
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):

July 1, 2017 through June 30, 2018

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

July 1, 2017

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

5-years (SFY 2017-18 through SFY 2021-22)

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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 create a new Designated Public Hospital (DPH) Quality Incentive Pool (QIP). Effective in the 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.*

- 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:

- 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.

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 specified below. California will specify the maximum allowable payment amount under the QIP annually. 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 and no more than 25 performance measures selected and jointly agreed to by the State, MCPs, and DPHs. 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/services/Documents/DHCS_Quhttp://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2017.pdfality_Strategy_2017.pdf

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

January 2017

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	2017 Medi-Cal Quality Strategy, page 2
If additional rows are required, please attach.		

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- 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.

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. To receive QIP payments the 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, 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.

The State will have a plan to evaluate the extent to which the payment mechanisms and performance measure incentives achieve the goals and objectives identified in the managed care quality strategy. The evaluation will be linked to the State’s process for updating the Medi-Cal Quality Strategy, and findings shall be used to influence the subsequent plan. The State will submit the evaluation plan to CMS for approval, consistent with the process set forth at 42 CFR § 438.6(c).

The evaluation plan will clearly identify the specific goals and objectives described in the State’s managed care quality strategy that the QIP is designed to achieve. Because Quality Improvement is a multi-year effort, requiring the steady measurement, process improvements, and sustained effort over time to achieve improved outcomes. The state will work to develop a program over the course of multiple years allows for the time necessary to observe changes in health outcomes and in institutional improvements, and provides the ongoing financial support and incentives to focus energy on the improvements.

- 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.

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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 each class. Hospitals will be rewarded for meeting the performance goals specified below. California will specify the maximum allowable payment amount under the QIP annually.

	SFY 2017-18
DPH Quality Incentive Program (Total Computable)	\$640 million

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. Prior to the start of each subsequent Demonstration Year, the State will work with the DPH systems and MCPs to update and revise the measures 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 and no more than 25 measures total from the list of performance measures included below in Table 1, for Demonstration Year 1.

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 (CDC): Eye exam
CDC: Blood Pressure control
CDC: A1C control (<8%)
Asthma Medication Ratio
Children and Adolescent access to PCP*
Medication reconciliation post discharge
Immunization for Adolescents
Childhood Immunizations (combo 3)*
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.
CAD: Antiplatelet Therapy
CAD: ACE Inhibitor or ARB - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
CAD: Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
Heart Failure (HF): ACE/ARB for LVSD
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Atrial Fibrillation/Atrial Flutter: Chronic Anti-coagulation
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
Perioperative Care: Venous Thromboemolism (VTE) Prophylaxis
Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections
Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic
Resource Utilization: These measures reflect an opportunity to reduce unnecessary utilization and improve quality of care.

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Emergency Department Use of CT for mild blunt head trauma (≥ 18) [‡]
Emergency Department Use of CT for mild blunt head trauma (2-17) ^{*‡}
Unplanned reoperation within 30 days of operation [‡]
Cardiac Stress Imaging for low risk procedures [‡]
Concurrent Use of Opioids and Benzodiazepines

*Pediatric measures

[‡] Investigating reporting feasibility by DPHs

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: 10% Gap Closure*

The gap is defined as the difference between the DPH system’s end of demonstration year performance and the Medicaid 90th percentile benchmark. The target setting methodology will be a 10% gap closure year-over-year. 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 is as follows:

- Improvement: performance $>25^{\text{th}}$ percentile and $<90^{\text{th}}$ 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%
 - » $70\% - 55\% = 15\%$
 - » $10\% \text{ of } 15\% = 1.5\%$
 - » $55\% + 1.5\% = 56.5\%$

2. *Target Setting for Measures which have no Medicaid benchmark, but that do have a Medicare benchmark: 10% Gap Closure*

- a. The gap is defined as the difference between the end of demonstration year performance and the Medicare 90th percentile benchmark. The target setting methodology will be a 10% gap closure year-over-year. DPH systems that have already achieved at or above the 90th

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percentile will be considered to be at 100% of their quality goal. A minimum performance level of Medicare 10th percentile will be required, as described in Table 3.

- b. This method will be used only if the Medicare decile performance is available.

3. *Target Setting for Measures which have neither a Medicaid nor a Medicare benchmark:*

1% Relative Improvement-Over-Self

- a. If neither Medicaid benchmarking nor Medicare decile benchmarking is available, the target will be set by multiplying the DPH system’s prior year measure performance by 1.01.
- b. DPH systems that achieve, or have already achieved at or above an absolute 90% performance rate (numerator/denominator x 100) will be considered to be at 100% of their quality goal.
- c. For “Inverse Measures,” defined as a measure for which a lower calculated performance rate indicates better clinical care or control, DPH systems that achieve, or have already achieved at or below an absolute 10% performance rate (numerator/denominator x 100) will be considered to be at 100% of their quality goal.

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. To the extent Medicare deciles are used, using the target setting methodology described in B.2, Table 2 below will be used to determine the achievement value for those metrics

DPH submission of baseline performance rate for each measure in the final year-end report will be considered as full achievement of meeting that measure’s target.

Table 2: Medicaid Benchmark 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
≥90th percentile	Performance <90 th percentile	NA	NA	Performance ≥90 th 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

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	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
<25th percentile Track A: If gap between performance and 25 th percentile is \geq 10% gap between performance and 90 th percentile	Performance <25 th percentile	NA	NA	Performance \geq 25 th percentile
<25th percentile Track B: If gap between performance and 25 th percentile is < 10% gap between performance and 90 th percentile	Performance <25 th percentile, or performance \geq 25 th percentile and < 50% of the 10% Gap is closed	Performance \geq 25 th percentile and \geq 50 % to <75% of the 10% Gap is closed	Performance \geq 25 th percentile and \geq 75 % to <99% of the 10% Gap is closed	100% of the 25% Gap is closed

Table 3: Medicare Decile 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
\geq 90th percentile	Performance <90 th percentile	NA	NA	Performance \geq 90 th percentile
\geq 10th and < 90th percentile	< 50% of the 10% Gap is closed	\geq 50 % to <75% of the 10% Gap is closed	\geq 75 % to <99% of the 10% Gap is closed	100% of the 10% Gap is closed
< 10th percentile Track A: If gap between performance and 10 th percentile is \geq 10% gap between performance and 90 th percentile	Performance <10 th percentile	NA	NA	Performance \geq 10 th percentile

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	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
< 10th percentile Track B: If gap between performance and 10 th percentile is <10% gap between performance and 90 th percentile	Performance <10 th percentile, or performance ≥10 th percentile and < 50% of the 10% Gap is closed	Performance ≥10 th percentile and ≥ 50 % to <75% of the 10% Gap is closed	Performance ≥10 th percentile and ≥ 75 % to <99% of the 10% Gap is closed	100% of the 10% Gap is closed

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. Full achievement will be given for each measure upon submission of the baseline data in the final year-end report. For subsequent QIP years, achievement value will be based on performance per the above tables

The State will include in its contracts with MCPs requirements for the MCP to pay QIP payments to contracted DPH systems according to the following process:

1. The State will specify a maximum allowable payment amount that it will direct each MCP to pay to each DPH during the subject rate-setting period. The maximum allowable payment that may be earned by each DPH system will be equal to the amount of total funds available in the QIP multiplied by each class’s proportion of the total DPH Medi-Cal managed care members receiving services, as measured by the number of Medi-Cal managed care enrollees services by the DPH system in the given year.
2. The maximum payment amount earned by a specific DPH system (i.e., the amount earned if the DPH system attains all of its quality targets) will be equal to the amount of funds available for all the DPHs multiplied by the DPH system’s proportion of the total Medi-Cal managed care receiving services in the given year.
 - a. If there is more than one MCP in the DPH system’s service area, the maximum QIP funds available to a DPH system will be allocated proportionally among the MCPs, and paid according to DPH system achievement of quality targets in the aggregate measured across all Medi-Cal managed care services provided by the DPH system.
3. The State will calculate interim QIP payments that MCPs will be directed to pay to each contracted DPH system based on:

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- a. The State's determination of each DPH system's projected Medi-Cal enrollees receiving services, calculated in the manner set forth above, and using the most recently available data trended forward, for the subject rate setting period.
 - b. Each DPH's expected quality performance under the QIP (based on prior year or other data);
 - c. A target for the MCP to pay a percentage of each DPH system's expected earned QIP payment in advance of a final reconciliation after the subject rate setting period.
4. Following the subject rate setting period, actual maximum allowable QIP payment amounts, quality performance, and actual payment amounts earned will be calculated for each DPH system in the aggregate across all MCPs.
5. MCPs will be directed to make a final payment for the year to DPH systems based on the difference between the interim QIP amounts paid to DPH systems during the subject rate setting period and the actual QIP amount earned. In the event that the interim payments made by the MCP to a DPH system during the subject rate setting period exceeded the total actual amount earned, the DPH system will remit the excess payment to the MCP as part of the final payment. Any amount remitted by a DPH system to a MCP as part of the final payment will be used by the MCP to fund current or future QIP payments, and may not be used for any other purpose.