North Dakota PPS Hospital Value-base Purchasing (VBP) Program

Payment Model Description

Date: July 11, 2024

Version 3.1

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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

Version Management:

This document will be updated when substantial policy changes have been vetted thoroughly with the PPS Hospital Systems and finalized.

Changes	Version
• Updated the 40th percentile for AMB-CH in Appendix A. • Updated due dates for supplemental data submission.	Version 3.1
• The PCP Visit Percentage measure was replaced by AAP but will not be scored. Instead, a dashboard for informational purposes will still be provided. • The Emergency Department per 1,000 measure was removed from the initial measure set and will be replaced by (1) Ambulatory Care: Emergency Department Visit (AMB-CH) Measure for ages 0-19 and (2) moving the Plan All-Cause Readmission (PCR-AD) Measure to the Initial Measure set from the Expanded Measure set. • Updated PPC-CH and PPC-AD to PPC2-CH and PPC2-AD as Prenatal and Postpartum (PPC2-CH/AD). • Removed Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs from the Expanded Option 2 measure set. • The Redistribution Pool policy was finalized along with the definition of success. • The Performance Maintenance policy was finalized.	Version 3.0

• The decision to move from the 75th percentile to the 50th percentile was finalized.	

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.

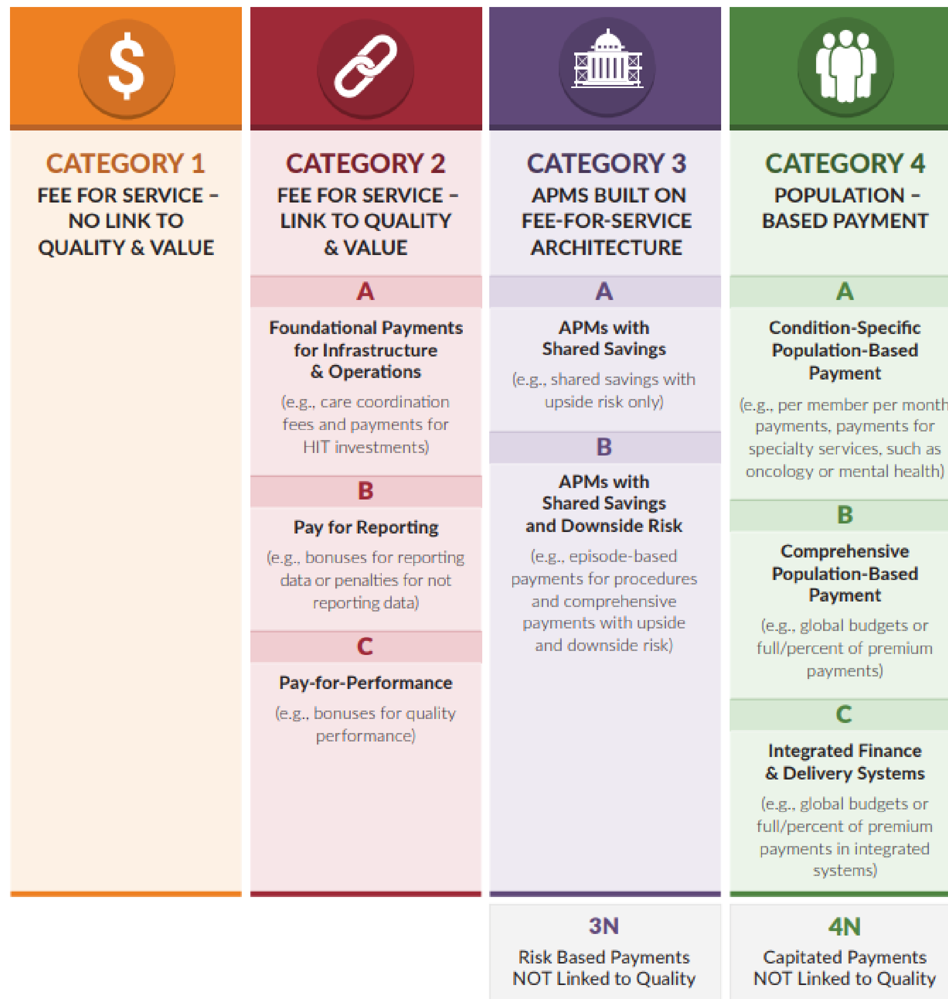
PPS hospital systems are paid under a variety of reimbursement methodologies depending on the type of services provided and which providers in the system rendered the service. A common feature of the reimbursement methodologies is that they are not tied to quality for traditional Medicaid population. 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. PPS hospital systems will see no loss of funding if they meet specific success criteria outlined in the "Pay for Performance" section of this document. 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 as outlined in the "Redistribution Pool" section of this document. 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 into the attribution logic and Quality. 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. Additionally, Figure 2 shows how Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers are considered for purposes of attribution, Quality, and at-risk dollars.

Figure 2: Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers

	Statewide Attribution	Quality	At Risk Dollars	PPS Health System affiliation
Critical Access Hospitals (CAH)	x	x	No	x
Rural Health Clinics (RHC)	x	x	Not applicable due to no Institutional Inpatient/Outpatient dollars	x
Federally Qualified Health Center (FQHC)	x	x		currently N/A

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 3: Attribution Criteria

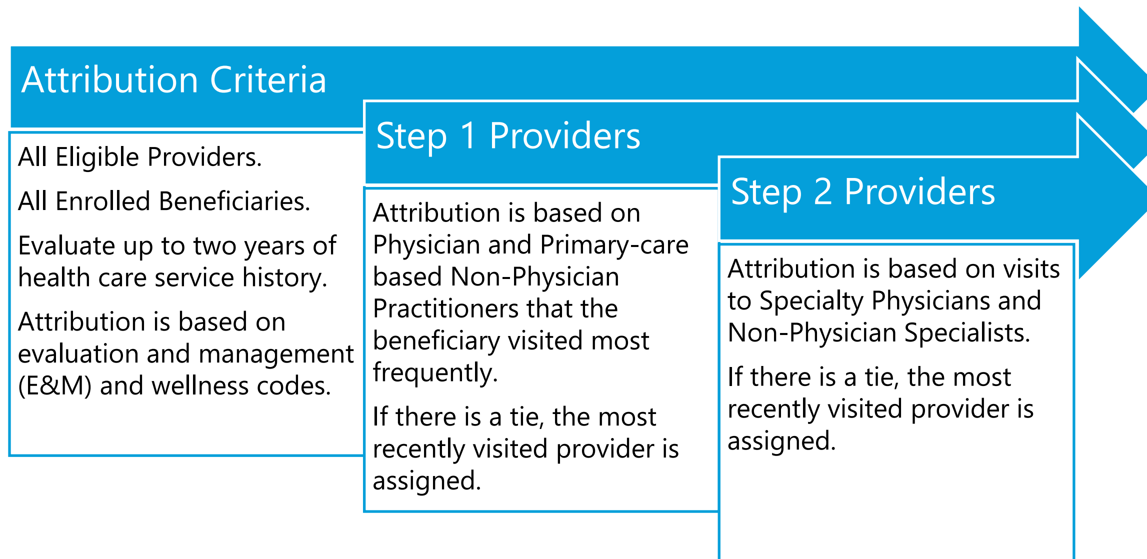
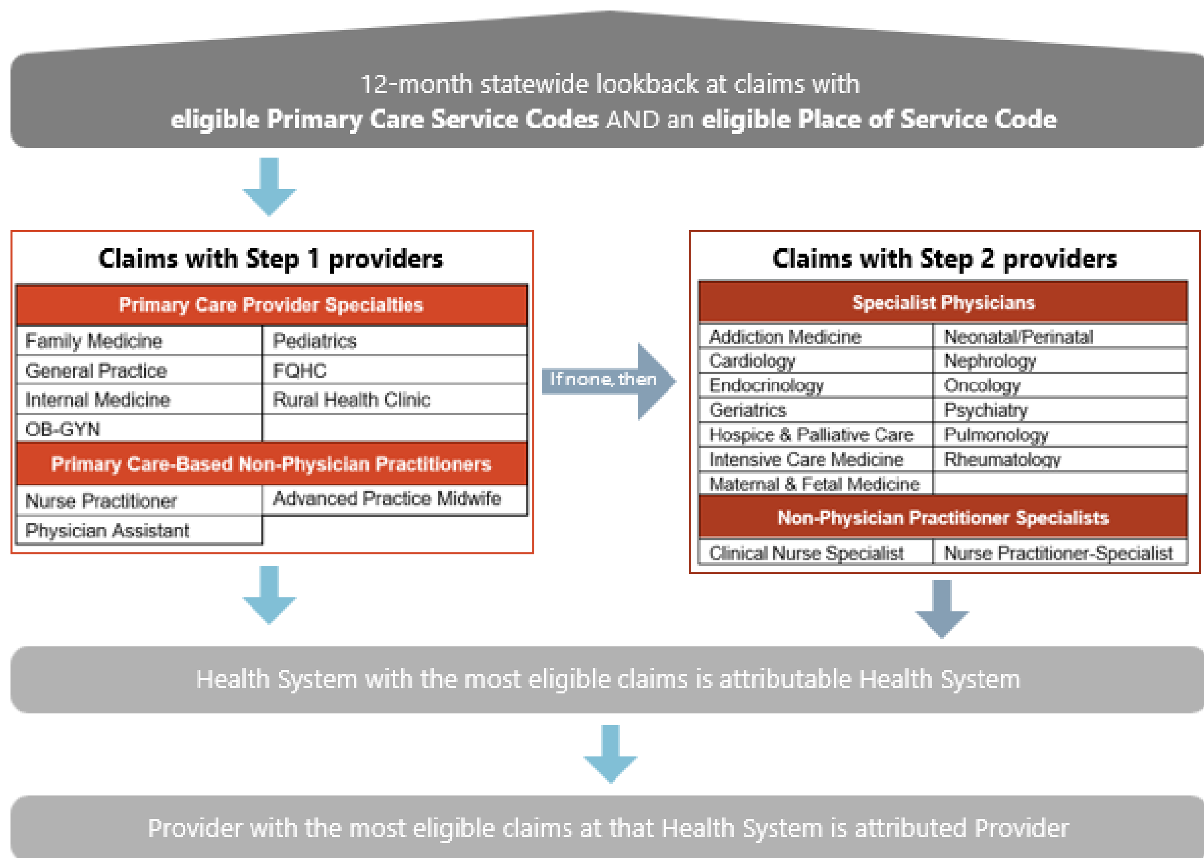


Figure 4: Attribution Logic



The detailed provider specialty grouping identification can be found in Appendix B: Attribution Provider Identification.

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:

Figure 5: Attribution CPT and Place of Service Codes

Primary Care Service Codes	
CPT	**Description**
99201-99205	New patient, office or other outpatient visit
99211-99215	Established patient, office, or other outpatient visit
99304-99306	Nursing Facility Care; new patient
99307-99310	Nursing Facility Care, Established patient
99315-99316	Established patient, discharge day management service
99318	Established patient, other nursing facility service
99324-99328	New patient, domiciliary or rest home visit
99334-99337	Established patient, domiciliary or rest home visit
99339-99340	rest home
99341-99345	New patient, home visit
99347-99350	Established patient, home visit
99381-99387	Preventative Medicine Service, new patient
99391-99397	Preventative Medicine Service, established patient
99441-99444	Non-face-to-face Telehealth E&M visit
G0402	Initial Medicare visit
G0438	Annual Wellness visit, initial
G0439	Annual Wellness visit, subsequent
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G0466	Federally qualified health center (fqhc) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a fqhc practitioner during which time one or more fqhc services are rendered and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving a fqhc visit
G0467	Federally qualified health center (fqhc) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a fqhc practitioner during which time one or more fqhc services are rendered and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving a fqhc visit
G0468	preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv
T1015	Clinic Visit/encounter all-inclusive
S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service

AND One of the following Place of Service Codes	
2	Telehealth
11	Office
13	Assisted Living Facility
17	Walk-In Retail Health Clinic
19	Off Campus- Outpatient Hospital
20	Urgent Care Facility
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

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[3,4] mission, aims and goals. The Quality Strategy framework defines and drives the overall vision for advancing the quality of care provided to Medicaid members.

ND VBP Program supports the overall HHS vision to make North Dakota the healthiest state in the nation.

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.

[3] 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.

[4] 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.

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 track both an initial measure set and expanded measure set in stages. The program will begin as a pay-for-reporting only program for the first 18 months (July 2023 – December 2024). PPS hospital systems can report on measures from the initial measure set and the expanded measure set for the first 18-month period. The initial measure set will transition to pay-for-performance in subsequent years; beginning January 2025. The expanded set of measures will be added to the set of pay-for-performance measures beginning January 2026.

The performance monitoring strategy will include a quarterly assessment of PPS hospital system results, as well as an annual assessment of the measure set. While completing the Performance Measure Specification Guide update, the Department will monitor for measure applicability, technical changes, and/or measure retirement that may impact the program. Throughout the program, a Quality Workgroup will be convened with PPS hospital systems representatives to review statewide performance and provide input on program features. Collaboration and transparency will remain key program values to support statewide health improvements.

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)
- Postpartum Care: Prenatal and Postpartum Care (PPC)
- Screening for Depression and Documented Follow-up Plan (CDF)
- Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
- Plan All-Cause Readmission (PCR-AD)
- Topical Fluoride for Children (TFL-CH)

Expanded Quality Measures (January 1, 2025, forward)

The expanded measures will add two 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 (CBP-AD)

Expanded Quality Measures: Options

Maternal Health Services (Option Set 1):

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

Behavioral Health Services (Option Set 2):

- Follow-up After Emergency Department Visit for Alcohol and Other Drugs Abuse or Dependence (FUA)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Informational Quality Measures

There are several dashboards included that are for informational purposes only. This information is included to assist PPS hospital systems in creating better health outcomes for North Dakotans.

- Adults' Access to Preventative/Ambulatory Health Services (AAP)

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 a pay-for-reporting period 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 with a deadline of February 29, 2024.
2. Achievement will include participation in an annual VBP Outcomes Meeting and will occur once per PPS hospital system between October 2024 and November 2024.
3. Achievement will include submission of supplemental data for associated measures at least once during the 18-month period. Data may be submitted as often as monthly. The final deadline to submit supplemental data will be February 28, 2025.

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 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, though only two of them apply to the initial 18-month period.
- **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 PPS hospital 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.

The VBP Reporting Tool can be found on the VBP SharePoint site. The VBP Reporting Tool was required to be submitted to Optumas's SFTP site by the last business day of February in 2024 for the initial 18-month period. 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 for the initial 18-month period, with the last deadline being February 28, 2025. 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.

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS® is permitted, and the release of this information requires no special patient consent or authorization. Please be assured our members' personal health information is maintained in accordance with all federal and state laws. Data is only publicly reported collectively. All providers' records are protected by these laws. HEDIS® data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities.

42 C.F.R. Part 2 regulatory requirements will generally not apply in this program. Supplemental data provided by PPS hospital systems for substance use related measures is limited to validating

patient exclusions such as death or hospice status. Part 2 provider data should not be shared. Additionally, the analytics supporting the program do not include gap closure lists for the substance use related measures as the measures are about timely follow-up care; data that is sufficiently timely to impact performance measurement cannot be provided due to the time it takes for billing submission, claims process, and subsequent analysis.

P4R Payment Calculation Methodology

If a PPS hospital system 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 for the initial 18-month period), the PPS hospital system 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 PPS hospital system does not satisfy all the reporting requirements, 100% of the at-risk funds 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.

Program Timeframe: January – December 2025

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

Figure 6: 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	33.3% of the at-risk dollars recouped if all 3 components are not met			66.7% 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 June 30, 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 for CY2025 with the final deadline being February 28, 2026). The Perinatal Collaborative Participation (Structural Measure) may be selected only in combination with another selected measure(s) and requires an additional attestation.

- **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 June 2025 report submission. Completion of this attestation will be required in all subsequent years for assessing measure achievement.

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 33.3% 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 PPS 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.

While not anticipated, there may be rare circumstances where retroactive restating of performance targets and baselines would be necessary. If an unforeseen circumstance arises, the State will collaborate with providers to ensure a fair and transparent process is used and results are as accurate a reflection of actual patient care as possible.

Statewide Target Determination

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:

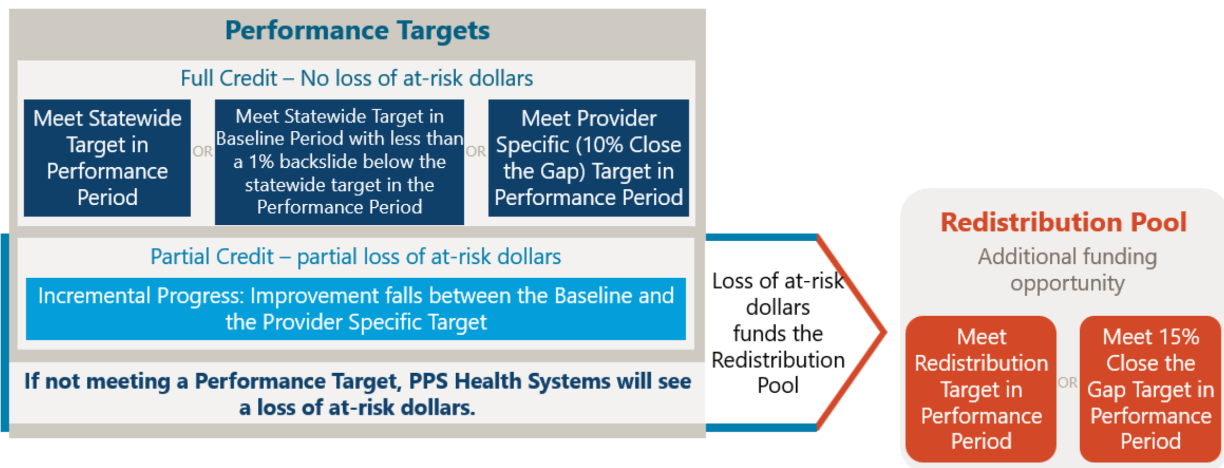
- Utilize the National HEDIS 50th percentile, or other applicable increment.
- Utilize the National Adult or Child Core Median.
- Utilize Regional data, as available.
- Utilize State-selected Target or Improvement over self.

If there is insufficient data to establish a statewide target, a minimum performance standard will be used. The Statewide Targets will be held steady for 2 years. The State will recommend and select new statewide targets in collaboration with providers (Fall 2025 for PY 2026).

Program Performance Targets

There are two sets of performance standards in the program. The first set is used to determine if and how much a provider will retain of their at-risk funding. The second set of performance targets is used to determine if a provider is eligible to receive funding from the redistribution pool. The performance targets relevant to the at-risk funding are shown below. Information about the redistribution pool and related performance targets can be found in the following section.

Figure 7: Program Performance Targets



Performance Target 1:

Meet or Exceed Statewide Target

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

Figure 5: Sample Calculation – Provider Meets/Exceeds Statewide Target

Example:
At-risk funding for measure: $60,000
Statewide Target: 90.00%
Provider Baseline: 88.00%
Actual Provider Performance: 90.00%
At-risk funding retained: $60,000

Performance Target 2:

Maintaining the Statewide Target

If a provider's baseline is above the statewide target, the provider will meet the definition of success for the performance year if the provider meets the statewide target or meets the statewide target less 1 percentage point.

Figure 8: Sample Calculation – Provider Maintains Statewide Target

Example:
At-risk funding for measure: $45,000
Statewide Target: 90.00%
Provider Baseline: 91.00%
Statewide Target Less 1 Percentage Point 89.00%
Actual Provider Performance: 89.50%
At-risk funding retained: $60,000

Performance Target 3:

Close the Gap: Provider-specific Target

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

Figure 9: Sample Calculation – Provider Meets/Exceeds Provider-Specific Target

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

Performance Target 4:

Incremental Progress

If a provider's performance is between the baseline 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:

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

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

Figure 10: Sample Calculation – Provider's Performance Between Baseline and Provider-Specific Target

Example:
At-risk funding for measure: $60,000
Statewide Target: 90.00%
Provider Baseline: 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%))]
At-risk funding retained: $20,000 [$60,000 - $40,000]

Pay-for-Performance Payment Calculation Methodology

Each quality measure (8 initial, 4 expanded for a total of 12) 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 relative to the relevant Program Performance Target(s) above.

Redistribution Pool Performance Targets

When a Redistribution Pool is funded, providers have the opportunity to earn funds from the pool based on their performance on quality measures during the measurement period. Performance is evaluated differently for the Redistribution Pool than it is for at-risk funds; the four performance targets used to determine how much of a provider's at-risk funding is retained do not apply when evaluating eligibility for Redistribution Pool funding. There are instead two performance targets relevant to the Redistribution Pool.

Redistribution Pool Performance Target 1:

Performance is at or above the estimated 40th Percentile

Performance at or above the estimated 40th Percentile performance for a measure will qualify for a portion of the Redistribution Pool.

Figure 11: Sample Calculation – Performance is at or above the estimated 40th Percentile

Example:
Estimated 40th Percentile: 75.00% Actual Provider Performance: 90.00% Measure Qualified for Portion of Redistribution Pool?: Yes

Redistribution Pool Performance Target 2:

15% or More Gap Closure

Gap closure of 15% or more between the provider's Baseline and the Statewide Target will qualify for a portion of the Redistribution Pool.

Figure 12: Sample Calculation – Gap closure of 15% or more

Example:
Statewide Target: 90.00% Provider Baseline: 60.00% 15% Gap Closure Target: 64.50% Actual Provider Performance: 65.00% Measure Qualified for Portion of Redistribution Pool?: Yes

Redistribution Pool Payment Calculation

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 measures where participating PPS hospital systems achieved either of the Redistribution Pool Performance Targets across all measures and systems to determine the unadjusted payment per event. If a provider hits both Redistribution Pool Performance Targets for a given measure, that measure is only counted once.
- 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 measures where they met either of the two Redistribution Pool Performance Targets (each measure can only count once per provider), multiplied by the lesser of the unadjusted payment per event or the maximum payment per event.

Figure 13: Sample Calculation – Redistribution Pool Payment Calculation

Example:
Redistribution Pool: $480,000 Count of Measures Meeting at Least One Redistribution Pool Performance Target: 3 Unadjusted Payment Per Event: $160,000 [$480,000 / 3] Maximum Payment Per Event: $72,000 [$480,000 * 15.00%] Amount paid per Measure Meeting at Least One Redistribution Pool Performance Target: $72,000 [lesser of $160,000 and $72,000]

During the first pay-for-performance period, the Redistribution Pool is 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. In the event there are funds remaining in the Redistribution Pool, the state intends to issue the funds via grants to support projects to improve performance and beneficiary outcomes in future performance years.

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 14: Performance Period and Payment Settlement Dates

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

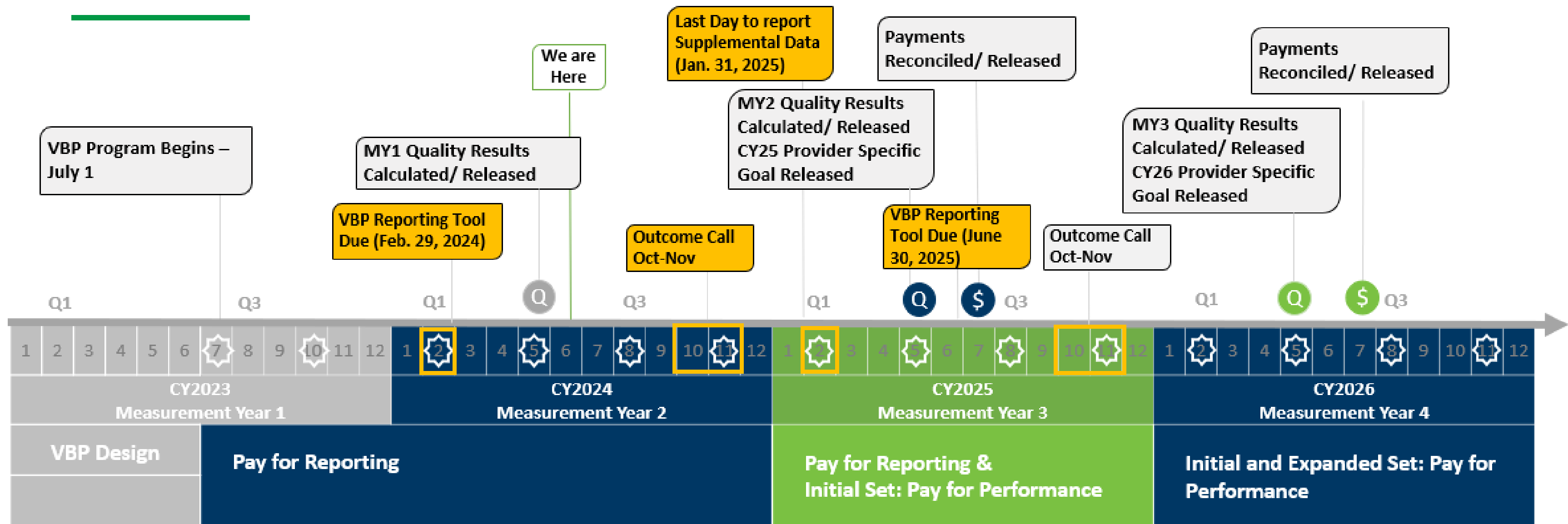
Both performance targets and performance will be measured to an accuracy of hundredths of a percent, or to two decimal places for non-percentage-based performance calculations. Calculation of dollars will be rounded to the nearest whole dollars.

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 performance report showing performance on each quality measure and 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 15: 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	Measure	Initial or Expanded Measure Set	Required or Option Selection Status	Payment Information		State Target		Redistribution Target Estimated 40th Percentile
Domain Area 1: Primary Care Access and Preventive Care	Well-Child Visits First 30 Months of Life (W30-CH)	Initial Measure Set	Required	Split allocation:	First 15 months	NCQA Quality Compass 50th 2023 (MY2022) percentile	58.38%	56.16%
					Age 15 months to 30 months		66.76%	64.88%
	Child & Adolescent Well-Care Visit (WCV-CH)	Initial Measure Set	Required	Full allocation to total (ages 3 to 21) range		NCQA Quality Compass 50th 2023 (MY2022) percentile	48.07%	46.04%
	Breast Cancer Screening (BCS-AD)	Initial Measure Set	Required	Full allocation for total (ages 52 to 74) range		NCQA Quality Compass 50th 2023 (MY2022) percentile	52.20%	50.11%
	Colorectal Cancer Screen (COL-AD)	Expanded Measure Set	Required	Full allocation for total (ages 46 to 75) range		NCQA Quality Compass 50th 2023 (MY2022) percentile	TBD	TBD
Domain Area 2: Maternal Health Services	Timeliness of Prenatal Care: Prenatal and Postpartum Care (PPC)	Expanded Measure Set	Option	Full allocation for Timeliness of Prenatal Care total age range		NCQA Quality Compass 50th 2023 (MY2022) percentile	84.23%	82.39%
	Postpartum Care: Prenatal and Postpartum Care (PPC)	Initial Measure Set	Required	Full allocation for Postpartum Care total age range		NCQA Quality Compass 50th 2023 (MY2022) percentile	78.10%	76.45%
	Contraceptive Care Postpartum Women (CCP-AD)	Expanded Measure Set	Option	Full allocation to age 21-44 LARC – 90 days		TBD	TBD	TBD
	Perinatal Collaborative Participation	Expanded Measure Set	Option	Pay for Reporting the attestation		NA	NA	NA

Domain	Measure	Initial or Expanded Measure Set	Required or Option Selection Status	Payment Information		State Target		Redistribution Target Estimated 40th Percentile
Domain Area 3: Behavioral Health Services	Screening for Depression and Documented Follow-up Plan (CDF)	Initial Measure Set	Required	Full allocation to total (ages 12 and older)		Median regional data from measure developer	72.60%	69.56%
	Follow-Up after Emergency Department Visit for Substance Use (FUA)	Expanded Measure Set	Option	Split Allocation:	30 days of the ED visits (31 total days)	NCQA Quality Compass 50th 2023 (MY2022) percentile	36.34%	32.90%
					7 days of the ED visit (8 total days)		24.51%	21.66%
	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Expanded Measure Set	Option	Split Allocation:	Initiation of SUD Treatment total (all ages)	NCQA Quality Compass 50th 2023 (MY2022) percentile	44.32%	42.46%
					Engagement of SUD Treatment total (all ages)		13.87%	12.25%
Domain Area 4: Care of Acute and Chronic Conditions	Controlling High Blood Pressure (CBP-AD)	Expanded Measure Set	Required	Full allocation for total (ages 18 to 85) range		NCQA Quality Compass 50th 2023 (MY2022) percentile	61.31%	58.97%
	Ambulatory Care: Emergency Department Utilization (AMB-CH)	Initial Measure Set	Required	Full allocation for total (0 to 19) range		CMS Child Core Set Median	31.90	33.62
	Plan All-Cause Readmission (PCR-AD)	Initial Measure Set	Required	Full allocation for total (18 to 64) range		NCQA Quality Compass 50th 2023 (MY2022) percentile	0.985	1.02
Domain Area 5: Oral Health Services	Topical Fluoride for Children (TFL-CH)	Initial Measure Set	Required	Full allocation for total (1 to 20) range		CMS Child Core Set Median	19.30%	18.30%

Appendix B: Attribution Provider Identification

Attribution Step	Provider Specialty Code Description	Provider Specialty Code
Step 1	Advanced Practice Midwife	485
Step 1	Family Medicine	173
Step 1	Federally Qualified Health Center	361
Step 1	General Practice	1
Step 1	Internal Medicine	11
Step 1	Nurse Practitioner Adult Health	431
Step 1	Nurse Practitioner Family	432
Step 1	Nurse Practitioner OB-GYN	434
Step 1	Nurse Practitioner Pediatrics	435
Step 1	Nurse Practitioner- Primary Care	469
Step 1	Nurse Practitioner- Womens Health	470
Step 1	Nurse Practitioner, Advanced Practice	55
Step 1	OB-GYN	16
Step 1	Pediatric Adolescent Medicine	564
Step 1	Pediatrics	49
Step 1	Physician Assistant	255
Step 1	Physician Assistant;Medical	518
Step 1	Rural Health Clinic	268
Step 2	Clinical Nurse Specialist	36
Step 2	Clinical Nurse Specialist, Adult Health	550
Step 2	Clinical Nurse Specialist, Child&Adol	629
Step 2	Clinical Nurse Specialist, Family Health	619
Step 2	Clinical Nurse Specialist, Oncology	559
Step 2	Clinical Nurse Specialist, Psychiatric/M	547
Step 2	CNS; Psychiatric/Mental Health	537
Step 2	Endocrinology, Diabetes & Metabolism	168
Step 2	Family Medicine; Addiction Medicine	562
Step 2	Family Medicine; Geriatric Medicine	586
Step 2	Family Medicine; Hospice & Palliative Me	590
Step 2	Hospice	454
Step 2	Hospice and Palliative Medicine	545
Step 2	Internal Medicine; Addiction Medicine	652
Step 2	Internal Medicine; Geriatric Medicine	587
Step 2	Internal Medicine; Hospice & Palliative	591
Step 2	Maternal & Fetal Medicine	404

Attribution Step	Provider Specialty Code Description	Provider Specialty Code
Step 2	Medical Oncology	529
Step 2	Neonatal-Perinatal Medicine	502
Step 2	Nephrology	105
Step 2	Nurse Practitioner- Psych-Mental Health	467
Step 2	Nurse Practitioner, Gerontology	551
Step 2	Nurse Practitioner; Neonatal	531
Step 2	Pediatric Cardiology	221
Step 2	Pediatric Developmental & Beha	223
Step 2	Pediatric Endocrinology	226
Step 2	Pediatric Hospice & Palliative Medicine	542
Step 2	Pediatric Pulmonology	240
Step 2	Pediatric Rheumatology	243
Step 2	Psychiatry	121
Step 2	Psychiatry	660
Step 2	Psychiatry; Child-Adolescent	142
Step 2	Rheumatology	267