DPH QIP 2.0 DIRECTED PAYMENTS (July 1, 2020 – December 31, 2020)
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):

Rating Period (RP) 2019-20: July 1, 2019 through December 31, 2020

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

July 1, 2020

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

July 1, 2020 through December 31, 2020. This preprint seeks approval for a 6-month transitional payment arrangement to a replacement DPH QIP program beginning CY 2021. The State anticipates submitting a subsequent, separate preprint to continue the DPH QIP program for CY 2021 and onward.

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

California will continue the Designated Public Hospital (DPH) Quality Incentive Pool (QIP) during the six months from July 1, 2020 through December 31, 2020 (referred to as Program Year [PY] 3.5) to move from a State Fiscal Year to a Calendar Year rating period. The measure set used in PY 3 will be used to determine Core QIP payments in PY 3.5.

During this time, the State will direct Medi-Cal Managed Care Plans (MCPs) to make Core QIP payments tied to performance on designated performance measures in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The measure set used in Program Year 3 will also be used to determine Core QIP payments in this new Program Year 3.5. 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, California will expand QIP to include an additional PRIME Transition sub-pool for measures from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program that were 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 terminate on June 30, 2020 with the Medi-Cal 2020 Demonstration.

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.

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, for both the Core QIP and PRIME Transition sub-pools, 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 the DPH. 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 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 Core QIP performance measures approved by DHCS. Targets and performance calculations for each measure, as discussed in Attachment 1, uniformly apply to all participating hospital systems.

All participating hospital systems will also report on any PRIME projects and measures that they have undertaken as part of PRIME for July 1, 2019 to June 30, 2020 (Demonstration Year 15). These projects and measures are referred to as PRIME Transition measures.

For all measures in PY 3.5, the measurement year will be January 1, 2020 through December 31, 2020. 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):

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 the Core QIP categories of Primary Care, Specialty Care, Inpatient Care and Resource Utilization, as well as continue the PRIME improvements in Outpatient Delivery System Transformation, Targeted High-Risk or High-Cost Populations, and Resource Utilization Efficiency. In order to receive QIP payments, DPHs must achieve specified improvement targets. QIP PY 3.5 is 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.

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.

DHCS has a CMS-approved evaluation plan for PYs 1-4 of the QIP program. DHCS plans to complete and share the PY 1 evaluation with CMS in October 2019, in accordance with that approved evaluation plan. DHCS will modify this approved evaluation plan slightly for PY 3.5 as described in this preprint and send in the evaluation plan to CMS, consistent with the process set forth at 42 CFR § 438.6(c)(2)(i)(D). Our plan will 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 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. 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 report each DPH's yearly performance achievement across all measures to CMS as part of the annual evaluation.

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.

DHCS will require stratification for a subset of measures by age, gender, and race/ethnicity.

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 – Value-Based Payment for DPH Services
Performance Standards and Payment Specifications
Program Year 3.5: July 1, 2020 – December 31, 2020

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. 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.

As part of the transition to a Calendar Year rating period, this preprint establishes a six month bridge Core QIP sub-pool for July 1, 2020 through December 31, 2020. Payments from this sub-pool may be earned for meeting designated Core QIP gap closure targets for performance measures, listed in Table 1, corresponding to this time period. Due to the measures requiring a 12-month reporting period, achievement of measures will be measured using data primarily from January 1, 2020 through December 31, 2020. The period is referred to as the measurement period.

As part of maintaining continuous improvement projects currently authorized under PRIME, this preprint establishes an additional PRIME Transition sub-pool for July 1, 2020 through December 31, 2020. Payments from this sub-pool may be earned by DPHs for meeting gap closure targets for designated PRIME Transition performance measures, listed in Table 2. Due to the measures requiring a 12-month reporting period, achievement of measures will be measured using data primarily from January 1, 2020 through December 31, 2020 (the measurement period).

A. Performance Measures

For the Core 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 using measures in the Core QIP categories set forth below. The quality measures will be measured across all Medi-Cal beneficiaries. All such measures 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 the 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 Core QIP performance measures included below in Table 1.

Each DPH system will also report on those PRIME Transition measures listed in Table 2 that they reported on in the final year of PRIME for the Medi-Cal 2020 Demonstration. The PRIME Transition measures will be measured in accordance with the protocols established under the Medi-Cal 2020 PRIME Program. All such measures will be based on the utilization and delivery of services.

Any revisions to the Core QIP or PRIME Transition performance measures listed in Table 1 or Table 2 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: Core QIP Performance Measures[1]

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 10*(NQF 0038, Quality ID 240)
Contraceptive Care – All Women (CCW) Most and Moderately Effective Methods, Ages 16-44 years (NQF 2903)
Chlamydia Screening in Women (CHL), Ages 16-24 (NQF 0033)*
HIV Viral Load Suppression (HVL-AD) (NQF 2082/ 3210e)
Well-Child Visits in the First 15 Months of Life (W15-CH), Six or more well-child visits (NQF 1392)*
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)

[1] Please refer to QIP Policy Letter 19-002 for a list of QIP measures that were retired effective PY 3.

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)
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients (Quality ID 322)
Concurrent Use of Opioids and Benzodiazepines
Use of Opioids at High Dosage in Persons Without Cancer (NQF 2940)

*Pediatric measures or includes the pediatric population

Table 2: PRIME Transition Measures

Domain 1: Outpatient Delivery System Transformation and Prevention

Project 1.1 Integration of Physical and Behavioral Health
Alcohol and Drug Misuse (SBIRT)
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Screening for Depression & Follow-Up Plan
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention
Depression Remission or Response for Adolescents and Adults (DRR)
Project 1.2 Ambulatory Care Redesign: Primary Care (includes reduction in disparities in health and health outcomes)
Alcohol and Drug Misuse (SBIRT)
CG-CAHPS: Provider Rating
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Controlling Blood Pressure
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet measure (NQF 0068)
Prevention Quality Overall Composite #90
REAL and/or SO/GI disparity reduction
REAL data completeness
Screening for Depression and follow-up
SO/GI data completeness
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention
Project 1.3 Ambulatory Care Redesign: Specialty Care
Closing the referral loop: receipt of specialist report (CMS504)
Plan All-Cause Readmissions (PCR-AD))
Influenza Immunization
Request for Specialty Care Expertise Turnaround Time
Specialty Care Touches: Specialty expertise requests managed solely via non-in-person specialty encounters
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention
Project 1.4 Patient Safety in the Ambulatory Setting
Abnormal Results Follow-up
Annual Monitoring for Patients on Persistent Medications
INR Monitoring for Individuals on Warfarin
Project 1.5 Million Hearts Initiative
Controlling Blood Pressure
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet measure (QPP 204, eCQM 164, NQF 0068)
PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention
Project 1.6 Cancer Screening and Follow-up
BIRADS to Biopsy
Breast Cancer Screening

Cervical Cancer Screening
Colorectal Cancer Screening
Receipt of appropriate follow-up for abnormal CRC screening
Project 1.7 Obesity Prevention and Healthier Foods Initiative
BMI Screening and Follow-up
Partnership for a Healthier America's Hospital Health Food Initiative external food service verification
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents – BMI

Domain 2: Targeted High Risk or High Cost Populations

Project 2.1 Improved Perinatal Care
Baby Friendly Hospital designation
Exclusive Breast Milk Feeding (PC-05)
OB Hemorrhage: Massive Transfusion**
PC-02 Cesarean Birth
Prenatal and Postpartum Care
Severe Maternal Morbidity (SMM) per 100 women with obstetric hemorrhage**
Unexpected Newborn Complications**
OB Hemorrhage Safety Bundle
Project 2.2 Care Transitions: Integration of Post-Acute Care
Plan All-Cause Readmissions (PCR-AD)
H-CAHPS: Care Transition Metrics
Medication Reconciliation - Post-Discharge
Reconciled Medication List Received by Discharged Patients
Timely Transmission of Transition Record
Project 2.3 Complex Care Management for High Risk Medical Populations
Medication Reconciliation – 30 Post-discharge
Timely Transmission of Transition Record
Project 2.4 Integrated Health Home for Foster Children
Adolescent Well-Care Visit
Developmental Screening in the First Three Years of Life
Documentation of Current Medications in the Medical Record (0-18 yo)
Screening for Depression and follow-up
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention(13 yo and older)
Well Child Visits - Third, Fourth, Fifth, and Sixth Years of life
Comprehensive Medical Evaluation Following Foster Youth Placement in Foster Care
Project 2.5 Transition to Integrated Care: Post Incarceration
Alcohol and Drug Misuse (SBIRT)
Controlling Blood Pressure
Screening for Depression and follow-up
Preventative Care and Screening: Tobacco Use – Screening and Cessation Intervention
Project 2.6 Chronic Non-Malignant Pain Management
Alcohol and Drug Misuse (SBIRT)
Assessment and management of chronic pain: patients diagnosed with chronic pain who are prescribed an

opioid who have an opioid agreement form and an annual urine toxicology screen
Patients with chronic pain on long term opioid therapy checked in PDMPs
Screening for Depression and follow-up
Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy
Project 2.7 Comprehensive Advanced Illness Planning and Care
Advance Care Plan
MWM#8 - Treatment Preferences (Inpatient)
MWM#8 - Treatment Preferences (Outpatient)
Palliative care service provided to patients with serious illness
Proportion admitted to hospice for less than 3 days

Domain 3: Resource Utilization Efficiency

Project 3.1 Antibiotic Stewardship
Avoidance of antibiotic treatment in adults with acute bronchitis
National Healthcare Safety Network (NHSN) Antimicrobial Use Measure
Peri-operative Prophylactic Antibiotics Administered after Surgical Closure
Reduction in Hospital Acquired Clostridium Difficile Infections
Project 3.2 Resource Stewardship: High Cost Imaging
Appropriate Emergency Department Utilization of CT for Pulmonary Embolism
Use of Imaging Studies for Low Back Pain
Appropriate Use of Imaging Studies for Low Back Pain (red flags, no time limit)
Project 3.3 Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
Adherence to Medications
High-cost Pharmaceutical Ordering Protocols
Documentation of Medication Reconciliation in the Medical Record for Patients on High Cost Pharmaceuticals
Project 3.4 Resource Stewardship: Blood Products
ePBM-01 Pre-op Anemia Screening, Selected Elective Surgical Patients
ePBM-03 Pre-op Type and Crossmatch, Type and Screen, Selected elective Surgical Patients
ePBM-04 Initial Transfusion Threshold

** Pay-for-reporting measures to balance other measures within the project and ensure safe quality improvement. These measures account for events that generally have low incident rates.

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 performance for the period of January 1, 2019 – December 31, 2019 and the Medicaid 90th percentile benchmark. The target setting methodology will be a 10% gap closure.

   DPHs, at a minimum will be required to perform at or above the Medicaid 25th percentile benchmark, as described in Table 3. DPHs performing at or above the Medicaid 90th percentile benchmark for a given measure for the period of January 1, 2019 through December 31, 2019 will be required to achieve performance that maintains or exceeds that measure's Medicaid 90th percentile benchmark for the PY 3.5 measurement period.

   An example of this target setting methodology for a benchmarked Medicaid measure for Program Year 3.5 is as follows:

   - Improvement: performance >25th percentile and <90th percentile
     - 10% gap closure between performance for the period of January 1, 2019 – December 31, 2019 (also referred to as baseline) & 90th percentile benchmark
       - *Example: Primary Care Performance Measure X*
         - *90th Percentile Benchmark: 70.0%*
         - *Baseline: 55.0%*
           - *Gap: 70% -55% = 15%*
           - *10% of 15% = 1.5%*
           - *55% + 1.5% = 56.5%*

2. *Target Setting for Measures which have no Medicaid decile benchmark: 10% 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 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.

   The gap is defined as the difference between the DPH system's performance for the period of January 1, 2019 – December 31, 2019 (referred to as the baseline) and the DHCS established top performance benchmark. The target setting methodology for non-Medicaid benchmark and gap closure requirements will be a 10% gap closure.

DPHs, at a minimum will be required to perform at or above the established minimum performance benchmark, as described in Table 4. DPHs performing at or above the top performance benchmark for a given measure for the period of January 1, 2019 – December 31, 2019 will be required to achieve performance that maintains or exceeds that measure's top performance benchmark for the PY 3.5 measurement period.

3. DPH systems choosing to report on a measure for which they have not reported prior measurement period data must report historical data from the prior measurement period to establish a baseline in order to receive an Achievement Value for that metric.

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.

Based on the progress reported, and using the target setting methodology described in B.1 above, Table 3 will be used to determine the achievement value for measures that have a Medicaid benchmark. For measures without Medicaid decile benchmarks, the target setting methodology described in B.2 will apply, and Table 4 below will be used to determine the achievement value.

Table 3: 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 4: 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:

For the Core QIP sub-pool, payments will be made based on a Core QIP 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 Core QIP sub-pool DPH allocation would then be multiplied by the DPH system's Quality Score to determine the final Core QIP sub-pool payment. Achievement Values will be based on performance per the above tables.

The maximum payment amount that may be earned by a specific DPH system from the Core QIP sub-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 Core QIP sub-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 the PRIME Transition sub-pool, DPH systems will be allocated a specified maximum amount of incentive funding per measure using the allocation methodology set forth in the Medi-Cal 2020 PRIME program. DPHs will receive final payment per measure based on Achievement Values as specified above in tables 3 and 4.

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.