opportunity Report on the Provider Portal?

The Lead Testing Opportunity Report is intended to serve as a supplemental tool to your practice workflows to identify children **at risk of** falling behind their required two blood lead tests. This report is separate from the Gaps in Care report, which identifies children that have not met the Quality Care Incentive Program quality measure. The Opportunity Report may be used to look ahead at children who have an upcoming birthday and may have not met their required lead tests. While QCIP does not incentivize for late blood lead tests, PCPs are responsible for the catch-up. For more information on the federal requirements for lead testing, please refer to the Provider Manual.

My patients have fluoride varnish applied by their dental provider. Do I need to apply varnish to receive credit in the program?

Because CenCal Health uses a variety of data sources available at the time of reporting, this includes claims billed to Denti-Cal. If the child's dentist is applying varnish and billing to Denti-Cal, CenCal

Health will receive supplemental data information. For QCIP credit, children aged 1-4 should receive at least two fluoride varnish applications during the measurement year.

If a parent or guardian refuses a service, such as a vaccine, can the patient be removed from the measure?

No. A patient cannot be removed from a measure due to parent or guardian refusal. It is the provider's responsibility to make a good-faith effort to offer the service and provide appropriate health education to encourage informed decision-making. In the event of refusal, it is recommended to document the refusal in the patient's medical record.

I see that my newborn patient has multiple member IDs. How do I remedy this?

Likely a result of complications with DHCS' Newborn Gateway Enrollment program, CenCal Health has identified the following scenarios:

- Newborn patients with multiple member IDs
- Newborn patients assigned to other locations
- Newborn patients with the name of "Baby Boy", "Baby Girl", or "Unknown"

In the event of these scenarios or others involving a member's information, please contact Member Services at memberservices@cencalhealth.org or 1-877-814-1861.

Managing Chronic Conditions

Who can perform a diabetic retinal eye exam?

For the Eye Exam for Patients with Diabetes measure, the rendering provider must be an eye care professional, such as an optometrist or an ophthalmologist.

Cancer Prevention

What are the validated tests for colorectal cancer?

Validated tests for colorectal cancer screening include:

- Fecal occult blood test during the measurement period
- Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
- CT colonography during the measurement period or the 4 years prior to the measurement period
- Colonoscopy during the measurement period or the 9 years prior to the measurement period

For additional measure-specific questions, please email qcip@cencalhealth.org.

Do members get notified by CenCal Health when they are due for a cancer screening?

Providers involved in direct patient care should notify patients due for recommended cancer screenings during regular medical visits. CenCal Health members that are past-due for a cancer screening are identified and included in Wellness and Prevention Campaigns. Wellness and Prevention Campaigns are health education materials mailed to member homes for members due for preventive health screenings.

What if my patients received a Cervical Cancer Screening elsewhere?

Please ensure comprehensive documentation in the EMR system, including:

- Type of test completed, with results
- Date testing was completed
- Location where testing was performed

To close the loop on patient care, request medical records to ensure that the patient's complete medical history is documented in their current chart. Additionally, we recommend contacting the Quality Measurement team to inquire about establishing an EMR data file exchange. This would enable your organization to collect and securely share information like this and more with CenCal Health through a confidential file transfer.

Operational Measures

Member Experience

How is operational measure performance calculated?

Operational measures are computed using member experience survey responses. Measure performance is then calculated using CAHPS-based member experience survey methodology.

Who is eligible to receive the survey?

All CenCal Health Members are eligible to receive the survey. Parents/ guardians may complete the survey for their children.

What are the CenCal Health member experience surveys?

The member experience surveys are post-visit questionnaires sent to CenCal Health members following primary care office visits to understand how they felt about access, communication, care coordination, and overall experience with their provider and care team.

Why are patient experience surveys tied to QCIP payment?

Patient experience is a key component of quality care that is included in state and national reporting through DHCS, NCQA, and CMS. As part of CenCal Health's mission to provide high-quality health services, we aim to reward providers who consistently deliver patient-centered, respectful, and accessible care.

Why does my practice not qualify for operational measures?

To qualify for operational measure incentives, the minimum survey response threshold is 30 responses during the lookback period. If a member asks about receiving a survey request, please encourage them to respond. Providers may encourage participation but should never coach members on how to respond. Surveys are to capture the member's genuine experience.

Will I receive member-specific responses from the surveys?

No, similar to CAHPS surveys, member responses are anonymous. However, providers will be able to see their performance on the measures through the provider reports within the provider portal.

Is there an age requirement for members to receive the survey?

No, all members that receive care from primary care providers are eligible to receive a survey. For children, parents or legal guardians are encouraged to complete the survey for the experience.