DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 27, 2023

Michelle Baass
Interim Medicaid Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Michelle Baass:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving California's submission of an amendment to a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The amendment was received by CMS on December 30, 2023 and has a control name of CA_VBP_IPH.OPH2_Amend_20210101-20231231.

CMS has completed our review of the following amendment to a Medicaid managed care state directed payment(s):

- Quality Incentive Pool for Designated Public Hospital systems for the rating periods covering January 1, 2021 through December 31, 2023, incorporated in the CY 2023 capitation rates through a separate payment term of up to $2,040,316,388.17.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for state directed payments described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations. The state is required to submit contract action(s) and related capitation rates that include all state directed payments.

All state directed payments must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review. The Medicaid Managed Care Rate Development Guide includes specific requirements associated with the use of separate payment terms. If the total amount of the separate payment term is exceeded from what is documented in the preprint or the payment methodology changes, CMS requires the state to submit a state directed payment preprint amendment. If the separate payment term amount documented within the rate certification exceeds the separate payment term amount documented in the preprint, the state is required to submit a rate certification amendment.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

Alexis E. Gibson -S

Digitally signed by Alexis E. Gibson -S
Date: 2023.12.27 15:21:02 -05'00'

Alexis Gibson
Acting Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

DPH QIP DIRECTED PAYMENTS (January 1, 2021 – December 31, 2023)
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):

Calendar Year (CY) 2021: January 1, 2021 through December 31, 2021
CY 2022: January 1, 2022 through December 31, 2022
CY 2023: January 1, 2023 through December 31, 2023

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

January 1, 2021

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

3 years; Program Year 4 (PY 4, CY 2021) through PY 6 (CY 2023). The State anticipates submitting subsequent preprints to continue the Designated Public Hospital (DPH) Quality Incentive Pool (QIP) program. The payment arrangement described in this preprint constitutes the total DPH QIP program payment for Program Years 4-6 and supersedes all other payment authorizations for the DPH QIP program during that period.

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 will continue the DPH QIP through PY 6. Effective PY 4, the State will direct Medi-Cal managed care health plans (MCPs) to make QIP payments tied to performance on designated performance measures in categories such as, but not limited to, primary care access and preventive care, acute and chronic care, behavioral health, maternal health, patient safety, and overuse/appropriateness of care. 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 MCP contracts.

Additionally, QIP PY 4 completes the PRIME to QIP Transition that incorporated the quality improvement and funding from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program that was established as part of the California Medi-Cal 2020 Demonstration (11-W-00193/9). California seeks to maintain and continue the momentum achieved with DPHs on improvements in the quality of care delivered to Medi-Cal beneficiaries. Otherwise, the continuous quality improvement and delivery system reforms related to the PRIME Program would have terminated on June 30, 2020 with the Medi-Cal 2020 Demonstration.

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 measures 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, or assigned by MCPs to, the DPH system. California will specify the maximum allowable payment amount under the QIP, 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 Providers
1) Designated public hospital systems defined by CA Welfare & Institutions Code section 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 DPH systems will report on a specific number of measures, as specified in Attachment 1. As discussed in Attachment 1, targets and performance calculations for each measure uniformly apply to all participating DPH systems.

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):

June 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.

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 QIP will advance the state's Quality Strategy through the use of targeted performance measures to drive DPH improvement in categories such as, but not limited to, primary care access and preventive care, acute and chronic care, behavioral health, maternal health, patient safety, and overuse/appropriateness of care. In order to receive QIP payments, DPH systems must achieve specified improvement targets. QIP PYs 4-6 are anticipated to continue the substantial year-over-year improvement in QIP and PRIME since their inception and to continue to promote access, value-based payment, and tie funding to quality outcomes, while at the same time further aligning state, MCP, and hospital system goals. Due to the COVID-19 Public Health Emergency (PHE), DHCS will temporarily modify the PY 4 measures and improvement targets otherwise applicable to QIP PYs 4-6 as outlined in Attachment 1. In addition, DHCS will be modifying PY 5 and PY 6 to allow flexibility for the DPHs on which measures are reported as well as an optional reduction in total measures. This modification is explained in Attachment 1.

The QIP creates a robust data monitoring and reporting mechanism which incentivizes quality data. This information will enable dependable data-driven analysis, issue spotting and solution design. The QIP also creates incentives to build DPH system data and quality infrastructure and ties provider funding directly to these goals, allowing California to pay for quality and build capacity. Finally,

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.

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, or assigned by MCPs to, participating DPH systems. 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.

At its discretion, DHCS may require stratification for a subset of measures by age, gender, and/or race/ethnicity. Starting in PY 4, DHCS will implement a Health Equity measure for DPH systems to continue work on disparity reduction, which will require stratification to identify the population targeted for quality improvement.

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

438.6(c) Proposal – DPH QIP Directed Payments
Performance Standards and Payment Specifications
Program Years 4–6: January 1, 2021 – December 31, 2023

Payments under the QIP will be made to DPH systems for meeting designated performance measures that are linked to the utilization and delivery of services under the MCP contracts. Performance standards will be applied equally within the class. DPH systems will be rewarded for meeting the performance goals specified below. Achievement of measure targets will be measured as specified in the QIP manual established for each program year (PY). As specified earlier, each PY is a calendar year. The payment arrangement described in this preprint constitutes the total DPH QIP program payment for PYs 4-6 and supersedes all other payment authorizations for the DPH QIP program during that period. California will specify the maximum allowable payment amount under the DPH QIP annually, which will be included in the supporting documentation through the rate submission process.

	PY 4, CY 2021	PYs 5-6
DPH QIP (Total Computable)	$1.833 billion	PY(n) = ($1.833 billion) x ((1 + Growth Rate[a])^(PY(n)-PY(4)))

[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

For PY 6 only, to address the ongoing impacts of the COVID-19 PHE, an additional adjustment may be made to increase the maximum allowable payment amount under the DPH QIP based on the amount of unearned payments from PY 5, subject to the new adjusted maximum allowable payment amount being included in the supporting documentation through the rate amendment process.

Additionally, for PYs 5 and 6, this preprint establishes the ability to earn additional funds through over-performance, which would allow a DPH system, through all claiming mechanisms, to earn up to 100 percent of its maximum allowable payment amount, or, for DPH systems that opt to report 30 total measures in PY 5 or PY 6, 90 percent or 75 percent, respectively, of its total maximum allowable payment amount.

A. Performance Measures

For QIP measures, the State will direct MCPs to make performance-based quality incentive payments to DPHs based on achievement of targets for quality of care. The quality measures will be measured across all Medi-Cal beneficiaries. All such measures will be based on utilization and delivery of services.

The proposed performance measures include process, outcome, 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.). Performance measures 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.

These criteria may be waived by DHCS for measures implemented due to the COVID-19 Public Health Emergency (PHE) as detailed below.

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 PY, 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 40 measures total from the list of performance measures included below in Tables 1 and 2. Each DPH system must report on all priority measures in Table 1 if it provides the relevant service and has a denominator of at least 30. The remaining measures, to reach the minimum of 40 measures, may be chosen from Table 2.

The list of performance measures included in Tables 1 and 2 is subject to change, pending availability of benchmarking data, changes made to measures at the national level, and other factors. Any changes to the performance measures will be uniformly treated for all DPH systems within the single class, and is subject to DHCS approval.

COVID-19 PHE-related Modifications to the QIP Program in PY 4

Due to the COVID-19 PHE, for PY 4 only each DPH system will report on an additional 5 COVID-19 related measures (included in Table A). Reporting of the 40 measures from Tables 1 and 2 will be as follows:

- 10 measures, chosen from Table 1 and/or 2 below, will be chosen by the DPH for reporting on a pay-for-performance basis and to set baseline for CY 2022 (PY 5).
- The remaining 30 measures, chosen from Table 1 and/or 2 below, will be reported on a pay-for-reporting basis to set baseline for CY 2022 (PY 5).

This section supersedes any conflicting sections regarding PY 4 measures only.

Table A: PY 4 COVID-19 PHE Measures

DPH systems must report on all COVID-19 measures in PY 4.

QIP COVID-19 PHE Measures
Implementation of employee COVID-19 testing in 2021
Implementation of employee COVID-19 vaccination in 2021
Implementation of infrastructure and partnerships for the provision of COVID-19 tests to Medi-Cal beneficiaries and community members in 2021

QIP COVID-19 PHE Measures
Implementation of infrastructure and partnerships for the provision of COVID-19 vaccines to Medi-Cal beneficiaries and community members in 2021
Implementation of hospital surge planning and/or response in 2021

COVID-19 PHE-related Modifications to the QIP Program in PY 5

To address the ongoing impacts of the COVID-19 PHE, for PY 5 only the following change will be made to the reporting requirements for the DPH systems participating in the QIP program: instead of 20 Priority measures, they will only be required to report on 9 Priority measures. These measures are indicated with asterisks in Table 1 below. DPH systems will have two reporting options to meet the required number of measures reported:

(a) Report 40 total measures (the remaining 31 measures will be chosen from the list of performance measures in Table 1 and Table 2), and performance targets will remain the same as outlined in Section B. Target Setting and Performance Measurement below with no changes in the maximum earnable amount
(b) Report 30 total measures (the remaining 21 measures will be chosen from the list of performance measures in Table 1 and Table 2), and performance targets will remain the same as outlined in Section B. Target Setting and Performance Measurement below. However, for DPH systems that report on 30 total measures the maximum earnable amount would be reduced to 90%. No adjustment will be made for DPH systems that report greater than 30 but less than 40 total measures.

This section supersedes any conflicting sections regarding PY 5 measures only.

COVID-19 PHE-related Modifications to the QIP Program in PY 6

To address the ongoing impacts of the COVID-19 PHE, for PY 6 only the following change will be made to the reporting requirements for the DPH systems participating in the QIP program: instead of 20 Priority measures, they will only be required to report on 9 Priority measures. These measures are indicated with asterisks in Table 1 below. DPH systems will have two reporting options to meet the required number of measures reported:

(a) Report 40 total measures (the remaining 31 measures will be chosen from the list of performance measures in Table 1 and Table 2), and performance targets will remain the same as outlined in Section B. Target Setting and Performance Measurement below with no changes in the maximum earnable amount
(b) Report 30 total measures (the remaining 21 measures will be chosen from the list of performance measures in Table 1 and Table 2), and performance targets will remain the same as outlined in Section B. Target Setting and Performance Measurement below. However, for DPH systems that report on 30 total measures the maximum earnable amount would be reduced to 75%. No adjustment will be made for DPH systems that report greater than 30 but less than 40 total measures.

This section supersedes any conflicting sections regarding PY 6 measures only.

Table 1: Priority QIP Performance Measures

DPH systems must report on all priority measures if they provide the relevant service and have a denominator ≥30.

QIP Priority Performance Measures
Improving Health Equity #1
Asthma Medication Ratio
Breast Cancer Screening
Cervical Cancer Screening
Child and Adolescent Well Care Visits*
Childhood Immunization Status (CIS 10)*
Chlamydia Screening in Women*
Colorectal Cancer Screening
Comprehensive Diabetes Care: Eye Exam
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Controlling High Blood Pressure
Developmental Screening in the First Three Years of Life*
HIV Viral Load Suppression
Immunizations for Adolescents*
Prenatal and Postpartum Care (Postpartum Care)*
Prenatal and Postpartum Care (Timeliness of Prenatal Care)*
Preventive Care and Screening: Influenza Immunization
Preventive Care and Screening: Screening for Depression and Follow-Up Plan*
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Well-Child Visits in the First 30 Months of Life*

* For PY 5 and PY 6 only, the QIP Priority Performance Measures list will be these 9 measures indicated.

Table 2: Elective QIP Performance Measures

DPH systems must select the remaining number of measures from this table to report the required minimum of 40 measures. DPH systems must report on at least 20 elective measures. If a DPH system reports less than 20 measures from Table 1, then the DPH system must report on enough elective measures to ensure it reaches the minimum of 40 measures required for reporting.

Elective QIP Performance Measures
Advance Care Plan
Appropriate Treatment for Upper Respiratory Infection
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
Cesarean Birth (PC-02)
Comprehensive Diabetes Control: Medical Attention for Nephropathy[1]
Concurrent Use of Opioids and Benzodiazepines
Contraceptive Care – All Women[1]
Coronary Artery Disease: Antiplatelet Therapy
Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
Depression Remission or Response for Adolescents and Adults
Discharged on Antithrombotic Therapy (STK-2)
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older
Exclusive Breast Milk Feeding (PC-05)
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence
Follow-Up After High-Intensity Care for Substance Use Disorder[2]
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
HIV Screening
Improving Health Equity #2
Kidney Evaluation for Diabetes[2]
Lead Screening in Children
Medication Reconciliation Post-discharge
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
Pharmacotherapy Management of COPD Exacerbation
Pharmacotherapy for Opioid Use Disorder[2]
Plan All-Cause Readmissions
Prenatal Immunization Status[2]
Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Reduction in Hospital Acquired C Difficile Infections
Statin Therapy For The Prevention And Treatment Of Cardiovascular Disease
Surgical Site Infection (SSI)
Use of Imaging Studies for Low Back Pain
Use of Opioids at High Dosage in Persons Without Cancer
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents

1. Effective for PY 4 only

2. Effective for PYs 5 and 6 only

B. Target Setting and Performance Measurement

For pay-for-performance measures in PY 4, to achieve the performance target, DPHs must perform at or above the PY 4 minimum performance benchmark established by DHCS as outlined here and in section C below. This section supersedes any conflicting sections regarding target setting for PY 4 only. All other QIP requirements will continue to apply for target setting and performance measurement for subsequent PYs.

For PYs 5 and 6, targets and performance will be determined as follows:

1. *Target Setting for QIP measures: 10% Gap Closure*

   The gap is defined as the difference between the DPH system's performance for the baseline period (the prior CY) and the high-performance benchmark. The target setting methodology will be a 10% gap closure. DPH systems, at a minimum will be required to perform at or above the minimum performance benchmark. DPH systems with baseline performance at or above the top performance benchmark for a given measure will be required to achieve performance that maintains or exceeds that measure's high-performance benchmark. Please see Table 3 below for achievement values based on gap closure targets.

   An example of this target setting methodology for PY 5 is as follows:

   - Improvement: performance > minimum performance benchmark and < high-performance benchmark
     - 10% gap closure between performance for the period of January 1, 2021 – December 31, 2021 (also referred to as baseline) & PY5 high-performance benchmark
       - *Example: Behavioral Health Care Performance Measure X*
         - *PY5 High-Performance Benchmark: 70.0%*
         - *Baseline: 55.0%*
           - *Gap: 70% -55% = 15%*
           - *10% of 15% = 1.5%*
           - *55% + 1.5% = 56.5%* = PY 5 Target

   For select measures that require risk adjustment, DHCS may create an alternate target setting methodology, utilizing information available from federal and state health agencies (including the Centers for Disease Control and Prevention's National Healthcare Safety Network and the National Committee for Quality Assurance), to account for risk adjustment.

2. *Benchmarks*

a. For measures that have national Medicaid benchmarks, the minimum and high-performance benchmarks will be the 25th and 90th percentiles respectively. For measures with national Medicaid benchmarks, the 50th percentile will also be used when assessing over-performance as described below in Section B.3.
b. For measures which have no Medicaid benchmarks, DHCS will establish appropriate minimum and high-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 available performance data on a given measure, be it national, state, or public hospital-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. DHCS will also establish a median benchmark for assessing over-performance as described in Section B.3.

3. *Over-Performance*

DPH systems that perform according to the following criteria on measures will be eligible to earn additional funds through over-performance. Through all claiming mechanisms, including over-performance, a DPH system can earn up to 100 percent of its maximum allowable payment amount.

a. For priority measures to earn over-performance values by Method 1 (as described below):
    i. ≥15% and <20% gap closure, and ≥50th percentile/median benchmark, or
    ii. ≥20% gap closure and ≥50th percentile/median benchmark, or
    iii. ≥90th percentile benchmark

b. For elective measures to earn over-performance values by Method 2 (as described below):
    i. ≥15% and <20% gap closure, and ≥50th percentile/median benchmark, or
    ii. ≥20% gap closure and ≥50th percentile/median benchmark

C. Achievement Values

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

For PY 4 only, due to the COVID-19 PHE, the AV for pay-for-performance measures in Tables 1 and 2 will be determined as follows:

- PY 4 performance < minimum performance benchmark, AV = 0
- PY 4 performance ≥ minimum performance benchmark, AV = 1

For PY 4 COVID PHE Measures in Table A only, the AV will be determined as follows:

- Successful implementation of the measure as determined by DHCS, AV = 1
- Unsuccessful or incomplete implementation of measure as determined by DHCS, AV = 0

For subsequent PYs, achievement will be determined as described below:

1. Based on the progress reported, and using the target setting methodologies described in B.1 above, the achievement value (AV) will be determined as outlined in Table 3 below.

Table 3: Measure Performance Achievement

	Achievement Values (AV)			
Measure Performance in Prior CY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
≥High-Performance Benchmark	Performance <High-Performance Benchmark	NA	NA	Performance ≥ High-Performance Benchmark
≥ Minimum Performance Benchmark and < High-Performance Benchmark	< 50% of the 10% Gap is closed	≥ 50% to <75% of the 10% Gap is closed	≥ 75% to <100% of the 10% Gap is closed	100% of the 10% Gap is closed
< Minimum Performance Benchmark Track A: If gap between performance and the Minimum Performance Benchmark ≥ 10% gap between performance and High-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 < 10% gap between performance and High-Performance Benchmark	Performance < Minimum Performance Benchmark, or performance ≥ Minimum Performance Benchmark and < 50% of the 10% gap is closed	Performance ≥ Minimum Performance Benchmark and ≥ 50% to <75% of the 10% gap is closed	Performance ≥ Minimum Performance Benchmark and ≥ 75% to <100% of the 10% gap is closed	100% of the 10% gap is closed

2. DPH systems choosing to report on a measure for which they have not reported baseline data must report statistically valid (denominator must be at least 30) historical data from the prior CY to establish a baseline in order to receive an AV for that measure. This requirement will not apply to PY 4 due to the COVID-19 PHE.

3. Furthermore, unless otherwise specified by DHCS, each reported measure must include data from at least one person enrolled in Medi-Cal managed care during the reporting PY in order to receive an AV for that measure in that PY. For reported subrated measures, at least one subrate must include data from at least one person enrolled in Medi-Cal managed care. An entity will

earn an AV of zero and will not receive payment for a reported measure in which data does not include at least one Medi-Cal managed care life. However, the measure may still be used to fulfill the required 40 measures for an entity's QIP reporting.

D. Over-performance Values

The over-performance claiming mechanism will not be available for PY 4. This section supersedes any conflicting provisions regarding PY4 over-performance.

1. *Determining Over-performance Values*
   The over-performance value of a measure will be based on the amount of progress made toward the measure's performance target. Based on the progress reported and using the target setting methodologies for over-performance described in B.3, the over-performance value (OV) will be determined as outlined in Table 4 below.

Table 4: Over-Performance Values

Progress toward performance target	**Over-performance Values (OV) for Over-performance on Priority Measures (Method 1)**	**Over-performance Values (OV) for Over-performance on Elective Measures (Method 2)**
≥ 15% and < 20% gap closure, and ≥50th percentile/median benchmark	0.5	0.25
≥ 20% gap closure and ≥50th percentile/median benchmark	1.0	0.50
≥90th percentile	1.0	N/A

2. *Using Over-performance Values*
   a. Over-performance values earned through over-performance on priority measures via Method 1 may be used to earn remaining priority measure achievement values and/or remaining elective measure achievement values. "Remaining achievement value" equals the number of reported measures minus total achievement values.
   b. Over-performance values earned through over-performance on elective measures via Method 2 may be used to earn remaining priority measure achievement values and/or remaining elective measures achievement values with the following limitations:
      i. In PYs 5 and 6, over-performance values earned through over-performance on elective measures may be used to earn:
         - ≤ 2 remaining priority measure achievement values, and
         - Any remaining elective measure achievement values.

E. Over-performance Incentive Process

Each DPH system may earn additional funds through over-performance, as described in B.3 and D, and in accordance with the following process. A DPH system can earn up to 100 percent of its maximum allowable payment amount, or, for DPH systems that opt to report 30 total measures in PY 5 or PY 6, 90 percent or 75 percent, respectively, of its total maximum allowable payment amount through all claiming mechanisms, including over-performance.

1. Calculate the DPH system's reported total achievement values and total remaining measure achievement values separately for priority measures and elective measures.
2. Calculate the DPH system's reported total over-performance values separately for priority measures and elective measures.
3. First, apply over-performance values earned through over-performance on priority measures by Method 1 to earn the DPH system's remaining priority measure achievement values first, as available, and then to earn the DPH system's remaining elective measure achievement values, until the DPH system exhausts its remaining over-performance values earned through over-performance on priority measures, or until the DPH system has earned all of its remaining achievement values.
4. Second, apply over-performance values earned through over-performance on elective measures via Method 2 to earn the DPH system's remaining priority measure achievement values and/or remaining elective measure achievement values, under the limitations described in D.2.b, until the DPH system uses all of its over-performance values earned through over-performance on elective measures, or until the DPH system has earned all of its remaining achievement values.

   Over-performance Example for PY 5:
   - DPH system A reports full achievement on 16 priority measures and 19 elective measures.
     - DPH system A achieves less than 5 percent gap closure, thus completely misses targets on 4 priority measures and 1 elective measure.
     - Its remaining priority measure achievement value is 4 and its remaining elective measure achievement value is 1.
   - DPH system A over-performs on 1 priority measure, worth 1 over-performance value and over-performs on 5 elective measures, worth 2.5 over-performance values.
   - First, DPH A applies its 1 over-performance value from over-performance on priority measures via Method 1 to earn 1 of the 4 remaining priority measure achievement values.
     - DPH system A has now used all of its over-performance values earned through over-performance on priority measures.
     - DPH system A still has 3 remaining priority measure achievement values and 1 remaining elective measure achievement value.
   - Second, DPH system A has 2.5 over-performance values from over-performance on elective measures via Method 2.
     - In PY 5, DPH system A can only use 2 of these over-performance values to earn 2 of the 3 remaining priority measure achievement values, and can use the balance of its 0.5 over-performance value to earn 0.5 of the 1 remaining elective measure achievement value.

- After accounting for over-performance values, the DPH has earned a total of 3.5 remaining measure achievement values, and has a total of 1.5 remaining elective measure achievement values that it cannot make-up via over-performance.

Final QIP Payments:

For PY 4 only, due to the COVID-19 PHE, each DPH's maximum allowable payment amount will be paid according to the following distribution:

- 50% of payment: based on achievement of 5 COVID-19 related measures.
- 40% of payment: based on achievement of 10 pay-for-performance measures chosen by the DPH.
- 10% of payment: based on reporting the remaining 30 measures for CY 2021. Reporting the measures, as specified by DHCS, will be considered full achievement for meeting these measures' PY 4 targets.

The maximum allowable payment amount that may be earned by a specific DPH system from the QIP pool (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 QIP pool multiplied by the DPH system's proportion of the total Medi-Cal managed care members served in the given year relative to all other participating DPH systems. For PY 6 only, to the extent the maximum allowable payment amount is increased based on the amount of unearned payments from PY 5, the maximum allowable payment amount that may be earned by a specific DPH system may be adjusted based on each DPH system's share of the unearned payments from PY 5, subject to actuarial evaluation of the reasonableness of the resulting payment levels. 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 DPH system's maximum allowable payment amount will be multiplied by the DPH system's Quality Score to determine the DPH system's QIP base payment.

Additionally, as described in Sections B.3, D and E, for PYs 5 and 6, each DPH system may earn additional funds through over-performance, up to a total of 100 percent of its maximum allowable payment amount, or, for DPH systems that opt to report 30 total measures in PY 5 or PY 6, 90 percent or 75 percent, respectively, of its total maximum allowable payment amount through all claiming mechanisms.

Example: DPH system B has a maximum allowable payment amount of $400 and reports 40 measures.

- The full funding value of each measure for DPH system B = $10
- DPH system B meets targets for 19 priority measures and 18 elective measures; DPH system B earns **$370** as a base payment.
    - DPH system B has 1 remaining priority measure achievement value (missed 1 of 20 priority measures) and 2 remaining elective measure achievement values (missed 2 of 20 elective measures) that are eligible to be earned through over-performance.
- DPH system B over-performs at 20% gap closure on 1 priority measure, earning an over-performance value of 1. It applies that over-performance value of 1 to the 1 remaining priority measure achievement value and earns 1 measure value, **$10**.
- DPH system B also over-performs at 20% gap closure on 1 elective measure, earning an over-performance value of 0.5. It applies that over-performance value of 0.5 to the 2 remaining

elective measure achievement values and earns 0.5 x $10, or **$5**. DPH system B is unable to earn 1.5 remaining elective measure achievement values.

- The sum of DPH system B payments = $385

For PYs 5 and 6, each DPH system's base payment and over-performance payment amounts will be added together to determine the DPH system's final QIP payment. The DPH system's final QIP payment must not be greater than 100 percent of the DPH system's maximum allowable payment amount, or, for DPH systems that opt to report 30 total measures in PY 5 or PY 6, 90 percent or 75 percent, respectively, of its total maximum allowable payment amount.

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.

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 by DHCS.

ATTACHMENT 2

CA 438.6(c) Proposal – DPH QIP Directed Payments
Program Years 4–6 Evaluation Plan
January 1, 2021 – December 31, 2023

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 Medi-Cal Managed Care Plans (MCP) to network provider Designated Public Hospitals (DPHs), improve the quality of inpatient and outpatient services for Medi-Cal members assigned to DPHs.

Stakeholders

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

Evaluation Questions

This evaluation is designed to answer the following question:

> Do performance-based quality incentive payments to DPH systems improve the quality of inpatient and outpatient services for Medi-Cal members?

Evaluation Design

During PYs 4-6, all participating DPH systems will report on at least 40 DHCS specified performance measures. Targets and performance calculations for each measure, as discussed in Attachment 1, uniformly apply to all participating DPH systems.

The detailed list of performance measures is included in Attachment 1.

DHCS will use aggregated data, submitted by DPH systems to DHCS, to determine:

- For each measure, of DPH systems reporting on that measure, what percentage met their quality performance targets,
- For each measure, the aggregate improvement seen across all DPH systems who reported on the measure (this will not apply for the PY 4 evaluation), and
- For each DPH system, the percentage of measures for which they met their quality performance targets.

Data Collection Methods

DHCS will collect all data necessary for quality measurement from DPH systems that will be required to report aggregated data on each measure. Depending on the specific measure and DPH system capabilities, DPH systems will collect aggregated data utilizing Electronic Health Records and/or claims and registry databases. Using the QIP reporting application, DPH systems will submit to DHCS encrypted system level performance data collected in the form and manner specified by DHCS. DHCS will conduct its analysis on 100 percent of the data received.

Timeline

Example for PY 4, with similar timeline for subsequent PYs:

- Program Year 4: January 1, 2021 – December 31, 2021
- June 15, 2022: Deadline for DPH systems to submit QIP data to DHCS
- June 16, 2022 through October 31, 2022: DHCS review of DPH system QIP reports
- November 2022: Data finalized and approved
- November 2022 through February 2023: DHCS will develop the evaluation report
- March 2023: Draft evaluation report reviewed by stakeholders
- April-May 2023: Stakeholder comments incorporated into evaluation report, draft to go through internal review and finalized by program.
- May 2023: Evaluation report posted on public DHCS website and sent to CMS

Communication and Reporting

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