Valley Health Plan

2023 PRIMARY CARE VALUE-BASED PAYMENT

Program Guide

VHP Valley Health Plan

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PROGRAM OVERVIEW

*The **Valley Health Plan (VHP) Primary Care Value-Based Payment (VBP) Program** is designed to support quality improvement and population health management for VHP members. The program includes financial incentives for providers who achieve population-level quality outcomes facilitated through data sharing, technical assistance, and operational process improvement opportunities.*

PROGRAM CONTACT

P4P@vhp.sccgov.org

OVERVIEW OF 2023 CHANGES

The 2023 program and this program guide encompass the major changes listed below:

1. The program tracks (family, adult, and pediatrics) are replaced with one list of measures.
2. A consolidated list of measures will apply to all VHP products included in VBP, except when the measure is not supported by national reporting practices for all products or was developed by VHP for a specific product.
3. Baseline participation requirements are added and encompass the following:
    a. Community Health Partnership participation components of the 2022 program, with revisions,
    b. Monthly meetings with VHP, and
    c. A Health Equity focused quality improvement project for one of four identified measures.
4. The payment threshold for all measures is lowered to the 50th percentile of each applicable benchmark and additional points may be earned for higher levels of achievement, as described in this program guide.
5. Payment for PCAP re-enrollment activities is not included in the 2023 program.
6. The updated payment methodology and examples are provided in this 2023 program guide.

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PROVIDER PARTICIPATION ELIGIBILITY

- **Continued participation status for 2022 participants:**

  Participants in VHP's 2022 VBP program will be considered participants in the 2023 program unless they notify VHP of the desire to not continue in 2023. 2023 requirements and performance will need to be met to be eligible for applicable payments based on 2023 performance.

- **New participants:**

  Participation by established and newly-contracted VHP providers that did not participate in the 2022 program is encouraged. Providers should contact VHP at **P4P@vhp.sccgov.org** to express interest in program participation no later than February 28, 2023. Program enrollment will be assessed and determined on a case-by-case basis at the sole discretion of VHP.

- **Contract status by applicable line of business:**

  Active January 1 – December 31 of the program/measurement year
  Active at the time of incentive pay-out

  **Newly contracted providers or providers who contract with VHP for a new line of business between Oct. 1 – Jan. 1 see below for additional participation eligibility criteria detail on the panel volume requirement.*

- **Assigned panel size/volume threshold:**

  100 members assigned by applicable product line as their primary insurance at the organization level as of Jan. 1 of the program/measurement year.

  **Program participation eligibility based on panel size is fixed at the beginning of the measurement period.*

  ***Newly contracted providers or providers who contract with VHP for a new line of business between Oct. 1 – Jan. 1 are given until March 31 of the measurement period to reach the 100 members assigned participation eligibility criteria. This allowance until March 31 applies to the newly contracted product lines during the defined period.*

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2023 BASELINE PARTICIPATION REQUIREMENTS

The 2023 program includes the three baseline participation requirements listed below. Participating providers who complete these requirements will receive a baseline payment of $25,000 for all three requirements combined. Participating providers who do not complete these requirements will not be eligible to receive payments for 2023 measurement year performance. (Providers with contracts renewing later than January 1, 2023 may have their 2022 contract terms applied until contract renewal, depending on the timing of renewal and specifics of each situation).

Requirement #1: Participation in Quarterly Spotlight Trainings and Learning Collaboratives as well as Participation in a Fourth Quarter Health Equity Provider Training

- Participate in quarterly Spotlight Trainings and Learning Collaboratives facilitated for VHP by Community Health Partnership as well as a fourth quarter health equity provider training.

Requirement #2: Monthly Bidirectional Coaching Calls

- Participate in a minimum of ten monthly coaching calls with VHP to receive and provide feedback and coaching.

Requirement #3: Health Equity Quality Improvement Project (HE QIP)

- Complete a Health Equity Quality Improvement Project to reduce health disparities for VHP members using one of the following measures:
    - Childhood Immunizations – Combo 10 (CIS-10)
    - Colorectal Cancer Screening (COL)
    - Controlling High Blood Pressure (CBP)
    - HbA1c <8% for Patients with Diabetes (HBD)
- HE QIPs must be based on quantified observations of health disparities for the above measures, as completed by the participating provider or VHP.
- A written HE QIP plan must be submitted to VHP for approval by March 31, 2023
- HE QIP activities must be completed by September 30, 2023
- A written HE QIP completion document with quantified achievements as well as identification of lessons learned must be submitted to VHP by Nov 30, 2023.

PRIMARY CARE VALUE-BASED PROGRAM REPORTS

Valley Health Plan will provide performance reports to support our provider network success under our value-based payment programs.

MEASUREMENT AND DATA TIMELINES (EXCLUDING BASELINE PARTICIPATION REQUIREMENTS)

Measurement Year	January 1 – December 31 (calendar year)	The measurement year is the year of compliance for all included performance measures. For some measures compliance can be based on services provided in prior calendar years. Please see measure specifications for details.
Administrative Data Submission Deadline	March 31 following the close of the measurement year	Administrative data includes qualifying claims, encounters, and approved supplemental data feeds (i.e., lab results, blood pressure results).
Supplemental Data Submission	Submissions during measurement year with final file no later than March 6, 2024	VHP will accept supplemental data files through SFTP. Files should be sent monthly in the approved file format. The final supplemental data file for the measurement year must be received no later than March 6 of the following year for inclusion in final VBP calendar year's rates, e.g., by March 6, 2024 for inclusion in final VBP 2023 rates. Instructions for the supplemental data file will be distributed once available.
Payment Finalization / Disbursement	May 1 – June 30 following the close of the measurement year	See Provider Participation Eligibility and Quality Performance Incentive Payment Calculation Formula program guide sections for details.

Final performance reports are anticipated to be distributed in May or June following the close of the applicable measurement year. Please see the program timeline outlined below.

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2023 VALUE-BASED PAYMENT MEASURES

Measure Name	Code	Steward	MCMC	Covered California	Commercial	PCAP
1. Adults' Access to Preventative/Ambulatory Health Services	AAP	NCQA	X		X	
2. Adolescent Immunizations Combination 2	IMA2	NCQA	X	X	X	
3. Breast Cancer Screening	BCS	NCQA	X	X	X	
4. Cervical Cancer Screening	CCS	NCQA	X	X	X	
5. Child and Adolescent Well-Care Visits	WCV	NCQA	X	X	X	
6. Childhood Immunizations Combination 10	CIS10	NCQA	X	X	X	
7. Chlamydia Screening in Women	CHL	NCQA	X	X	X	
8. Colorectal Cancer Screening	COL	NCQA	X	X	X	
9. Controlling High Blood Pressure	CBP	NCQA	X	X	X	
10. Eye Exam for Patients with Diabetes	EED	NCQA	X	X	X	
11. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	HBD	NCQA	X	X	X	
12. Lead Screening in Children ***(new for 2023)***	LSC	NCQA	X			
13. Panel Engagement/Management	PEM	VHP				X
14. Well-Child Visits in the First 15 Months of Life	W30A	NCQA	X	X	X	
15. Well-Child Visits in the First 15 - 30 Months of Life	W30B	NCQA	X	X	X	

Measures Removed:

1. Appropriate Treatment for Upper Respiratory Infection (URI)
2. Asthma Medication Ratio (AMR)
3. Blood Pressure Control for Patients With Diabetes (BPD)
4. Depression Screening and Follow Up for Adolescents and Adults (DSF-E)
5. Tobacco Screening (TBS)
6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents (WCC -Composite and sub-measures)

PAYMENT CALCULATIONS FOR MEDI-CAL, COVERED CALIFORNIA, AND COMMERCIAL PRODUCTS

1. Completion of the baseline participation requirements is required to receive a performance payment.
2. If a provider receives performance payments for multiple products, *only one baseline participation requirement payment will be made*.
3. One point will be earned for each measure that meets or exceeds the 50th percentile for the applicable benchmark
4. An additional one-quarter point may be earned for measures using one of the two scenarios below:

   (a) One-quarter point will be earned for each measure if a provider has seven or more measures that meet or exceed the 75th percentile for the applicable benchmark and this will be earned for all measures for the product for which the provider has one or more members in the denominator.

   OR

   (b) If less than 7 measures meet or exceed the 75th percentile for the applicable benchmark, one-quarter point will be earned only for those measures meeting or exceeding the 75th percentile.

5. {(TOTAL POINTS EARNED)/(TOTAL POINTS AVAILABLE)] * ($PMPM AVAILABLE FOR VBP[1]) x (TOTAL MEMBER MONTHS)= PERFORMANCE PAYMENT.
6. (PERFORMANCE PAYMENT) + (BASELINE PARTICIPATION REQUIREMENT PAYMENT) = TOTAL PAYMENT
7. This model will be used for each product separately.
8. If a provider has zero members in the denominator for a measure, the available points for that measure will be removed in the calculation of the performance payment for that provider for the applicable product.

Footnote 1: VBP $PMPM is above and beyond any contracted $PMPM for health care services and medical benefits

Point availability schedules are provided on the pages that follow as well as two payment calculation examples.

PAYMENT CALCULATIONS FOR PCAP

Payment will be made as a percentage of paid capitation for healthcare based on the 2023 measured panel engagement rate for PCAP members.

Panel Engagement/Management Measured Rate	VBP Payment As A Percentage of Paid PCAP $PMPM for Healthcare (These Are Not Additive)
50%	6%
60%	7%
70%	8%
80%	9%
90%	10%

Baseline participation requirements must be met in order to receive a VBP payment for PCAP.

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2023 PAYMENT MODEL POINTS SCHEDULE FOR MEDI-CAL

Measure Name	Product VBP Base Points Available for 50TH Percentile	Product VBP Additional Points Available (If 7 Measures Meet or Exceed 75TH Percentile)	Product VBP Total Points Available
1. Adults' Access to Preventative/Ambulatory Health Services	1	0.25	1.25
2. Adolescent Immunizations	1	0.25	1.25
3. Breast Cancer Screening	1	0.25	1.25
4. Cervical Cancer Screening	1	0.25	1.25
5. Child and Adolescent Well-Care	1	0.25	1.25
6. Childhood Immunization Status (10 antigens at 24 months)	1	0.25	1.25
7. Chlamydia Screening in Women	1	0.25	1.25
8. Colorectal Cancer Screening	1	0.25	1.25
9. Controlling High Blood Pressure	1	0.25	1.25
10. Eye Exam for Patients with Diabetes	1	0.25	1.25
11. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	1	0.25	1.25
12. Lead Screening for Children ***(new for 2023)***	1	0.25	1.25
Panel Engagement/Management	0	0	0
13. Well-Child Visits in the First 15 Months of Life	1	0.25	1.25
14. Well-Child Visits in the First 15 - 30 Months of Life	1	0.25	1.25
Total Points Available	14	3.5	17.5

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2023 PAYMENT MODEL POINTS SCHEDULE FOR COVERED CALIFORNIA

Measure Name	Product VBP Base Points Available for 50TH Percentile	Product VBP Additional Points Available (If 7 Measures Meet or Exceed 75TH Percentile)	Product VBP Total Points Available
1. Adults' Access to Preventative/Ambulatory Health Services	0	0	0
1. Adolescent Immunizations	1	0.25	1.25
2. Breast Cancer Screening	1	0.25	1.25
3. Cervical Cancer Screening	1	0.25	1.25
4. Child and Adolescent Well-Care	1	0.25	1.25
5. Childhood Immunization Status (10 antigens at 24 months)	1	0.25	1.25
6. Chlamydia Screening in Women	1	0.25	1.25
7. Colorectal Cancer Screening	1	0.25	1.25
8. Controlling High Blood Pressure	1	0.25	1.25
9. Eye Exam for Patients with Diabetes	1	0.25	1.25
10. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	1	0.25	1.25
Lead Screening for Children ***(new for 2023)***	0	0	0
Panel Engagement/Management	0	0	0
11. Well-Child Visits in the First 15 Months of Life	1	0.25	1.25
12. Well-Child Visits in the First 15 - 30 Months of Life	1	0.25	1.25
Total Points Available	12	3	15

2023 PAYMENT MODEL POINTS SCHEDULE FOR COMMERCIAL

Measure Name	Product VBP Base Points Available for 50TH Percentile	Product VBP Additional Points Available (If 7 Measures Meet or Exceed 75TH Percentile)	Product VBP Total Points Available
1. Adults' Access to Preventative/Ambulatory Health Services	1	0.25	1.25
2. Adolescent Immunizations	1	0.25	1.25
3. Breast Cancer Screening	1	0.25	1.25
4. Cervical Cancer Screening	1	0.25	1.25
5. Child and Adolescent Well-Care	1	0.25	1.25
6. Childhood Immunization Status (10 antigens at 24 months)	1	0.25	1.25
7. Chlamydia Screening in Women	1	0.25	1.25
8. Colorectal Cancer Screening	1	0.25	1.25
9. Controlling High Blood Pressure	1	0.25	1.25
10. Eye Exam for Patients with Diabetes	1	0.25	1.25
11. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	1	0.25	1.25
Lead Screening for Children ***(new for 2023)***	0	0	0
Panel Engagement/Management	0	0	0
12. Well-Child Visits in the First 15 Months of Life	1	0.25	1.25
13. Well-Child Visits in the First 15 - 30 Months of Life	1	0.25	1.25
Total Points Available	13	3.25	16.25

EXAMPLE #1: PAYMENT MODEL (MEDI-CAL)

(A) All measures have one or more members in the denominator for the provider.
(B) Eight measures meet or exceed the 50th percentile of the applicable benchmark.
(C) Seven or more measures meet or exceed the 75th percentile of the applicable benchmark.

Measure Code	Product VBP Base Points Available for 50TH Percentile	Base Points Earned	Additional Product VBP Points Available (If 7 Measures Meet or Exceed 75TH Percentile)	Additional Points Earned	Product VBP Total Points Available	Total Points Earned
1. AAP	1	1	0.25	.25	1.25	1.25
2. IMA2	1	0	0.25	.25	1.25	0.25
3. BCS	1	1	0.25	.25	1.25	1.25
4. CCS	1	0	0.25	.25	1.25	0.25
5. WCV	1	1	0.25	.25	1.25	1.25
6. CIS10	1	1	0.25	.25	1.25	1.25
7. CHL	1	1	0.25	.25	1.25	1.25
8. COL	1	1	0.25	.25	1.25	1.25
9. CBP	1	0	0.25	.25	1.25	0.25
10. EED	1	0	0.25	.25	1.25	0.25
11. HBD	1	1	0.25	.25	1.25	1.25
12. LSC	1	1	0.25	.25	1.25	1.25
PEM	0		0	0	0	0
13. W30A	1	0	0.25	.25	1.25	0.25
14. W30B	1	0	0.25	.25	1.25	0.25
Total Points Available	14	8	3.5	3.5	17.50	11.50

1. **BASELINE PARTICIPATION REQUIREMENTS MET? Yes - $25,000 Payable**
2. **PERFORMANCE PAYMENT:**
    a. **$X = VBP $PMPM Available**
    b. **Performance = 11.50 Points Earned/17.50 Points Available = 0.66**
    c. **Member Months = 30,000 (for example purposes only: 2,500 per month x 12)**
    d. **Performance Payment = (0.66)($X)(30,000)**
3. **TOTAL PAYMENT = BASELINE PARTICIPATION PAYMENT + PERFORMACE PAYMENT**

EXAMPLE #2: PAYMENT MODEL (MEDI-CAL)

(A) Eight measures have one or more members in the denominator for the provider and all meet or exceed the 50th percentile of the applicable benchmark
(B) Six measures have zero members in the denominator
(C) Two measures meet or exceed the 75th percentile of the applicable benchmark.

Measure Code	Product VBP Base Points Available for 50TH Percentile	Base Points Earned	Additional Product VBP Points Available (If 7 Measures Meet or Exceed 75TH Percentile)	Additional Points Earned	Product VBP Total Points Available	Total Points Earned
1. AAP	0	0	0	0	0	0
2. IMA2	0	0	0	0	0	0
3. BCS	1	1	0.25	0.25	1.25	1.25
4. CCS	1	1	0.25	0	1	1
5. WCV	1	1	0.25	0	1	1
6. CIS10	0	0	0	0	0	0
7. CHL	1	1	0.25	0	1	1
8. COL	1	1	0.25	0.25	1.25	1.25
9. CBP	1	1	0.25	0	1	1
10. EED	1	1	0.25	0	1	1
11. HBD	1	1	0.25	0	1	1
12. LSC	0	0	0	0	0	0
PEM	0	0	0	0	0	0
13. W30A	0	0	0	0	0	0
14. W30B	0	0	0	0	0	0
Total Points Available	8	8	2	0.5	10	8.5

1. **BASELINE PARTICIPATION REQUIREMENTS MET? Yes - $25,000 Payable**
2. **PERFORMANCE PAYMENT:**
    a. **$X = VBP $PMPM Available**
    b. **Performance = 8.5 Points Earned/10 Points Available = 0.85**
    c. **Member Months = 12,000 (for example purposes only: 1,000 per month x 12)**
    d. **Performance Payment = (0.85)($X)(12,000)**
3. **TOTAL PAYMENT = BASELINE PARTICIPATION PAYMENT + PERFORMACE PAYMENT**

ADULTS' ACCESS TO PREVENTIVE / AMBULATORY HEALTH SERVICES (AAP)

Measure steward: NCQA

Measure description: The percentage of members 20 years of age and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medi-Cal members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Member measure eligibility: Commercial and Medi-Cal members 20 years of age and older.

Denominator exclusion(s): Members in hospice or using hospice services anytime during the measurement year. Members in hospice or using hospice services anytime during the measurement year.

Code list tab label: AAP

Measure abbreviation: AAP

ADOLESCENT IMMUNIZATIONS - COMBO 2 (IMA2)

Measure steward: NCQA

Measure description: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Member measure eligibility: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

> **Denominator exclusion(s):** Exclude members who were in hospice, using hospice services, or died any time during the measurement year.

Code list tab label: IMA-2

Measure abbreviation: IMA-2

BREAST CANCER SCREENING (BCS)

Measure steward: NCQA

Measure description: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Member measure eligibility (denominator): Women 52–74 years as of December 31 of the measurement year.

> **Denominator exclusion(s):** Members receiving palliative care, in hospice or using hospice services anytime during the measurement year, and members who have had a bilateral mastectomy.

Code list tab label: BCS

Measure abbreviation: BCS

CERVICAL CANCER SCREENING (CCS)

Measure steward: NCQA

Measure description: The percentage of women 21–64 years of age who were screened for cervical cancer.

Member measure eligibility (denominator): Women 24–64 years as of December 31 of the measurement year.

> **Denominator exclusion(s):** Members receiving palliative care, in hospice or using hospice services anytime during the measurement year, and members who have had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of their cervix.

Code list tab label: CCS

Measure abbreviation: CCS

CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

Measure steward: NCQA

Measure description: The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Member measure eligibility (denominator): Members 3–21 years of age.

> **Denominator exclusion(s):** Members in hospice or using hospice services anytime during the measurement year.

Code list tab label: WCV

Measure abbreviation: WCV

CHILDHOOD IMMUNIZATIONS - COMBO 10 (CIS10)

Measure steward: NCQA/IHA

Measure description: The percentage of children 2 years of age 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 (HepB), 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.

Member measure eligibility (denominator): Children who turn 2 years of age during the measurement year.

Denominator exclusion(s): Members in hospice or using hospice services anytime during the measurement year; and

Members who had any of the following on or before their second birthday:

- Severe combined immunodeficiency
- Immunodeficiency
- HIV
- Lymphoreticular cancer, multiple myeloma or leukemia
- Intussusception

Code list tab label: CIS-10

CHLAMYDIA SCREENING IN WOMEN (CHL)

Measure steward: NCQA

Measure description: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Member measure eligibility (denominator): Women 16–24 years as of December 31 of the measurement year. Two methods identify sexually active women: pharmacy data and claim/encounter data.

> **Denominator exclusion(s):** Members in hospice or using hospice services anytime during the measurement year.

Code list tab label: CHL

Measure abbreviation: CHL

COLORECTAL CANCER SCREENING (COL)

Measure steward: NCQA

Measure description: The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Member measure eligibility (denominator): Members 50–75 years of age.

> **Denominator exclusion(s):** Members in hospice, receiving palliative care, or members with frailty and advanced illness. Members may also be excluded if they have a diagnosis of colorectal cancer or have undergone a total colectomy.

Code list tab label: COL

Measure abbreviation: COL

CONTROLLING HIGH BLOOD PRESSURE (CBP)

Measure steward: NCQA

Measure description: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Member measure eligibility (denominator): Members 18–85 years of age who had a diagnosis of hypertension.

> **Denominator exclusion(s):** Members in hospice, receiving palliative care, or members with frailty and advanced illness. Members may also be excluded if they have evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant on or prior to December 31 of the measurement year. Pregnant women during the measurement year are also excluded.

Code list tab label: CBP

Measure abbreviation: CBP

Health Equity Initiative: Controlling high blood pressure is a VHP health equity priority measure. This means we will measure and report outcomes across sub-populations by race and ethnicity for applicable product lines. Please see Appendix 2a for the current race and ethnicity categories.

EYE EXAMS FOR PATIENTS WITH DIABETES (EED)

Measure steward: NCQA

Measure description: The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Member measure eligibility (denominator): See diabetes identification criteria in Appendix 1 of this program guide.

Denominator exclusion(s): See diabetes identification criteria in Appendix 1 of this program guide.

Code list tab label: EED

Measure abbreviation: EED

HbA1c GOOD CONTROL (<8.0) FOR PATIENTS WITH DIABETES (HBD)

Measure steward: NCQA

Measure description: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% as of the final reading during the measurement year.

Member measure eligibility (denominator): Diabetic patients can be identified through claims, encounters, or pharmacy data. If using claims/encounters, the patient must have at least one inpatient visit in the measurement year with a diagnosis of diabetes, or the patient must have at least two outpatient visits with a different date of service with a diagnosis of diabetes. With pharmacy data, members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year also qualify. Please contact VHP for additional details.

Denominator exclusion(s): Members who meet the following are excluded:

- Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members in hospice, using hospice services, or died any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Code list tab label: HBD

Measure abbreviation: HBD

LEAD SCREENING IN CHILDREN (LSC)

Measure steward: NCQA

Measure description: The percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Member measure eligibility: Children who turn two years old during the measurement year.

> **Denominator exclusion(s):** Exclude members who were in hospice, using hospice services, or died any time during the measurement year.

Code list tab label: LSC

Measure abbreviation: LSC

PANEL ENGAGEMENT / MANAGEMENT (PEM)

Measure steward: Valley Health Plan

Measure description: The percentage of assigned members who had at least one primary care engagement with the assigned primary care group/organization during the measurement period. Primary care engagement identified by claims/encounters submitted for services provided by one of the following primary care specialty types:

- Family medicine
- General medicine
- Geriatrics
- Internal medicine
- Pediatrics
- Physician extender: certified nurse practitioner; and
- Physician extender: physician assistant

Member measure eligibility (denominator): All members assigned for 9/12 calendar months in the current measurement year.

Denominator exclusion(s): Members not assigned for 9/12 calendar months in the current measurement year.

Code list tab label: PEM

Measure abbreviation: PEM

WELL-CHILD VISITS IN THE FIRST 15 MONTHS (W30A)

Measure steward: NCQA

Measure description: The percentage of children who turn 15 months old during the measurement year and had 6 or more well-child visits. The 15-month birthday is calculated as the child's first birthday plus 90 days.

Member measure eligibility (denominator): Children who turn 15 months old during the measurement year.

> **Denominator exclusion(s):** Members in hospice or using hospice services anytime during the measurement year

Code list tab label: W30A

Measure abbreviation: W30A

WELL-CHILD VISITS FOR AGE 15–30 MONTHS (W30B)

Measure steward: NCQA

Measure description: The percentage of children who turn 30 months old during the measurement year and had 2 or more well-child visits between 15 months and 30 months old. The 30-month birthday is calculated as the child's second birthday plus 180 days.

Member measure eligibility (denominator): Children who turn 30 months old during the measurement year.

> **Denominator exclusion(s):** Members in hospice or using hospice services anytime during the measurement year.

Code list tab label: W30B

Measure abbreviation: W30B

PARTICIPATION TERMS & CONDITIONS

Participation in VHP's Primary Care Value-Based Payment (VBP) Program, as well as acceptance performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between VHP and participating providers. There is no guarantee of future funding or payment under any VHP VBP performance bonus program. VHP's Primary Care Value-Based Payment Program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at VHP's sole discretion.

In consideration of VHP's offering of its Primary Care Value-Based Payment Program, provider agrees to fully and forever release and discharge VHP from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by VHP of the Primary Care Value-Based Payment Program.

VHP reserves the right to audit medical records at no charge to VHP, medical record abstraction vendors, or VHP members to validate that those services have been completed as billed/submitted. If evidence of fraud, waste, or abuse is found, VHP will recoup payments for services found to be invalidly or inappropriately submitted/billed and the provider could lose privileges to participate in future VHP VBP programs. All cases of suspected fraud, waste, or abuse will be investigated thoroughly and reported to the appropriate authorities.

Participating providers must be in good standing with all VHP contract and compliance requirements to receive VHP VBP program payments. If participating providers are not in good standing, VBP program payments will not be made until such time that providers have corrected or meet all contract and compliance requirements (i.e., regulatory survey participation, medical record abstraction
compliance, etc.).