Valley Health Plan

2024 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.*

PROGRAM CONTACT

P4P@vhp.sccgov.org

Last Updated 2/2/2024

OVERVIEW OF 2024 CHANGES

The 2024 program and this program guide include the following changes from 2023:

1. A provider must have a minimum of 30 members in the denominator, to qualify for payment for that measure. This applies to each combination of measure and line of business.

2. Members must be assigned to a provider's clinic for a minimum of nine months to qualify for the measure.

3. Providers can earn a cash bonus for each member who: is assigned to the provider's clinic for nine months, is diagnosed with hypertension or diabetes, and complies with all eligible measures regardless of denominator size.

4. "Bi-directional coaching calls" will be renamed to "Quality Collaborative Calls", but they will otherwise be the same in content. In 2024, 12 calls be scheduled, and providers are required to attend six, but the other six are optional.

5. Required participation activities include the following:

    - Participation in quarterly Spotlight Trainings, Learning Collaboratives and monthly Quality Collaborative Calls with VHP,
    - a supplemental data submission to be approved by VHP's auditors, and
    - a clinical quality improvement project to address one access and one clinical quality measure.

PROVIDER PARTICIPATION ELIGIBILITY

- **Continued participation status for 2023 participants:**

  Participants in VHP's 2023 VBP program will be considered participants in the 2024 program unless they notify VHP at **P4P@vhp.sccgov.org** of their desire to not continue in 2024.

- **New participants:**

  VHP invites established and newly-contracted VHP providers that did not participate in the 2023 program to participate. Providers should contact VHP at **P4P@vhp.sccgov.org** to express interest in program participation no later than February 28, 2024. 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:**

  Providers with active contracts with VHP January 1 – December 31 of the program/measurement year and active at the time of incentive pay-out.

  Newly contracted providers or providers who contract with VHP for a new line of business between October 1st, 2023 – January 1, 2024 and meet the assigned panel volume threshold.

- **Assigned panel volume threshold:**

  For established providers, a minimum of 100 members assigned to the provider's applicable line(s) of business as their primary insurance as of Jan. 1 of the program/measurement year is required to participate.

  Newly contracted providers or providers who contract with VHP for a new line of business between October 1st, 2023 – January 1st, 2024 are given until March 31, 2024 of the measurement period to reach the assigned 100 members requirement.

2024 REQUIRED PARTICIPATION ACTIVITIES

The 2024 program includes three required participation activities listed below, which providers will receive $25,000 for their completion. Participating providers who do not complete all activities will not be eligible to receive any payments for the 2024 measurement year performance. Providers with contracts renewing later than January 1, 2024, may have their 2023 contract terms applied until contract renewal, depending on the timing of renewal and specifics of each situation.

Activity One (Required): Participation in Spotlight Trainings, Learning Collaboratives, and Bi-Monthly Quality Collaborative Calls

1. Participate in quarterly Spotlight Trainings, Learning Collaboratives, and six bi-monthly Quality Collaborative Calls facilitated for VHP by Community Health Partnership to review data, discuss and train on improvement strategies, and to give and receive feedback. The trainings are designed to facilitate the clinic's transformation to value-based care. Examples of strategies and methods covered include (but not limited to): improving access to care, ensuring staff work to the top of their license, and maximizing the use of on-line patient portals to increase their empowerment and engagement.

Activity Two (Required): Supplemental Data Submission

1. Providers must submit supplemental data that will address at least one VBP measure for all assigned members in each line of business in VHP's supplemental data format. For clinics whose 2023 supplemental data were not approved by VHP's auditors or if their data source(s) or method(s) changed in 2024, clinics must send one 2024 YTD supplemental data test file by November 30th, 2024 followed by the final data set due March 6th, 2025. Note that supplemental data for CBP, WCC, and DSF-E are required for any performance payment for those measures.

2. VHP encourages providers to send vitals, immunizations, laboratory results, and depression screening results that will address gaps in care for the 2024 VBP measures outlined below. Please do not send laboratory results or encounters for HIV/AIDS or substance use disorders (SUD).
    a. Blood pressure readings taken at the clinic (not in a hospital, ED, or therapeutic setting) with a corresponding LOINC or CPT2 code for the diastolic and systolic blood pressures.
    b. HbA1c point-of-care (POC) if they are used at your clinic with a valid LOINC code.
    c. Laboratory results to close gaps for CHL, CCS-E, GSD, and COL-E.
    d. Immunizations, if captured in your EHR.
    e. Pediatric BMI percentiles with a valid LOINC code.
    f. PHQ-2 and PHQ-9 depression screening assessments with a valid LOINC code.

3. Providers are required to cooperate with VHP's requests for any required documentation and primary source validation (i.e., patient chart retrieval) of their supplemental data to ensure compliance with all relevant audit standards to qualify for this activity.

4. VHP recommends an automated, monthly supplemental data feed delivered to VHP's SFTP by the first of the month. Otherwise, VHP will accept an end-of-year file (with applicable test file(s)) discussed above. Please contact VHP early in 2024 to plan this.

Activity Three (Required): Clinical Quality Improvement Project

The requirements for the clinical improvement project are as follows:

1. Select one clinical quality and one access measure from the list below. A clinic must have a minimum of 30 eligible members, regardless of line of business, to qualify for the measure.
    a. One quality measure: CIS10-E, GSD, CBP, COL-E, or BCS-E and
    b. One access measure: WCV, W30B, AAP

2. Select any clinical quality improvement method or combination from the list below to address the measures and apply and measure the method for a minimum of three months.

    a. Chart review. If chart review is selected, the following activities must occur. VHP will provide a template to report.
        - Review a minimum of 30 charts of patients with the selected quality measure.
        - Summarize results of the review and any findings
        - Design and implement an intervention based on the chart review findings
        - Monitor and report on process and outcomes

    b. Access improvement techniques. – Clinics selecting this topic must submit a template provided by CHP and VHP.

    c. Patient/provider on-line portal strategies. Implement strategies to maximize enrollment and/or utilization of any EHR patient or provider portal to improve the access and/or quality measures selected. If the direct patient outreach method is selected, please follow the requirements under item e.

    d. PDSA cycles. Clinics electing this method must submit a PDSA template provided by CHP/VHP and run a minimum of two cycles.

    e. Direct patient outreach improvement project. If direct patient outreach is selected, the following must occur: CHP/VHP will provide a template to report.
        - Report the number of outreach attempts, responses, and other supporting data (e.g. wrong numbers, etc) at the monthly quality collaborative calls for the duration of the project.
        - Implement specific activities to improve response or reduce inaccurate contact information.
        - Report final the response rate and lessons learned at the last learning collaborative.

f. Implement any other clinical quality, population health, or business process improvement method as specified by a professional or peer-reviewed publication (e.g., textbook, journal article), which you believe will yield the best outcomes for the measures selected. Please reference the method in your proposal.

3. Identify one priority population defined by race, ethnicity, or primary language.

4. Submit a pre-intervention performance rate for both the total and priority populations for the quality and access measures selected.

5. Send your project proposal to VHP for its approval by March 31, 2024. VHP reserves the right to approve, deny, or modify the proposal to fulfill the program requirement.

6. VHP must approve the project before any payment will be given.

7. The data collection period for the project is April through October 31st, 2024. Please conduct and measure your project for at least three months.

8. Report quantified achievements, identification of lessons learned, and the post-intervention results for the total and priority populations to VHP by Nov 30, 2024. VHP will provide these forms and additional instructions as needed.

9. Present your project at the December learning collaborative.

PRIMARY CARE VALUE-BASED PROGRAM REPORTS

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

MEASUREMENT AND DATA TIMELINES

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 and encounters
Supplemental Data Submission [Required]	2024 YTD supplemental data production file	Clinics must send a YTD supplemental test file to VHP by November 30th, 2024 and cooperate with VHP's audit activities, if their 2023 supplemental data were not approved by VHP's auditors in 2023, or a new EHR or extraction method is used.
	2024 final supplemental data submission	Clinics must send a final supplemental file for all 2024 dates of service to VHP by March 6th, 2025
	Monthly supplemental data [Optional]	Providers should generate files automatically and send to VHP monthly in the approved file format to ensure accurate gaps in care reports by the first of the month. This is recommended but optional.
Clinical Quality Improvement Project [Required]	Final project proposal	Clinics must submit their selected measures and method(s) by March 31st 2024.
	Latest project start and completion dates after VHP approval	August 1, 2024 – October 31, 2024
	Final outcome report to VHP	November 30th 2024
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.

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

1. Completion of participation activities one, two, and three is necessary to receive any performance payment.

2. If a provider receives performance payments for multiple lines of business, *only one participation payment will be made*.

3. One point will be earned for each measure (except FUA, FUM, PCR, and W30A) that meets or exceeds the applicable 50th percentile benchmark. Members must be assigned to the provider's clinic for at least nine months to be included in the measure(s), respective to the line of business.
   - One point will be earned for DSF-E and WCC only if the provider submits supplemental data for these measures for the Commercial and Exchange lines regardless of performance.

   - One point for CBP will be earned if the provider submits supplemental data and performance meets or exceeds the applicable 50th percentile benchmark.

4. To qualify for a measure, a clinic must have a minimum of 30 members assigned to the provider's clinic for at least nine months in the measurement year for that measure and line of business. Measures that don't meet these criteria will be removed in the calculation of the performance payment for that provider for the applicable line(s) of business.

5. In addition to payments based on individual measures, VHP will award a chronic care bonus for each assigned member who qualifies for the controlling blood pressure (CBP) or HbA1c good control measure (GSD) and meets all other measures for which they qualify. A member must qualify for a minimum of two measures (e.g., CBP and COL) and be assigned to the provider's clinic for at least nine months to be eligible for the bonus.

6. The below payment model will be applied to each line of business separately.

PERFORMANCE PAYMENT = [(TOTAL POINTS EARNED) / (TOTAL POINTS AVAILABLE)] * (VBP $PMPM AVAILABLE FOR VBP[1]) * (TOTAL APPLICABLE MEMBER MONTHS)

TOTAL BASELINE PARTICIPATION ($25,000):

- Completion of activities one, two, and three

CHRONIC CARE BONUS:

- For members younger than 45 years of age, the bonus amount is $30 per member
- For members 45 years of age or older, the bonus amount is $60 per member

TOTAL PAYMENT = (PERFORMANCE PAYMENT) + (TOTAL BASELINE PARTICIPATION REQUIREMENT PAYMENT) + (CHRONIC CARE BONUS)

[1]VBP $PMPM is above and beyond any contracted $PMPM for health care services and medical benefits.

VHP Valley Health Plan

2024 VALUE-BASED PAYMENT MEASURES

Measure Name	Code	Steward	Reporting Only[1]	Medi-Cal	Covered California	Commercial
Adults' Access to Preventative/Ambulatory Health Services	AAP	NCQA		X	X	X
Breast Cancer Screening	BCS-E	NCQA			X	X
Cervical Cancer Screening	CCS-E	NCQA		X	X	X
Child and Adolescent Well-Care Visits	WCV	NCQA		X	X	X
Childhood Immunization Status	CIS-E	NCQA			X	X
Chlamydia Screening in Women	CHL	NCQA		X	X	X
Colorectal Cancer Screening	COL-E	NCQA		X	X	X
Controlling High Blood Pressure[2]	CBP	NCQA		X	X	X
Depression Screening and Follow Up[3]	DSF-E	NCQA			X	X
Follow Up After Emergency Department Visit for Substance Use	FUA	NCQA	X			
Follow Up After Emergency Department Visit for Mental Illness	FUM	NCQA	X			
Glycemic Status Assessment for Patients with Diabetes (HbA1c < 8%)	GSD	NCQA		X	X	X
Panel Engagement / Management (PCAP only)	PEM	VHP				
Plan All-Cause Readmission	PCR	NCQA	X			
Prenatal and Postpartum Care	PPC	NCQA		X		
Topical Fluoride for Children	TFL	DQA	X			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[3]	WCC	NCQA			X	X
Well-Child Visits in the First 15 Months of Life	W30A	NCQA	X			
Well-Child Visits in the First 15 – 30 Months of Life	W30B	NCQA		X	X	X

[1] Reporting measures are not included in the payment calculations, but VHP will monitor and discuss interventions with the clinics.

[2] For CBP, supplemental data are required to receive any payment.

[3] For DSF-E and WCC, the only requirement to receive payment is to submit supplemental data.

PAYMENT CALCULATIONS FOR PCAP

Payment will be made as a percentage of paid PCAP capitation for healthcare based on the 2024 measured panel engagement rate for PCAP members. Required participation activities must be met to receive payment.

PCAP 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%

HYPOTHETICAL EXAMPLE: PAYMENT MODEL (MEDI-CAL)

(A) All measures have at least 30 assigned members or more in the denominator for the provider.
(B) Six measures meet or exceed the 50th percentile of the applicable benchmark.
(C) The provider participated in all required activities.

Measure Code	Product VBP Base Points Available for 50TH Percentile or Above	Measures above 50th Percentile
AAP	1	1
CCS-E	1	0
WCV	1	1
CHL	1	1
COL-E	1	1
CBP	1	0
GSD	1	1
PPC	1	0
W30B	1	1
Total Points Available	9	6

PARTICIPATION ACTIVITIES:

$25,000 = Activities one, two, and three

PERFORMANCE PAYMENT:

$X = VBP $PMPM Available

Performance = 6 Points Earned / 9 Points Available = 0.67

Member Months = 30,000 (for example purposes only: 2,500 members enrolled for 12 months is calculated as 2,500 * 12.)

Performance Payment = ($X)(0.67)(30,000)

CHRONIC CARE BONUS:

50 members diagnosed with diabetes or hypertension aged 45 years or older have all eligible care gaps met.
50 * $60 = $3000

TOTAL PAYMENT = BASELINE PARTICIPATION + PERFORMANCE PAYMENT + CHRONIC CARE BONUS

= $25,000 +(($X)(0.67)(30,000)) + $3000

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

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, and Medi-Cal

Measure Description: 1) The percentage of Medi-Cal members 20 years of age and older who had one or more ambulatory or preventive care visit during the measurement year or 2) the percentage of Commercial and Covered California members aged 20 years and older with one or more ambulatory or preventive care visit during the measurement year and 730 days prior to the measurement year.

Member Measure Eligibility:

Denominator Criteria:

For Medi-Cal members, 20 years of age and older as of December 31 of the measurement year and continuously enrolled with VHP for the measurement year with no enrollment gap greater than 45 days.

For Commercial and Covered California members, 20 years of age and older as of December 31 of the measurement year and continuously enrolled with VHP in the measurement year and the 730 days prior to the measurement year with no enrollment gap greater than 45 days in each year.

Numerator Criteria:

Medi-Cal members who had one or more ambulatory or preventive care visit during the measurement year.

Commercial and Covered California members who had one or more ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Exclusions: Members who use hospice services or elect to use a hospice benefit any time during the measurement year or who die any time during the measurement year.

Code list tab label: AAP

Measure abbreviation: AAP

BREAST CANCER SCREENING (BCS-E)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California

Measure Description: The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Member Measure Eligibility:

Denominator Criteria: Members 52–74 years by the end of the measurement period who were recommended for routine breast cancer screening.

Numerator Criteria: One or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period.

Exclusions:

- Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period.
- Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
    - **Frailty:** At least two indications of frailty with different dates of service during the measurement period.
    - **Advanced Illness:** Either of the following during the measurement period or the year prior to the measurement period:
        - Advanced illness on at least two different dates of service.
        - Dispensed dementia medication
- Members receiving palliative care any time during the measurement period.
- Members who had an encounter for palliative care any time during the measurement period.

Code List Tab Label: BCS-E

Measure Abbreviation: BCS-E

CERVICAL CANCER SCREENING (CCS-E)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

Measure Description: The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.

- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.

- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Member Measure Eligibility:

Denominator Criteria: Members 24–64 years of age recommended for routine cervical cancer screening by the end of the measurement period who also meet the criteria for participation.

Numerator Criteria: The number of members recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria:

- Members 24–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology during the measurement period or the 2 years prior to the measurement period.

- Members 30–64 years of age by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing during the measurement period or the 4 years prior to the measurement period, and who were 30 years or older on the test date.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit or who die any time during the measurement period.
- Hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year.
- Cervical agenesis or acquired absence of cervix any time during the member's history through the end of the measurement period. (Do not include laboratory claims.)
- Members receiving palliative care or had an encounter for palliative care any time during the measurement period. (Do not include laboratory claims.)
- Members with sex assigned at birth of male at any time during the patient's history.

Code List Tab Label: CCS-E

Measure Abbreviation: CCS-E

CHILD AND ADOLESCENT WELL-CARE VISITS (WCV)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

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 Criteria: Members 3–21 years of age.

Numerator Criteria: One or more well-care visits or encounters with a PCP or OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year or who die any time during the measurement year.

Code List Tab Label: WCV

Measure Abbreviation: WCV

CHILDHOOD IMMUNIZATIONS STATUS (CIS-E)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California

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 Criteria: Children who turn 2 years of age during the measurement period.

Numerator Criteria: 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.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period or who die any time during the measurement period.
- Members who had a contraindication to a childhood vaccine on or before their second birthday.

Code list tab label: CIS-E

Measure abbreviation: CIS-E

CHLAMYDIA SCREENING IN WOMEN (CHL)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

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 Criteria:** Women 16–24 years as of December 31 of the measurement year. Three administrative data sources exist to identify sexually active women: prescriptions for contraception from pharmacy data, pregnancy tests from laboratories, and diagnosis of sexual activity from claim/encounter data.
>
> **Numerator Criteria:** 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.

Exclusions: Members who use hospice services or elect to use a hospice benefit any time during the measurement year or who die any time during the measurement year.

Code list tab label: CHL

Measure abbreviation: CHL

COLORECTAL CANCER SCREENING (COL-E)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

Measure Description: The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Member Measure Eligibility:

Denominator Criteria: Members 46–75 years as of the end of the measurement period.

Numerator Criteria: Members with one or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period.
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period.
- CT colonography during the measurement period or the 4 years prior to the measurement period.
- Colonoscopy during the measurement period or the 9 years prior to the measurement period.

Exclusions:

- Members who use hospice or elect to use a hospice benefit any time during the measurement period or who die any time during the measurement period.
- Members who had colorectal cancer any time during the member's history through December 31 of the measurement year.
- Members who had a total colectomy any time during the member's history through December 31 of the measurement period.

- Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:
    - Frailty: At least two indications of frailty with different dates of service during the measurement period. *(Do not include laboratory claims.)*
    - Advanced Illness: Either of the following during the measurement period or the year prior to the measurement period:
        - Advanced illness on at least two different dates of service. *(Do not include laboratory claims.)*
        - Dispensed dementia medication

- Members receiving palliative care any time during the measurement period.

- Members who had an encounter for palliative care any time during the measurement year. *(Do not include laboratory claims.)*

Code list tab label: COL-E

Measure abbreviation: COL-E

CONTROLLING HIGH BLOOD PRESSURE (CBP)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

Measure Description: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. The measure uses the most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading.

Member Measure Eligibility

Denominator Criteria: Members 18–85 years of age who had a diagnosis of hypertension during the measurement year.

Numerator Criteria: The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative care anytime during the measurement year. *(Do not include laboratory claims.)*
- Members with a diagnosis that indicates end-stage renal disease (ESRD) any time during the member's history on or prior to December 31 of the measurement year. *(Do not include laboratory claims.)*
- Members with a procedure that indicates ESRD: dialysis, nephrectomy or kidney transplant any time during the member's history on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy any time during the measurement year. *(Do not include laboratory claims.)*

- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:
    - Frailty: At least two indications of frailty with different dates of service during the measurement year. *(Do not include laboratory claims.)*
    - Advanced Illness: Either of the following during the measurement year or the year prior to the measurement year:
        - Advanced illness on at least two different dates of service. *(Do not include laboratory claims.)*
        - Dispensed dementia medication

- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year. *(Do not include laboratory claims.)*

Code List Tab Label: CBP

Measure Abbreviation: CBP

DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS (DSF-E)

Measure Steward: NCQA

Lines of Business: [Reporting Only] Commercial, Covered California

Measure Description: For the VBP program, clinics are only required to submit depression screenings of VHP members on their supplemental data feed. VHP will include this measure and discuss with the clinics during the monthly quality calls. The measure calculates the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- *Depression Screening:* The percentage of members who were screened for clinical depression using a standardized instrument.

- *Follow-Up on Positive Screen:* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Member Measure Eligibility:

Denominator Criteria:

Denominator 1: Members 12 years of age and older at the start of the measurement period.

Denominator 2: All members from numerator 1 (below) with a positive depression screen finding between January 1 and December 1 of the measurement period.

Numerator Criteria:

Numerator 1—Depression Screening: Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.

Numerator 2—Follow-Up on Positive Screen

- Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

- Any of the following on or up to 30 days after the first positive screen:
  - An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.

- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.

- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.

- A dispensed antidepressant medication.

OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. For example, a PHQ9 administered after a positive PHQ2 on the same day will fulfill the requirement.

Exclusions:

- Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.

- Members with depression that starts during the year prior to the measurement period.

- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.

- Members who die any time during the measurement period.

Code List Tab Label: DSF-E

Measure Abbreviation: DSF-E

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE (FUA)

Measure Steward: NCQA

Lines of Business: [Reporting Only] Commercial, Covered California, and Medi-Cal

Measure Description: VHP will include in monthly scorecards and discuss on quality calls, but no performance is required for 2024. The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Member Measure Eligibility:

Denominator Criteria: An ED visit with a principal diagnosis of substance use disorder SUD ***or*** any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.

Numerator Criteria: A follow-up visit or a pharmacotherapy dispensing event within 30 days and 7 days after the ED visit. Include visits and pharmacotherapy events that occur on the date of the ED visit. Follow up visits include those with substance use disorder or unintentional drug overdose diagnosis to health care providers, mental health providers, intensive outpatient or partial hospitalizations, non-residential substance-abuse treatment facilities, community mental health centers, or other relevant services.

Exclusions: Exclude members who use hospice services, whose visits that result in an inpatient stay, or who die at any time during the measurement year.

Code List Tab Label: FUA

Measure Abbreviation: FUA

FOLLOW UP AFTER EMERGENCY DEPARTMENT FOR MENTAL ILLNESS (FUM)

Measure Steward: NCQA

Lines of Business: [Reporting Only] Commercial, Covered California, Medi-Cal

Measure Description: VHP will include in monthly scorecards and discuss on quality calls, but no performance is required for 2024. This measure calculates the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Member Measure Eligibility:

Denominator Criteria: An ED visit with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period.

Numerator Criteria: A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days and 7 days after the ED visit. Include visits that occur on the date of the ED visit. Follow up visits include those with mental health disorder or intentional self-harm diagnosis to health care providers, mental health providers, intensive outpatient or partial hospitalizations, community mental health centers, or other relevant services.

Exclusions: Exclude members who use hospice services, whose visits that result in an inpatient stay, or who die at any time during the measurement year.

Code List Tab Label: FUM

Measure Abbreviation: FUM

GLYCEMIC STATUS ASSESSMENT OF PATIENTS WITH DIABETES (GSD)

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

Measure Description: The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status < 8.0%.

Member Measure Eligibility:

Denominator Criteria: There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims

Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year. Do not include laboratory claims.

Numerator Criteria: The result of the *most recent* glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is < 8.0% as documented through laboratory data or medical record review.

Exclusions: Members are excluded from the measure if they meet any of the following: enrolled in hospice; receiving palliative care; enrolled in a skilled nursing or long-term care facility; or diagnosed as frailty, dementia, or other advanced illness.

Code List Tab Label: GSD

Measure Abbreviation: GSD

PANEL ENGAGEMENT / MANAGEMENT (PEM)

Measure Steward: Valley Health Plan

Line of Business: PCAP

Measure Description: The percentage of assigned PCAP 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
- Obstetrics and Gynecology (OB/GYN)
- Pediatrics
- Physician extender: certified nurse practitioner; and
- Physician extender: physician assistant

Member Measure Eligibility

Denominator Criteria: All PCAP members assigned in the current measurement year.

Numerator Criteria: All PCAP members who had at least one primary care visit to a primary care specialist listed above.

Exclusions: None.

Code List Tab Label: AAP

Measure abbreviation: PEM

PLAN ALL-CAUSE READMISSION (PCR)

Measure Steward: NCQA

Lines of Business: [Reporting only] Commercial, Covered California, Medi-Cal

Measure Description: VHP will include in monthly scorecards and discuss on quality calls, but no performance is required for 2024. For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Member Measure Eligibility:

Denominator Criteria: An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year, the index hospital discharge. The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year.

Numerator Criteria: At least one acute readmission for any diagnosis within 30 days of the index hospital discharge.

Exclusions: Members who use hospice services or elect to use a hospice benefit any time during the measurement year.

Code list tab label: PCR

Measure abbreviation: PCR

PRENATAL AND POSTPARTUM CARE (PPC)

Measure Steward: NCQA

Lines of Business: Medi-Cal

Measure Description: The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following:

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.

- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Member Measure Eligibility:

Denominator Criteria: All members with a live birth delivery on or between October 8th 2023 and October 7th 2024 and continuously enrolled 43 days prior to through 60 days after delivery.

Numerator Criteria Timeliness of Prenatal Care:

1) All members continuously enrolled from at least 219 days before delivery through 60 days after delivery with a prenatal visit during the first trimester with a prenatal visit during the first trimester OR

2)All members not continuously enrolled as defined in criteria 1 with a prenatal visit 280 days prior to delivery through 42 days after their enrollment start date. Do not count visits that occur on or after the date of delivery. Visits that occur prior to the member's enrollment start date during the pregnancy meet criteria.

Numerator Postpartum Care: A postpartum visit between 7 and 84 days after a live-birth delivery.

Exclusions: Members who use hospice services or elect to use a hospice benefit or die at any time during the measurement year.

Code list tab label: PPC

Measure abbreviation: PPC

TOPICAL FLUORIDE for CHILDREN (TFL)

Measure Steward: Dental Quality Alliance (DQA)

Line of Business: [Reporting Only] Medi-Cal

Measure Description: Percentage of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.

Member Measure Eligibility

Denominator Criteria: Children ages 1 through 20 years as of December 31 of the measurement year.

Numerator Criteria: The unduplicated number of enrolled children who received at least two fluoride applications as dental or oral health services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided (Table TFL_1).

Code List Tab Label: TFL

Measure Abbreviation: TFL

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN ADOLESCENTS (WCC)

Measure Steward: NCQA

Lines of Business: [Reporting Only] Commercial, Covered California

Measure Description: For the VBP program, clinics are only required to submit height, weight, BMI, and BMI percentile for the eligible population in their supplemental data feed to qualify for payment. VHP will include this measure and discuss with the clinics during the monthly quality calls. The measure calculates the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI Percentile Documentation.
- Counseling for Nutrition.
- Counseling for Physical Activity.

Member Measure Eligibility

Denominator Criteria: Children aged 3-17 years as of December 31st of the measurement year who had an outpatient visit with a PCP or OB/GYN.

Numerator Criteria: Members in the denominator who have evidence of the following:

- **BMI Percentile:** A BMI percentile calculated by the clinic's EHR based on the patient's last height, weight, and BMI during the measurement year and included in the supplemental data feed.
- **Counseling for Nutrition:** Counseling for nutrition during the measurement year billed through claims/encounters or through supplemental data.
- **Counseling for Physical Activity:** Counseling for physical activity during the measurement year billed through claims/encounter or through supplemental data.

Exclusions: Members who use hospice services or elect to use a hospice benefit, who are diagnosed as pregnant, or who die any time during the measurement year.

Code List Tab Label: WCC

Measure Abbreviation: WCC

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

Measure Steward: NCQA

Lines of Business: [Reporting Only] Commercial, Covered California, Medi-Cal

Measure Description: VHP will include in monthly scorecards and discuss on quality calls, but no performance is required for 2024. The percentage of children who turn 15 months old during the measurement year and had 6 or more well-child visits with a PCP. (*The PCP does not have to be the practitioner assigned to the child.)*

Member Measure Eligibility

> **Denominator Criteria:** Children who turn 15 months old during the measurement year. The 15-month birthday is calculated as the child's first birthday plus 90 days.
>
> **Numerator Criteria:** Children who turn 15 months old during the measurement year and had 6 or more well-child visits with a PCP.

Exclusion(s): Members who use hospice services or elect to use a hospice benefit any time during the measurement year or who die any time during the measurement year.

Code list tab label: W30A

Measure abbreviation: W30A

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

Measure Steward: NCQA

Lines of Business: Commercial, Covered California, Medi-Cal

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 with a PCP. (*The PCP does not have to be the practitioner assigned to the child.)*

Member Measure Eligibility

> **Denominator Criteria:** Children who turn 30 months old during the measurement year. The 30-month birthday is calculated as the child's second birthday plus 180 days.
>
> **Numerator Criteria:** Children who turn 30 months old during the measurement year and had 2 or more well-child visits with a PCP.

Exclusions: Members who use hospice services or elect to use a hospice benefit any time during the measurement year or who die any time 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 of 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.).