



Value Based Payment (VBP) Program: Performance Measures

Department of Health Care Services



Background

- Governor's Budget FY 19-20 proposes a VBP through Medi-Cal managed care health plans (MCPs)
- VBP program will provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations
- Risk-based incentive payments will be targeted at providers that meet specific achievement on metrics targeting areas such as:
 - behavioral health integration
 - chronic disease management
 - prenatal/post-partum care
 - early childhood prevention



Background Continued

- DHCS took into consideration several factors in determining these measures including:
 - stakeholder and advocate comments
 - whether or not a measure aligned with other Department quality efforts
 - the number of impacted beneficiaries
 - whether or not the measure could be run administratively
- To address and consider health disparities, DHCS will pay an increased incentive amount for events tied to beneficiaries diagnosed as having a substance use disorder or serious mental illness, or who are homeless



Funding – May Revision

- Total of \$544.2M (\$250M Proposition 56 funds) in 2019-20 is proposed for this program
- \$140M (\$70M in Proposition 56 funds) of which is specifically for Behavioral Health Integration



Program Implementation

- VBP program will be implemented for at least three years in the managed care delivery system, subject to funding approved in the final 2019 Budget
- Implementation date will be July 1, 2019 for all measures including behavioral health measures
- Implementation date will be January 1, 2020 for the Behavioral Health Integration Project Plan component



Overarching Payment Conditions



Providers to be paid

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)

If the encounter data does not include an individual (Type 1) NPI, then no payment will be made for the encounter



Beneficiary inclusion criteria

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data
- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, or Cost Based Reimbursement Clinics will be excluded from payment



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



Additional payment factors

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



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



Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial, first trimester 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
- Payment for the first visit in a plan that is for pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) 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.



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.



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>



Early Childhood Measures



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. (8 visits are recommended between birth and 15 months)

- Separate payment to 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: Z0000, Z0001, Z00110, Z00111, Z00121, Z00129, Z005, Z008, Z020, Z021, Z022, Z023, Z024, Z025, Z026, Z0271, Z0279, Z0281, Z0282, Z0283, Z0289, Z029



Well Child Visits in 3rd – 6th years of life

- Separate payment to 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: Z0000, Z0001, Z00110, Z00111, Z00121, Z00129, Z005, Z008, Z020, Z021, Z022, Z023, Z024, Z025, Z026, Z0271, Z0279, Z0281, Z0282, Z0283, Z0289, Z029



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

- Payment to 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



Blood Lead Screening

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

- Payment to rendering provider for each occurrence of CPT code 83655 prior to or on 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



Dental Fluoride Varnish

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

- Payment to 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



Controlling High Blood Pressure Codes

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)



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 rendering provider for each event of diabetes (HbA1c) 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.



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 prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma based on the Asthma Value Set within 12 months of the prescription
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit



Control of Persistent Asthma Codes

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



Tobacco Use Screening

Incentive payment to provider for tobacco use screening 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



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



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
- No more than one payment per provider per patient per year
- Must be an outpatient visit



Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and 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
- 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



Management of Depression Medication Definitions

- Intake period - 12-month window starting on May 1 of the year prior to measurement year and ending on April 30 of 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) <https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/>



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
- No more than one payment per provider per patient per year



Questions?

**Comments or concerns can be submitted to
DHCS_PMMB@dhcs.ca.gov**