DPH QIP DIRECTED PAYMENTS (PY2-PY4)
Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

Program Year (PY) 2: July 1, 2018 through June 30, 2019

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

Program Year 2: July 1, 2018 (PY 1 approved March 6, 2018)

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

Program Year 2 (SFY 2018-19) through Program Year 4 (SFY 2020-21)

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

   ☒ Quality Payments / Pay for Performance (Category 2 APM, or similar)
   ☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
   ☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
   ☐ Multi-Payer Delivery System Reform
   ☐ Medicaid-Specific Delivery System Reform
   ☒ Performance Improvement Initiative
   ☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If “other” was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application’s payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

California proposes to continue the Designated Public Hospital (DPH) Quality Incentive Pool (QIP) through PY 4 (SFY 2020-21). Effective in the PY 1 (SFY 2017-18) rate year, the State will direct MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. This program will support the State’s quality strategy by promoting access and value-based payment, increasing the amount of funding tied to quality outcomes, while at the same time further aligning state, MCP, and hospital system goals. This payment arrangement moves California towards value-based alternative payment models. It integrates historical supplemental payments to come into compliance with the managed care rule by linking payments to the utilization and delivery of services under the Managed Care Plan (MCP) contracts.

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

   Not Applicable

   ☐ Minimum Fee Schedule
   ☐ Maximum Fee Schedule
   ☐ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

   Not Applicable

   ☐ The State is proposing to use an approved State plan fee schedule
   ☐ The State is proposing to use a Medicare fee schedule
   ☐ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

Not Applicable

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

   ☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

   Not Applicable

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

Payments under the QIP will be made to DPH systems for meeting designated performance metrics that are linked to the utilization and delivery of services under the MCP contracts. Performance standards will be applied equally within a single class. Hospitals will be rewarded for meeting the performance goals, measured for all Medi-Cal beneficiaries utilizing services at the DPH. California will specify the maximum allowable payment amount under the QIP annually, which will be included in the supporting documentation in the rate submission process. See Attachment 1 for further detail.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

Class of DPH Systems
1) Designated public hospital systems defined by CA Welfare & Institutions Code: 14184.10(f)(1).

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

All participating hospital systems will report on at least 20 performance measures approved by DHCS. Targets and performance calculations for each measure, as discussed in Attachment 1, uniformly apply to all participating hospital systems. See Attachment 1 for further detail.

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf

b. Date of quality strategy (month, year):

July 2018

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	**Quality strategy page**
Enhance quality, including the patient care experience, in all DHCS programs	Deliver effective, efficient, affordable care	Medi-Cal Managed Care Quality Strategy Report, Page 6
If additional rows are required, please attach.		

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

Over the 4-year program (specifically, this preprint requests approval of a 3-year extension (PY2 through PY4)), the State will direct MCPs to make performance-based quality incentive payments to DPH systems based on their performance on a specified set of measures that address: primary, specialty, and inpatient care, including measures of appropriate health care utilization. The QIP will advance the state's Quality Strategy through the use of targeted performance measures to drive DPH improvement in the categories of Primary Care, Specialty Care, Inpatient Care and Resource Utilization. In order to receive QIP payments, DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The program is anticipated to lead to substantial year-over-year improvement, promote access, value-based payment, and tie funding to quality outcomes, while at the same time further aligning state, MCP, and hospital system goals.

The QIP creates a robust data monitoring and reporting mechanism with strong incentives for quality data. This information will enable dependable data-driven analysis, issue spotting and solution design. The QIP also creates incentives to build data and quality infrastructure and ties provider funding directly to these goals, allowing California to pay for quality and build capacity. Finally, implementing QIP will also drive changes to policy and legal frameworks to facilitate future data-driven quality improvement programs.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

Please see Attachment 2 for additional details.

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

The payment arrangement targets all Medi-Cal managed care enrollees receiving care from participating DPHs. The QIP is not intended to drive quality improvement for a specific subgroup of Medi-Cal enrollees. Certain subsets of enrollees or populations may be excluded from the QIP arrangement as necessary for actuarial or other reasons.

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

Not applicable

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

Not applicable

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

See Attachment 1.

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
1.	See Attachment 1, Part A.				
2.					
3.					
4.					
5.					
6.					
If additional rows are required, please attach.					

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

See Attachment 1, B. Target Setting and Performance Measurement.

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

18. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

☒ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

Attachment 1

Payments under the QIP will be made to DPH systems for meeting designated performance metrics that are linked to the utilization and delivery of services under the MCP contracts. Performance standards will be applied equally within the class. Hospitals will be rewarded for meeting the performance goals specified below. California will specify the maximum allowable payment amount under the QIP annually, which will be included in the supporting documentation through the rate submission process.

	PY 1, SFY 2017-18 Approved by CMS	PY2-PY4 3-year extension
DPH QIP (Total Computable)	$640 million (PY 1, Base year)	PY(n) = ($640M) x (1 + Growth Rate[a])^(PY(n)-PY(1)) + Transition portion of EPP PY(n)[b] + Increase QIP funding[c]

[a]Growth Rate: annual growth rate will be the Consumer Price Index for All Urban Consumers (CPI-U) Hospital and Related Services, Source: Bureau of Labor Statistics

[b]Transitioning portion of Enhanced Payment Program (EPP) PY(n): each year the state, in collaboration with the DPHs, will evaluate the benefit of shifting a portion of the EPP funding into QIP, as part of an effort to further our collective goal of moving away from the utilization based directed payments and focusing on more performance based/value based directed payments. If the state determines to transition a portion of EPP into QIP, the reduction of EPP will be equal to the increase of QIP. Finally, the state and DPHs will not consider this option until PY 3 (SFY 2019-20) at the earliest.

[C] Increase QIP funding: the state will, in collaboration with the DPHs, assess the initial success of the QIP program and determine whether an increase in the maximum allowable QIP annual payment amount is appropriate. The state will not consider this option until PY 4 (SFY 2020-21). For any material increase in the QIP funding, DHCS will determine the need for increasing performance measures.

A. Performance Measures

The State will direct MCPs to make performance-based quality incentive payments to DPHs based on achievement of targets for quality of care using measures in the categories set forth below. The quality metrics will be measured across all Medi-Cal beneficiaries. All such metrics will be based on utilization and delivery of services.

- Category I: Primary Care
- Category II: Specialty Care
- Category III: Inpatient Care
- Category IV: Resource Utilization

The proposed performance measures in each category include process, outcomes, system transformation, and other indicators that are consistent with state, MCP, and DPH delivery system reform and quality strategy goals. Measures are drawn from nationally vetted and endorsed measure sets (e.g., National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc.) or measures in wide use across Medicare and Medicaid quality initiatives (e.g., the Medicaid Child and Adult Core Set Measures, CMS Core Quality Measures Collaborative measure sets, Health Home

measure sets, Behavioral Health Clinic measure sets, and Merit-based Incentive Payment System and Alternative Payment Model measures, etc.).

Measures selected will not duplicate any measures for which federal funds are already available to DPH systems, unless approved by DHCS. Prior to the start of each subsequent Program Year, the State may work with the DPH systems and MCPs to update and revise the measures, measure sets, and target setting methodology as needed to reflect current clinical practices and changes to national measures.

Each DPH system will report on at least 20 measures total from the list of performance measures included below in Table 1, for all Program Years approved in accordance with this pre-print, which may include revisions in subsequent Program Years.

Any revisions to the performance measures listed in Table 1 in subsequent Program Years, will be made prior to the targeted Program Year, must include known benchmarks applicable to the Medicaid population, and must meet one or more of the following criteria:

- is an NQF-endorsed measure,
- is considered a national Medicaid performance measure, or
- has been used with financial performance accountability in a CMS approved performance program and is not duplicative of a current CMS approved Medicaid program.

Any changes to the performance measures will be uniformly treated for all DPHs within the single class, and subject to DHCS approval.

Table 1: Performance Measures

MEASURE NAME
Primary Care: (EAS+): These measures were selected to align with health plan efforts and promote higher quality care in the ambulatory care setting.
Comprehensive Diabetes Care: Eye exam (CDC-E) (NQF 0055, Quality ID 117)
Comprehensive Diabetes Care: Blood Pressure Control (CDC-BP)
Comprehensive Diabetes Care: A1C Control (CDC-H8)
Asthma Medication Ratio (AMR)
Children and Adolescent access to PCP* (CAP
Medication reconciliation Post Discharge (MRP)
Immunization for Adolescents (IMA) Combination 2* (NQF 1407, Quality ID 394)
Childhood Immunizations (CIS) Combination 3*(NQF 0038, Quality ID 240)
7-Day Post-Discharge Follow-Up Encounter for High Risk Beneficiaries
Specialty Care (CVD): These measures align with the state's quality strategy in promoting high quality care and improving overall health.
Coronary Artery Disease (CAD): Antiplatelet Therapy (NQF 0067, Quality ID 006)
Coronary Artery Disease (CAD): ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%) (NQF 0066, Quality ID 118)
Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) (NQF 0070, Quality ID #007, eMeasure ID CMS145v6)
Heart Failure (HF): ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF: 0081, Quality ID 005) (eMeasure ID: CMS135v6, eMeasure NQF: 2907)
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF 0083, Quality ID #008) (eMeasure ID CMS144v6, eMeasure NQF 2908)
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (NQF 1525, Quality ID 326)
Inpatient: These high value patient safety measures align with work already underway in public health care systems that began in DSRIP but are not part of PRIME.
Surgical Site Infections (SSI)
Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin (NQF 268, Quality ID 21)
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (NQF 239, Quality ID 23)
Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections (Quality ID 76)
Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia (Quality ID 407)
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic (TJC STK-2, eMeasure ID: CMS104v6)

Resource Utilization: These measures reflect an opportunity to reduce unnecessary utilization and improve quality of care.
Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patient 18 years and Older (Quality ID 415)
Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 to 17 years old* (Quality ID 416)
Unplanned Reoperation within 30 Day Postoperative Period (Quality ID 355)
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients (Quality ID 322)
Concurrent Use of Opioids and Benzodiazepines

*Pediatric measures

B. Target Setting and Performance Measurement

Targets and performance will be determined based on the availability of national Medicaid benchmarks as follows:

1. *Target Setting for Measures that have a national Medicaid benchmark: Gap Closure*

   The gap is defined as the difference between the DPH system's end of program year performance and the Medicaid 90th percentile benchmark. The target setting methodology will be as follows for PY 2-PY 4:

   - 10.0% gap closure for 1st year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 10.0% gap closure in the prior year,
   - 8.5% gap closure for 2nd year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 8.5% gap closure in the prior year,
   - 6.0% gap closure for 3rd year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 6.0% gap closure in the prior year.

   This approach recognizes the increasing difficulty of year-over-year gap closure, while still maintaining robust performance improvement targets.. DPH systems that have already achieved at or above the 90th percentile will be considered to be at 100% of their quality goal. A minimum performance level of the Medicaid 25th percentile will be required, as described in Table 2.

   An example of this target setting methodology for a benchmarked Medicaid measure for Program Year 2 is as follows:

   - Improvement: performance >25th percentile and <90th percentile
     - 10% gap closure between prior year performance & 90th percentile benchmark
       - *Example: Primary Care Performance Measure X*
         - *90th Percentile Benchmark: 70.0%*

- *Baseline: 55.0%*
- *Year 1 target: 56.53%*
  - *Gap: 70% -55% = 15%*
  - *10% of 15% = 1.5%*
  - *55% + 1.5% = 56.5%*

In the event, the performance measures identified in Table 1 change in a subsequent Program Years, a DPHs choosing to report on a new performance measure must report historical data from the prior Program Year in order to receive a gap-closure score for that metric. After Program Year 1, a DPH will receive credit for achieving gap closure goals only, and there will be no further credit given for reporting only.

2. *Target Setting for Measures which have no Medicaid decile benchmark: Gap Closure to DHCS established top performance benchmark*

DHCS will establish appropriate minimum and top performance benchmarks by using processes and criteria approved for identifying benchmarks for non-Medicaid benchmarked measures in the PRIME program. This process takes into account all available performance data on a given metric, be it national, state, or DPH-specific data, as well as known variances between the populations measured by the available performance data and the Managed Care Medi-Cal populations measured by QIP. DHCS may update these benchmarks annually, as appropriate based on the most recently available data.

The gap is defined as the difference between the DPH system's end of program year performance and the DHCS established maximum performance benchmark. The target setting methodology for non-Medicaid benchmark and gap closure requirements will be as follows for PY 2-PY 4:

- 10.0% gap closure for 1st year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 10.0% gap closure in the prior year,
- 8.5% gap closure for 2nd year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 8.5% gap closure in the prior year,
- 6.0% gap closure for 3rd year of QIP reporting, or subsequent PYs assuming the DPH failed to meet a 6.0% gap closure in the prior year.
-

DPHs, at a minimum will be required to perform at or above the established minimum performance benchmark. DPHs with end of year performance on a given measure at or above the top performance benchmark for that measure will be required to achieve performance that maintains or exceeds that measure's top performance benchmark for the coming year.

C. Achievement Values

Pay-for-Performance: The achievement value of a metric will be based on the amount of progress made toward achieving the metric performance target.

Based on the progress reported, and using the target setting methodology described in B.1 above, Table 2 will be used to determine the achievement value for metrics that have a Medicaid benchmark. For measures without a Medicaid decile benchmarks, the target setting methodology described in B.2, Table 2 below will be used to determine the achievement value.

Table 2: Medicaid Benchmark Measures - Year-End Measure Performance Achievement

	Year-End Measure Performance Achievement Values (AV)			
Year End Measures Performance in Prior DY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
≥90th percentile	Performance <90th percentile	NA	NA	Performance ≥90th percentile
≥25th and <90th percentile	< 50% of the applicable Gap closure (see B.1)	≥ 50 % to <75% of the applicable Gap closure (see B.1)	≥ 75 % to <100% of the applicable Gap closure (see B.1)	100% of the applicable Gap closure (see B.1)
<25th percentile Track A: If gap between performance and 25th percentile is ≥ the applicable gap closure (see B.1), between performance and 90th percentile	Performance <25th percentile	NA	NA	Performance ≥25th percentile
<25th percentile Track B: If gap between performance and 25th percentile is < the applicable gap closure (see B.1), between performance and 90th percentile	Performance <25th percentile, or performance ≥25th percentile and < 50% of the applicable Gap closure (see B.1)	Performance ≥25th percentile and ≥ 50 % to <75% of the applicable Gap closure (see B.1)	Performance ≥25th percentile and ≥ 75 % to <100% of the applicable Gap closure (see B.1)	100% of the applicable Gap closure (see B.1)

Table 3: Non-Medicaid Benchmarked Measures - Year-End Measure Performance Achievement

	Year-End Measure Performance Achievement Values (AV)			
Year End Metric Performance in Prior DY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
Top Performance Benchmark	Performance <Top Performance Benchmark	NA	NA	Performance ≥Top Performance Benchmark
≥ Minimum Performance Benchmark and < Top Performance Benchmark	< 50% of the applicable Gap closure (see B.2)	≥ 50 % to <75% of the applicable Gap closure (see B.2)	≥ 75 % to <100% of the applicable Gap closure (see B.2)	100% of the applicable Gap closure (see B.2)
< Minimum Performance Benchmark Track A: If gap between performance and Minimum Performance Benchmark is ≥the applicable gap closure between performance and the Top Performance Benchmark	Performance < Minimum Performance Benchmark	NA	NA	Performance ≥ Minimum Performance Benchmark
< Minimum Performance Benchmark Track B: If gap between performance and Minimum Performance Benchmark is <the applicable gap closure between performance and Top Performance Benchmark	Performance <minimum performance benchmark and < 50% of the applicable Gap closure (see B.2)	Performance ≥minimum performance benchmark and ≥ 50 % to <75% of the applicable Gap closure (see B.2)	Performance ≥minimum performance benchmark and ≥ 75 % to <100% of the applicable Gap closure (see B.2)	100% of the applicable Gap closure (see B.2)

Final QIP Payments:

Payments will be made based on a Quality Score that measures the sum of the achievement values for all measures selected for reporting by the DPH system divided by the number of measures it selected for reporting. Each maximum DPH allocation would then be multiplied by the DPH Quality Score to determine the final QIP payment. For Program Year 1 only, full achievement will be given for each measure upon submission of the baseline data in the final year-end report. For subsequent QIP Program Years, achievement value will be based on performance per the above tables.

The State will require MCPs, via its contracts, all-plan-letters, or similar instruction to make final QIP payments to contracted DPH systems. The State will identify the amount of final QIP payments each MCP must make to each contracted DPH system, with the sum of these amounts not to exceed the amount of total funds available in the applicable QIP PY.

The maximum payment amount that may be earned by a specific DPH system (i.e., the amount earned if the DPH system attains all of its selected quality targets) will be equal to the amount of total funds available in the applicable QIP PY multiplied by the DPH system's proportion of the total Medi-Cal managed care members served in the given year. If there is more than one MCP in the specific DPH system's service area, the final QIP payment to the DPH system will be allocated proportionally among the MCPs.

Attachment 2

CA 438.6(c) Proposal F - Designated Public Hospital (DPH) Quality Incentive Pool (QIP)
Program Years 1-4 Evaluation Plan
July 1, 2017 – June 30, 2021

Evaluation Purpose

The purpose of this evaluation is to determine if the proposed directed payments made through California Department of Health Care Services (DHCS) contracts with the Medi-Cal Managed Care Plan (MCP) contracts to network provider Designated Public Hospitals (DPHs) result in improving the current quality of inpatient and outpatient services for Medi-Cal members assigned to DPHs, which serve approximately 30% of Medi-Cal members.

Background

During this 4-year program, DHCS will direct MCPs to make performance-based quality incentive payments to 17 participating DPH systems based on their performance on at least 20 of 26 specified quality measures that address primary, specialty, and inpatient care, including measures of appropriate resource utilization. The QIP will advance the state's Quality Strategy goal of enhancing quality in DHCS programs by supporting DPHs to deliver effective, efficient, and affordable care. In order to receive QIP payments, DPHs must achieve specified improvement targets, measured for all Medi-Cal beneficiaries utilizing services at the DPH.

The first program year (PY), from July 1, 2017 to June 30, 2018, will consist of baseline reporting. All subsequent PYs will consist of pay-for-performance (P4P) only.
The first PY was approved by CMS on March 6, 2018. The 3-year extension of the DPH QIP (PY 2 – PY 4) is still pending CMS approval.

Stakeholders

- Designated Public Hospitals
- California Association of Public Hospitals (CAPH) and Safety Net Institute (SNI)
- California Association of Health Plans (CAHP)
- Local Health Plans of California (LHPC)
- MCPs

Evaluation Question

This evaluation is designed to answer the following question:

1) Do performance-based quality incentive payments to DPHs through the MCPs improve the quality of inpatient and outpatient services for Medi-Cal members?

Evaluation Design

The state will use hospital system aggregate data reported to DHCS pertaining to the performance measures listed in Table 1. Each DPH is required to pick 20 out of the 26 measures to report to DHCS.

Table 1: Performance Measures

MEASURE NAME
Primary Care: (EAS+): These measures were selected to align with health plan efforts and promote higher quality care in the ambulatory care setting.
Comprehensive Diabetes Care: Eye exam (CDC-E) (NQF 0055, Quality ID 117)
Comprehensive Diabetes Care: Blood Pressure Control (CDC-BP)
Comprehensive Diabetes Care: A1C Control (CDC-H8)
Asthma Medication Ratio (AMR)
Children and Adolescent access to PCP* (CAP
Medication reconciliation Post Discharge (MRP)
Immunization for Adolescents (IMA) Combination 2* (NQF 1407, Quality ID 394)
Childhood Immunizations (CIS) Combination 3*(NQF 0038, Quality ID 240)
7-Day Post-Discharge Follow-Up Encounter for High Risk Beneficiaries
Specialty Care (CVD): These measures align with the state's quality strategy in promoting high quality care and improving overall health.
Coronary Artery Disease (CAD): Antiplatelet Therapy (NQF 0067, Quality ID 006)
Coronary Artery Disease (CAD): ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%) (NQF 0066, Quality ID 118)
Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) (NQF 0070, Quality ID #007, eMeasure ID CMS145v6)
Heart Failure (HF): ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF: 0081, Quality ID 005) (eMeasure ID: CMS135v6, eMeasure NQF: 2907)
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (NQF 0083, Quality ID #008) (eMeasure ID CMS144v6, eMeasure NQF 2908)
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (NQF 1525, Quality ID 326)
Inpatient: These high value patient safety measures align with work already underway in public health care systems that began in DSRIP but are not part of PRIME.
Surgical Site Infections (SSI)
Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin (NQF 268, Quality ID 21)
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (NQF 239, Quality ID 23)
Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections (Quality ID 76)
Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia (Quality ID 407)
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic (TJC STK-2, eMeasure ID: CMS104v6)
Resource Utilization: These measures reflect an opportunity to reduce unnecessary utilization and improve quality of care.
Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patient 18 years and Older (Quality ID 415)
Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 to 17 years old* (Quality ID 416)
Unplanned Reoperation within 30 Day Postoperative Period (Quality ID 355)
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients (Quality ID 322)
Concurrent Use of Opioids and Benzodiazepines

*Pediatric measures

In PY 1 (July 1, 2017 to June 30, 2018), DHCS will use aggregated data submitted by DPHs to DHCS to determine:

- The number of measures each hospital reported
- The percentage of hospitals that reported on each measure

Annually in PY 2 through 4, DHCS will use aggregated data, submitted by DPHs to DHCS, to determine:

- For each measure, of public hospitals reporting on that measure, what percentage met their quality improvement goal
- For each measure, the aggregate improvement seen across all DPHs who reported on the measure.
- For each public hospital, the percentage of measures for which they meet their quality improvement goal

Data Collection Methods

- DPHs will report aggregated data on each measure to DHCS.
- Depending on the specific measure and DPH capabilities, DPHs will collect aggregated data utilizing Electronic Health Records and/or claims and registry databases.
- DPHs will submit encrypted aggregated data collected in accordance with the QIP Reporting Manual to DHCS, in the manner required by DHCS. For PY 1, DPHs will submit encrypted data using an Excel data template.
- The state will conduct its analysis on 100% of the data received.

Timeline

Example for PY1, with similar timeline for subsequent PYs:

- PY: July 1, 2017 to June 30, 2018
- Dec. 15, 2018 –Deadline for DPHs to submit data to DHCS
- Dec. 16, 2018 to May 30, 2019 – DHCS review of DPH reports
- June 2019 – Final approved data submitted to DHCS Capitated Rates Development Division for payment to DPHs
- June to July 2019 – DHCS will develop the annual QIP evaluation report
- July 2019 – Draft annual QIP evaluation report reviewed by stakeholders
- August to September 2019 – Stakeholder comments incorporated into annual QIP evaluation report
- October 2019 – Annual QIP evaluation report posted on public DHCS website and shared with CMS

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the State's QIP website.