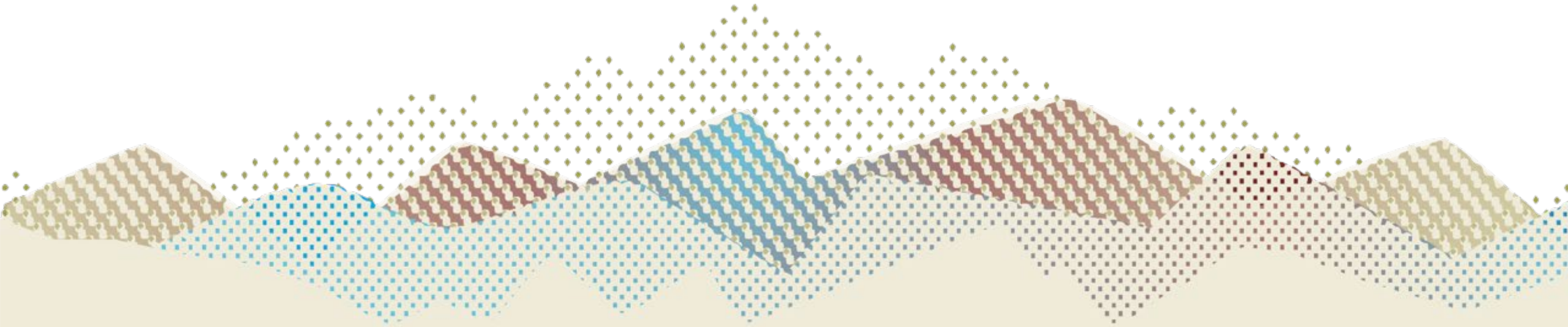
Hospital Quality Incentive Program (HQIP) Kickoff Webinar

Presented by: Troy Foster, Program Manager II



Webinar Objectives

1. Hospital QIP Background
2. 2025-26 Timeline
3. 2025-26 HQIP Measures
4. Q&A

About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Hospital Quality Incentive Program (HQIP)

- The HQIP is a Pay-for-Performance program **supporting hospitals** serving Partnership members **to improve quality and health outcomes**.

- Hospitals Earn Substantial Financial Incentives: Approximately $7 million was awarded among 33 hospitals in the 2024-25 measurement year.

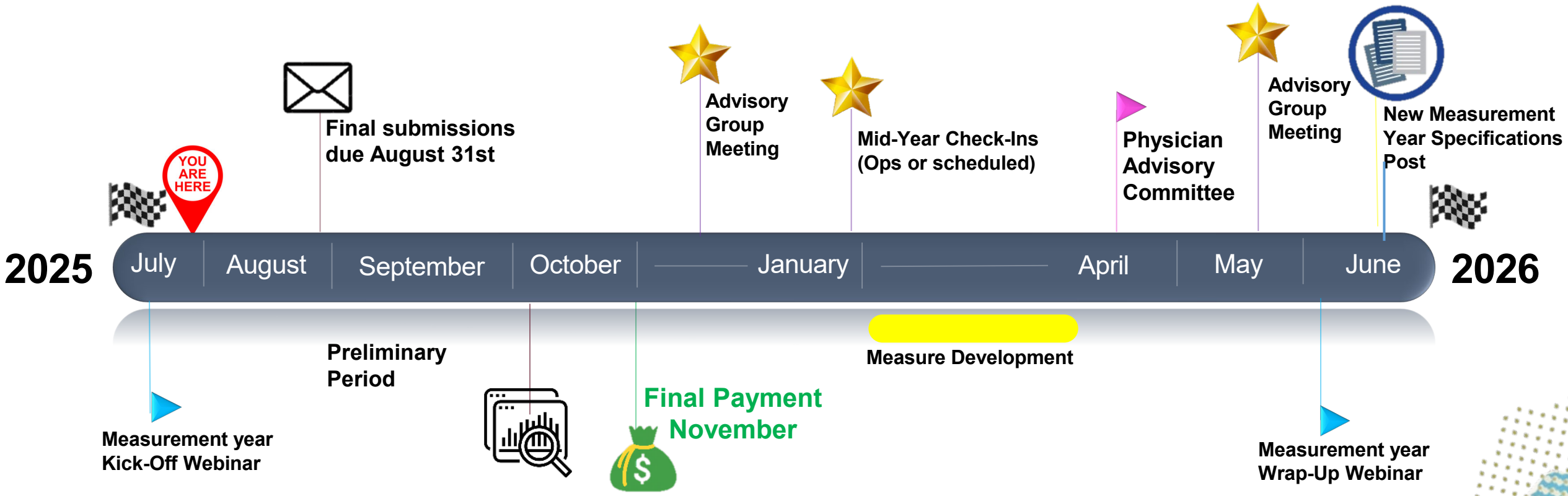
- 17 measures spread over six domains: Readmissions, Advance Care Planning, Clinical Quality (OB / Newborn / Pediatrics), Patient Safety, Patient Experience, and Operations and Efficiency

Guiding Principles

1. Where possible, pay for outcomes instead of processes
2. Actionable measures
3. Feasible data collection
4. Collaboration with providers in measure development
5. Simplicity in the number of measures
6. Representation of different domains of care
7. Align measures that are meaningful
8. Stable measures

HQIP Timeline

Measurement Period July 1st – June 30th



Year end attestation and reports are due by August 31st.

HIE & EDIE Participation

Health Information Exchange (HIE) & Emergency Department Information Exchange (EDIE) implementation and maintenance is a pre-requisite to participating in the Hospital QIP. To have the potential to earn 100% of your hospital's HQIP incentive dollars, all the items below must be met.

- **Admissions, Discharge, Transfer (ADT)**
  plus HL7 or XDS interface with either:
  Sac Valley Med Share
  North Coast Health Information Network

- **ADT interface with EDIE**

- **Link to one of the following national HIE networks**:
  CareQuality,
  eHealth Exchange, or
  Commonwell

Requirements for Capitated Hospitals

Capitated Hospitals also have the additional requirements below that impact the percent amount of HQIP incentive dollars they can earn.

From July 1, 2025 to June 30, 2026, Hospitals must utilize **PointClickCare's EDIE** for their capitated members to alert their internal utilization Management team to out of network admissions. PointClickCare will report usage data to Partnership HealthPlan confirming routing (month-by-month) utilization of the module via responsiveness to previously established alerts.

Delegation Reporting

To receive the full Hospital QIP incentive payment capitated hospitals must submit timely and accurate delegation deliverables to Partnership according to deadlines outlined in your hospital's Utilization Management Delegation Agreement. Timely submission percentages can be reviewed on page 6 of the measurement set specifications document.

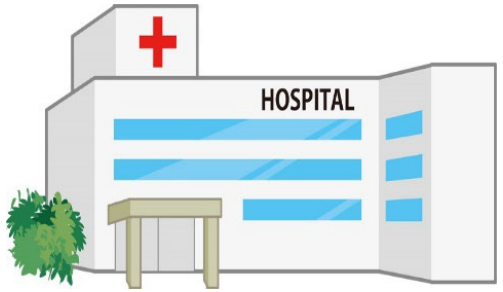
All reporting submissions and written Utilization Program Structure may be sent to: DelegationOversight@partnershiphp.org.

2025-26 Measure Set

New Measures in Green Updated Measures in Red
1. Risk Adjusted Readmissions Rate (RAR)
2. 7-day Clinical Follow-up Visit
3. Palliative Care Capacity
4. Elective Delivery
5. Exclusive Breast Milk Feeding
6. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate
7. Vaginal Birth After Cesarean
8. Expanding Delivery Privileges
9. Doula Support
10. Increasing Screening Mammogram Capacity
11. Vaccines For Children Program Enrollment
12. California Hospital Patient Safety (CHPSO)
13. Substance Use Referral
14. QI Capacity
15. Hospital Quality Improvement Platform
16. Cal Hospital Compare Patient Experience
17. Health Equity

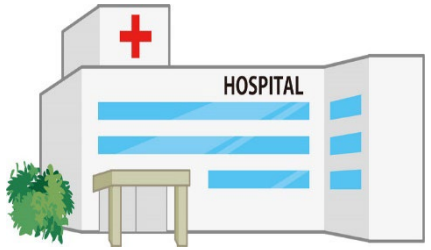
Hospital Size	Max Points
X-Large	100
Large with OB	100
Small with OB	100
Very Small	75

Hospital Size Designations



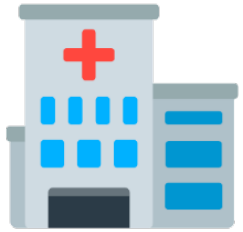
X-Large Hospitals

≥ 100 licensed general acute beds



Large Hospitals

≥ 50 licensed general acute beds



Small Hospitals

< 50 licensed general acute beds

Very Small Hospitals

< 25 licensed general acute beds

1. Risk Adjusted Readmissions

Measure Summary

For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays* (denominator)
- Observed Readmissions: Count of 30-Day readmissions (numerator)
- Expected Readmissions: Sum of adjusted readmission risk (numerator)
- Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year

Large & X-Large Size Hospitals Targets	Small & Very Small Size Hospitals Targets
<1.0 Full Points = 10 Points	**<1.0 Full Points = 5 Points**
≥1.0 - 1.2 for Partial Points = 5 Points	**≥1.0 - 1.2 for Partial Points = 2.5 Points**

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between July 1st and June 1st of the measurement year by members age 18 to 64 years of age continuously enrolled for at least 90-days prior admission date and 30 days after admission date.

Numerator

Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 3rd and June 30th of the measurement year by Partnership members included in the denominator.

RAR Calculations

30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 1 and June 1 of the measurement year by PHC members included in the denominator.

Calculation: $\textbf{Observed 30 Day Readmissions Rate} = \frac{\textbf{Observed 30 Day } \textbf{\textit{Readmissions}}}{\textbf{Total Count of Index Hospital } \textbf{\textit{Stays}}}$

Expected 30-Day Readmission: An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

Calculation: $\textbf{Expected 30 Day Readmissions Rate} = \frac{\textbf{Expected 30 Day } \textbf{\textit{Readmissions}}}{\textbf{Total Count of Index Hospital } \textbf{\textit{Stays}}}$

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

2. 7- Day Follow-up Clinical Visits

For assigned members 18 to 64 years of age, the percentage of acute inpatient and observation stays for which the member received follow-up within 7 calendar days of discharge. The date of discharge is day zero. Follow-up visits may include in person, telephone, and telehealth visits done at the hospital or outpatient setting. Clinical visits by a qualified medical professional include those with a patient's primary care provider, other specialist, mental health professional, PA, NP, RN, CNM, or a hospitalist/hospital based clinician in a hospital discharge visit. Visits with a case manager (non-RN) would not count towards the numerator for this measure.

Target

X-Large & Large Size Hospitals:

Full Points: 10 points: ≥ 35% of members with a follow-up visit within 7 calendar days of hospital discharge.

Partial Points: 5 points: 30 – 34.9% of patients with a follow-up visit within 7 calendar days of hospital discharge.

Small & Very Small Size Hospitals:

Full Points: 15 points: ≥ 35% of members with a follow-up visit within 7 calendar days of hospital discharge.

Partial Points: 10 points: 30 – 34.9% of patients with a follow-up visit within 7 calendar days of hospital discharge.

Denominator

The number of acute inpatient and observation visits on or between July 1st and June 30th of the measurement year by members' age 18 to 64 years of age continuously enrolled from the date of discharge through 30 days after discharge (31 days)

Numerator

The number of members in the denominator who had a follow-up visit within 7 calendar days of hospital discharge.

Exclusions

Discharges for death, Pregnancy & Perinatal conditions, SNF transfers, Out-Patient in Bed

3. Palliative Care

Measure Requirements for X-Large Hospitals with > 100 beds

Required to provide the following to Partnership:

Part 1. Hospitals must submit a report summarizing the number of palliative care consults per month for the measurement year July 1, 2025 – June 30, 2026

Part 2. Rate of consults who have completed an Advance Care Directive or have a signed POLST to be included in the report described in Part 1:

> **Numerator**: Anyone with an Advance Directive or POLST status in the hospital's inpatient EMR and on the palliative care service at either the time of consult ***or*** the time of discharge.
>
> **Denominator:** Patients with a palliative care consult recorded in the hospital's inpatient EMR and on the palliative care service, discharged alive from July 1, 2025 – June 30, 2026.

Part 3. Submit Attestation form Appendix II showing inpatient palliative care capacity: at least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician

X-Large Full Points Target (5 points)	X-Large Partial Points Target (2.5 points)
Part 1: Minimum of 10 patient consults per month, **and**	Part 1: Minimum of 5-9 patient consults per month, **and**
Part 2: ≥ 40% of patients with a completed AD or signed POLST, **and**	Part 2: ≥ 40% of patients with a completed AD or signed POLST, **and**
Part 3: Pay for reporting Palliative Care Capacity Attestation Form	Part 3: Pay for reporting Palliative Care Capacity Attestation Form

Palliative Care continued

Measure Requirements for Large Hospitals with 50-99 Beds

Hospitals 50-99 beds: Inpatient palliative care capacity: at least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician (option for hospitals with less than 100 beds).

Large Hospital Target

Pay for reporting Palliative Care Capacity Attestation Form, Appendix III including the information listed under Measure Requirements above.

Large Hospital Full points = 5 points. No partial points are available for this measure.

Measure Requirements for Hospitals with Small <50 Beds

Hospitals <50 beds: Dedicated inpatient palliative care team: one Physician Champion, one trained* Licensed Clinical Social Worker or trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician (option for all hospitals). *Training must total 4 CE or CME hours. Training options include ELNEC, EPEC, the CSU Institute for Palliative Care, or other approved Palliative Care Training. Training valid for 4 years.

Small Hospital Target

Pay for reporting Palliative Care Capacity Attestation Form, Appendix III including the information listed under Measure Requirements above.

Small Hospital Full points = 5 points. No partial points are available for this measure.

Exclusions

Hospitals with < 25 general acute beds are excluded from this measure.

Exclusions

Reports & Attestations are due by August 31, 2026.

Maternity Measures (Applicable to OB Hospitals Only)

Data Submission Instructions

Hospitals must submit timely* data to California Maternal Quality Care Collaborative (CMQCC). Hospitals must authorize PHC to receive data from CMQCC by completing the authorization form available on the Maternal Data Center.

For hospitals new to CMQCC:

- Legal agreement: due September 30
- First data submission for July - October: due December 15.
- Timely data submission after that, starting January.

For hospitals already participating in CMQCC:

- 12 months of timely data submission for each month during the measurement year.

Per CMQCC, timely submissions are defined as those submitted within 45-60 days after the end of the month.

4. Elective Delivery before 39 Weeks

Description:

Percent of patients with newborn deliveries at ≥ 37 to < 39 weeks gestation completed, where the delivery was elective within the measurement year.

Numerator: The number of patients in the denominator who had elective deliveries.

Denominator: Patients delivering newborns at ≥ 37 to < 39 weeks gestation.

Target:

- Full Points: ≤ 1.0% = 5 points
- Partial Points: > 1.0% - 2.0% = 2.5 points

5. Exclusive Breast Milk Feeding Rate

Description:
Exclusive breast milk feeding rate for all newborns during the newborn's entire hospitalization within the measurement year.

Numerator: The number of newborns in the denominator that were fed breast milk only since birth

Denominator: Single term newborns discharged alive from the hospital during the measurement year

Target:

- Full Points: ≥ 75.0% = 5 points
- Partial Points: 70.0% - < 75.0% = 2.5 points

6. Nulliparous Term, Singleton Vertex (NTSV) Cesarean Rate

Measure Summary

Rate of Nulliparous, Term, Singleton, Vertex Cesarean births occurring at each HQIP hospital within the measurement period.

Targets

X-Large Size Hospitals

Full Points: < 22.0% NTSV cesarean rate = 5 points

Partial Points: ≥ 22.0% - 23.9% NTSV rate = 2.5 points

Large & Small Size Hospitals

Full Points: < 22.0% NTSV cesarean rate = 10 points

Partial Points: ≥ 22.0% - 23.9% NTSV rate = 5 points

Target thresholds determined considering the HealthyPeople2020 goal, and statewide and HQIP participant averages calculated using Cal Hospital Compare data.

Specifications

Joint Commission National Quality Care Measures Specifications v2018A used for this measure (Perinatal Care Measure PC-02).
For detailed specifications, follow this link:
https://manual.jointcommission.org/releases/TJC2018A/

Numerator: Patients with cesarean births.
Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation.

7. Vaginal Birth After Delivery (X-Large Hospitals Only)

Description:
For hospitals with ≥ 100 beds that offer maternity services: Percent of patients who had a previous Cesarean delivery who deliver vaginally during the Measurement Year.

Numerator: Patients who deliver vaginally that have had a previous Cesarean delivery.

Denominator: Patients with a previous cesarean birth.

Target:
Full Points: ≥ 5.0% VBAC Uncomplicated = 5 points

8. Expanding Delivery Privileges

Specifications

In this second phase of measure implementation, hospitals are now required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity.

Measure Requirements

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year starting July 1, 2025.

Phase Two Requirement:

Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges. Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

Target (5 Points)

Provide evidence* of recruitment during the measurement year and/or provider privileges list for those family physicians and midwives with privileges sent to Partnership by August 31, 2026.

Reporting

Evidence may include a list of family physicians and midwives with current privileges and/or other evidence of their privileges. If hospitals have actively recruited or completed outreach to midwives and physicians, but have not contracted with providers yet, they can submit evidence of recruitment and outreach for their submission. All documentation must be submitted to Partnership no later than August 31, 2026.

9. Doula Support

Measure Summary

This measure is intended to encourage hospitals to allow doulas to provide support during labor and delivery. Doulas can play a vital role during and after pregnancy as they support and comfort birthing parents. The benefit of doulas to the mother, baby, and birth outcomes is significant. These benefits include fewer interventions during delivery, being an advocate for the patient, providing extra attention and another set of hands, a person to help walk through difficult situations, offering additional coping skills as well as physical, emotional, and spiritual support, postpartum support, and a more satisfying birth experience.

Specifications

This measure will be implemented over multiple years, with **Phase One** starting with the 2025-26 measurement year. In future years, hospitals will be required to work toward actively recruiting and allowing doulas to provide support during labor and delivery.

Measure Requirements

Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery. In future years, we anticipate a second phase of this measure to include evidence that doulas are being utilized in labor and delivery. Hospitals with existing bylaws and/or written policies that allow doulas to provide support during labor and delivery will get full points for the measure.

Target (5 Points)

Evidence* that approved policies and procedures are in place by June 30, 2026 and/or submission of the list of doulas used by the hospital.

Reporting

*Evidence may include written policy and procedure respective to the measure requirements above. Alternatively, a list of current doulas who supported births during the measurement year may be submitted. All documentation must be submitted to Partnership no later than August 31, 2026.

10. Increasing Screening Mammogram Capacity

Specifications

Hospitals with on-site mammography can be incentivized by increasing access/capacity to mammogram screening through increasing breast cancer screening access/capacity for Partnership members by at least 5 to 10%. Hospitals without on-site mammography may meet the measure by hosting a mobile mammography event. Each hospital's baseline rate will be calculated from services provided during the previous measurement year (July 1 through June 30) in which the hospital participated in the HQIP.

Measure Requirements

Hospitals with on-site access to mammography:

Full Points = 5 Points: Increase access/capacity for breast cancer diagnostics and screening by 10% over the previous year's baseline.

Partial Points = 2.5 Points: Increase access/capacity for breast cancer diagnostics and screening by 5-9.9% over the previous year's baseline.

Hospitals without on-site access to mammography:

Full Points = 10 Points: Host at least one(1) mobile mammography clinic during measurement year with at least 25 exams conducted with priority given to Partnership members. Mammography may be hosted at the hospital or another location such as a Primary Care Provider (PCP) site if collaborating with the clinic with a PCP site.

Reporting

Partnership will utilize claims data to determine the percentage of capacity increase each year.

Exclusions

Breast Magnetic Resonance Images (MRIs) do not count toward the targets.

11. Vaccines For Children Program Enrollment

Hospitals play a critical role in both fighting viruses like respiratory syncytial virus (RSV) after it is contracted and in preventing it. Vaccinating newborns before discharge from the hospital is an excellent way to help protect against illnesses like RSV; especially for those individuals who may be more likely to not have or miss follow-up well-child visits.

The California Department of Public Health (CDPH) has a Vaccines for Children (VFC) program that can cut costs significantly for hospitals by providing them with a variety of vaccines, like Beyfortus® (Nirsevimab) at ***no cost*** for eligible infants, which includes Medi-Cal members. Vaccines included in program are: DTaP, and DTaP combinations, HepA, HepB, HIB, HPV, IPV, MenACWY, MABCWY, MENB , MMR, PCV, PPSV23, RSV, RV, Td, Tdap, and Freezer vaccines: Covid-19, MMR, MMRV, VARRecent. Since the current list price for newer vaccines like Beyfortus® (Nirsevimab) is significantly high per dose, receiving them for free is a substantial cost savings, and can positively impact the newborn population.

Measure Summary

HQIP birthing hospitals can save costs and positively impact their newborn populations by enrolling in the 'no cost" Vaccines for Children program through CDPH. Partnership's HQIP birthing hospitals will be eligible to receive points by successfully enrolling in the CDPH's VFC program by the end of the measurement year.

Target (5 Points)

Target: Enrollment in VFC program by June 30, 2026

Reporting

Hospitals will send proof of enrollment to Partnership by June 30, 2026.

Resources

Hospitals should visit https://eziz.org/vfc/ to find all pertinent information about the program. The 2025 Program Participation Requirements at a Glance document is a key guide that includes resources and job aid links to understand enrollment and program requirements.

Hospitals can also contact VFCEnrollment@cdph.ca.gov to receive more support for enrolling in this unique cost saving program.

12. CHPSO Patient Safety Organization Participation

Measure Summary

Participation in the California Hospital Patient Safety Organization. Membership is free for members of the California Hospital Association (CHA) and California's regional hospital associations. To see if your hospital is already a member of CHPSO, refer to the member listing. Please reference AHRQ's common reporting formats for information on the elements that may comprise a complete report. You may also contact CHPSO via email at info@hqinstitute.org to seek more information or examples of what may be considered a patient safety event.

Large Hospitals:

- Participation in at least four (4) "Safe Table Forums", either in-person or virtually, during the Measurement Year
- Submission of 100 patient safety events to CHPSO, for events occurring within the measurement year or the year prior

Small Hospitals:

- Participation in at least one (1) "Safe Table Forum", either in-person or virtually, during the Measurement Year
- Submission of 10 - 25 patient safety events to CHPSO, for events occurring within the measurement year or the year prior

Targets

***X-Large, Large, & Small Hospitals*: Full Points = 5 points**.

***Very Small Hospitals*: Full Points = 10 points**.

Reporting

Hospitals will report directly to CHPSO using their risk management reporting system. Please contact CHPSO/HQI via email at info@hqinstitute.org for more information. No reporting by hospital to Partnership is required. To receive credit for this measure, hospitals must grant CHPSO/HQI permission to share submission status updates with Partnership by **August 31, 2026**.

13. Substance Use Disorder (SUD) & Medication Assisted Treatment (MAT)

Specifications

Option 1:

Hospitals of all sizes can earn full credit for the measure by providing proof of a dedicated full-time substance use navigator for SUD referrals (i.e., Bridge Program Model). Hospitals' proof of dedicated full-time Substance Use Navigator consists of job description, and sample of weekly work schedule.

Option 2:

Denominator: Emergency Department or inpatient admissions of Partnership Members with ICD10: F11.1x diagnosis code of opioid use disorder billed in any position on the claim.

Numerator: Any subsequent prescription of buprenorphine ***or*** any subsequent office visit with a diagnosis of F11.x

Buprenorphine Rx may include Buprenorphine, Buprenorphine HCl, Buprenorphine-naloxone, Suboxone, Zubsolv, Vivitrol, and/or Butrans.

"Subsequent" is defined as the period between 1 and 60-days post discharge after an ED or inpatient stay, during the Measurement Year.

Data Collection: Partnership will use medical and Buprenorphine pharmacy claims data for the period 1-60 days post-discharge during the Measurement Year, as well as outpatient provider data to determine performance.

SUD/MAT Targets (10 Points)

Below are the two ways in which hospitals can meet this measure by option 1 or option 2:

Option 1:	Option 2:	Option 2:	Option 2:
All Hospital Sizes:	**Large and X-Large Hospitals** **with ≥ 50 LGA beds:**	**Small Hospitals** **with 25 - 50 LGA beds:**	***Very Small Hospitals*** ***with < 25 beds:***
Proof of Full-time, dedicated navigator position	Full points ≥ 10 Partnership Members **and** 40% of Partnership Members received prescription or office visit	Full Points ≥ 5 Partnership Members	Full Points ≥ 3 Partnership Members

Reporting

Partnership will access claims data to determine performance.

14. Quality Improvement Capacity (5 Points)

Measure Summary

This measure is intended to introduce resources to all Partnership network hospitals, particularly small and rural hospitals, to provide hospital administrators, physicians, and staff of all levels with tools, strategies, and inspiration for improving the quality of care provided to our members. Many of our hospitals are far from major cities or so small that it becomes difficult to facilitate training attendance.

Partnership offers the *Hospital Quality Symposium* with the intent to encourage Partnership contracted hospitals to send staff of all levels to an informative learning session (one (1) representative per entity site location). Full credit is also available for attending the national meeting of the Institute for HealthCare Improvement.

Specifications

- CE/CME hours per person are available to attend this event
- Partnership will verify attendance at the event.
- The following are examples of potential quality topics that may be presented at this event:
  - Health Equity
  - Infection control or prevention
  - Outpatient care coordination
  - Opioid epidemic
  - Perinatal care services
  - Emerging data resources
  - Ways to reduce readmissions
  - Addressing Workforce Challenges

15. Hospital Quality Institute Platform

Measure Summary

Participation in the Hospital Quality Improvement Platform and timely, complete data submissions. The HQI Platform is available to all California Hospital Association members at no additional charge. This measure is broken into three (3) parts;

1. Participation in HQI Platform (verified by December 31, 2025), including NHSN rights conferral (Partnership will assess hospital usage June 30, 2026) **and**,
2. One (1) submission of data into the HQI platform by December 31, 2025 **and**,
3. Timely, complete and consistent submission of discharge data into HQI Platform

Target

Full Points = 5 points: Hospitals maintain data sharing agreement with HQI for prior measurement year or successfully sign up with HQII, confer NHSN rights, submit all discharge data due to HCAI into the Hospital Quality Improvement Platform by December 31, 2025 and continue to submit all discharge data into the platform for the remainder of the measurement year. Partnership assesses timely data submission at the end of the measurement year.

Partial Points = 2.5 points: Hospitals maintain data share agreement with HQI from prior measurement year or successfully sign up with HQI, confer NHSN rights, and submit all discharge data due to HCAI into the Hospital Quality Improvement Platform by December 31, 2025.

Measurement Period

Part 1 and 2: July 1, 2025 – December 31, 2025, Part 3: January 1, 2026 – June 30, 2026

All reporting happens through the HQI platform.

To begin participation in the HQI platform: visit https://hqinstitute.org/the-hospital-quality-improvement-platform/, complete the Business Associate and Participation Agreements in the "Join the Program" section, and retrieve upload instructions.

16. Cal Hospital Compare – Patient Experience

Specifications

Hospital Patient Experience data is measured as an aggregate score in comparison to the aggregate score of Patient Experience for all acute care hospitals in the state of California with publicly available information.

Numerator = The total numerical value of the hospital's Patient Experience Scores.

Denominator = The total numerical value of the State's Patient Experience Scores.

Target

Large and Small Size Hospitals - Full Points: 5 Points;

Very Small Hospitals – 10 points

Hospital aggregate score is greater than average California hospital score * 1.00/100%

Large and Small Size Hospitals - Partial Points: 2.5 points;

Very Small Hospitals – 5 points

Hospital aggregate score is greater than average California hospital score .95-.99/95-99%

Reporting

*No reporting to Partnership necessary. Partnership will collect data that hospitals submit to Cal Hospital Compare from the CMS Data File and compare aggregate score to the average California hospital score.

17. Health Equity

Specifications Partnership recognizes that health equity work can be very diverse and take many forms and Hospitals are being asked by multiple agencies to be committed to health equity. Since all hospitals need to report to CMS on health equity, rather than ask organizations to produce additional proof of their health equity work, Partnership has decided to reduce the administrative burden on hospitals by aligning our measure with CMS requirements. Hospitals may now report their health equity work to Partnership by submitting the same documentation submitted to the Centers for Medicare and Medicaid Services (CMS) for the Hospital Commitment to Health Equity Measures.

Measure Requirements

Hospitals shall submit a copy of their most recent CMS program attestation for the Hospital Commitment to Health Equity Measure to earn points for this measure. The attestation should cover at least half of the HQIP measurement year.

Target

Full Points: 5 Points earned for submitting current CMS Health Equity Attestation that attests to meeting all five domains.

Reporting

All attestations must be submitted to Partnership no later than August 31, 2026.

Exclusions

Very Small sized hospitals with less than 25 Licensed General Acute beds are excluded from participation in this measure.

Thank you for attending the HQIP Kickoff Webinar!

Resources and Contact Information

Your HQIP Team:

Amy McCune,

Manager of Quality Incentive Programs

Health Services - Quality and Performance Improvement

Troy Foster, Program Manager II

Hospital & Perinatal QIPs

Please visit the HQIP webpage for everything HQIP including specifications, newsletters and webinars

You can send questions or comments to hqip@partnershiphp.org