The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

Contents

Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on 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 positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

Technical Updates to the Specifications

Updated in May 7, 2020 Version:

- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.