# ALL PRACTICE TYPES

## Primary Care Provider

## Quality Incentive Program (PCP QIP)
## Equity Adjustment Specifications

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# 2024

MEASUREMENT YEAR

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

# Equity Adjustment Overview

In 2023, the Primary Care Provider (PCP) Quality Incentive Program (QIP) was analyzed and revealed some underlying sources of inequity. Collectively, these sources resulted in lower PCP QIP payments going to PCPs:

- In counties with less social support services and more sociodemographic stresses
- With a higher than average proportion of complex patients
- In counties with more challenges recruiting clinicians.
- With less baseline financial and staffing resources
- Sites with major impacts associated with local natural disasters (mainly fires, but also potentially floods, earthquakes)
- Large providers who take a larger percentage of Medi-Cal patients.

After review, the underlying dollar amount available for the PCP QIP Core Measure set was approved to be adjusted at the PCP site level to begin to rectify these inequities.

Goals of QIP payment equity adjustment:

1. Leave no site behind: Every PCP site is given resources to help them provide the best care they are capable of to the members they serve.
2. Most adjustments are made based on factors beyond the control of the PCP site. The focus at the site level is to provide the best care possible (i.e. focus on the QIP measures and factors that contribute to them). These adjustments will serve to redistribute resources that are distributed.

## Previous Payment Methodology

Previously, dollars going into the pool for the PCP QIP were only dependent on assigned Partnership members with primary Medi-Cal coverage. There was no adjustment in payment amount for the complexity of the member, the degree of socio-demographic stress, the difficulty in recruiting high quality staff, or the baseline resources of the PCP. Dollars available for PCP QIP was historically set at $9.25 Per Member Per Month (PMPM) for members capitated or assigned to a PCP site. Of this amount in 2022, 62% of funds were earned (weighted average), or about $5.75 PMPM.

## Equity Adjustment Change Summary

*Gateway*
PCP site must have at least 100 assigned members as of December of the measurement year.

*Core adjustments*

1. Acuity of patient panel
2. Socio-demographic risk, at patient level, rolled up to PCP site level
3. Site difficulty in recruiting PCP physicians
4. Lower than average baseline per visit resources available to PCP

*Supplemental Adjustments*

1. Natural Disaster Adjustment
2. Pediatric Access Equity Adjustment

## New Payment Methodology

The methodology for calculating the PCP site PMPM amount will have two (2) components:

1. A base rate of a $4 PMPM minimum
2. A site adjusted supplemental rate (may range from an additional $0 to a maximum of approximately $20 PMPM).

The following six (6) factors will be used to generate the site adjusted supplemental rate:

- **Factors 1a & 1b (Core Adjustment)**
  - An adjustment for the severity of the patient mix of the site, based on an estimate of the additional workload of caring for that patient population
- **Factor 2 (Core Adjustment)**
  - An adjustment for unfavorable socio-demographic mix of patient population
- **Factors 3a & 3b (Core Adjustment)**
  - An adjustment for the difficulty in hiring primary care clinicians at the site
- **Factor 4 (Core Adjustment)**
  - An adjustment for low practice resources
- **Factor 5 (Supplemental Adjustment)**
  - An adjustment for major disruptions in service related to natural disasters
- **Factor 6 (Supplemental Adjustment)**
  - An adjustment to support pediatric access for sites meeting certain criteria

## Weighting of Core Adjustments

| Percentage Weight | Equity Adjustment Factor |
|---|---|
| **40%** | Acuity Adjustment (2 components: 20% each) |
| **20%** | Socio-demographic risk factors |
| **20%** | Difficulty in Recruiting PCPs (2 components: 10% each) |
| **20%** | Below Average Resources |

*Only PCP sites with at least 100 assigned members as of December of the measurement year will be eligible for the above adjustments (Factors 1-6)

## Dollars at stake

1. Lower the base rate at risk from $9.25 PMPM to $4.00 PMPM
2. All six (6) categories above result in additional PMPM payments, at risk depending on QIP score.
3. Globally the program will be set up to be budget neutral, with an estimated range of PMPM at risk ranging from $4.00 to approximately $20.00 PMPM. This PMPM may fluctuate from year to year but will never less than $4 or greater than $20.

## Table A: Major Category of Equity Risk Adjustment

| Weight | Factor | Description | Level of adjustment | Adjustment Method | Zero Adjustment | Max Adjustment | Data Source |
|---|---|---|---|---|---|---|---|
| 20% | 1a | Acuity: Number of diagonses | PCP Site | Continuous | <2.5 diagnoses/ encounter | >4 diagnoses/ encounter | PHC Claims & Membership Data; Denominator=claims from PCP site |
| 20% | **1b** | Acuity: Non Utilizer rate | PCP site | Continuous | >20% | <10% | PHC Claims Data; Denominator=2 year lookback of assigned patients |
| 20% | **2** | Sociodemographic Factors | Rolled up member risk to PCP site | Continuous | >0.8 | < -0.4 | Healthy Places Index. Address of each Resident (homeless patients assigned to PHC location for address) |
| 10% | **3a** | Physician Shortage area- Frontier Location | Location of PCP Site (Frontier) | full credit for frontier level 2 (all or nothing) | Non-frontier | Frontier Level 2 | USDA |
| 10% | **3b** | Physician Shortage area PCP density in county | County of PCP site (PCPs/1000 residents | Continuous | Greater than 1.05 PCPs/1000 residents | 0.4 or less PCPs/1000 residents | County Health Rankings |
| 20% | **4** | Structurally unfavorable per visit reimbursement | Site level | Continuous | > $220 | < $120 | DHCS, PHC contracts |
| | **5** | Natural Disasters | Site level | Continuous | | >13 weeks | PHC contracts |
| | **6** | Pediatric Access - CHDP | Site level | Continuous | | | DHCS, PHC contracts |

## Equity Adjustment Gateway Measure: Adjustment Exclusion for Larger Percentage of PHC Member

### Description

For providers with very small numbers of PHC members enrolled in their practice, they will not find the PCP QIP dollars to be sufficient to lead to focused behavior change.

### Calculation

PCP sites with less than 100 members assigned on December of the measurement year, the baseline PMPM available for the PCP QIP will be $4 with no additional equity adjustments.

### Data Sources

PHC Database

# Equity Adjustment 1a & 1b: Acuity Diagnosis

## Overview

Patient Acuity is a description of how sick a person is at the present time. PHC aligns the PCP QIP incentives using Acuity as an estimate of Primary Care work and as an estimate of PHC risk. This alignment can be best described as:

- If your members are more sick, they will be worth more dollars at stake in the PCP QIP
- DHCS is moving towards acuity adjustment of Managed Care Plan Rates. In the future, risk adjustment is a critical feature of a DHCS mandated implementation of a MediCare Dual Special Needs plan.

The acuity diagnosis adjustment has two factors:

1. Number of Diagnoses (1a)
2. Non-utilizer Rate (1b)

For both components, an upper target and lower baseline threshold are established at approximately the 90th percentile and 10th percentile, respectively. Between these values, increased acuity scores will lead to a higher supplemental PMPM. The number of diagnoses (1a) is used as a weighted average per claim received for each PCP clinic based on the members' aid category at the time of service.

## Factor 1a

### Denominator

Count of number of PCP visits performed at the PCP site during the measurement year for assigned members, based on PHC claims data submitted.

### Numerator

The number of diagnoses found in claims for primary care services (PCP visits) submitted by PCP QIP providers during measurement year (2024), for the PCP site.

PHC defines PCP Visit as an encounter happening at any location regardless of if it is the members' assigned PCP site.

### Inclusions

- PCP site participating in the PCP QIP with >100 assigned members in December of the measurement year
- Aid Categories: DHCS mapping - version 1H-2022 (See Appendix 1 – Aid Code Mapping Table)
- Partial dual members who have been moved to the SPD category
- Members identified as California Children Services (CCS)

### Exclusions

- Wellness & Recovery only members
- Full dual members
- Medicare Part B only members
- Newborns
- Members not continuously enrolled in Calendar Year (CY) 2023 and CY 2024
- PCP sites with less than 100 members assigned as of December of the measurement year

**Data Sources**

- PCP Visits (Claims)
- Member Months

## Factor 1b

**Denominator**

Members assigned to the PCP site in December of 2024 and who had at least one paid claim for a health care encounter in any setting in 2023 (all services except for Pharmacy, ambulatory and independent laboratory services) and were continuously enrolled in CYs 2023 and 2024

**Numerator**

Count of members from the denominator who did not have any claims for encounters in 2024 (all service except for Pharmacy, ambulatory and independent laboratory services)

**Exclusions**

- Wellness & Recovery only members
- Full dual members
- Part B only members
- Newborns
- Members not continuously enrolled in CY 2023 and CY 2024
- PCP sites with less than 100 members assigned as of December of the measurement year

**Data Sources**

- Claims
- Member Months

## Equity Adjustment 2: Socio-Demographic Risk Factors

### Description

Some portion of the quality measure results is related to factors related to the underlying sociodemographic status of the patient population, which are not under the control of the PCP.

Without any adjustment, the effect is that the wealthier, well-resourced communities get more resources and the poorer, less healthy communities get less. County level adjustment is imperfect; some providers specialize in more complex sub-populations. This is accounted for in the acuity adjustment (factors 1a and 1b)

This adjustment is reliant on California Healthy Places Index (HPI) data produced by the Public Health Alliance of Southern California (healthyplacesindex.org). This freely available data set ranks California census tracts on a composite score of health disadvantage by incorporating data on 25 individual indicators organized in 8 domains, namely economy, education, healthcare access, housing, neighborhoods, clean environment, transportation, and social environment.

Healthy Places Index (HPI) scores are assigned at the census tract level of the member's most recent address information.

For members without any address information, their assigned provider site census tract was used to assign the HPI score. HPI scores were not available for providers who fell into the five percent (5%) of California census tracts due to population limitations. For these providers, the HPI score of the nearest census tract with an available score was assigned. For PCP parent organizations with more than one (1) location, the average HPI score was computed based on the site ID #. For PCP sites without any assigned members in December 2024, HPI scores are assigned at the census tract level of the provider site location.

### Numerator

Aggregate HPI score of all assigned members by PCP site number and Parent Organization identifier

### Denominator

Members who were assigned to a QIP PCP site as of December 2024

### Exclusions

- Wellness & Recovery only members
- Full dual members

- Part B only members
- Newborns
- PCP sites with less than 100 members assigned as of December of the measurement year

## Data Source

- Claims data
- Member months
- HPI 3.0 Dataset, Version 2/10/2022

## Equity Adjustment 3a & 3b: Physician Shortage Area

### Description

Differential willingness of PCPs to locate in different locations can be overcome with increased PCP reimbursement, as has been demonstrated in the United Kingdom. While some clinicians will only practice near urban or suburban centers, and some only wish to be in more rural areas, differential pay can sway a group in the middle willing to potentially practice in either setting.

As a partial step to help give resources to increase pay for clinicians in locations that are harder to recruit for, an adjustment to the PMPM available in the PCP QIP is included.

Two factors will be included:

1. **3a**: Frontier status (site located in level 2 or greater frontier or remote area) – (50% weight)
    a. Rural or urban areas up to 25,000 people
    b. 45 minutes or more from an urban area of 25,000 - 49,999 people
    c. 60 minutes or more from an urban area of 50,000 or more people
2. **3b**: Current level of Population/PCP in county – (50% weight)

### Data Sources

**3a**

- USDA
- Zero Adjustment = Non-frontier status
- Max Adjustment = Frontier Level 2

**3b**

- County Health Rankings
- Zero Adjustment = 0.6 or less physicians/1000 residents
- Max Adjustment = Greater than 3 physicians/1000 residents

### Exclusions

PCP sites with less than 100 assigned members as of December of the measurement year

## Equity Adjustment 4: Structurally Unfavorable per Visit Reimbursement

### Description

PCP sites have significantly different resources available for patient care based on factors outside the PCP contracted rates. By 2024, 89% of our primary care providers will be paid based on some type of PPS system, with per visit reimbursement rates ranging from approximately $73 to $654.

For PCP sites with low resources, this equity adjustment will have allocated additional resources to partially offset the negative financial effect of their decreased resources, and allow these practices to use this adjustment to more equitably provide services to the Partnership patients they serve.

PCP sites not subject to a PPS system and not part of a large medical group contracting process will be adjusted based on a calculation of an equivalent per-visit rate.

### Exclusions

PCP sites with less than 100 assigned members as of December of the measurement year

### Data Sources

- DHCS
- PHC Contracts
- Zero Adjustment Adjusted per visit reimbursement = > $220
- Max Adjustment Adjusted per visit reimbursement = < $120

## Equity Adjustment 5: Adjustment for Natural Disasters
**(Applied only when disaster happens)**

### Description

Natural disasters affect one or more counties in the PHC service area each year, most commonly fires, but occasionally earthquakes, floods, and power disruptions. Occasionally a PCP site is subject to more major disruption as a result of natural disaster, which impact the ability to focus on quality interventions.

The nature and length of disruption of a particular site varies from staying open but responding to the disaster to complete destruction of the site. Any adjustment should take into account the number of weeks of disruption in services, in which most routine services cannot be performed. Budget neutral approach would be to have all PCPs sited not affected by disaster to have a small decrease in funding with a major adjustment available to the site affected by the disaster, similar to an insurance policy.

The maximum possible adjustment cannot be so high that it exceeds DHCS guidelines. Therefore, the maximum adjustment would be doubling the baseline PMPM available for the PCP QIP.

If the baseline PCP QIP incentive were $10 PMPM, for example, it would double to $20. The amount of disruption which would make this maximum adjustment is set at 13 weeks. Disruptions of 13 weeks or more in the year would be allowed this maximum adjustment to apply.

For example, if one site with a net PCP QIP PMPM of $10 has 10,000 members and experiences a disruption lasting 8 weeks, their adjustment would be 8 weeks/13 weeks' x $10 PMPM or an increase of $6.15 PMPM for that site for the year.

Note, that this last adjustment factor is different from the others; it functions more as an insurance policy and thus has a much larger potential increase than the other adjustments.

### Calculation

Equity adjusted PMPM QIP dollars at risk **x** Number of full weeks the site was closed (up to a maximum of 13) **/** 13 **=** Supplemental PMPM for disaster adjustment

### Exclusions

PCP sites with less than 100 assigned members as of December of the measurement year

### Data Sources

Provider reporting to Partnership's Provider Relations representatives. The Provider Relations Department will submit a report to the QI department listing the sites closed, the nature of the closures, and the dates the sites were closed.

## Equity Adjustment 6: Pediatric Access Equity Adjustment

### Description

Pediatric Access is a major challenge in California, and in the Partnership HealthPlan region. To provide additional resources for providers struggling to provide pediatric access, additional resources will be assigned, based on several factors.

### Calculation

In MY2023, the methodology was based on several year-old agreements with PCPs who agreed to have CHDP visits removed from Capitation. This included adjustments for Family Practices and Pediatric Practices in certain FQHCs, RHCs, and Tribal Health Centers, but not entities with an ACO-like intermediary.

For MY2024, several changes are being considered, including linking the payment to the size of the provider's pediatric practice, and accepting new pediatric patients.

Specifications for MY2024 will be revised and communicated to the network with details of the approved changes to Factor 6 when they become available.

### Exclusions

PCP sites with less than 100 enrolled members as of December of the measurement year

### Data Sources

PHC Database