PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS (MULTI-YEAR)

Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

Rating Period (RP) 2019-20: July 1, 2019 through December 31, 2020
RP 2021: January 1, 2021 through December 31, 2021
RP 2022: January 1, 2022 through June 30, 2022

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

July 1, 2019

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

Program Year 1 (PY 1, RP 2019-20) through PY 3 (January 1 through June 30, 2022), contingent on appropriation of funds by the California Legislature for this purpose

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

   ☐ Quality Payments / Pay for Performance (Category 2 APM, or similar)
   ☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
   ☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
   ☐ Multi-Payer Delivery System Reform
   ☐ Medicaid-Specific Delivery System Reform
   ☒ Performance Improvement Initiative
   ☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

This arrangement will direct Medi-Cal Managed Care Plans (MCPs) to make value-based enhanced payments to eligible network providers (see question 11) for specific events (see Question 10) tied to performance on 17 core measures across four domains:

- Prenatal/postpartum care
- Early childhood preventive care
- Chronic disease management
- Behavioral health care

To address health disparities, this arrangement will direct MCPs to make enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder or serious mental illness, or who are homeless.

This multi-year program is intended to incentivize provider behaviors and improvements in individual providers' standards of practice related to the delivery of care in the four specified domains. In addition, this program incentivizes improved data quality and completeness, which can help to inform future health care policy for Medi-Cal beneficiaries.

Payments to MCPs under this arrangement shall be subject to a two-sided risk corridor, which will be calculated retrospectively by the State. Please see Attachment 1 for more details.

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

   Not applicable

   ☐ Minimum Fee Schedule
   ☐ Maximum Fee Schedule
   ☐ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

   Not applicable

   ☐ The State is proposing to use an approved State plan fee schedule
   ☐ The State is proposing to use a Medicare fee schedule
   ☐ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

Not applicable

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

   Not applicable

   ☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

Payments under the VBP will be made to eligible network providers (see Question 11) linked to the utilization and delivery of services for eligible enrollees under the MCP contracts in accordance with the payment amounts and specifications identified in Attachment 2.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

Class of Providers
1) All individual rendering network providers qualified to provide the services specified in Attachment 2, but excluding provider types within these categories that are subject to distinct reimbursement methodologies such as: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Tribal Health Clinics (IHS/MOA), and Cost-Based Reimbursement Clinics (CBRC).

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

Payment amounts and specifications, as discussed, in Attachment 2, apply uniformly to all eligible network providers (see Question 11).

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf

b. Date of quality strategy (month, year):

June 2018

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
• Improve the health of all Californians • Enhance quality, including the patient care experience, in all DHCS programs	• Deliver effective, efficient, affordable care • Advance prevention • Eliminate health disparities	Medi-Cal Managed Care Quality Strategy Report, Page 6

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

Over the 3-year program, California will direct MCPs to make value-based enhanced payments to eligible network providers (see Question 11) for specific events (see Question 10) tied to performance on 17 core measures across four domains:

- Prenatal/postpartum care – 4 measures aimed at improving the content, quality, and timeliness of prenatal and postpartum care.
- Early childhood preventive care – 5 measures aimed at increasing the number of well-child visits and improving rates of childhood vaccination, identification and treatment of blood lead levels, and preventive dental care.
- Chronic disease management – 5 measures aimed at improving management of high blood pressure, diabetes, persistent asthma, and increasing rates of tobacco screening (and ultimately tobacco cessation) and influenza vaccination.
- Behavioral health care – 3 measures aimed at increasing screening for depression and unhealthy alcohol use, and improving management of depression medications.

The enhanced payments are in addition to the existing contracted payments eligible network providers receive from MCPs, and are expected to enhance quality, including the patient care experience, by ensuring that providers in California receive adequate payment to deliver effective, efficient, and affordable care, including primary and specialty care. To address and consider health disparities, this arrangement will direct MCPs to make enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder or serious mental illness, or who are homeless.

The directed payment proposal creates a robust data monitoring and reporting mechanism with strong incentives for quality data, especially since this proposal links payments to actual reported encounters submitted to the MCP. This information will enable dependable data-driven analysis, issue spotting, and solution design.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

See Attachment 3

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

California is proposing to implement this directed payment arrangement for certain managed care categories of aid. Subsets of enrollees or categories of aid may be excluded from the payment arrangement as necessary for actuarial or other reasons.

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

Not applicable

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

Not applicable

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

See Attachment 3

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures

Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
1	**See Attachment 3**				
2					

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
3					
4					
5					
6					
If additional rows are required, please attach.					

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

See Attachment 3

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

18. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

☒ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

ATTACHMENT 1

438.6(c) Proposal – Value-Based Payment Program Performance Improvement Initiative
Risk Corridor
Program Years 1–3: July 1, 2019 – June 30, 2022

Risk Corridor

A two-sided risk corridor shall be in effect for Proposition 56 Value-Based Payment Program Directed Payments capitation payments to MCPs. The risk corridor shall be based on the Medical Expenditure Percentage (MEP) achieved by each MCP. The MEP shall be calculated in aggregate across all applicable categories of aid (see Question 14.b) and rating regions where the MCP operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period.

DHCS will calculate the MEP using an MCP's submitted encounters that have been accepted by DHCS, in accordance with its policies, to calculate the numerator of the MEP, which shall be equal to the amount of Proposition 56 Value-Based Payment Program Directed Payments expenditures issued by the MCP to its eligible network providers in accordance with this preprint for dates of service during the PY. DHCS will calculate the denominator of the MEP, which shall be equal to the total of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's Proposition 56 Value-Based Payment Program Directed Payments capitation payment revenues for the rating period, as calculated by DHCS.

If the MCP's MEP, as calculated by DHCS, is less than a minimum threshold to be specified by DHCS, the MCP shall remit to DHCS the full amount calculated within 90 days of notice. If the MCP's MEP, as calculated by DHCS, is greater than a maximum threshold to be specified by DHCS, DHCS shall remit to the MCP the full amount calculated by DHCS. In all such cases, the remittance amount shall equal the difference between the applicable threshold percentage of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's Proposition 56 Value-Based Payment Program Directed Payments capitation payment revenues and the MCP's actual Proposition 56 Value-Based Payment Program Directed Payments expenditures.

ATTACHMENT 2

438.6(c) Proposal – Value-Based Payment Program Performance Improvement Initiative
Measure and Payment Specifications
Program Years 1–3: July 1, 2019 – June 30, 2022

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 DTaP 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 (DTaP) 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 CCP-D at: https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%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 well-child 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 Cores Set Childhood Immunization Status (CIS-CH). 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%
  - 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 (HA1C-AD) Testing and 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, G0436, G0437, 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/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions
- Adolescents: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-and-nicotine-use-prevention-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.

Behavioral Health Integration

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 Follow-up 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-ndc-license/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, 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-behavioral-counseling-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 – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness – 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%2Fquality-of-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

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

ATTACHMENT 3

438.6(c) Proposal – Value-Based Payment Program Performance Improvement Initiative
Evaluation Plan
Program Years 1–3: July 1, 2019 – June 30, 2022

Evaluation Purpose

The purpose of this evaluation is to determine the impact of the proposed multiyear directed payments made through the California Department of Health Care Services' (DHCS) Medi-Cal managed care health plans (MCPs) to network providers for the Value Based Payment (VBP) program. The evaluation will include metrics on the specified VBP performance measures and metrics for administrative data quality. The evaluation will be completed after the end of the multiyear VBP program and will evaluate the impact on provider behavior changes tied to these directed payments for which the VBP program was in effect.

Stakeholders

- MCPs
- California Medical Association (CMA)
- California Association of Health Plans (CAHP)
- Local Health Plans of California (LHPC)
- Medi-Cal Managed Care Advisory Group (MCAG)

Evaluation Questions

This evaluation is designed to determine the impact of directed payments in influencing provider behavior in several areas:

1. To what extent do payments to individual providers influence patient-centered behaviors? For example, if visits for pre- and postnatal care and well child checks increase, it will likely be due either to efforts to schedule and/or re-schedule recommended visits, or to take advantage of an unplanned healthcare visit to satisfy well child visit requirements.

2. How quickly will providers respond to payments aimed at decreasing MCP reliance on chart reviews for calculation of CMS Core Set measures?

3. How quickly will providers respond to payment requirements that a type 1 NPI must be entered for a payment to occur?

Evaluation Design

- The first measurement year will be January 1, 2019 - December 31, 2019, which will have six months of payments. The baseline year will be January 1, 2018 - December 31, 2018. DHCS will compare the each measurement year to the baseline year to identify any changes in:
- VBP Measures and related CMS Child and Adult Core Set Measures
- Individual provider NPI reporting

- Use of codes that support administrative data for measures previously reported by the hybrid method
- More robust use of International Classification of Diseases (ICD10) codes to support patient care

MEASURE NAME
Prenatal/Postpartum Care
Prenatal Pertussis ('Whooping Cough') Vaccine
Prenatal Care Visit
Postpartum Care Visits
Postpartum Birth Control
Early Childhood
Well Child Visits in First 15 months of Life
Well Child Visits in 3rd – 6th years of Life
All Childhood Vaccines for Two Year Olds
Blood Lead Screening
Dental Fluoride Varnish
Chronic Disease Management
Controlling High Blood Pressure
Diabetes Care
Control of Persistent Asthma
Tobacco Use Screening
Adult Influenza ('Flu') Vaccine
Behavioral Health Integration
Screening for Clinical Depression
Management of Depression Medication
Screening for Unhealthy Alcohol Use

Data Collection Methods

All data necessary for the evaluation of the VBP measures will be extracted from DHCS' Post-Adjudicated Claims and Encounters System (PACES) and Management Information System/Decision Support System (MIS/DSS) and external data sets received from MCPs for quality score reporting.

Timeline

All necessary measurement data will be extracted after a sufficient lag period post-VBP multiyear program end date. The data will be pulled no sooner than 12 months after the close

of the multiyear program end date to allow for sufficient lag period, with a report being completed within 6 months of the data pull.

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the State's directed payment website.