DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 27, 2020

Ms. Jacey Cooper
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Ms. Cooper:

The Centers for Medicare & Medicaid Services (CMS) is approving a modification to the state's Special Terms and Conditions (STCs) for California's section 1115(a) demonstration titled, "Medi-Cal 2020" (project no. 11-W-00193/9).

On April 3, 2020, California submitted an application to amend its Medi-Cal 2020 section 1115(a) demonstration to address the COVID-19 public health emergency. The state's application requested programmatic modifications to the Medi-Cal Organized Delivery Systems (DMC-ODS) program and modify the performance indicators for the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program and the Global Payment Program (GPP). Modifications detailed below, are necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 public health emergency.

After several discussions with the state and our Subject Matter Experts (SME), CMS determined that the state could effectuate the requested changes to the outlined programs through a revision to the state's STCs and the associated protocols incorporated within the STCs. In accordance with this determination, CMS hereby approves the following program modifications:

- Drug Medi-Cal Organized Delivery Systems (DMC-ODS) Modifications
    - Modification to suspend the following limits on residential treatment for participating DMC-ODS pilots with respect to DMC-ODS beneficiaries impacted by the COVID-19 emergency:
        - Modification to the STCs to suspend the limitation on 2 non-continuous 90-day regimens per year during the PHE
        - Modification to the STCs to suspend the current 30-day (for adolescents) and 90-day (for adults) maximums for a single residential stay, during the PHE.
    - Modifications to the rate-setting methodology of the DMC-ODS Certified Public Expenditure (CPE) protocol in Attachment AA.

- Modifications to the methodology for the distribution of incentive payments under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program to participating PRIME entities identified in Attachment II.
- Adjustments to the Public Health Care System (PHCS) thresholds for the Global Payment Program identified in Section B of Attachment FF.

This modification will support California to ensure that sufficient health care services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers are able to adapt the performance indicators for PRIME and GPP in demonstration years 15-16 in light of the unforeseen impact that COVID-19. With the approval of these program modifications, the flexibilities requested by the state in its April 3, 2020 COVID-19 application have been addressed.

We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic and we look forward to our continued partnership on the Medi-Cal 2020 section 1115(a) demonstration. If you have any questions regarding this correspondence, please contact your CMS project officer, Ms. Lorraine Nawara, at Lorraine.nawara1@cms.hhs.gov or at (410) 786- 4252.

Sincerely,

7/27/2020

X Andrea J. Casart

Signed by: Andrea J. Casart -A

Andrea J. Casart
Director
Division of Eligibility and Coverage
Demonstrations

Enclosure

cc: Cheryl Young, State Monitoring Lead, Medicaid and CHIP Operations Group

Attachment AA
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol
(Updated March 1, 2020)

GENERAL

Consistent with 42 CFR 433.51, a State or a unit of local government may use for its share in claiming federal financial participation (FFP) its public funds appropriated directly to the State or local Medicaid agency, transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. Public funds must not be federal funds unless specifically authorized by Federal law to be used for such purpose.

The certified public expenditures of each Drug Medi-Cal (DMC) Organized Delivery System (ODS) County are comprised of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers, for the furnishing of DMC ODS waiver services specified in the special terms and conditions of this 1115 demonstration waiver to eligible Medi-Cal beneficiaries.

DMC ODS county expenditures for contracted provider services are the payments made to the contracted providers. For the NTP/OTP modality of service, each DMC ODS county pays contracted providers at the lower of the uniform statewide daily rate (USDR) or the provider's usual and customary charge to the general public for the same or similar services. For non-NTP/OTP modalities, each DMC ODS county pays contracted providers at county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed below. The rates are proposed as part of the county fiscal plan that is submitted as addendum to the implementation plan and approved by the Department of Health Care Services (DHCS).

The county-specific negotiated rates are based on several criteria as required in the fiscal guidance that has been provided in Mental Health and Substance Use Disorders (MHSUDS) INFORMATION NOTICE NO: 15-034 and MHSUDS INFORMATION NOTICE NO: 16-050. The county will use the projected actual cost for services based on the most current prior fiscal year cost report data, where these services were previously available, with adjustments for increased projected beneficiary counts and the resulting projected increase in units of service (projected utilization) that will result from participation in the pilot. In the cases where the services have not been previously available, the counties will project staff hours for providing the services and calculate a projected cost per unit. Additional adjustments can be applied for inflation, using an approved government inflation factor, in similar manner to the county interim rate development.

As the State reviews proposed county interim rates, the additional information that is considered in the review includes data that illustrates the contract providers' projected cost per unit for each DMC ODS service. The State is able to provide oversight to the contract provider rate development at this stage of the review. If the projected expenditure or the projected utilization appears to be excessive or unsubstantiated, the State will provide feedback in the review process and request additional justification and/or correction to the projections.

DMC ODS county expenditures for county-operated provider services are determined through county provider cost reports. Section 14124.24(9) (1) of the Welfare and Institutions Code (WIC) requires that legal entities (i.e., counties and contracted providers), except for those contracted providers providing only narcotic treatment, submit substance use disorder (SUD) cost reports to DHCS by November 1 for the previous state fiscal year, unless DHCS grants a formal extension. A county-operated narcotic treatment facility will be required to submit the complete SUD cost report.

The SUD cost report forms are structured to obtain each legal entity's methodology for allocating costs between the various services provided by the legal entity, separate by provider number. The provider must demonstrate in their cost report the allocation base they used to distribute their total program costs to specific SUD programs and modality types.

There is one Excel file that must be completed by the legal entity for each service site that has its own DMC number and DMC certification and maintains its separate accounting records. There are 23 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

The SUD cost reporting forms were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid state plan amendment 09-022 review. Direct costs and indirect costs are recognized consistent with federal cost principles, including 2 CFR 200 Subpart E, Medicare cost principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS.

For the purposes of determining DMC ODS county certified public expenditures under the 1115 waiver, each county as contractor with the State receives and aggregates the provider cost reports into a cost report for all DMC ODS services provided under the contract to eligible Medi-Cal beneficiaries. The county is responsible for certification of public expenditures. DHCS is reconciling the county cost, based on the aggregate of costs incurred by the county for payments to all subcontracted providers and costs incurred by the county-operated providers. Cost reports completed by non-county (i.e., contracted) providers (which are required to file cost reports for non-NTP services under the Medicaid state plan), and cost reports completed by county-operated providers, are used to determine the DMC ODS expenditures under the 1115 waiver. These cost reports are used to determine if the reconciled amount was the lower of cost or customary charge (and in the case of dosing and individual/group sessions provided by county-operated NTP providers, the lowest of USDR or cost or customary charge). These cost reports are subject to audit by State and Federal authorities.

DEFINITIONS

1. "CMS" means the Centers for Medicare and Medicaid Services.

2. "Cost center" means a department or other unit within an organization to which costs may be charged for accounting purposes.

3. "DHCS" means the California Department of Health Care Services.

4. "Direct costs" means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. Examples of direct costs include unallocated (i.e., directly assigned or directly charged) wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient drug free treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.

5. "DMC" means Drug Medi-Cal.

6. "DMC unreimbursable costs" means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance to the California's Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare Provider Reimbursement Manuals, CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).

7. "Indirect costs" means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.

8. "Indirect cost rate" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A provider's indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).

9. "IOT" means intensive outpatient treatment.

10. "Legal Entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.

11. "NTP" or "OTP" means narcotic treatment program treatment.

12. "ODF" means outpatient drug free treatment.

13. "Percent of Direct Costs" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs. Percent of Direct Costs is a variation of the Indirect Cost Rate which allows the allocation of indirect costs by line item rather than in aggregate.

"PH" means partial hospitalization.

14. "SUD" means substance use disorder.

SUMMARY OF STATE-DEVELOPED COST REPORT

Modifications to the Current CMS Approved SUD Cost Report Forms

In order to collect accurate cost data for the additional services offered in the DMC ODS, it will be necessary to insert sections into each of the four modality-specific worksheets to capture data for all of the added DMC ODS services that will be offered in each level of care. These include adding case management, physician consultation, withdrawal management, recovery services. and additional medication-assisted treatment. DHCS will also need to add new tabs for Partial Hospitalization (PH) services. These tabs will also include the additional DMC ODS services as described above. These changes will not change how the forms calculate the amounts; they will just add the additional services into the current structure.

The other necessary modification is to remove the current statewide rates that are currently included on the forms. The Cost Allocation tab of the forms will calculate the cost per unit based on total allowable cost/total allowable units. This cost per unit will be used to reconcile the interim payments. The state will not use the current DMC Maximum Allowed for the ODS cost settlement. However, all other limits including the USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC services.

Inpatient hospital-based residential and withdrawal management services include ASAM levels 3.7 and 4.

These services are reimbursable in the DMC ODS when they are delivered by a licensed and certified chemical dependency rehabilitation hospital (CDRH) or a licensed and certified freestanding acute psychiatric hospital (FAPH). CMS requires the use of the form CMS 2552-10 for all hospital cost reporting. Contracted CDHRs and FAPHs should submit a copy of the CMS 2552-10 to the county for the purpose of DMC ODS cost reporting. The information from the CMS 2552-10 submitted to the county will be used to identify the relevant cost data that the county will enter into the cost report system.

Cost Report Forms Description:

Provider Information and Certification Worksheet (Tab 1)

This worksheet collects provider details, including entity name, address, other contact information, DMC number and National Provider Identifier (NPI). This worksheet is also where the provider representative signs and certifies that the cost report is accurate and complies with all Federal and State requirements.

Overall Cost Summary Worksheet (Tab 2)

This worksheet displays a summary of the totals for all the cost centers being reported. No data entry is necessary in this worksheet; information will automatically populate from the Overall Detailed Costs worksheet.

Overall Detailed Costs Worksheet (Tab 3)

This worksheet requires the provider to enter all necessary data related to all direct and indirect costs being reported. This worksheet must reflect all costs incurred by the provider related to their SUD services and it must demonstrate the allocation methodologies used by the provider (in accordance with applicable cost reimbursement standards) to distribute their costs across various cost centers.

Detailed Costs Worksheet (Tab 4 - ODF: Tab I - PH: Tab 12 - IOT: Tab 16 - Residential: Tab 20 - NTPI

This worksheet displays the results of all calculations for the cost reported for the specific modality. No data entry is necessary in this worksheet; information will automatically populate from other worksheets.

Detailed Adjustments For DMC Unreimbursable & Direct Costs Worksheet (Tab 5 - ODF: Tab 9 - PH: Tab 13 - IOT: Tab 17 - Residential: Tab 21 - NTP

This worksheet allows the provider to enter the breakout of costs from the program's general ledger for each of the cost categories between the different services. This information automatically populates data in the Detailed Costs worksheet and the Cost Allocation worksheet.

Cost Allocation Worksheet (Tab 6 - ODF; Tab 10 - PH: Tab 14 - IOT: Tab 18 Residential: Tab 22 - NTP)

This worksheet further identifies the breakout of costs between the different services and between private pay, DMC and non-DMC. The provider will enter the units of service and the rates that have been charged for the services. The worksheet calculates the maximum reimbursement for DMC services. All other areas are automatically populated based on data entry in other worksheet tabs.

Reimbursed Units Worksheet (Tab 7 - ODF: Tab 1l - PH: Tab 15 - IOT: Tab 19 Residential: Tab 23 - NTP)

This worksheet requires the provider to enter the approved units of DMC service based on a report generated by DHCS. There are areas on this sheet that are automatically populated from other worksheets. The worksheet produces specific reimbursement amounts by funding source and aid code category. The county will use the amounts from this worksheet for data entry into the cost report system application.

INTERIM RATE SETTING METHODOLOGY

Each county's interim CPE claim submitted to the state will be based on the services provided and the approved county interim rates for the covered services. Annual interim rates for each covered service will be developed by the county and approved by the State. The approved interim rates will be specified in the State/County contract. These interim rates must conform to SSA §1903(w)(6) and §42 CFR 433.51, and all certified public expenditures will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

Proposed rates must be developed for each required and (if indicated) optional service modality. The proposed rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation and settlement.

The proposed county interim rates should be based on the most recently calculated or estimated total county cost with adjustments for projected increases in utilization and the application of the Home Health Agency Market Basket inflation factor. The proposed interim rate should be calculated for each service including both county directly delivered (if appropriate), and subcontracted fee for service provider costs. For county-operated services the county will be reimbursed based on actual allowable costs. County payments to contracted fee for service providers are considered to be actual expenditures according to the terms and conditions of the waiver.

Uniform Statewide Daily Reimbursement Rate Methodology for DMC ODS Narcotic Treatment Programs

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in State Plan Amendment (SPA) 09-022, Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators. The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under SPA 09-022, Section E.1.a.

For interim rate purposes, county-operated NTP/OTP providers are reimbursed at the USDR for dosing, individual/group sessions. However, additional ODS services available to county-operated NTPs (case management, physician consultation, recovery services) will be reimbursed at county interim rates discussed above.

INTERIM MEDICAID PAYMENTS

The State makes interim payments of FFP to the DMC ODS counties based upon submitted expenditures. The DMC ODS counties will submit monthly CPE claims to the state for interim payments for services provided during the fiscal period. When submitting a claim for FFP for services provided by a county-operated or contracted provider, the DMC ODS county is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual county cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP.

Interim payments for FFP will be available through claim adjudication for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the annual interim rates for each covered service developed by the county participating in the demonstration and approved by the State. All interim rates must conform to 42 CFP. 433.51, and all certified public expenditures continue to be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

INTERIM RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, DHCS will complete the interim settlement of the DMC ODS county cost report no later than eighteen months after the close of the State fiscal

year. Each DMC ODS county's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. Each DMC ODS county cost report package is an aggregate of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers as determined through individual legal entity cost reports. Reimbursement under the DMC ODS program is available only for allowable costs incurred for providing DMC ODS services during the fiscal year to eligible Medi-Cal beneficiaries as specified in the special terms and conditions of this 1115 waiver demonstration. If, at the end of the interim reconciliation process, it is determined that a county received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a county received an underpayment, an additional payment is made to the county. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP.

Participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement.

All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

Participating counties and their contracted non-NTP providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS noninstitutional reimbursement policy, and California Code of Regulations (CCR) Title 9 and Title 22 (to the extent that they do not conflict with federal cost principles). Direct and indirect costs are determined and allocated using a methodology consistent with that approved for DMC state plan services, except that the methodology is applied to waiver services. The cost allocation plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of indirect costs. Although there are various methodologies available for determining actual direct costs and for allocating actual indirect costs, for consistency, efficiency and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and establishes a standard methodology of percentage of total direct cost to allocate indirect costs. This methodology is a variation of the indirect cost rate methodology in 2 CFR Part 225 (OMB Circular A-87) and 2 CFR Part 230 (OMB Circular A-122). DHCS recognizes that there are other indirect cost allocation bases (such as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an indirect cost allocation basis other than the one prescribed in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used. All allocation plans will still be subject to a review during a DHCS financial audit.

FINAL RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, the State will audit and complete the final

reconciliation and settlement of the cost report within three years from the date of the interim settlement. The audit performed by the State determines whether the income, expenses, and statistical data reported on the cost report are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and CMS. The audit also determines that the county's cost report accurately represents the actual cost of operating the DMC program in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the county in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State determines that the county received an underpayment, the State makes an additional payment to the county.

COVID-19 PUBLIC HEALTH EMERGENCY

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for non-NTP services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- **Each DMC ODS county may pay contracted providers at up to 100 percent above the approved county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed in this Attachment.**
- **For purposes of interim Medicaid payments, claims will be reimbursed at the lower of the county's billed amount or the approved annual interim rates for each covered service increased by 100 percent.**
- **For purposes of interim and final reconciliation, DHCS will settle interim payments for outpatient services to actual allowable cost. The limitation of customary charges is suspended.**
- **For inpatient hospital-based residential and withdrawal management services (including ASAM levels 3.7 and 4), DHCS will continue to settle interim payments to the lower of actual allowable cost or usual and customary charges.**

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.

Attachment II - PRIME Program Funding and Mechanics Protocol

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II. Preface

A. Public Hospital Redesign and Incentives in Medi-Cal

On December 30, 2015 , the Centers for Medicare and Medicaid Services (CMS) approved California's request for a renewal to California's section 1115(a) Medicaid demonstration (hereinafter "demonstration") authorizing the creation of a Public Hospital Redesign and Incentives in Medi-Cal (hereinafter "PRIME"). This demonstration is approved through December 31, 2020. Paragraphs 70-103 of the Special Terms and Conditions (STCs) describe the general rules and requirements of PRIME.

B. PRIME Protocols

The PRIME requirements specified in the STCs are supplemented by the following attachments to the STCs:

Attachment D.	Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME entities
Attachment Q.	PRIME Projects and Metrics: This Attachment details the specific delivery system improvement activities ("projects"), including requirements regarding project metrics, that are eligible for PRIME funding; for each project, Attachment Q specifies the details of the projects, projects' metrics, and metrics' targets that will be the basis for earning PRIME incentive payments. Attachment Q also specifies the key elements of and the review and approval process for participating PRIME entities' 5-year PRIME Project Plans. Participating PRIME entities will utilize this document for purposes of selecting projects (each of which specifies required metrics) to include in their 5-year PRIME Project Plans.
Attachment R.	Alternative Payment Methodologies: Attachment R will outline additional payment methodologies that will qualify as APM outside of the capitation payment methodologies.
Attachment S.	PRIME Evaluation and Monitoring: Attachment S will describe the state's plan for meeting PRIME monitoring requirements as well as will include the final evaluation plan.
Attachment II.	PRIME Funding and Mechanics: Attachment II describes the general requirements for receiving incentive payments under PRIME, including the allocation, payment mechanisms and disbursement of pool funds; reporting requirements; and reinvestment of unallocated funds.

III. Eligible Hospital Systems to Receive Funding

As identified in Attachment D, designated public hospital (DPH) systems, (which include their affiliated governmental providers and contracted governmental and non-governmental entities as applicable), and District and Municipal public hospitals (DMPHs) are eligible to receive PRIME incentive payments (hereinafter "participating PRIME entities"), subject to each DPH system and DMPH submitting a completed Five-year PRIME Project Plan and approval of that Plan by the state. Multiple DPH systems operating under common government ownership may be considered a single participating PRIME entity, or may submit separate applications and be treated as separate participating PRIME entities. Multiple DMPHs operating under common government ownership may submit separate applications or a single application. DMPHs that are under different government ownership may submit a joint plan for consideration, however, a lead DMPH must be identified.

Funding for this pool will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for DPHs and DMPHs to support reforms for care delivery, provider organization and adoption of APMs. The demonstration will provide up to $1.4 billion annually for the DPHs within the DPH Sub-Pool and $200 million annually for the DMPHs within the DMPH Sub-Pool for the first three years of the demonstration. The respective Sub Pools will then phase down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration

PRIME incentive funds shall be disbursed solely to the DPHs and DMPHs listed on Attachment D as eligible participating PRIME entities in accordance with their approved PRIME Project plans. A specified amount of incentive funding will be available annually to each eligible participating PRIME entity for the project metrics approved for that participating PRIME entity in its PRIME plan. The actual receipt of funds will be conditioned on reporting by the participating PRIME entity of progress towards and achievement of the specified targets approved in the PRIME Project Plan. Aside from early stage process metrics, awards in later years will be based on per beneficiary measures of improvement. Each participating PRIME entity (for multiple DPHs operating under a single PRIME project plan or multiple DMPHs operating under a single PRIME project plan, the combined DPHS or DMPHs are collectively considered the participating PRIME entity) will be individually responsible for performance on its metrics in order to receive its potential incentive funding. The inability of one participating PRIME entity to meet a specified target will not preclude other participating PRIME entities operating under separate PRIME Project Plans from receiving incentive payments for achievement of a target.

IV. PRIME Domains and Projects

PRIME projects are grouped into three domains (listed below), each of which has explicit connection to the achievement of: (a) patient-centered, data-driven, team-based care; (b) point of-

care services, complex care management, population health management driven by electronic health records and data analytic capacity for system-level improvement and culturally competent care; and (c) improved health outcomes as evidenced by clinical, preventable events, and patient experience metrics. The below three domains represent important themes that drive quality improvement and population health advancement:

Domain 1: Outpatient Delivery System Transformation and Prevention: Projects in this domain are intended to achieve major improvements in clinical quality and population health, with a particular focus on ambulatory care redesign, integration of physical and behavioral health, patient safety and prevention. These projects are intended to help make sure that patients experience timely access to high-quality, efficient, and patient-centered care. The menu of projects under this domain includes:

1.1 Integration of Physical and Behavioral Health (required for DPH)
1.2. Ambulatory Care Redesign: Primary Care (required for DPH)
1.3 Ambulatory Care Redesign: Specialty Care (required for DPH)
1.4 Patient Safety in the Ambulatory Setting
1.5 Million Hearts Initiative
1.6 Cancer Screening and Follow-up
1.7 Obesity Prevention and Healthier Foods Initiative

Domain 2: Targeted High-Risk or High-Cost Populations: Projects in this domain are focused on specific populations that would benefit most significantly from care coordination and alignment. The menu of projects under this domain includes:

2.1 Improved Perinatal Care (required for DPH)
2.2 Care Transitions: Integration of Post-Acute Care (required for DPH)
2.3 Complex Care Management for High Risk Medical Populations (Required for DPH)
2.4 Integrated Health Home for Foster Children
2.5 Transition to Integrated Care: Post Incarceration
2.6 Chronic Non-Malignant Pain Management
2.7 Comprehensive Advanced Illness Planning and Care

Domain 3: Resource Utilization Efficiency: Projects in this domain are designed to reduce ineffective or harmful clinical services and reduce unwarranted variation in the use of evidence based diagnostics and treatments. The menu of projects under this domain includes:

3.1 Antibiotic Stewardship
3.2 Resource Stewardship: High-Cost Imaging
3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals
3.4 Resource Stewardship: Blood Products.

V. Key Elements of Five- Year PRIME Project Plans

PRIME participating DPH systems will implement a minimum of 9 PRIME projects: at least four Domain 1 projects (of which three specific projects are required projects), at least four Domain 2 projects (of which three specific projects are required), and at least one Domain 3 project. PRIME participating DMPHs will implement at least one PRIME project, selected from the Projects and Metrics Protocol (Attachment Q), however, may implement additional projects as approved by the state in the PRIME Plan Application.

PRIME projects will be implemented over the course of five PRIME demonstration years, each corresponding to the state fiscal year from July 1 through June 30 ("PRIME DY"). The first PRIME DY is from July 1, 2015, through June 30, 2016.

No later than one week following the approval of the PRIME protocols, DHCS will provide participating PRIME entities with a standardized Five-year PRIME Project Plan template, consistent with the requirements in STC 75 in Section IX. The plan shall include the following sections:

1. Participating Entity Information
2. Executive Summary of 5-Year Plan that includes a summary of the overall Five-year PRIME Project Plan, a description of the participating PRIME entity and local needs, and goals and objectives for being a high-performing safety net system
3. Narrative on how the Five-year PRIME Project Plan will result in improved care for the patients they serve and a path for sustained delivery system improvement
4. Project Selection
5. Statement of Understanding of Project Metrics
6. Program Incentive Payment Amounts
7. Signed Certification statement attesting that the leadership of PRIME participating entities attests to the accuracy of all PRIME-related information submitted to DHCS.

VI. Plan Review and Approval Process

A. DHCS Plan Approval Process

DHCS will review all Five-year PRIME Project Plans according to the following timeline:

1. By February 1, 2016, or 30 days after the approval of the PRIME protocols (whichever is later), each participating PRIME entity seeking to participate in PRIME will submit the completed Five-year PRIME Pool Plan to DHCS for review.

2. DHCS shall review each plan to verify that it conforms to the below checklist:

    a. The plan is in the prescribed format.
    b. The plan contains and completes all required elements described herein and is consistent with the STCs.
    c. The plan conforms to the requirements for Domains 1, 2 and 3 as described herein, as well as in the Projects and Metrics Protocol (Attachment Q).
    d. The amount and distribution of funding is in accordance with Section 0 of this protocol "Disbursement of Pool Funds."

3. By March 15, 2016, or 45 days following the due date for submission of the Five-year PRIME Project Plans, DHCS will complete its review of the plan, and will respond to the participating PRIME entity in writing with any questions, concerns or problems identified.

4. The participating PRIME entity will respond to any of DHCS' questions and concerns in writing within 3 business days of notification by DHCS.

5. By April 1, 2016, or 60 days following the due date for submission of the Five-year PRIME Project Plans DHCS will take action on all plans, and will approve or disapprove each plan.

B. Plan Modification Process

1. Consistent with the recognized need to provide flexibility for participating PRIME entities to modify their plans over time and take into account evidence and learning from their own experience and from the field, as well as for unforeseen circumstances, no more than once a year, and by June 30th of each PRIME DY, a participating PRIME entity may submit a request to DHCS to modify its plan. The modification shall be effective as of the date approved by DHCS. PRIME Plan modifications are limited to the circumstances described below.

2. Project removals:
    a. Should a participating PRIME entity no longer meet the minimum 30 patient volume criteria, as specified in Projects and Metrics Protocol (Attachment Q), or no longer finds it practical (e.g. from a clinical or operational standpoint) to continue one or more projects in its approved plan, a participating PRIME entity may seek to remove a project:
        i. A DPH system may seek to remove an optional project as long as the minimum requirement of 9 total projects, including the 6 required

projects, continues to be met, which may be satisfied through a substitute project in the same domain as necessary.

ii. A DPH system may seek to remove a required project if it meets the Exclusions for Project criteria in the Projects and Metrics Protocol (Attachment Q) at the end of DY 11. A DPH system may seek to remove a required project after DY 11 but only in the case that the DPH system no longer meets the 30 patient volume requirement for that project. If a DPH system removes a required project, it must select another project in the same domain as the project that was removed. A DMPH may seek to remove a project from its plan, as long as it meets the 1 project minimum, or terminate its participation in PRIME.

b. A participating PRIME entity as of the effective date of a project's removal will forfeit any further funding for that project. The participating PRIME entity system shall retain all incentive payments associated with achievements related to that project prior to the removal of that project.

3. Should a participating PRIME entity undergo significant changes in data sources, such a wholesale implementation of a new electronic health record, a plan modification can be submitted for DHCS approval to change annual targets. In addition, should a participating PRIME entity securing a new Medi-Cal managed care contract that results in a significant increase in the number of assigned lives a plan modification can be submitted for DHCS approval to change annual targets.

4. Requests for modification must describe the basis for the proposed modification. If the participating PRIME entity seeks to replace one project with another, it must indicate this proposed change in the request for modification. The 60-day timeline for DHCS to review that is delineated for the Five-year PRIME Project Plans will apply. In the event that DHCS does not approve a modification to a participating PRIME entity's plan, the participating PRIME entity may seek redress by requesting a meeting with the DHCS Director to resolve any issues. The meeting shall take place in a timely manner.

C. Metric Modification Process

1. Over the course of the PRIME, participating PRIME entities may request a project metric change. DPHs must submit one request on behalf of all of the DPHs that are implementing projects that include a relevant metric, and DMPHs must submit a request on behalf of all DMPHs on behalf of all DMPHs that are implementing a project that include a relevant metric. Requests must include evidence of concurrence by all other DPHs or DMPHs reporting on the applicable metric.

2. Request for metric changes may be submitted no more than once a year and by June 30th of the Demonstration Year. Requests for metric changes must describe the basis for the

proposed change, the proposed change itself, and the applicable project. Requests may recommend metric substitution or removal.

3. For innovative metrics only (as defined in the PRIME Projects and Metrics Protocol Attachment Q), in addition to substitutions or removal, requests may also recommend metric modification. Metric modification requests will be forwarded to the Measure Steward for review. The Measure Steward may accept or reject the modification request. In the case of acceptance, the modified metric will enter a rigorous testing process (as described in the Metrics and Specifications manual), and if approved for use in PRIME by DHCS, the modified metric will be used in all applicable projects as Pay for Reporting until which time it has been deemed acceptable for Pay for Performance status. Should the modification request be rejected by the Measure Steward, DHCS will review whether or not to continue to use the metric for the specified project.

4. DHCS will seek input from all participating PRIME entities engaged in projects that include the metric in question. The 60 day timeline for DHCS to review that is delineated for the Five-year PRIME Project Plans will apply. In the event that DHCS does not approve the requested metric change, the original metric will remain in use for the specified projects and the participating PRIME entities may seek redress by requesting a meeting with the DHCS Director to resolve any issues. The meeting shall take place in a timely manner.

VII. Allocation and Disbursement of Pool Funds

Subject to the annual limits set forth in the STCs, aggregate incentive payments available over the 5-year demonstration period to a participating entity will be based on the methodology described below.

A. Total Available PRIME Incentive Payments for a DPH Five-Year PRIME Pool Plan

PRIME payments for each participating PRIME entity are contingent on that entity meeting project metrics' targets in its approved Five-year PRIME Pool Plans.

For PRIME DY 11 only, 25% of the total available PRIME funding will be paid based on the submission and approval of the Five-year PRIME Project Plan, pursuant to STC 100a. The remaining 75% will be paid based on the submission and approval of project baseline data collected through July 1, 2015 – June 30, 2016 in conjunction with the final year-end report. All of the PRIME funding in subsequent DYs will be available as incentive payments based on metric achievement to each DPH system across the three domains. The measurement year for all metrics will coincide with the applicable demonstration year, and for DY 11, metrics for the baseline year will be measured based on July 1, 2015 – June 30, 2016.

The maximum available PRIME payment amount by PRIME DY by domain under the DPH systems pool is summarized in Table 1 below.

Table 1: Total Computable PRIME Payments for DPHs

$ (total computable)	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**
5-Year PRIME Plan	25.0% 350,000,000	0.0% 0	0.0% 0	0.0% 0	0.0% 0
Domain 1: System Transformation	37.5% 525,000,000	50.0% 700,000,000	50.0% 700,000,000	50.0% 630,000,000	50.0% 535,500,000
Domain 2: High-Risk Populations	30.0% 420,000,000	40.0% 560,000,000	40.0% 560,000,000	40.0% 504,000,000	40.0% 428,400,000
Domain 3: Resource Utilization	7.5% 105,000,000	10.0% 140,000,000	10.0% 140,000,000	10.0% 126,000,000	10.0% 107,100,000
Total	100.0% 1,400,000,000	100.0% 1,400,000,000	100.0% 1,400,000,000	100.0% 1,260,000,000	100.0% 1,071,000,000

1. Every PRIME metric in a given domain will have an annual base value that is calculated by dividing the annual total available amount of PRIME funds in the domain by the base number of metrics across all projects, which is thirty one for domain 1, twenty-three for domain 2, and four for domain 3. The base number of metrics (31, 23, and 4) are estimated averages based on the number of metrics for each required project by domain, plus the average number of metrics per optional project in each domain. The annual base value per metric by domain and per year is summarized in Table 2 below.

Table 2: Annual Base Value Per Metric and Domain for DPHs

$ (total computable)	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Domain 1: System Transformation	16,935,484	22,580,645	22,580,645	20,322,581	17,274,194
Domain 2: High-Risk Populations	18,260,870	24,347,826	24,347,826	21,913,043	18,626,087
Domain 3: Resource Utilization	26,250,000	35,000,000	35,000,000	31,500,000	26,775,000

2. If the number of projects and metrics within a domain in the DPH system's Five-Year PRIME Project Plan varies from the applicable base number of 31, 23, or 4, the base metric value for the domain for the DPH system will be adjusted by multiplying by the following ratio: (base metric number / number of metrics in all projects in domain in approved PRIME Project Plan for given year).
3. The amount of PRIME funding available to a DPH system for each metric will be equal to the base value for each metric, adjusted as necessary in step 2, multiplied by a DPH

system-specific proportional allotment factor. The DPH system-specific proportional allotment factor is developed from system-specific data, reflecting each DPH system's unique number of Medi-Cal beneficiaries treated as well as overall costs incurred for those patients, to reflect the different mixes of services provided and acuities of patient populations treated by different DPH systems participating in PRIME. The DPH system specific proportional allotment factor is set forth in Table 3 below for each DPH system.

Table 3: Proportional allotment factors

Eligible DPH System	*Proportional allotment factor*
UC Davis Medical Center	0.041738
UC Irvine Medical Center	0.026019
UC San Diego Medical Center	0.025031
UC San Francisco Medical Center	0.031586
UC Los Angeles Medical Center and Santa Monica UCLA Medical Center	0.018658
Los Angeles County health system	0.319584
Alameda Health System	0.045959
Arrowhead Regional Medical Center	0.061520
Contra Costa Regional Medical Center	0.053761
Kern Medical Center	0.045296
Natividad Medical Center	0.022714
Riverside University Health System - Medical Center	0.047685
San Francisco General Hospital	0.048880
San Joaquin General Hospital	0.028667
San Mateo County General Hospital	0.029885
Santa Clara Valley Medical Center	0.085631
Ventura County Medical Center	0.067386

4. To determine the amount distributed available to DPH systems upon approval of their Five-Year PRIME Project Plan in DY 11, each DPH system must multiply the aggregate amount available contingent on such approval by its own proportional allotment factor in Table 3 above.

B. Total Available PRIME Incentive Payments for a DMPH Five-Year PRIME

PRIME payments for each participating PRIME entity are contingent on that entity meeting project metrics' targets in its approved Five-year PRIME Pool Plans.

Table 4: Total Computable PRIME Payments for DMPHs

$ (total computable)	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Total	$200,000,000	$200,000,000	$200,000,000	$180,000,000	$153,000,000

1. The maximum available PRIME funding shall be allocated across all DMPH systems as follows:
2. A proportional allotment factor for each DMPH (reflected in Table 5) is using the following factors:
    a. Medi-Cal and uninsured acute net revenue (using data from 2014 Office of Statewide Health Planning and Development).
    b. An adjustment factor based on the number of projects undertaken by each DMPH to recognize the diversity among these facilities.
    c. A baseline floor amount of .0075 in recognition of small/rural hospitals and the baseline effort required of any participating entity
3. The proportional allotment factors were determined using the above factors as follows:
    a. Initially, 80% of the total annual PRIME funding for DMPHs is allocated to each DMPH based on their pro-rata share of total Medi-Cal and uninsured acute net revenue from (2)(a)
    b. The initial remaining 20% of the total annual PRIME funding for DMPHs is divided by the total number of projects projected to be undertaken by participating DMPHs (108) to determine a per project additional amount to recognize the diversity among the facilities and the additional effort of doing multiple projects.
    c. An initial allocation of total annual PRIME funding across the DMPHs is then done by adding the results of (a) and (b).
    d. In order to ensure a baseline floor amount of funding as noted in (2)(a) any DMPH-specific allocation determined in (c) that would result in an allocation factor below .0075 is adjust to achieve the baseline floor allocation equal to the .0075 allotment factor
    e. The remaining DMPHs not adjusted to achieve the baseline floor of .0075, are adjusted on a pro-rata basis so as to not exceed the total funding available.
    f. The resulting allocations after the adjustments in (e) and (f) are then converted into proportional allotment factors by dividing the individual allocation amount by the total PRIME funding for all DMPHs. Table 5 represents the final proportional allotment factors.

Table 5: Proportional allotment factors

Eligible DMPH	*Proportional allotment factor*
Antelope Valley Hospital	0.1193
Bear Valley Community Hospital	0.0075
Coalinga Regional Medical Center	0.0075
Eastern Plumas Health Care	0.0075
El Camino Hospital	0.0234
El Centro Regional Medical Center	0.0453
Hazel Hawkins Memorial Hospital	0.0131
Healdsburg District Hospital	0.0113
Jerold Phelps Community Hospital	0.0075
John C. Fremont Healthcare District	0.0075
Kaweah Delta Health Care District	0.1579
Kern Valley Healthcare District	0.0075
Lompoc Valley Medical Center	0.0285
Mammoth Hospital	0.0116
Marin General Hospital	0.0122
Mayers Memorial Hospital District	0.0075
Mendocino Coast District Hospital	0.0075
Modoc Medical Center	0.0075
Northern Inyo Hospital	0.0198
Oak Valley Hospital District	0.0178
Palo Verde Hospital	0.0175
Palomar Medical Center *(Includes both Palomar Medical Center and Pomerado Hospital)*	0.1010
Pioneers Memorial Healthcare District	0.0308
Plumas District Hospital	0.0075
Salinas Valley Memorial Healthcare System	0.0509
San Bernardino Mountains Community Hospital	0.0075
San Gorgonio Memorial Hospital	0.0175
Seneca Healthcare District	0.0075
Sierra View District Hospital	0.0470
Sonoma Valley Hospital	0.0075
Sonoma West Medical Center	0.0075
Southern Inyo Hospital	0.0075
Tahoe Forest Hospital District	0.0085

Eligible DMPH	*Proportional allotment factor*
Tehachapi Valley Healthcare District	0.0075
Tri-City Medical Center	0.0702
Trinity Hospital	0.0075
Tulare Regional Medical Center	0.0306
Washington Hospital Healthcare System	0.0382

4. To determine the amount available to the DMPH upon approval of their Five-Year PRIME Project Plan in DY 11, each DMPH must multiply the aggregate annual amount available to all DMPHs by its own proportional allotment factor in Table 5 above.

5. Total available PRIME payments for each DMPH are allocated as follows:

    a. In DY 11 only, 25% of the total available PRIME funding will be paid based on the submission and approval of the Five-year PRIME Project Plan, pursuant to STC 100a.
        i. For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, the remaining 75% will be based on the achievement of the approved DY11 infrastructure building metrics for the DMPH through the final year-end report. The annual base value for each infrastructure building metric shall be calculated by dividing the value of the remaining 75% by the number of infrastructure building metrics in the DMPH's approved PRIME Project Plan.
        ii. For DMPHs not requiring infrastructure building metrics, the remaining 75% will be based on the submission and approval of project baseline data, through the final year-end report.
6. In DY 12 only:
    a. For DMPHs requiring infrastructure building metrics that are approved in the PRIME Project Plan:
        i. Up to 40% of the total PRIME funding will be based on the achievement of the approved DY 12 infrastructure building metrics through the midyear and final year-end report. The annual base value for each infrastructure building metric shall be calculated by dividing the value of the infrastructure building funding percentage by the number of infrastructure building metrics in the DMPH's approved PRIME Project Plan.
        ii. The remaining 60% or more will be available as incentive payments based on the metric achievement. The annual base value for each metric shall be calculated by dividing the value of the remaining percentage by the number of metrics in the DMPH's approved PRIME Project Plan.
    b. For DMPHs not requiring infrastructure building metrics, all of the PRIME funds will be available as incentive payments based on the metric achievement. The

annual base value of each metric shall be calculated by dividing the total DY12 PRIME Project Plan funding for the DMPH by the number of metrics across all the projects included in the DMPH's approved PRIME Project Plan

7. For DYs 13-15: All of the PRIME funds will be available as incentive payments based on metric achievement to each DMPH as contained in their PRIME Project Plan.

   c. Each DMPH's PRIME metric will have an annual base value which is calculated by dividing the annual total PRIME Project Plan funding for the DMPH by the number of metrics across all the projects included in the DMPH's approved PRIME Project Plan.

C. Payment Based on Metric Target Achievement

1. Each participating PRIME entity will be individually responsible for performance on its metrics in order to receive its potential incentive funding from the relevant Sub-Pool. Every 6 months, participating PRIME entities will be able to receive incentive payments related to performance on metrics, as specified below.

2. In order to receive incentive funding, the participating PRIME entity must submit the required Mid-Year Report and Final Year-End Report as described in this Attachment.

3. Incentive payments are calculated separately for each metric. The amount of the incentive funding paid to a participating PRIME entity will be based on the amount of progress made on each specific metrics, and the incentive payment amounts associated with those metrics as determined in Sections A & B above and contained in the entity's Prime Project Plan.

4. Calculating Achievement Values
   a. *Pay-for-Reporting Project (P4R) Metrics:* Progress for a metric target will be categorized as fully achieved or not achieved. As an interim payment, the DPH or DMPH is eligible to receive 50% of the metric value for a P4R metric if reported in the Mid-Year Report. The DPH or DMPH may earn the full incentive amount for reporting a P4R metric in the Final Year-End Report.
   b. *Pay-for-Performance Project Metrics:* The amount of the incentive funding paid to a participating PRIME entity will be based on the amount of progress made toward achieving its performance target on the standard metric. Based on the progress reported, Tables 6 and 7 will be used to determine the achievement value for metrics with established 90th percentile and 25^{th} percentile benchmarks, which comprise a significant majority of standard metrics. Tables 8 and 9 will be used to determine achievement value for metrics with established benchmarks but without 90^{th} and 25^{th} percentile rankings. Targets for these metrics will be established based on a standard percent improvement relative to a participating PRIME entity prior end-of-year performance. Achievement value for these non- ranked benchmark metrics will be based on the ability of the PRIME entity to

close the gap between the prior end-of-year performance and their individual target.

Table 6: Interim Mid-Year Metric Performance Achievement

	Interim Mid-Year Metric Performance Achievement Values (AV)	
End of Year Metric Performance in Prior DY	AV = 0	AV = 0.5
≥ 90th percentile	Performance below 90th percentile	Performance ≥90th percentile
≥ 25th and < 90th percentile	< 50% of the 10% Gap is closed	≥ 50 % of the 10% Gap is closed
< 25th percentile Track A: If gap between performance and 25th percentile is ≥ 10% gap between performance and 90th percentile	Performance ≤25th percentile	Performance ≥25th percentile
< 25th percentile Track B: If gap between performance and 25th percentile is < 10% gap between performance and 90th percentile	Performance < 25th percentile, or performance ≥25th percentile and < 50% of the 10% Gap is closed	Performance ≥25th percentile and ≥ 50 % of the 10% Gap is closed

Table 7: Final Year-End Metric Performance Achievement

	Final Year-End Metric Performance Achievement Values (AV)			
End of Year Metric Performance in Prior DY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
≥ 90th percentile	Performance below 90th percentile	NA	NA	Performance at or above 90th percentile
≥ 25th and < 90th percentile	< 50% of the 10% Gap is closed	≥ 50 % to <75% of the 10% Gap is closed	≥ 75 % to <99% of the 10% Gap is closed	100% of the 10% Gap is closed
< 25th percentile Track A: If gap between performance and 25th percentile is ≥ 10% gap between performance and 90th percentile	Performance <25th percentile	NA	NA	Performance at or above 25th percentile
< 25th percentile Track B: If gap between performance and 25th percentile is < 10% gap between performance and 90th percentile	Performance <25th percentile, or performance ≥25th percentile and < 50% of the 10% Gap is closed	Performance ≥25th percentile and ≥ 50 % to <75% of the 10% Gap is closed	Performance ≥25th percentile and ≥ 75 % to <99% of the 10% Gap is closed	100% of the 10% Gap is closed

Table 8: Interim Mid-Year Metric Performance Achievement for Metrics without National/State Benchmarks

Interim Mid-Year Metric Performance Achievement Values (AV)	
AV = 0	AV = 0.5
< 50% of the gap between end of year performance and current year target* is closed	≥ 50 % of the gap between end of year performance and current year target* is closed

*DHCS to set a standard percent improvement target relative to individual current annual performance

Table 9: Final Year-End Metric Performance Achievement for Metrics without National/State Benchmarks

Final Year-End Metric Performance Achievement Values (AV)			
AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
< 50% of the gap between end of year performance and current year target* is closed	≥ 50 % to <75% of the gap between end of year performance and current year target* is closed	≥ 75 % to <99% of the gap between end of year performance and current year target* is closed	100% of the gap between end of year performance and current year target* is closed

*DHCS to set a standard percent improvement target relative to individual current annual performance

b. The participating PRIME entity is eligible to receive an amount of incentive funding for the project metric determined by multiplying the total amount of funding related to the metric by the reported achievement value.
c. If a participating PRIME entity has received funding during a previous reporting period for a given metric, only the remaining amount is eligible for funding in the current reporting period.

5. Due to the COVID-19 public health emergency, participating PRIME entities will be eligible to receive DY 15 payments related to performance as follows:
    a. The DY 15 Mid-Year interim payments will be based on DY 15 Mid-Year reports in accordance with Section VII(C)(4).
    b. To determine the DY 15 Year-End payments the following will be calculated:

        i. The percent of the total DY14 allocation earned for each individual participating PRIME entity based on their DY14 YE performance, excluding funds reclaimed through over performance or high performance, and

        ii. The statewide average of the percent of the total DY 14 allocation earned, calculated separately for all DPHs and all DMPHs, and excluding funds reclaimed through over performance or high performance.

iii. The greater of (i) or (ii) above will be applied to the DY 15 allocation for each participating PRIME entity.

iv. DY 15 Mid-Year payments will be reconciled with DY 15 Year-End payments.

v. Section VII(C)(5) applicable to DY 15 incentive payments supersedes conflicting sections. All other PRIME requirements continue to apply.

c. Participating PRIME entities will be eligible to reclaim unearned funds and high performance funds as described in sections IX.B.2.a.(6), IX.B.2.b.(5), IX.B.2.c.(1)(f) , and IX.B.2.c(2)(f).

D. Progress and Payment Reconciliation

If within a given DY a participating PRIME entity has reported progress on a metric in an interim mid-year report and received partial funding based on that reported mid-year performance, only the remaining funding for full performance in the year is eligible to be earned upon submission of the final year-end report that documents the applicable full year metric performance.

If, upon review of the interim mid-year and final year-end reports, it is determined that the progress by the participating PRIME entity had not been achieved as reported and that such progress would have resulted in a lower payment amount, the participating PRIME entity will be required to re-pay the federal portion of the overpayment amount. If the review of the report determines that actual progress exceeded the progress previously reported and paid for, and the actual progress would have resulted in increased payment (up to the maximum allocated for the metric), then the participating PRIME entity will be able to receive the appropriate additional payment in conjunction with an updated report subject to the intergovernmental transfer process below.

E. Reporting for Payment

All participating PRIME entities will produce an interim mid-year and final year report on metric progress specific to the participating PRIME entity's project and its PRIME defined population. The reports shall be submitted using the standardized reporting mechanism approved by DHCS and CMS. The standardized reporting mechanism shall calculate the incentive payment amount being requested for the progress achieved in accordance with the metric achievement values estimated above.

The report must include submission of the data for each of the metrics for which the participating PRIME entity has achieved progress and seeks payment under the PRIME, except that a PRIME entity may provide estimates or reasonable projections if particular data is unavailable due to circumstances beyond the PRIME entity's control, including data that is collected and maintained by an external entity, such as a managed care organization, which has not been provided to the participating PRIME entity in a timely and accurate manner.

The reports will be due in accordance with the following:

1. Interim Mid-Year Report: Reporting on metrics measuring through December 31. The report and request for payment is due March 31, with payment occurring no later than April 30. For PRIME DY 11 only, the submission of the Five-year PRIME Project Plan will constitute the submission of the Interim Mid-Year Report.
2. Final Year-End Report: Reporting on metrics measuring through June 30. The report and request for payment is due September 30, with payment occurring no later than October 30. For PRIME DY 11 only, the final year-end report must include the submission of the baseline data and a narrative that describes the source of this information, the reporting infrastructure, how it was developed, and how this data will serve as the basis for improvement over the remaining Demonstration.

The Measurement Period for Mid-Year and Final Year-End Reports is listed in the Projects and Metrics Protocol (Attachment Q).

The State must use this documentation in support of PRIME claims made on the MBES/CBES 64.9 Waiver form.

F. Intergovernmental (IGT) Transfer Process

DHCS will issue requests to the entities for intergovernmental transfer amounts necessary for the nonfederal share of the applicable incentive payment amounts, and within the timeframe necessary for the payments to be paid by the dates specified in E(1) and E (2) above. A DPH or DMPH, or its affiliated public agencies, will make an intergovernmental transfer of funds to DHCS in the amount specified within 7 days of receiving the DHCS request. Upon timely receipt of the intergovernmental transfers, DHCS will draw the federal funding and pay both the non-federal and federal shares of the payment to DPHs or DMPHs as applicable. In the event of any misreported or insufficient data, DHCS will not be bound to the 30 day payment timelines in E(1) and E(2), as otherwise applicable, with respect to a participating PRIME entity until its reports are adequately corrected for approval for payment.

VIII. STATE REVIEW PROCESS

Hospital payments will be initiated by the submission of complete reports. DHCS will conduct an initial review of all submitted reports for data completeness. If reports are complete, DHCS will issue IGT letters consistent with the timeframe for payment described above. DHCS will then conduct the administrative and clinical reviews, as outlined below, and will adhere to Progress and Payment Reconciliation Procedures as outlined in section VII.B above. The reviews consist of the following:

1. *Administrative Review:* DHCS will conduct an administrative review of the reports for technical and administrative issues using guidelines approved by CMS.
2. *Clinical Review:* DHCS will conduct a review of the reports for clinical issues using the guidelines approved by CMS.

3. Reviews will be issued to participating PRIME entities. The PRIME entities will be given up to fourteen (14) calendar days to respond to issues and to revise reports as needed.
4. DHCS will review revisions and will coordinate any further revisions with the participating PRIME entity.

IX. Reinvestment of Unallocated Funds

Notwithstanding the annual limits set forth in the STCs, participating PRIME entities will have the opportunity to recapture unused or unclaimed PRIME pool payments:

A. Unused Pool Fund

1. If, through the PRIME Project plan submission and approval process, there is Pool funding that remains unallocated pursuant to Section 0 and B. above, then the affected participating PRIME entity, in addition to all other participating PRIME entities, may implement additional projects or demonstrate greater performance that will be applicable to the remaining Demonstration Years to earn the unused funds.

2. The opportunity to submit earn additional funding will be offered and allocated first to the affected participating PRIME entity, then to participating PRIME entities within the same Sub Pool, then among participating PRIME entities in the same Pool.

3. Requests for additional projects must be approved by the state.

B. Unclaimed Pool Payment

1. As set forth in section VII C. above, pay-for-performance metrics have annual pay-for-performance targets with an identified quantitative achievement target set at the beginning of each demonstration year. Pay-for-performance metrics will earn incentive payments proportional to the achievement value on a percentage basis, whereas pay-for-reporting metrics do not have a quantitative achievement target, and thus may only earn the full incentive payment value based on submission of the metric report.

2. If, at the end of the DY, a pay-for-performance project metric target is not met by a participating PRIME entity and that entity is not able to fully claim funds that otherwise would have been earned for meeting the metric target (“unearned funds”), a participating PRIME entity shall have the opportunity to claim such unearned funds through the following mechanisms. This 90% limitation applies to the aggregate amount of unearned funds that can be reclaimed through the mechanisms described in both IX.B.2.a. and IX.B.2.b.

a. Within a PRIME DY, participating PRIME entities can reclaim up to 90% of any unearned funds on pay-for-performance metrics by over performing (exceeding the target) in other pay-for-performance metrics in any PRIME project in that same demonstration year.

(1) Over-performance must be demonstrated by exceeding other project metric targets by at least 50% or greater.

(2) Table 9: Unearned Claiming (for current DY) demonstrates the amount of unearned funds that can be claimed through over-performance on pay-for-performance on a metric. The total amount of unearned funds that can be claimed by a participating PRIME entity will be proportional to the amount of over performance on all other pay for performance metric targets in the aggregate.

Table 9: Unearned Claiming (for current DY)

End of Year Metric Performance	**Amount of unearned funds that are eligible for re-claiming**
50-74% over performance	25% of the metric value
75%-99% over performance	37.5% of the metric value
100% over performance	50% of the metric value

(3) Participating PRIME entities are eligible to claim up to 90% of the amount of its total unearned funds based on the aggregate value of the over performance on the other metrics.

(4) The remaining 10% of unearned PRIME funds will be withheld and will be included in the DPH or DMPH PRIME High Performance Pool, described in (c) below. Unearned PRIME funds from DPHs will be included in the DPH High Performance Pool and unearned PRIME funds from DMPHs will be included in the DMPH High Performance Pool.

(5) When participating PRIME entities submit their year-end reports, they must indicate which, if any, metrics they have not fully met and have unearned funds, and which metrics they have over-performed and are being used to claim such unearned funds.

(6) Due to the COVID-19 public health emergency, participating PRIME entities will be eligible to claim DY 15 unearned funds based on their individual over-performance at DY 14 Year-End. Each participating PRIME entity's individual percent of its total DY 14 allocation earned through this reclaiming mechanism will be applied to its DY 15 allocation.

b. If a participating PRIME entity is not able to earn the full 90% value of its unearned funds through the mechanisms set forth in paragraph a. above, the participating PRIME entity will have another opportunity to earn and claim the remainder up to 90% of unearned funds during the subsequent demonstration year on any unmet pay-for-performance metric by demonstrating over-performance on the same unmet metric in the following manner:

(1) Over-performance must be demonstrated by exceeding an unearned funds metric demonstration year target by a minimum of 50% or greater.

(2) The proportion of unearned funds from a given metric that can be claimed will be based on the percentage of over-performance on that same metric. Table 10: Unearned Claiming (for subsequent DY) below demonstrates the amount of unearned funds that can be claimed through over-performance on pay-for-performance metrics.

Table 10: Unearned Claiming (for subsequent DY)

End of Year Metric Performance	**Amount of the same metric's prior year's unearned funds that are eligible for re-claiming**
50-74% over performance	25% of a metric's unearned funds
75%-99% over performance	37.5% of a metric's unearned funds
100% over performance	50% of a metric's unearned funds

(3) If a participating PRIME entity experiences two consecutive years of not meeting the applicable annual targets for a metric, it will no longer be eligible for any over-performance reclaiming in that demonstration year or subsequent demonstration year for that metric.

(4) When a participating PRIME entity submits its year-end final report, it must indicate which, if any, over performance metrics are being used to reclaim funds on prior unmet targets for those same metrics.

(5) For DY 15 only, due to the COVID-19 public health emergency, participating PRIME entities will be eligible to claim the remaining DY 14 unearned funds based on their individual over-performance at DY 14 Year-End. Each participating PRIME entity's percent of its total DY 13 unearned funds claimed by over performing at DY 14 Year-End through this reclaiming mechanism will be applied to its DY 14 unearned funds.

c. If, through the above mechanisms set forth above in paragraph a. and b. above a participating DPH system or DMPH is not able to claim 90% of their unearned funds from the prior year, any remainder of the 90% of unearned

funds for that metric from DPH systems shall be available to be earned by any DPH system through the establishment of a DPH PRIME High Performance Pool and any remainder of the 90% of unearned funds for that metric from DMPHs shall be available to be earned by any DMPH through the establishment of a DMPH PRIME High Performance Pool. The High Performance Pools will also include the 10% withhold of unearned funds referenced in (a) above for the respective DPHs and DMPHs separately.

(1) The DPH High Performance Pool

(a) The DPH PRIME High Performance Pools will be available annually for DY 13 through DY 15 for any DPH system achieving high performance (defined as achieving ≥90th percentile benchmark performance or 20% gap closure) in any of the eligible 19 National Quality Forum (NQF) metrics in the six DPH required PRIME projects.

(b) Eligible metrics in the PRIME High Performance fund do not include any metrics for which a DPH system used to reclaim unearned PRIME funds through mechanisms IX.B.2.a. and b. above.

(c) DPH PRIME High Performance Pool funds shall be allocated on a pro rata basis to each eligible DPH system, based on the value of each DPH system's eligible NQF metrics for which they have achieved high performance (herein referred to as "high performance metrics"), the aggregate of those values and the total amount of funding available in the pool.

i. Should the total remaining prior year unearned funds from all the DPH systems exceed the aggregate value of all DPH systems' high performance metrics, all DPH systems will be paid the full value of each of their high performance metrics.

ii. Should the total remaining prior year unearned funds from all the DPH systems be less than the aggregate value of all DPH systems' high performance metrics, all DPH systems will be paid a proportion of the full value of each of their high performing metrics. That proportion of funds will be equal to the ratio of the total remaining prior year unearned funds and the aggregate value of all DPH systems high performance metrics.

(d) For DY 13, the DPH High Performance Pool includes the DY 12's remaining of the 90% unearned DPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 12 and DY 13. For DY 14, the DPH High Performance Pool includes the DY 13's remaining of the

90% unearned DPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 14. For DY 15, the DPH High Performance Pool includes DY 14's remaining of the 90% unearned DPH funds (after application of the mechanisms described in IX.B.2.a and b), DY 15's remaining of the 90% unearned DPH funds (after application of the mechanism described in IX.B.2.a), and the 10% withhold for DY 15. The DPH High Performance Pool for each DY does not carry over to the next DY.

(e) When participating DPH PRIME entities submit their year-end final reports, they must indicate which, if any, eligible NQF metrics were used to claim funds from the DPH High Performance Pool.

(f) Due to the COVID-19 public health emergency, DPH PRIME entities will be eligible to claim DY 15 DPH high performance pool funds based on each participating PRIME entity's pro rata distribution, if any, of the DY 14 DPH high performance pool.

(2) The DMPH High Performance Pool

a. The DMPH PRIME High Performance Pools will be available annually for DY 13 through DY 15 for any DMPH achieving high performance (defined as achieving ≥90th percentile benchmark performance or 20% gap closure) in any of the eligible 19 National Quality Forum (NQF) metrics in the following projects as numbered in Attachment Q: Project 1.1, 1.2, 1.3, 2.1, 2.2 or 2.3.

b. Eligible metrics in the PRIME High Performance fund do not include any metrics for which a DMPH used to reclaim unearned PRIME funds through mechanisms IX.B.2.a. and b. above.

c. DMPH PRIME High Performance Pool funds shall be allocated on a pro rata basis to each eligible DMPH, based on the value of each DMPH's eligible NQF metrics for which they have achieved high performance (herein referred to as "high performance metrics"), the aggregate of those values and the total amount of funding available in the pool.

    i. Should the total remaining prior year unearned funds from all the DMPHs exceed the aggregate value of all DMPHs' high performance metrics, all DMPHs will be paid the full value of each of their high performance metrics.

    ii. Should the total remaining prior year unearned funds from all the DMPHs be less than the aggregate value of all DMPHs' high performance metrics, all DMPHs will be paid a proportion of the full value of each of their high

performing metrics. That proportion of funds will be equal to the ratio of the total remaining prior year unearned funds and the aggregate value of all DMPH high performance metrics.

d. For DY 13, the DMPH High Performance Pool includes the DY 12's remaining of the 90% unearned DMPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 12 and DY 13. For DY 14, the DMPH High Performance Pool includes the DY 13's remaining of the 90% unearned DMPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 14. For DY 15, the DMPH High Performance Pool includes DY 14's remaining of the 90% unearned DMPH funds (after application of the mechanisms described in IX.B.2.a and b), DY 15's remaining of the 90% unearned DMPH funds (after application of the mechanism described in IX.B.2.a), and the 10% withhold for DY 15. The DMPH High Performance Pool for each DY does not carry over to the next DY.
e. When participating DMPH PRIME entities submit their year-end final reports, they must indicate which, if any, eligible NQF metrics were used to claim funds from the DMPH High Performance Pool.
f. Due to the COVID-19 public health emergency, DMPH PRIME entities will be eligible to claim DY15 DMPH high performance pool funds based on each participating PRIME entity's pro rata distribution, if any, of the DY 14 DMPH high performance pool.

X. Learning Collaboratives

As part of this demonstration, DHCS will work in collaboration with participating PRIME entities to support regular learning collaboratives, which will be a required activity for all participating PRIME entities, and may be organized by the goals of PRIME or by the specific PRIME projects as described in the PRIME Funding and Mechanics Protocol (Attachment II). Learning collaboratives are forums for participating PRIME entities to share best practices and get assistance with implementing their PRIME projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but DHCS should coordinate with participating PRIME entities to organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help participating PRIME entities share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals with training in quality improvement who can answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others. Participating PRIME entities shall fund the non-federal share to support the conducting and operations of learning collaboratives.