North Dakota Medicaid Payment Reform

PPS Hospital System Payment Model Description

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The following documents are referenced throughout this document but require access to the North Dakota Value Based Purchasing Program SharePoint site. Links are provided here for reference. Should someone need access to the SharePoint site, please make the request by emailing ND_VBP@optumas.com.

Additional Program Materials and Links

The following items can be found in the 1.Tools folder on the ND VBP SharePoint site:

- ND VBP Reporting Tool
- ND VBP Performance to Payment Model
- ND VBP Supplemental File Data Collection Tool

The following items can be found in the 2.Reference Documents folder on the ND VBP SharePoint site:

- ND VBP Performance Comparison Resource
- ND VBP Quality Measure Specification Guide
- Various Dashboard user guides, overviews, and updates

Link to Optumas's SFTP Site: https://sftp.optumas.com/login

Introduction

Since late 2021, the North Dakota Department of Health and Human Services (Department) and Prospective Payment System (PPS) hospital systems have actively partnered in the development of a value-based purchasing (VBP) model to drive improved health outcomes and reduced cost growth for the fee-for-service Medicaid population.

This document describes the policy surrounding key model elements.

Payment Reform

In a traditional fee-for-service system, the only financial incentive for providers is to provide more services; payment is not contingent on quality of care, efficiency, or patient outcomes. Consequently, there has been a national drive for health insurers to move away from fee-for-service reimbursement methodologies using alternative payment methodologies (change how you pay) and value-based purchasing (change what you pay for).

To support these national payment reform efforts, the Health Care Payment Learning & Action Network[1] (HCPLAN) developed a framework for characterizing and progressing different payment methodologies.[2]

The framework, seen in the image below, has four categories that progress from pure fee-for-service models in Category 1 to population-based payments at Category 4. Within this framework, the progression of payment models has two defining characteristics. First, more advanced payment models have a greater connection between outcomes/quality/efficiency and payment. Second, more advanced payment models ensure providers have the flexibility to deliver the most appropriate care without losing revenue. This second component is achieved by moving away from paying for individual units of service and instead paying based on condition or even at the patient level (e.g., per-member-per-month). In concept, this means that payment reform is about finding a better balance between flexibility with care delivery and accountability for outcomes.

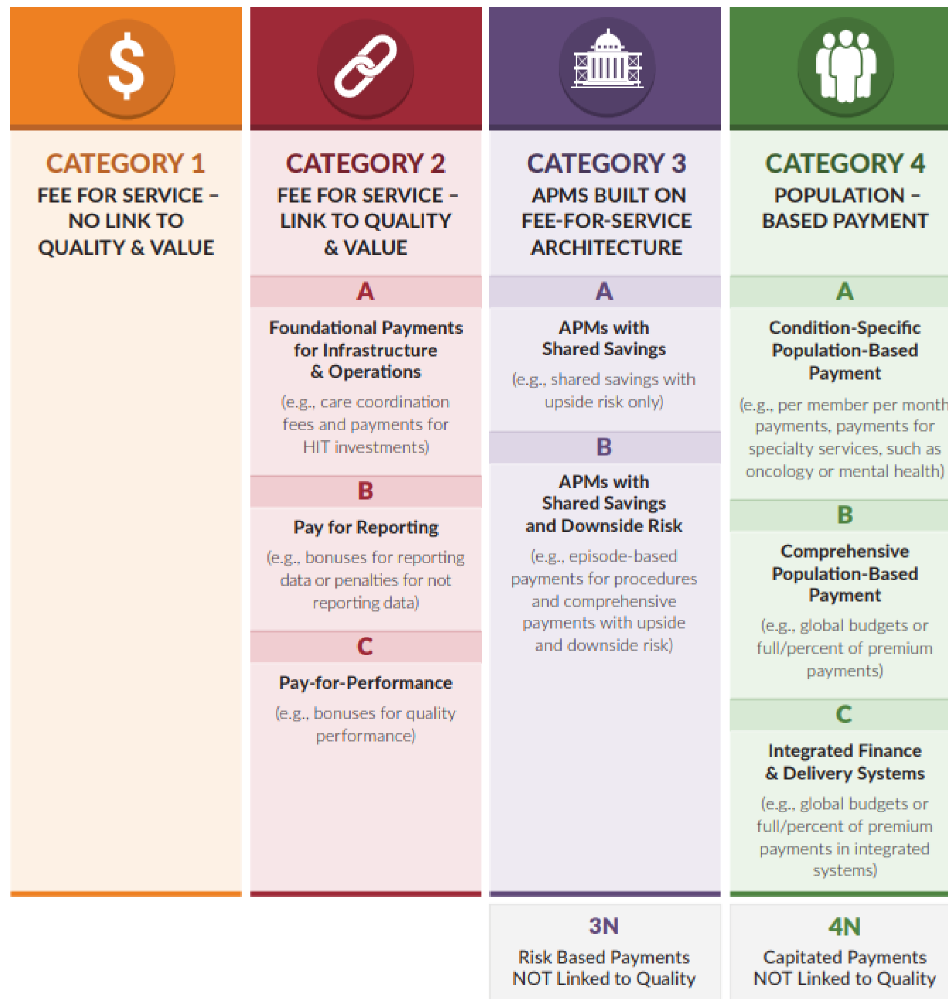
PPS hospital systems are paid under a variety of reimbursement methodologies depending on the type of services provided and which providers in the system rendered the service. A common feature of the reimbursement methodologies is that they are not tied to quality for traditional Medicaid population. Within the HCPLAN framework, the reimbursement methodologies generally fall under Category 1. With the implementation of the PPS hospital system payment reforms, these reimbursement methodologies will progress to Category 2 through the addition of an explicit connection between payment and performance on quality measures.

[1] The HCPLAN is a national collaborative network of public and private stakeholders supporting adoption of alternative payment models (APMs).

[2] APM_onepager_v1 (hcp-lan.org)

In future years, the Department intends to explore expansion of VBP, including Category 3 and 4 payment methodologies.

Figure 1: HCPLAN Alternative Payment Methodology Framework



PPS Hospital System VBP Program Overview

The PPS Hospital System VBP Program puts a portion of hospital payments at risk for performance on a suite of quality measures. If the PPS hospital systems can hit either statewide or provider-specific, reasonable targets, they will see no loss of funding. If PPS hospital systems fail to hit the targets, they will be required to return up to 4% of select Medicaid revenue to the State. PPS hospital systems are given an opportunity to earn additional funds by exceeding statewide targets when funds are available through a redistribution pool. Statewide targets define the standard of performance that the Department wishes to achieve across the state to provide high quality care to all North Dakotans. Payments made to the State due to underperformance will be used to fund the Redistribution Pool (except for funds collected from pay-for-reporting measures). Additional detail can be found below in "Definition of Success on Quality Measures". PPS hospital systems

will be able to monitor performance using dashboards that will be made available and updated on a quarterly basis.

Eligible Health Systems

Health systems with PPS hospitals in North Dakota are mandatory participants in the model. As of July 1, 2023, the six PPS hospital systems are: Altru Health System, CHI St. Alexius, Essentia Health, Sanford – Bismarck, Sanford – Fargo, and Trinity Health.

At Risk Dollars/Eligible Services

The scope of services used to calculate the at risk funding pool for performance is limited to institutional inpatient and outpatient claims dollars, incurred at PPS hospitals for attributed members (henceforth referred to as *dollars based on at risk services*). Claims incurred at Critical Access Hospitals will not be part of the at risk funding pool though claims at those facilities will factor in to the attribution logic. For more details, see the Attribution/Eligible Members section below.

PPS hospital systems will be able to see estimated at risk dollars on a regular basis in their system specific dashboards.

Attribution/Eligible Members

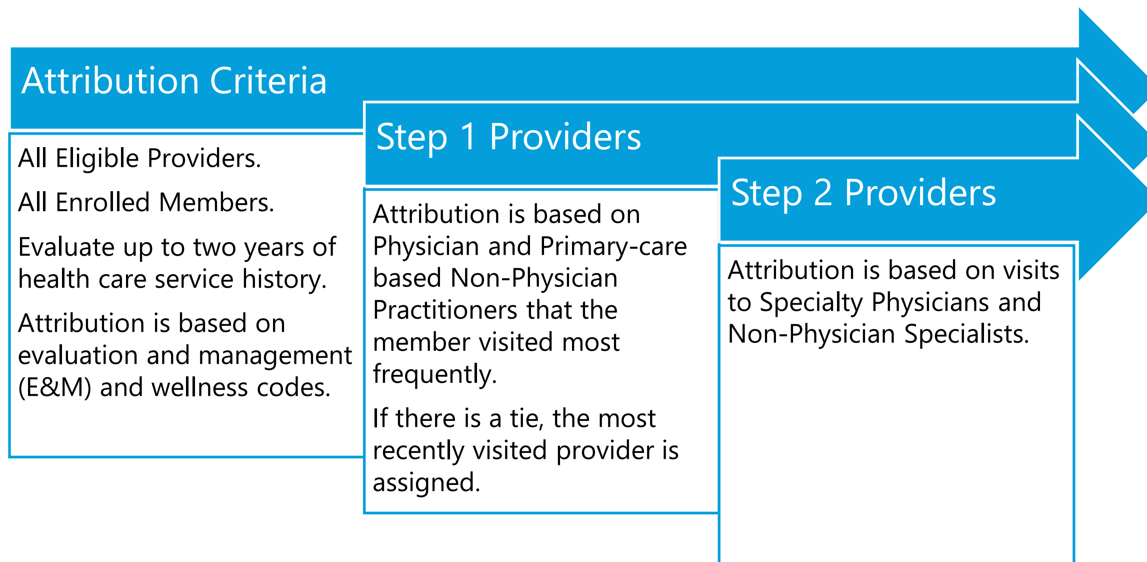
Attribution is a method of identifying a patient-provider relationship. The attribution methodology serves the following purposes for the quality incentive program:

- Accountability at point of care: attribution builds accountability for current patient-provider connections to emphasize preventive care and chronic care management.
- Performance measurement: when measuring a hospital system's performance on quality measures, analysis is limited to members attributed to the health system.
- Financing at risk: the attribution methodology identifies the subset of the population whose utilization contributes to calculation of funds at risk for each hospital system.

Attribution Logic

Members will be attributed to all eligible providers in the state, including providers not participating in the current PPS hospital system VBP program. This ensures patients that are currently seeing a primary care provider not affiliated with any of the PPS hospital systems would not be forced into a new relationship with a PPS hospital system. For example, if a patient is currently being seen at a Federally Qualified Health Center (FQHC) for primary care service and that FQHC is not affiliated with a PPS hospital system, the patient would not be attributed to one of the PPS hospital systems. No out-of-state provider groups will be considered as part of this program. Attribution will be evaluated and updated quarterly.

Figure 2: Attribution Criteria



Attribution will be applied to the 12-month reporting period retrospectively to associate members with the PPS hospital systems in the state. For the reporting period, the 12 months of claims data will be utilized to attribute the member to a provider based on the provider ID associated with the provider group that the member visited most frequently for evaluation and management (E&M) and wellness visits during the reporting period. If there is a tie in the number of visits for a member visiting providers, the most recently visited provider is assigned. This provider group ID is then linked to the tax ID to associate the member with the broader hospital system. Optumas worked with the Department to ensure the appropriate mapping between the tax ID and the hospital system. In addition, this information was shared with each hospital system to obtain additional feedback and validate the mapping. In the future, the mapping will be reviewed with the Department and PPS hospital systems, so that any necessary changes are captured in the attribution methodology.

If a member is not able to be assigned using the 12 months of claims from the reporting period, an additional 12 months of claims will be utilized in an attempt to attribute the member. For instance, for a CY22 reporting period, if a member could not be attributed based on CY22 claims data, the CY21 data is used in an effort to attribute the member according to the same E&M and wellness visits methodology.

Attribution is first performed based on Step 1 providers, representing primary care physicians and primary care-based non-physician practitioners. If a member cannot be attributed based on a Step 1 provider, the attribution logic is performed again using Step 2 providers in attempt to attribute the member. Step 2 providers represent primary care services from specialist physicians and non-physician practitioner specialists. If any of a provider's specialties are in the list shown in Step 2 below, they will be an included provider.

To identify a patient-clinician relationship and the hospital system accountable for the patient's care, the following must be included:

- E&M & wellness procedure codes: 99201-99205, 99211-99215, 99304-99350, 99381-99397, 99441-99444, G0402, G0438, G0439, G0463, G0466, G0467, G0468, T1015, and S0302
- And one of the following place of service codes: 02, 11, 13, 17, 19, 20, 22, 31, 32, 33, 49, 50, 71, 72[3]
- Provider specialty groupings:
  - Step 1: General Practice, Internal Medicine, OB-GYN, Pediatrics, Nurse Practitioner, Family Medicine, Physician Assistant, Advanced Practice Midwife, and Rural Health Clinic
  - Step 2: Psychiatry, Cardiology, Nephrology, Maternal & Fetal Medicine, Geriatrics, Pulmonology, Endocrinology, Rheumatology, Neonatal/Perinatal, Oncology, Intensive Care Medicine, Addiction Medicine, Hospice & Palliative Care, Primary Care, Pediatric Medicine, Internal Medicine, and Family Medicine

Eligibility requirements for members in performance measures are addressed in the Quality Measure Specification documentation which can be found on the VBP SharePoint site.

Revenue associated with members who were attributed to a PPS hospital system at some point during the measurement period, but who are no longer eligible for Medicaid, are still part of the at risk dollars for the PPS hospital system to which the member was most recently attributed.

It is important to note that there are pros and cons to any methodology. There are scenarios where a PPS hospital system will not have as much influence over a patient's utilization for the full year even though the patient is included in the system's final attribution for the performance period. The program was designed to accommodate some of the challenges that inevitably arise with any payment and attribution methodology by using provider-specific baseline performance and pragmatic progress as a definition of success.

Quality Measurement and Performance Monitoring Strategy

The VBP Program has been developed to align with the North Dakota Quality Strategy framework[4,5] mission, aims and goals. The Quality Strategy framework defines and drives the overall vision for advancing the quality of care provided to Medicaid members.

[3] Place of Service Codes Descriptions

[4] North Dakota Medicaid Quality Strategy Public Testimony. https://www.nd.gov/dhs//info/testimony/2021-2022-interim/human-services/2022-4-27-dhs-quality-strategy.pdf.

[5] North Dakota Medicaid Expansion Quality Strategy Plan. https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/nd-medicaid-expansion-quality-strategy-2023.pdf.

The North Dakota mission is:

To provide quality, efficient and effective human services, which improve the lives of people.

North Dakota aims to:

- ***Healthier Populations.*** Improve the health status of North Dakotans by promoting healthy lifestyles, preventive care, disease management, and disparity elimination.
- ***Better Outcomes.*** Improve access to quality healthcare at an affordable price to improve outcomes.
- ***Better Experience.*** Enhance member and provider experience.
- ***Smarter Spending.*** Increase effectiveness and efficiency in the delivery of healthcare programs and ensure value in healthcare contracts.

Within the VBP Program, there are five priority health care domains included to improve population health. All measures selected align to these domain areas.

- Primary Care Access and Preventive Care
- Maternal Health Services
- Behavioral Health Services
- Care of Acute and Chronic Conditions
- Oral Health Services

The VBP Program quality measurement and performance monitoring strategy will roll out in stages; expanding and building greater accountability over time. The program will begin as a pay-for-reporting only program with an initial measure set for the first 18 months of the program (July 2023 – December 2024). The initial measure set will transition to pay-for-performance in subsequent years; beginning January 2025. The program will also expand to add performance measures. The expanded set of measures will be under pay-for-reporting for a 12-month period (January 2025 – December 2025) and then transition to pay-for-performance in subsequent years; beginning January 2026.

The measures and associated timelines are further described below, and a summary table can be found in Appendix A.

Initial Quality Measures (July 1, 2023, forward)

All initial quality measures are mandatory for every provider and includes the following measures:

- Well-Child Visits First 30 Months of Life (W30-CH)
- Child & Adolescent Well-Care Visit (WCV-CH)
- Breast Cancer Screening (BCS-AD)
- PCP Visit Percentage
- Postpartum Care: Prenatal and Postpartum Care (PPC-AD)
- Screening for Depression and Documented Follow-up Plan (CDF-AD; CDF-CH)
- ED Utilization per 1000

- Topical Fluoride for Children (TFL-CH)

Expanded Quality Measures (January 1, 2025, forward)

The expanded measures will add three additional required measures and two measures that are selected by providers. Of the optional measures, providers must select one behavioral health measure, and one maternal health services measure.

Expanded Quality Measures: Required

- Colorectal Cancer Screen (COL-AD)
- Controlling High Blood Pressure
- Plan All-Cause Readmission (PCR-AD)

Expanded Quality Measures: Options

Maternal Health Services Options:

- Prenatal Care: Prenatal and Postpartum Care (PPC-AD)
- Contraceptive Care-Postpartum Women (CCP-AD)
- Structural Measure: Perinatal Collaborative Participation

Behavioral Health Services Options:

- Follow-up After Emergency Department Visit for Alcohol and Other Drugs Abuse or Dependence (FUA-AD)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)
- Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs

Definition of Success on Quality Measures

Program Timeframe: July 2023 – December 2024

Pay-for-Reporting

As previously noted, the VBP Program will roll out in stages; expanding and building greater accountability over time. The program will begin with pay-for-reporting periods during which the definition of successful performance will comprise three major components.

1. Achievement will include the completion of an annual VBP Reporting Tool with associated attestations. Submission will occur once per year by the last day in February.
2. Achievement will include participation in an annual VBP Outcomes Meeting and will occur once per year per PPS hospital system between October and November.
3. Achievement will include submission of supplemental data for associated measures at least once per year. Data may be submitted as often as monthly.

VBP Reporting Tool

PPS hospital systems will be expected to define their Quality Improvement Plan (QIP) that reflects ongoing activities throughout the year for system-selected measure(s). PPS hospital systems are to select one or more measures and associated domains to include in their QIP. The Perinatal Collaborative Participation (Structural Measure) may be selected only in combination with another selected measure(s).

The objective of the VBP Reporting Tool will be to collect the following QIP information:

- Which measure(s) are impacted based on identified gaps and improvement efforts.
- QIP goals and objectives.
- Planned activities or interventions for improving areas that address health outcomes and performance goals, quality of services, and/or members' experience within the selected area of domain(s).
- Outline the process for evaluating the above ongoing quality improvement activities/interventions that includes regular review of performance data against goals or benchmark targets.
- Describe impacted care setting(s) or the movement across care settings.

In addition to the QIP, the VBP Reporting Tool includes three attestations.

- **Perinatal Collaborative Participation (Structural Measure) Attestation** – This attestation will only be completed as part of the Expanded Measure Set and only by PPS hospital systems that have selected the Perinatal Collaborative Participation measure. Initial attestation will occur with the February 2025 report submission. Completion of this attestation will be required in all subsequent years for assessing measure achievement.
- **Supplemental File Attestation** – This attestation will be completed by a PPS hospital system representative with delegated authority to do so. This requests the system attest to having a process in place to submit data to supplement calculated claim results for all measures according to the quarterly reporting timeline and acknowledges the associated deadlines.

- **General Attestation** – The general attestation will be completed by a system representative with delegated authority to do so.

  This attestation requests the system acknowledge that by filing this attestation a claim is being submitted for State and Federal funds, and that the use of any false claims, statements, or documents, or the concealment of material fact, may be prosecuted under applicable State or Federal criminal laws and may be subject to civil monetary penalties, or recoupment. In addition, each PPS Hospital System Practice has agreed to keep its practice information, including practitioner and staff rosters, up to date to support timely and accurate attribution. Timely and accurate information will ensure correct payments, assist the Centers for Medicare & Medicaid Services (CMS) and North Dakota Health and

Human Services in monitoring practice performance, and ensure practices receive timely and accurate program information. Lastly, to acknowledge that the State and Federal government reserves the right to perform an audit of this information. Documentation will be available for review upon request.

An initial QIP will be submitted in 2024 and an updated QIP will be submitted in 2025. The updated QIP is to include adjustments to planned activities as a result of the evaluation. If a system does not meet the provider specific target in CY2024 on a measure, the QIP is also to include at least one planned activity to support improvement.

The VBP Reporting Tool can be found on the VBP SharePoint site. The VBP Reporting Tool will be required to be submitted to Optumas's SFTP site by the last business day of February in 2024 and in 2025. To sign-in to Optumas's SFTP site, follow the link listed after the Table of Contents. Please note: Member specific data, including protected health information (PHI), should not be included in the VBP Reporting Tool. Systems will be able to access submissions via an individual hospital folder on the North Dakota VBP SharePoint site.

The VBP Reporting Tool will go through an initial minimum submission review to confirm that questions were responded to, and that no PHI was submitted. Once confirmed, the submission will be reviewed and scored by each item which can receive a Met or Not Met score. For any item that receives a Not Met score, the PPS hospital system may receive a follow-up question from the Department.

VBP Outcomes Meeting

The objective of the VBP Outcomes Meeting will be for the organization to summarize its findings in its annual evaluation of how well performance goals and objectives for improving the quality and clinical care and services specified within its QIP were met. The agenda will include such topics as:

- Organization's QIP displayed & discussion based on:
  - Whether planned yearly activities were completed, and objectives were met.
  - Summarized findings for appropriate measures trended over time with use of Organization-specific data, Tableau Dashboard, and/or use of the Care Improvement Opportunity Tool (CIOT), etc.
  - Challenges and barriers to achieving objectives.
  - Recommended interventions for overcoming challenges and barriers.
  - The QIP's major accomplishments.
  - Whether the QIP will be restructured or changed in the subsequent year.
- Selection and confirmation of optional, expanded measures for 2025.

Supplemental File Submission

PPS hospital systems may submit supplemental data as often as monthly but must submit at least once annually. Supplemental data is information that is not submitted on an administrative claim

but contains qualifying inclusion or exclusion criteria relative to measure performance. The Supplemental File Data Collection Tool can be found on the VBP SharePoint site.

P4R Payment Calculation Methodology

If a provider satisfies the pay-for-reporting requirements (i.e., submission of the required VBP Reporting Tool, participation in the VBP Outcomes Meeting, and submission of supplemental data at least once per year), the provider retains 100% of the at risk funding for that measure. As the reporting framework evaluates measures collectively, all pay-for-reporting measures in a given period will receive the same met/not met score.

If a provider does not satisfy all of the reporting requirements, the provider must pay the State 100% of the at risk funds. Funds collected from pay-for-reporting measures will not be used to support the Redistribution Pool.

Program Timeframe: January – December 2025

This program period includes both pay-for-reporting and pay-for-performance elements.

Figure 3: At Risk Split Between Pay for Reporting and Pay for Performance

	Pay for Reporting			Pay for Performance
	QIP	Meeting	Data Submission	
July 2023 – December 2024	100% of the at risk dollars recouped if all 3 components are not met			N/A
CY 2025	38.5% of the at risk dollars recouped if all 3 components are not met			61.5% of the at risk dollars divided equally across initial measure set & measured against performance

* Completion of the Perinatal Collaborative Participation (structural measure) attestation (when selected), supplemental data file submission attestation, and the general attestation will be required in all subsequent years. Beyond 2025, the Department will employ ongoing continuous quality improvement (CQI) activities; applicable attestations and VBP outcomes meetings are minimally to be expected.

Pay-for-Reporting

PPS hospital systems will be expected to submit an updated QIP by the end of February 2025 and include adjustments to planned activities. If a system does not meet the provider specific target in CY2024 on a measure, the QIP is also to include at least one planned activity to support improvement. Refer to the VBP Reporting Tool section above for further information on these components (i.e., submission of the required VBP Reporting Tool, participation in the VBP Outcomes Meeting, and submission of supplemental data at least once per year).

As the reporting framework evaluates measures collectively, all pay for reporting measures in a given period will receive the same met/not met score. During the pay-for-reporting period from

January – December 2025, all reporting requirements must be met, otherwise 38.5% of the at risk dollars will be recouped through the payment settlement process. Funds collected from pay-for-reporting measures will not be used to fund the Redistribution Pool, but will be returned to the State.

Pay-for-Performance

The program will expand accountability to add pay-for-performance where hospital system performance will be evaluated against statewide targets as well as their own historical performance. Statewide targets define the standard of performance that the Department wishes to achieve across the state in order to provide high quality care to all North Dakotans. Statewide targets will be selected for each measure except the structural measure which will be rated as met/not met. Performance will be on a calendar year basis to align with standard quality measurement processes and will be referred to as the measurement year.

Baseline Performance

Statewide and provider-specific baseline performance will be set during the measurement year that represents calendar year 2024 performance for the initial measure set and calendar year 2025 performance for expanded measures.

As currently designed, health systems are expected to improve performance annually relative to their prior year performance; prior year performance becomes the new baseline performance for each new performance year.

Statewide Target

Statewide historical data will be utilized to evaluate current performance and establish statewide targets. Statewide targets will be set based on availability and a reasonable, incremental rate of change according to the following hierarchy based:

- Utilize the National HEDIS 75th percentile, or other applicable increment.
- Utilize the National Adult or Child Core Median.
- Utilize Regional data, as available.
- Utilize State-selected Target or Improvement over self.

If there is insufficient data to establish a statewide target, a minimum performance standard will be used. PPS hospital systems that are at or above are responsible for maintaining performance instead of achieving incremental progress. This is defined in the calculation methodology sections that follow.

Close the Gap: Provider-specific Target

If current PPS hospital system performance does not meet the statewide target, they will be charged with closing the gap between their prior year performance and the statewide target for each of the measures by a minimum of 10.00%. This is referred to as the provider-specific performance target that rewards incremental improvement from baseline performance. For example, if a hospital system's prior year performance was 60.0, the statewide target is 80.0, the

current provider-specific performance year target for successful performance would be 62.0 (60 + (80.0 – 60.0) * 10.00%).

If a provider meets or exceeds their provider-specific performance target, the provider retains 100% of the at risk funds for the measure. Partial credit is awarded if the provider-specific performance target is partially met.

Pay-for-performance Payment Calculation Methodology

Each quality measure (8 initial, 5 expanded for a total of 13) will have an equal portion of the total funds at risk for the provider. For measures with multiple components, the total funds at risk for the measure is divided equally for each component. The amount of funding for each quality measure will be based on the provider's performance as follows:

Step 1:

If a provider meets or exceeds the statewide target, the provider retains 100% of the at risk funds for the measure.

Figure 4: Sample Calculation – Provider Meets/Exceeds Statewide Target

Example:
At risk funding for measure: $60,000 Statewide Target: 90.00% Provider Prior Year Performance: 88.00% Actual Provider Performance: 90.00% At risk earned: $60,000

Step 2:

The Department intends to further explore with stakeholders the scenario where a provider's prior year performance is at or above the statewide target, but there is a small decline in performance. Payment policy for this scenario will be updated in future versions of this document prior to the first pay-for-performance period (currently planned for CY 2025).

Step 3:

If a provider meets or exceeds their provider-specific performance target, the provider retains 100% of the at risk funds for the measure.

Figure 5: Sample Calculation – Provider Meets/Exceeds Provider-Specific Target

Example:
At risk funding for measure: $45,000 Statewide Target: 90.00% Provider Prior Year Performance: 60.00% Provider-specific Target: 63.00% Actual Provider Performance: 65.00% At risk earned: $45,000

Step 4:

If a provider's performance is between the prior year performance level and the provider-specific target, the provider will pay the state a portion of the at risk funding. That portion is calculated with the following formula:

$$\frac{Provider\ Specific\ Target - Actual\ Performance}{Provider\ Specific\ Target - Provider\ Prior\ Year\ Performance}$$

Note that for some measures a lower performance statistic is considered better performance. For these measures (e.g., ED Utilization per 1000), calculations are adjusted accordingly. Please refer to the measure specification documentation for additional detail on units of measurement and direction of improvement.

Figure 6: Sample Calculation – Provider's Performance Between Prior Year Performance and Provider-Specific Target

Example:
At risk funding for measure: $60,000 Statewide Target: 90.00% Provider Prior Year Performance: 60.00% Provider-specific Performance Target: 63.00% [60.00% + 10%*(90.00-60.00%)] Actual Provider Performance: 61.00% Amount due to State: $40,000 [$60,000*((63.00%-61.00%)/(63.00%-60.00%))]

Redistribution Pool Payment Calculation Methodology

When a Redistribution Pool is funded, providers that achieve statewide targets can earn a portion of the available funding as an incentive above and beyond the at risk funding portion of the program. Funds received by a PPS hospital system from the Redistribution Pool will not exceed the PPS hospital system's at risk dollars. Being eligible for funds from the Redistribution Pool is currently defined as achieving the statewide target for a measure, but this may be reevaluated prior to this component of the model being implemented (currently planned for the 2025

performance period). During the first pay-for-performance period, the Redistribution Pool is expected to be funded by any at risk payments made to the State due to underperformance on quality metrics. Funding will not be available during the initial phase of the program, which is on a pay-for-reporting only basis. Payments made from the Redistribution Pool are calculated using the following formula:

- The total funds in the Redistribution Pool will be divided by the statewide count of the number of times participating PPS hospital systems hit the statewide target across all measures and systems to determine the unadjusted payment per event.
- The payment per event cannot exceed 15.00% of the funds in the Redistribution Pool. This calculation is the maximum payment per event.
- An individual PPS hospital system's payment is equal to the number of times they exceeded the statewide target multiplied by the lesser of the unadjusted payment per event or the maximum payment per event.

Figure 7: Sample Calculation – Redistribution Pool Payment Calculation

Example:
Redistribution Pool: $480,000 Count of Times Statewide Target Exceeded: 3 Unadjusted Payment Per Event: $160,000 [$480,000 / 3] Maximum Payment Per Event: $72,000 [$480,000 * 15.00%] Amount paid per Time Statewide Target Was Exceeded: $72,000 [lesser of $160,000 and $72,000]

Performance Period and Payment Settlement Dates

Performance periods will be on a calendar year basis to align with standard quality measurement processes. Because the program is beginning mid-year, the initial performance period will be 18 months. Future performance periods will last 12 months. This, and other information relevant to each period, is summarized in the table below for the first three performance periods. Additionally, a timeline graphic can be found at the end of this section.

Figure 8: Performance Period and Payment Settlement Dates

Program Period	Accountability	Baseline Period	Relevant Performance Data Periods	Payment Settlement Date
7/1/2023 – 12/31/2024	Pay-for-reporting on initial measure set	N/A	CY 2023 CY 2024	7/1/2025

Program Period	Accountability	Baseline Period	Relevant Performance Data Periods	Payment Settlement Date
1/1/2025 – 12/31/2025	Pay-for-performance on initial measure set Pay-for-reporting on expanded measure set	Pay-for-performance: CY 2024 Pay-for-reporting: N/A	CY 2025	7/1/2026
1/1/2026 – 12/31/2026	Pay-for-performance on all measures	CY 2025	CY 2026	7/1/2027

Rounding Policies

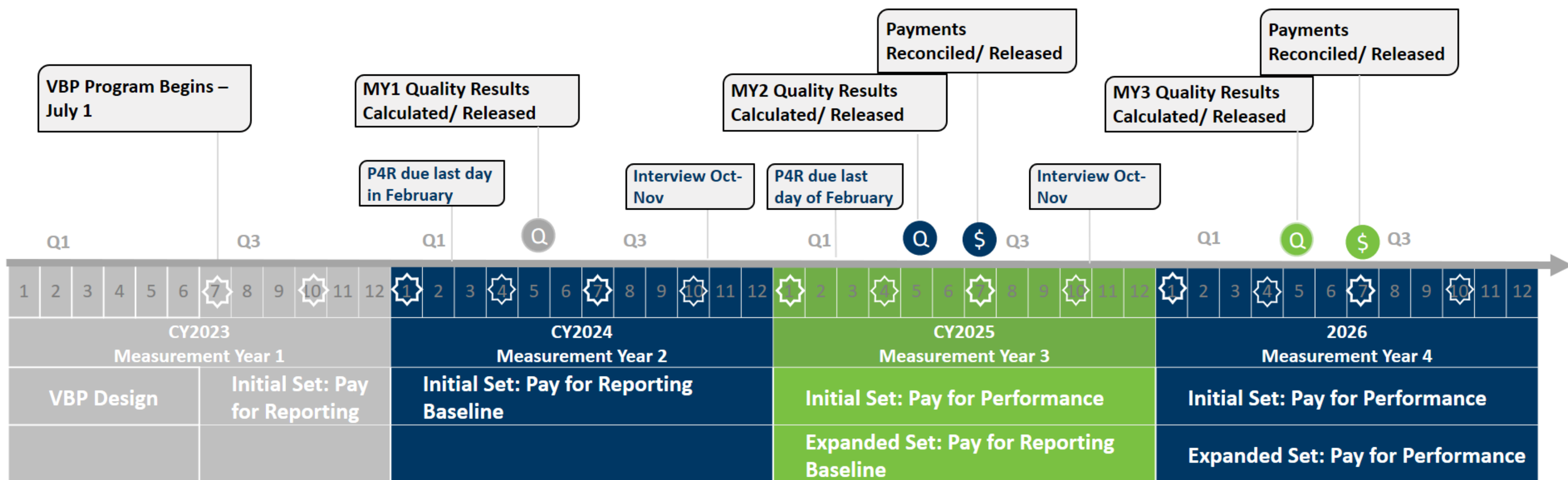
Both performance targets and performance will be measured to an accuracy of hundredths of a percent, or to two decimal places for non-percentage-based performance calculations. Calculation of dollars will be rounded to the nearest whole dollars.

Payment Settlement Process

Final determination of attributed members will be done using performance year claims data with three months of runout. Member attribution may change during the performance year, but final attribution will be what was determined in a member's most recent period of eligibility. The same data used to determine attribution will be used to calculate the final at risk dollars and only those claims incurred at the PPS hospital system to which a member has final attribution will be at risk. The data to finalize attribution, at risk dollars, and quality results, will not be available until April after the end of the performance year which is why the final dashboard release will not be done until May.

Upon finalization and release of the quality results in May of each year, a payment settlement process will be initiated. PPS hospital systems will receive a payment notification letter indicating final PPS hospital-specific performance measure and payment calculation results. Performance results will be indicated for pay-for-reporting and pay-for-performance per measure, as applicable. Payment calculation results will include total at risk funding, at risk dollars earned, at risk dollars unearned, and redistributed funds, as applicable.

Program Timeline



Analytics and Data Exchange

To support providers in their program success and to improve patient care, the Department will be providing access to several different types of analytics and attribution data. Providers will also submit supplemental data to include in the performance analysis. In total, there are four primary types of data exchange in this program, including the following:

- **Quality performance and gaps in care analysis** – providers can access online dashboards that show their own historical performance, a comparison against peers, and gaps in care for the various quality measures. This dashboard will be updated quarterly.
- **Care Improvement Opportunity Tool (CIOT) analysis** – providers can also access episodes of care- based analysis that provides insights on clinically relevant groupings of services related to specific patient conditions. The analysis is intended to highlight potentially avoidable utilization that could be eliminated through improved upstream care. This dashboard will be updated twice annually.
- **Attribution data** – providers will receive detailed attribution data on attributed patients through the quality performance dashboard. Attribution data will be updated quarterly.
- **Supplemental data** – providers will have the option to submit supplemental data for performance measurement up to monthly. Data will be incorporated into the quality performance dashboard quarterly. Providers must attest that they have submitted all data they intend to submit once annually.

Figure 9: Timeline for Analytics and Data Exchange

	Release Dates			
Dashboard/Data	**January**	**May***	**July**	**October**
Attribution	Incurred Claims Through September/Paid Through November	Incurred Claims Through December/Paid Through March	Incurred Claims Through March/Paid Through May	Incurred Claims Through June/Paid Through August
VBP Dashboards	Incurred Claims Through September/Paid Through November	Incurred Claims Through December/Paid Through March	Incurred Claims Through March/Paid Through May	Incurred Claims Through June/Paid Through August
CIOT Dashboards	Incurred Claims Through September/Paid Through November		Incurred Claims Through March/Paid Through May	

****3 months of runout, all other dashboard releases will include 2 months of runout***

Appendix A: Quality Measure Summary Table

Domain Quality Measure	Measure Description	Initial or Expanded Measure Set	Required or Option
Domain Area 1: Primary Care Access and Preventive Care			
Well-Child Visits First 30 Months of Life (W30-CH)	Percentage of children who had the following number of well-child visits with a primary care practitioner (PCP) during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned age 15 months during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned age 30 months during the measurement year: Two or more well-child visits	Initial	Required
Child & Adolescent Well-Care Visit (WCV-CH)	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	Initial	Required
Breast Cancer Screening (BCS-AD)	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	Initial	Required
Colorectal Cancer Screening (COL-AD)	Assesses adults 46–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years.	Expanded	Required
PCP Visit Percentage	The percentage of attributed members with a visit to any PCP where qualified services were rendered at a qualified place of service in the measurement year. Measure will be expressed as a percentage of total attributed population. The PCP percentage will be measured among Medicaid beneficiaries aged 18 years and older with at least 10 months of attributed enrollment to a PPS hospital. This metric is considered to be a threshold requirement for high value primary care.	Initial	Required
Domain Area 2: Maternal Health Services			
Prenatal Care: Prenatal and Postpartum Care (PPC-AD)	The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.	Expanded	Option Set 1

Domain Quality Measure	Measure Description	Initial or Expanded Measure Set	Required or Option
Postpartum Care: Prenatal and Postpartum Care (PPC-AD)	Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	Initial	Required
Contraceptive Care-Postpartum Women (CCP-AD)	Among women ages 21-44 who had a live birth, the percentage that: (1) were provided a most effective or moderately effective FDA-approved method of contraception within 3 and 60 days of delivery and/or (2) Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	Expanded	Option Set 1
Perinatal Collaborative Participation (Structural Measure)	Hospital has implemented safety practices or bundles included as part of a Perinatal Quality Initiative Collaborative (PQC).	Expanded	Option Set 1
Domain Area 3: Behavioral Health Services			
Screening for Depression and Documented Follow-up Plan (CDF-AD; CDF-CH)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.	Initial	Required
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Expanded	Option Set 2
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	Expanded	Option Set 2

Domain Quality Measure	Measure Description	Initial or Expanded Measure Set	Required or Option
	• Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.		
Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs	Percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18–64, that were followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder [pharmacotherapy]) within 7 or 14 days after discharge.	Expanded	Option Set 2
Domain Area 4: Care of Acute and Chronic Conditions			
Controlling High Blood Pressure (CBP-AD)	The percentage of beneficiaries 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	Expanded	Required
ED Utilization per 1000	The measure is defined as the number of all-cause ED visits per 1,000 beneficiary months among Medicaid beneficiaries with at least 10 months of enrollment. Higher values (those toward the high end of the percentile distribution) may indicate overuse of the ED for Medicaid participants and may indicate that disparities in access to treatment exist for Medicaid participants.	Initial	Required
Plan All-Cause Readmission (PCR-AD)	For beneficiaries ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	Expanded	Required
Domain 5: Oral Health Services			
Topical Fluoride for Children (TFL-CH)	Percentage of children aged 1–21 years who are at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications as dental OR oral health services within the reporting year.	Initial	Required