L.A. Care

Value Initiative for IPA Performance (VIIP) + Pay-for-Performance (P4P)

Medi-Cal Program Description

Measurement Year 2022
Report Year 2023

LA1517 092

Anthem BlueCross

blue california
Promise Health Plan

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Contact Us

- **VIIP@lacare.org**: all VIIP+P4P Program questions
- **Incentive_Ops@lacare.org**: POR/Gaps in Care report questions
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Introduction: L.A. Care, Anthem Blue Cross and Blue Shield Promise Health Plans' VIIP+P4P Program

The **Value Initiative for IPA Performance + Pay-for-Performance ('VIIP+P4P') Program** measures, reports, and provides financial rewards for provider group performance across multiple industry standard metrics, including Healthcare Effectiveness Data and Information Set (HEDIS) clinical quality, utilization, encounters and member experience. The goal of the program is to improve the quality of care for L.A. Care Health Plan (L.A. Care), Anthem Blue Cross and Blue Shield Promise Health Plans' members by supporting the development of a robust network of high performing IPAs. The future designation of L.A. Care's auto-assigned members to Medical Groups and IPAs may be affected based on performance in the program as well. The program falls under the oversight of the Joint Performance Improvement Collaborative Committee & Physician Quality Committee (PICC/PQC) and the Quality Improvement Steering Committee (QISC), which reports to the Quality Oversight Committee (QOC). The PICC/PQC includes representatives from the Plan Partners and select IPAs.

The purpose of this document is to provide a full description of the VIIP+P4P Program including its goals, implementation processes, and action plans for process improvement. This document also includes information on the data sources, time periods, measures, and methodology for each domain outlined below. Individualized calculation detail is available in each IPA's VIIP packet.

Payment Amounts

VIIP+P4P offers performance-based incentive payments to eligible provider groups for services delivered in 2022[1]. Provider groups are rewarded for both superior performance compared to peers and year-over-year improvement.

Approximately ***$17 million***[2] is the expected payout in 2023 for the 2022 VIIP+P4P Program, representing an opportunity for groups to receive significant revenue above capitation. Incentive payments are scheduled to be made in the fourth quarter of 2023[3]. L.A. Care paid out over $15 million in performance-based incentives for the 2020 VIIP+P4P Program, 53 provider groups received a payment. The median incentive payment was equivalent to $0.86 per member per month (PMPM), with the highest performers receiving $1.93 PMPM.

1 Most performance measures in VIIP+P4P assess services rendered in a calendar year. Exceptions are noted in *Appendix A*.
2 This budget value is an estimate only and is subject to change. The budget available to the VIIP+P4P Program is typically determined late in a program year and depends on multiple factors including, but not limited to, L.A. Care's membership, changes in rates and/or revenue from the State of California, payouts in other provider incentives, as well as budgetary discretion exercised by L.A. Care. PMPM values are estimates only and are subject to change.
3 Performance measurement and incentive payments are based on L.A. Care's final results (measurement year 2022). These are expected to become available in late summer 2023, and incentive payments will be calculated thereafter.

Eligibility for Incentive Payments

Independent Physician Association (IPA) is defined as a medical group that has entered into an agreement with L.A. Care or a Plan Partner to provide or arrange for the provision of health care services to members enrolled in L.A. Care. The total number of groups used for performance scoring includes directly contracted L.A. Care IPAs, DHS, Kaiser and IPAs contracted with our Plan Partners, Anthem Blue Cross and Blue Shield Promise Health Plans.

To be eligible for incentive payments in VIIP+P4P, provider groups must be contracted with L.A. Care and/or one of its sub-contracted health plans, *including Anthem Blue Cross and Blue Shield of California Promise Health Plans*, and have L.A. Care Medi-Cal members as of December 31, 2022. This includes L.A. Care Medi-Cal members, as well as those served in conjunction with L.A. Care's sub-contracted health plans. Provider groups that do not qualify for incentive payment will still receive VIIP performance reports.

Program Terms and Conditions

- Participation in the Medi-Cal Value Initiative for IPA Performance + Pay-for-Performance Program (VIIP+P4P), as well as acceptance of incentive payments, does not in any way modify or supersede any terms or conditions of any agreement between L.A. Care and provider groups, whether that agreement is entered into prior to, or subsequent to, the date of this communication.
- There is no guarantee of future funding for, or payment under, any L.A. Care provider group incentive program. The VIIP+P4P Program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at L.A. Care's sole discretion.
- Criteria for calculating incentive payments are subject to change at any time, with or without notice, at L.A. Care's sole discretion.
- In consideration of L.A. Care's offering of the VIIP+P4P Program, participants agree to fully and forever release and discharge L.A. Care from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by L.A. Care of the VIIP+P4P Program.
- The determination of L.A. Care regarding performance scoring and payments under the VIIP+P4P Program is final.
- As a condition of receiving payment under the VIIP+P4P Program, provider groups must be active and contracted with L.A. Care and or one of its sub-contracted health plans, including Anthem Blue Cross and Blue Shield Promise Health Plans, and have active assigned members, at the time of payment.

W9 Forms and Receiving Payments.

- Payments in the VIIP+P4P Program are made directly to the IPA unless otherwise specified (i.e. MSO). To make payments, L.A. Care must have a verified W-9 on file. It is the responsibility of each group to ensure that L.A. Care's P4P staff is in possession of current and accurate W-9 information. If your tax ID or payment address changes or if you are unsure if the payment information on file is correct, please email **VIIP@lacare.org**.
- If L.A. Care is unable to make an incentive payment due to incomplete, missing or incorrect W-9 information, groups will be contacted and payment will be re-attempted once. Incentive payments that cannot be made after a second attempt are forfeited.

- As a condition of receiving an incentive payment, if a group does not have an active Medi-Cal panel (with active, assigned membership) in L.A. Care's network in December of the program year AND at the time payments are calculated, they are subject to removal from eligibility in the program.
- At the time payments are made, each provider group will receive a performance report showing their measure-specific attainment and improvement scores, and overall performance scores by domain. They will also receive notification of the total budget used in payment calculations, as well as the dollar value per member point.

How to Participate

There is no need to sign up to participate in VIIP+P4P. Eligible provider groups participate by providing services for L.A. Care, Anthem Blue Cross and Blue Shield Promise Health Plans' members and by submitting associated encounter and lab data.[4]

Encounter Data Submission

Submission of encounter data is vitally important to L.A. Care, Anthem Blue Cross and Blue Shield of California Promise Health Plans and their provider partners. Provider groups are strongly encouraged to submit *accurate, complete,* and *timely* encounter data for all services rendered to members through the normal reporting channels. Encounter reporting is the basis of performance scoring, and is essential to success in VIIP+P4P. L.A. Care is responsible to submit encounter data to the state for future payment accuracy. This ensures that L.A. Care and provider groups receive the highest level of reimbursement.

Additionally, provider groups should ensure submission of *complete lab data* for services rendered to members. Lab data is essential to several program measures, including the diabetes control measure. Patients are automatically marked as having "poor control" for diabetes HbA1c control when lab results are missing. For CHDP services, L.A. Care requires providers to submit claims using the CMS-1500 or electronic equivalent. Since the California Department of Health Care Services discontinued use of the PM 160 form as of 1/1/2018 for all purposes, efforts should be made for all claim or encounter submissions to include as much children's services data as possible.

VIIP+P4P uses L.A. Care's *administrative* HEDIS clinical quality data to determine performance scores and incentive payments in the HEDIS domain.[5]

California Immunization Registry (CAIR)

To maximize performance on the *Childhood Immunization Status – Combo 10 and Immunizations for Adolescents – Combo 2 measures*, L.A. Care strongly suggests that physicians and/or provider groups report all immunizations via CAIR. CAIR immunization data is used by L.A. Care in calculating HEDIS rates, and therefore impacts provider group performance scores and incentive payments. By documenting immunizations in CAIR, including past immunizations administered early in life or before enrollment in a health plan, providers can increase the accuracy of their reported performance on immunization measures.

Providers should make sure to sign up and register at: **http://cairweb.org/**.

4 Provider groups may not opt out of incentive scoring or reporting of related performance data.

5 Administrative data refers to standard encounter and claims data, as well as allowable supplemental data captured by L.A. Care using supplemental administrative databases. Acceptance of supplemental data may be restricted by NCQA. Data obtained using HEDIS hybrid methodology (chart review) are not considered administrative data, and are excluded from scoring and payment in VIIP+P4P.

Measure Selection

Measures are selected for their clinical relevance, opportunity for improvement, compatibility with the VIIP+P4P Program's scoring methodology, relevance to L.A. Care's patient population, and a desire to impact a broad cross-section of IPA membership (the program includes measures targeting children, adults, women, chronic diseases, acute conditions, and preventive care). Additionally, select National Committee for Quality Assurance (NCQA) accreditation measures, as well as select measures from the state's Managed Care Accountability Set (MCAS), formerly known as the External Accountability Set (EAS), are incorporated into the VIIP measure set. These measures are reported to NCQA and the California Department of Health Care Services (DHCS), and help prioritize measures for alignment, including measures chosen for double-weighting. The VIIP+P4P Program is also aligned with incentives aimed at other participants in L.A. Care's network, including solo and small group physicians and health plan partners. This helps ensure that all of L.A. Care's provider network work toward shared quality improvement goals.

Future Health Equity Measures

In the future, L.A. Care is looking into adding Health Equity measures that target specific demographics and aim to help close disparity gaps within the Medi-Cal population. Some of these measures may include prenatal care, diabetes care and BP control for Black/African Americans.

Initial Health Assessment (IHA)

The Initial Health Assessment (IHA) includes an in person or virtual complete history and physical examination and an Individualized Health Education Behavioral Assessment (IHEBA), often the Staying Healthy Assessment (SHA) for each new member within 120 calendar days of enrollment or 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less). PCPs are responsible to cover and ensure the provision of an IHA. Additionally, documentation of a member's refusal to complete the IHA or documentation of the providers' outreach attempts to complete a member's IHA counts as a completed IHA.

Social Determinants of Health (SDoH)

L.A. Care is introducing a screening for Social Determinants of Health into the VIIP+P4P program. As a new metric, this will have no payment attached to it and will be displayed on the performance reports as reporting-only. L.A. Care will be calculating provider performance on Social Determinants of Health based on z-codes included on submitted Encounter data.

VIIP+P4P Tool Development and Methodology

The tool was developed by L.A. Care's Quality Improvement-Incentives, Health Informatics and Quality Performance Management teams with contribution from multiple L.A. Care departments: Strategic Planning, Quality Improvement-Initiatives, Quality Improvement-Accreditation, Provider Network Management, Compliance, Clinical Assurance, Finance, Grievance and Appeals, Pharmacy and others. The Plan Partners, Anthem Blue Cross and Blue Shield Promise Health Plans as well as IPAs provided input. Various measures were considered, developed, tested and validated for best fit for the final score as determined by approval of the VIIP Steering Committee.

The current scoring tool is comprised of four domains: HEDIS scores derived from administrative data, Member Experience scores from the Clinical and Group Assessment of Healthcare Providers and Systems (CG-CAHPS) survey, Utilization Management scores from encounters and claims data, and Encounter scores from IPA-submitted encounter data. Detailed information regarding data and methodologies are described in the following pages.

Domain	Points
HEDIS	30
Member Experience	30
Utilization Management	20
Encounters	20
Total	**100**

The L.A. Care team uses survey and encounter data as it is available. This data is used to develop scores, which are weighted according to priority. These are then added to generate an overall score from 0-100.

In a situation where a given IPA does not have sufficient membership to calculate a score in a given domain, the measure is marked as not reported or “N.R.” The denominator is then adjusted so that IPAs are only scored on the domains they were measured on (e.g. IPA X does not have sufficient membership to calculate Member Experience, worth 30 points out of the total score. They receive an “N.R.” for that score and their total possible points (denominator) adjusts to 100-30=70).

The VIIP+P4P Program will be evaluated annually. Any changes will be documented in this program description.

Major Changes

- **Measure Changes**
  - **Removed**
    - Well Child Visits in the First 30 Months of Life
  - **Added**
    - Well Child Visits in the First 30 Months of Life - First 15 Months: 6 or more well-child visits
    - Well Child Visits in the First 30 Months of Life - Age 15 Months-30 Months: 2 or more well-child visits
    - Adult Office Staff
    - Child Office Staff
    - Adult Care Coordination
  - **Test Measures Added**
    - Lead Screening in Children
    - Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Follow-Up Within 30 Days of ED Visit
    - Initial Health Assessment
    - Social Determinants of Health
- **Domain Changes**
  - Encounters domain is now limited to specified eligible professional encounters

Methodology: The Attainment and Improvement Scores

VIIP+P4P's scoring methodology in all four performance domains is based on the *Centers for Medicare and Medicaid Services (CMS) Value-Based Purchasing Program*. This methodology has been modified for use in L.A. Care's network at the provider group level.[6] The following describes how provider group-level HEDIS, member experience, utilization, and encounters scores are used to produce final scores for each measure, and how final scores are converted into incentive payments.

6 Several Federal Register publications describe the CMS Value-Based Purchasing Program. Links to two program design documents (a January 2011 Proposed Rule and a May 2011 Final Rule) can be found at: **http://healthreform.kff.org/document-finder/cms/cms-final-rule-establishing-the-hospital-value-based-purchasing-program.aspx**. CMS program information is also available by request at **Incentive_Ops@lacare.org**.

Calculating Attainment and Improvement Scores

- These attainment and improvement scores are calculated relative to peer group performance for each measure.[7] There are two markers of peer group performance:
  - ***Threshold*** = the minimum score a provider group needs to receive an attainment score greater than zero. This is set at the 50th percentile (median) of the prior year's distribution.
  - ***Benchmark*** = the high-end score that qualifies a provider group for maximum attainment points for a given measure. This is set at the 95th percentile of the prior year's distribution (at the 5th percentile for the Utilization domain). [8]
- Attainment scores: Attainment scores are calculated relative to both the threshold and benchmark. If a provider group's score for a measure is at or above the benchmark (or at or below the benchmark for measures in the Utilization domain), a full 10 points are awarded. If the provider group's score is below the threshold (or above the threshold for measures in the Utilization Domain), 0 points are awarded. For all domains except Utilization, if a provider group's score is greater than the threshold (but less than the benchmark), it is awarded 1 to 9 points, reflecting the linear distance between threshold and benchmark values.[9]
- Improvement scores: Improvement scores are calculated relative to a provider group's prior year score and the benchmark. If a group's current-year score for a measure is greater than the prior year score (but below the benchmark – or above the benchmark for measures in the Utilization domain), the group is awarded up to 9 points, reflecting the linear distance between the prior year score and the benchmark. If the provider group's current-year score is equal to or lower than the prior-year score, 0 improvement points are awarded.[10]

Assignment of Final Scores

- **Eligible provider groups receive an *attainment* score and an *improvement* score for each performance measure:**
  - Attainment reflects a provider group's compliance rate in the program year compared to peer group, and is scored on a scale of 0-10 points (10 points = best).
  - Improvement reflects a provider group's compliance rate in the program year compared to its compliance rate one year prior. Improvement is scored on a scale of 0-9 points (9 points = best).
- **The *better of these two scores* becomes the provider group's *final* score for each measure.[11] This ensures that high performers receive high scores, and that lower performers demonstrating improvement also score well.**
- For scoring reliability, provider groups are only scored on measures for which they hold sufficient membership; **provider groups are not penalized for having too few members to be scored in a measure.**
  - To receive an attainment score, a provider group must have at least 30 members in the measure's eligible population.
  - To receive an improvement score, a provider group must have at least 30 members in the measure's eligible population for two consecutive years.

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7 Peer group comparisons in measurement 2022 are based on provider group-level scores from measurement year 2021. Provider groups must have at least 30 members in a measure's eligible population to be included in calculations of peer group performance. Criteria used to determine threshold and benchmark values are subject to change.
8 Threshold and benchmark values for each measure are shown in *Appendix A*.
9 Attainment formula: Attainment = [9 * ((provider group's score – threshold) / (benchmark – threshold))] + 0.5
10 Improvement formula: Improvement = [10* ((provider group's current score – prior year score) / (benchmark – prior year score))] – 0.5
11 Attainment, improvement, and final scores are integers rounded to two decimal places.

Domain Details

HEDIS

Data Source and Source Year	L.A. Care's HEDIS engine, which includes data from Encounters, Claims, Labs, Pharmacy & Supplemental Databases. Measurement Year 2022, Report Year 2023
Data Source Description	Data includes all of L.A. Care's Medi-Cal data, including data from Plan Partners: Anthem Blue Cross and Blue Shield Promise Health Plans. Data is inclusive of Administrative data only, not Hybrid (Medical Record abstracted data).
Included Measures	14 HEDIS measures considered high focus by L.A. Care Quality Improvement and used in the Auto Assignment and Pay-For-Performance Programs: 1. Asthma Medication Ratio - Ages 5-64 (AMR) 2. Breast Cancer Screening (BCS) 3. **Cervical Cancer Screening*** (CCS) 4. **Child and Adolescent Well-Care Visits* (WCV)** 5. **Childhood Immunization Status - Combo 10*** (CIS-10) 6. Chlamydia Screening in Women (CHL) 7. **Comprehensive Diabetes Care: HbA1c control (<8.0%)*** (CDC) 8. **Controlling High Blood Pressure*** (CBP) 9. Immunizations for Adolescents - Combo 2 (IMA-2) 10. Prenatal & Postpartum Care: Postpartum Care (PPC2) 11. **Prenatal & Postpartum Care: Timeliness of Prenatal Care*** (PPC1) 12. Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents – Physical Activity (WCC) 13. Well Child Visits in the First 30 Months of Life - First 15 Months: 6 or more well-child visits (W30a) 14. Well Child Visits in the First 30 Months of Life - Age 15 Months-30 Months: 2 or more well-child visits (W30b) ****Double weighting:** *Some measures above are **bolded** to signify being double-weighted. Performance on these measures has a greater role in determining provider group performance scores, performance rankings, and incentive payments. Please pay extra attention to these measures to maximize performance scoring and incentives income.*
Methodology	• HEDIS results are determined using each measure's complete HEDIS-eligible population. The eligible population is defined as the set of members that satisfies all criteria specified by the National Committee for Quality Assurance (NCQA), including continuous enrollment, anchor date, event diagnosis, age and gender, and benefit parameters. • Members in the eligible population are attributed to the appropriate provider group on each measure's anchor date, as defined by NCQA.[12] Members contribute to a provider group's HEDIS scoring if they meet continuous enrollment criteria at the provider group level.[13] • HEDIS data for each measure is aggregated at the provider group level. For each measure, a provider group's HEDIS score is a compliance rate, which expresses the proportion of a provider group's eligible membership that received recommended care in the measurement year.[14] • If a measure has < 30 members, it will be excluded from scoring.
Weight of Measure in Tool	30%

12 For most HEDIS measures the anchor date is December 31 of the measurement year. Exceptions are noted in Appendix A.
13 Provider group-level continuous enrollment is calculated for all measures except Prenatal & Postpartum Care, Continuous enrollment is defined as enrollment with a provider group for at least 11/12 months of the program year
14 Compliance rates reflect the HEDIS-eligible population after exclusions. L.A. Care's HEDIS and other measurement results are final, and are the sole source of data used in calculation of final scores and payments. L.A. Care is unable to accept encounter, supplemental, or other data once the data collection period for a HEDIS measurement year ends.

Member Experience

Data Source	CG-CAHPS
Data Source Description	The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey is a standardized tool to measure patients' perception of care provided by physicians in an office setting. Data includes all of Medi-Cal including Plan Partners. CG-CAHPS requires that a member had at least one service in the past six months and is still assigned to the IPA for the member to be included in the sample for the IPA.
Source Year(s)	2022 CG-CAHPS
Included Measures	11 Member Experience measures: six for Adult, five for Child: **1. Adult Timely Care and Service*** **2. Adult Getting Needed Care*** 3. Adult Rating of All Health Care Combined 4. Adult Rating of PCP 5. Adult Office Staff** 6. Adult Care Coordination** **7. Child Timely Care and Service*** **8. Child Getting Needed Care*** 9. Child Rating of All Health Care Combined 10. Child Rating of PCP 11. Child Office Staff** **Double weighting: Some measures above are bolded to signify being double-weighted. Performance on these measures has a greater role in determining provider group performance scores, performance rankings, and incentive payments. Please pay extra attention to these measures to maximize performance scoring and incentives income.* ***While new measures are usually added to the program as test measures, Adult Office Staff, Adult Care Coordination and Child Office Staff were previously part of the Medi-Cal VIIP+P4P Program and will be added as payment measures for MY 2022, RY 2023.*
Methodology	The eight CG-CAHPS measures will each have a rate on the 2022 survey. The final score is calculated for each measure, based on the attainment and improvement formulas described above, then averaged to create the Domain performance score. Exclusions: 1. < 30 members for measure or metric
Weight of Measure in Tool	30%

Utilization Management

Data Source	Encounters & Claims Data
Data Source Description	Data generated by Quality Performance Management and analyzed by L.A. Care's Health Information Management Team Plan Partner data included
Source Year(s)	January-December 2022
Included Measures	1. Acute Hospitalization Utilization (AHU) 2. Plan All-Cause Readmissions (PCR) 3. Emergency Department Utilization (EDU)
Methodology	Risk Adjustment and weighting methods used: • For the utilization metrics, we are using the HEDIS methodology for AHU, PCR and EDU. • Members contribute to a provider group's Utilization Management scoring if they meet continuous enrollment criteria at the provider group level. The final score is calculated for each measure, based on the attainment and improvement formulas described above, then averaged to create the Domain performance score. The reason why we use the 5th percentile is because lower utilization is considered to be better, and we give a higher score to those IPA's that have lower rates for utilization.
Weight of Measure in Tool	20%

Encounters[15]

Data Source	L.A. Care Encounters Database
Data Source Description	Data generated and analyzed by the Health Information Management team is based on new incoming eligible Medi-Cal professional encounters[16].
Source Year(s)	2022
Included Measures	Encounter Volume Encounter Timeliness
Methodology	1. Encounter Volume • Provider groups' encounter data performance will be measured based on accepted professional encounters for services identified in the DOFR and received by L.A. Care in the Measurement Year (dates of service in 2022). Included eligible professional encounters will be based on the following place of service codes: ○ 2 – Telehealth Provided Other than in Patient's Home; ○ 10 – Telehealth Provided in Patient's Home; ○ 11 – Office; ○ 49 – Independent Clinic; ○ 50 – Federally Qualified Health Center; and ○ 72 – Rural Health Clinic • Supplemental data, and data captured through hybrid chart review are excluded from this measure. Encounter rates are expressed as number of encounters per member per year (PMPY). The percentile is then generated from the range of rates. • The rates are based on the application of a multiple regression model that predicts overall encounter rates with the percent of membership within the state aid code categories. Specifically, the model includes as predictors the percent of members who are in the Optional Targeted Low Income Children (OTLIC) program, the percent that are in the Aged category, and the percent in the Long Term Care category. This model is more accurate than the prior model, and adjusts for membership mix more rigorously 2. Encounter Timeliness • Percent of total eligible professional encounters received within 60 days of Date of Service. • Separate thresholds and benchmarks calculated based on: a. Eligible professional encounters submitted for L.A. Care Medi-Cal (MCLA) through clearinghouse, TransUnion b. Eligible Plan Partner IPA professional encounters submitted to L.A. Care after Plan Partner specific process c. Minimum of 30 eligible professional encounters in the denominator to be reported. The final score is calculated for each measure, based on the attainment and improvement formulas described above, then averaged to create the Domain performance score.
Weight of Measure in Tool	20%

[15] Please note that the Encounters Domain does not include pharmacy or dental encounters.
[16] Beginning with MY 2022/RY 2023, the encounters domain will only include eligible professional encounters and will no longer count institutional encounters. This change is in line with L.A. Care's efforts to focus on measures that are actionable.

Reporting-Only Test Measures

Data Source	The following eight measures are being introduced as test measures for MY 2022 and will not be included in the overall scoring or payment: 1. Depression Screening and Follow-Up for Adolescents and Adults (DSF) 2. Transition of Care: Medication Reconciliation Post Discharge (TRC) 3. Transitions of Care: Patient Engagement After Inpatient Discharge (TRC) 4. Lead Screening in Children (LSC) 5. Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Follow-Up Within 30 Days of ED Visit 6. Follow up after ED Visit for People with Multiple High Risk Chronic Conditions (FMC) 7. Initial Health Assessment 8. Social Determinants of Health

Aggregation of Final Scores and Calculation of Incentive Payments

- **A provider group must have at least four scored measures in the HEDIS, two scored measures in Member Experience and one measure in the Utilization Management and Encounters domains to receive a performance score for each of those domains. To receive an overall performance score (and therefore an incentive payment), a provider group must be scored in at least two domains.**
- Final scores for individual measures are aggregated so that each provider group receives an overall performance score for each domain. This domain performance score is an un-weighted average of a provider group's measure-specific final scores.
- Performance scores in each domain are then weighted based on the domain points weighting in the table in the VIIP+P4P Tool Development and Methodology section. Weighted domain performance scores are then converted into member points. A provider group's member points are determined by multiplying a domain's final weighted performance score by the count of eligible, assigned Medi-Cal members.[17]
- L.A. Care assigns a *dollar value* per member point to calculate incentive payments. **A provider group's incentive payment is determined by multiplying this dollar value by the provider group's member point count.** The dollar value per member point is determined by dividing the total budget by the sum of member points earned by all eligible provider groups. This dollar value per member point will vary each year, and is determined at the time incentive payments are calculated. This methodology ensures that L.A. Care's entire VIIP+P4P Program budget is distributed to provider groups.

Performance Reports

To support VIIP+P4P and the performance improvement efforts of provider groups, L.A. Care will provide the following reports during the year:

- **Quarterly Encounter Data Progress Reports:**
  - These reports show a provider group's target encounter submission rates for the Encounter Volume and Timeliness portion of VIIP+P4P.
  - These reports are distributed quarterly to provider groups. They display encounter volume and timeliness data by quarter for the current year, as well as encounter rates for several recent rolling 12 month periods.
- **L.A. Care Provider Opportunity Reports:**
  - We urge all IPAs to use the Provider Opportunity Reports to monitor performance and address gaps in care. These reports are made available on or around the 10th of the month. Contracted IPAs can access their reports via the L.A. Care Provider Portal. IPAs that are not directly contracted with L.A. Care will receive their reports via secure email.
  - The summary page of the report provides detail on year-to-date compliance rates by measure and progress toward achieving incentive targets. The report includes an overall summary, a physician-level summary, and member details broken out by measure, which can be filtered to

17 The count of assigned members is calculated as average monthly membership in the measurement year. This value is determined using L.A. Care's provider data system. Member points are rounded values.

display non-compliant members. Using this information, IPAs should work with providers to reach out to patients in need of health care services to close data gaps by submitting encounters for services already completed. In addition, a raw file is provided to facilitate data ingestion and allow for easier report creation and data analysis.

- **CG-CAHPS Reports:**
  - These reports show a provider group's performance on the CG-CAHPS survey. There are three reports made available to provider groups; a summary report, a banner tables report and a full report.
  - The reports are distributed once a year, starting around late spring through summer.
- **Mid-year update to thresholds and benchmarks:**
  - *Appendix A* in this document shows threshold and benchmark values for all measures included in VIIP+P4P. The values provided early in the year are interim values (based on 2019), which are revised mid-year when final HEDIS data for the prior measurement year become available. The mid-year update will show the final threshold and benchmark values (based on 2021) that will be used in performance scoring and payment.
- **Final performance and payment reports:**
  - The VIIP+P4P Provider Group Payment Report shows a provider group's final performance for each domain, incentive scoring, and incentive payment for a completed program year.
  - The VIIP+P4P Provider Group Performance Report shows a provider group's final performance for each domain for a completed program year, but does not include incentive payment information.

Un-blinding Data and Public Reporting

Starting in the 2021 report year, un-blinded rank charts were shared with IPAs participating in the VIIP Program. IPAs ranking of un-blinding is to encourage peer-based competition and sharing of best practices.

Public reporting of provider performance is a central feature of the Affordable Care Act (ACA). Public reporting is intended to assist consumers and purchasers in making more informed medical choices, as well as support efforts of IPAs, medical groups, and health plans to more effectively coordinate care and identify opportunities for improvement.

In the future, L.A. Care may decide to participate in public reporting initiatives. IPA-level performance data may be publicly shared and/or reported as part of the VIIP+P4P Program. This includes (but is not limited to) reporting on L.A. Care's website, publicly-available websites, as well as reporting to the IPAs, medical groups, and health plans that work with physicians and clinics to deliver care to L.A. Care members.

Performance Improvement Action Plan

Introduction

L.A. Care, Anthem Blue Cross, and Blue Shield of California Promise Health Plans will continue to request documentation of performance improvement activities from each IPA as in previous years. In 2022, L.A. Care is requesting those IPAs that fell at the middle and/or bottom tertiles from MY 2017 through MY 2020 based on VIIP performance to submit an Action Plan for two domains. This year Action Plans will be measure specific as L.A. Care will identify the measures IPAs will have the opportunity to work on. IPAs that fell in the upper tertile will not be requested to submit an Action Plan.

As per network request, the deadline for the Final Action Plan will be extended to Q1 2023. Detailed instructions for the Action Plan will be received via e-mail. Appendix B and C below provide example performance improvement activities and a template for your reference."

The goal and performance improvement activities proposed by the IPA will be vetted by L.A. Care reviewers. The reviewers will provide feedback and additional suggestions to ensure the goal and actives result in a successful Action Plan. It is imperative that IPAs choose activities, projects or programs that address the goal of the domain and have metrics to measure improvement. The key requirement will be that the activity must be measured before and after with the intention being that the post-activity metrics will demonstrate improvement. Data should be Medi-Cal only, but not necessarily limited to L.A. Care. Improvement in metrics results are not required, but the final report will include a short discussion on each action as to what worked well, what didn't and what changes will be implemented. Learnings will be shared among all IPAs for best practices, pitfalls and how we can all most efficiently improve the service to our members, together.

Action Plan Submission

IPAs should submit their completed Action Plan and Updates to **VIIP@lacare.org** with the subject line "VIIP+P4P Action Plan- IPA NAME". For example "VIIP +P4P Action Plan- Excellent IPA".

- Initial Action Plan due date: July 8, 2022
- Update Action Plan due date: October 14, 2022
- Final Action Plan due date: January 27, 2023

Meetings with IPAs

Currently, multiple meetings are coordinated between L.A. Care, Anthem Blue Cross and Blue Shield of California Promise Health Plans and contracted IPAs. The VIIP+P4P will coordinate as much as possible with those standing meetings in order to streamline communications with the IPAs.

Meeting examples:

1. WebEx meeting(s) with all stakeholders
2. Live Meetings with select groups
3. Operational Meetings with IPAs
    a. Joint Operations Meetings
    b. QI Collaborative

APPENDIX A: 2021 VIIP+P4P Measures with Final Threshold and Benchmark

(Based on Measurement Year 2021)

HEDIS

Measure Name	Measure Description	Measurement Period	Anchor Date (Attribution of a Member to a Provider Group)	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (95th Percentile)
Asthma Medication Ratio – Ages 5-64 (AMR)	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Calendar Year	December 31	58.17%	71.26%
Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. Score reflects the percentage of women receiving mammograms between October 1, 2020 and December 31, 2022.	October 1 two years prior to the measurement year through December 31 of the calendar year.	December 31	55.38%	72.61%
Cervical Cancer Screening (CCS)	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following 2 criteria: <u>For women age 21–64:</u> cervical cytology performed in the measurement year or the two years prior. <u>For women age 30-64:</u> cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or the four years prior. Cervical cytology/high-risk human papillomavirus (hrHPV) contesting within the measurement year or the four years prior.	Calendar Year	December 31	54.63%	68.73%

HEDIS

Measure Name	Measure Description	Measurement Period	Anchor Date (Attribution of a Member to a Provider Group)	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (95th Percentile)
Child and Adolescent Well-Care Visits (WCV)	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OBGYN practitioner during the Measurement Year.	Calendar Year	December 31	38.83%	52.56%
Childhood Immunization Status - Combo 10 (CIS)	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 H 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.	Up to the child's second birthday	Child's second birthday	20.07%	43.81%
Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age (identified as sexually active) who had at least one test for chlamydia during the measurement year.	Calendar Year	December 31	63.09%	71.69%
Comprehensive Diabetes Care - HbA1c Control (< 8.0%) (CDC)	The percentage of members aged 18-75 years of age with diabetes (type 1 and type 2) who received a Hemoglobin A1c (HbA1c) test with a reported lab result of less than 8.0%. A higher rate represents better performance.	Calendar Year	December 31	40.58%	60.00%
Controlling High Blood Pressure (CBP)	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.	Calendar Year	December 31	23.05%	52.30%
Immunizations for Adolescents - Combo 2 (IMA)	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine AND have completed the human papillomavirus (HPV) series by their 13th birthday .	Prior to Member's 13th Birthday	Member's 13th Birthday	36.00%	59.00%

HEDIS

Measure Name	Measure Description	Measurement Period	Anchor Date (Attribution of a Member to a Provider Group)	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (95th Percentile)
Prenatal & Postpartum Care - Postpartum Care (PPC)	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	For live birth deliveries in the 12-month window beginning October 8 of the prior year, and ending October 7 of the measurement year.	Date of Delivery	58.50%	81.58%
Prenatal & Postpartum Care - Timeliness of Prenatal Care (PPC)	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.	For live birth deliveries in the 12-month window beginning October 8 of the prior year, and ending October 7 of the measurement year.	Date of Delivery	77.25%	85.57%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Physical Activity (WCC)	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 counseling for physical activity during the measurement year.	Calendar Year	December 31	51.74%	74.79%
Well-Child Visits in the First 15 Months of Life (W30a, W30b)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the Measurement Year: Six or more well-child visits. 2. Well-Child Visits for Age 15-30 Months. Children who turned 30 months old during the Measurement Year: Two or more well-child visits.	Start of Measurement Year- 15 months Start of Measurement Year-30 months	Day child turns 15 months old Day child turns 30 months old	58.06%	76.25%

Member Experience

Measure Name	Measurement Period	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (95th Percentile)
Adult Timely Care and Service	Calendar Year	50.44%	61.40%
Adult Getting Needed Care	Calendar Year	53.52%	64.48%
Adult Rating of All Health Care	Calendar Year	62.86%	74.83%
Adult Rating of PCP	Calendar Year	64.87%	79.16%
Adult Office Staff	Calendar Year	TBD	TBD
Adult Care Coordination	Calendar Year	TBD	TBD
Child Timely Care and Service	Calendar Year	62.04%	71.87%
Child Getting Needed Care	Calendar Year	59.18%	69.74%
Child Rating of All Health Care	Calendar Year	76.24%	85.38%
Child Rating of PCP	Calendar Year	72.41%	87.5%
Child Office Staff	Calendar Year	TBD	TBD

Utilization Management

Measure Name	Measure Description	Measurement Period	Anchor Date (Attribution of a Member to a Provider Group)	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (5th Percentile)
Acute Hospital Utilization (AHU)	For members 18 years of age or older, the risk-adjusted ratio of observed to expected acute inpatient and observation stay discharges during the measurement year reported Surgery, Medicine and Total.	Calendar Year	Date of Service	48.09%	15.62%
Plan All-Cause Readmissions (PCR)	For members 18 years of age and older, the number of acute inpatient 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. Data are reported in the following categories: 1. Count of Index Hospital Stays (HIS) (denominator). 2. Count of Observed 30-Day Readmissions (numerator). Count of Expected 30-Day Readmissions.	Calendar Year	Date of Service	5.87	2.65
Emergency Department Utilization (EDU)	For members 18 years of age or older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year	Calendar Year	Date of Service	755.29	383.04

Encounters

Measure Name	Measure Description	Measurement Period	Anchor Date (Attribution of a Member to a Provider Group)	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (95th Percentile)
Encounter Volume	Percent of accepted professional encounters for services identified in the DOFR and received by L.A. Care in the Measurement Year (dates of service in 2022). Included eligible professional encounters will be based on the following place of service codes: 2 – Telehealth Provided Other than in Patient's Home; 10 – Telehealth Provided in Patient's Home; 11 – Office; 49 – Independent Clinic; 50 – Federally Qualified Health Center; and 72 – Rural Health Clinic. Supplemental data and data captured through hybrid chart review are excluded from this measure. Encounter rates are expressed as number of encounters per member per year (PMPY).	Calendar Year	Date of Service	4.85	8.57
Encounter Timeliness For MCLA	Percent of total eligible professional encounters received within 60 days of Date of Service through L.A. Care's clearinghouse, TransUnion.	Calendar Year	Date of Service	79.16%	87.62%
Encounter Timeliness for Plan Partners	Percent of total eligible professional encounters received within 60 days of Date of Service	Calendar Year	Date of Service	62.55%	71.63%

Test Measures

Measure Name	Measure Description	Measurement Period	Anchor Date (Attribution of a Member to a Provider Group)	Incentive Scoring Threshold (50th Percentile)	Incentive Scoring Benchmark (5th Percentile)
Depression Screening and Follow-Up for Adolescents and Adults Depression Screening (DSF)	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument.	Calendar Year	December 31	TBD	TBD
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Condition (FMC)	The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	365 days prior to the ED visit through 7 days after the ED visit	None	TBD	TBD
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Follow-Up Within 30 Days of ED Visit	The percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness within 30 days of ED visit.	January 1- December 24	None	TBD	TBD
Initial Health Assessment (IHA)	The percentage of members who received a comprehensive Initial Health Assessment (IHA) within the first 120 days of enrollment.	Calendar Year	Date of Enrollment	TBD	TBD
Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday	12 months prior to the child's second birthday	Enrolled on child's second birthday	TBD	TBD
Transitions of Care – Patient Engagement (TRC)	The percentage of discharges for members 18 years of age and older who had each of the following. Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	Date of discharge through 30 days after discharge (31 total days).	None	TBD	TBD

Transitions of Care – Medication Reconciliation Post Discharge (TRC)	The percentage of discharges for members 18 years of age and older who had each of the following. Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	Date of discharge through 30 days after discharge (31 total days).	None	TBD	TBD
Social Determinants of Health (SDOH)	The percentage of members who were screened for social determinants of health during the measurement year and who had at least 1 social determinant of health identified.	Calendar Year	December 31, 2022	TBD	TBD

APPENDIX B: VIIP + P4P Action Plan Guidance

- ✓ **All calculated results should be attainable by the final due date of January 27, 2023 to determine if the goal was met or not.**
- ✓ **Only ONE project/SMART goal is needed for the domain specified for your IPA by L.A. Care.**

VIIP Domain	Performance Activity Examples	Sample Metrics
HEDIS	• Greater than 50% of Providers and Office Staff viewed at least one L.A Care QI Webinar	• Name List of Viewers with dates viewed and roles. • Pre and Post-Webinar Survey
	• Performance Improvement project focused on at least two HEDIS measures within Domain • Significant data gap affecting one or more HEDIS measures addressed and resolved Suggestions: ○ Childhood Immunization ○ HBA1C control ○ Prenatal and Postpartum Care ○ Cervical Cancer Screening	• Pre Metrics • Project Plan • Project Results after at least 90 days • Post Project Metrics
	• Be active part of L.A. Care PIP or PDSA (limited)	• Meeting deliverable timeline
	• Oversight & Monitoring of Physicians who are non-compliant with the After-hours standard until they are compliant (Utilizing L.A. Care's ATC O&M process & tools)	• List of the number providers who are non-compliant in L.A. Care's annual Timely Access to Care survey • Quarterly list with the number of providers who remain non-compliant, along with detailed audit results
Member Experience	• Greater than 50% of Providers and Office Staff viewed L.A Care QI Webinar	• Name List of Viewers with dates viewed and roles • Pre and Post-Webinar Survey
	• Performance Improvement project focused on at least one Member Experience measure within Domain, prioritized based on CG-CAHPS priority matrix	• Pre Metrics • Project Plan • Project Results after at least 90 days • Post Project Metrics
Utilization	• IPA Driven Performance Improvement Project (PIP) focused on: ○ Acute Hospital Utilization ○ Plan All-Cause Readmissions (PCR) ○ Emergency Department Utilization (EDU)	• Pre Metrics • Project Plan • Project Results after at least 90 days • Post Project Metrics
Encounters	• Performance Improvement project focused on: ○ Encounters data ○ Coding Quality	• Pre Metrics • Project Plan • Project Results after at least 90 days • Post Project Metrics

If you would like further assistance or guidance with completing your Action Plan, please email **VIIP@lacare.org**.

APPENDIX C: Action Plan Template

- ✓ **All calculated results should be attainable by the final due date of January 27, 2023 to determine if the goal was met or not.**
- ✓ **Only ONE project/SMART goal is needed for the domain specified for your IPA by L.A. Care.**

IPA NAME:

A. [DOMAIN SPECIFIED BY L.A. CARE]: Select measures with greatest opportunity to impact outcomes.			
INITIAL – Due July 8, 2022			
ACTIVITY TITLE	**ACTION PLAN GOAL**	**ACTION PLAN PLANNED ACTIVITY**	**RESPONSIBLE DEPARTMENT(S) & TARGET DATE(S) FOR COMPLETION**
UPDATE & FINAL RESULTS			
	KEY FINDINGS & ANALYSIS *List problems or data* *State if goal was met or not met, include what caused problems/issues*	**ACTIONS/INTERVENTIONS** *State what was/will be done to meet goal*	**RESPONSIBLE PERSON(S)/DEPARTMENT(S) & TARGET DATES FOR COMPLETION** *List actions to correct problems, target dates, and responsible person*
Update on Action Plan Due October 14, 2022			
Final Action Plan Results Due January 27, 2023	Goal Met ◯ Goal Not Met ◯		

If this Action Plan is completed by the IPA, please ensure that someone from the IPAs Leadership team signs off on the completed plan.

*If this Action Plan is completed by the MSO of the IPA, please ensure that someone from **BOTH** the MSO and the IPA Leadership team signs off on the completed plan.*

PERSON SUBMITTING REPORTS	Name (please print)	Phone #	Fax #	Email
Initial Action Plan				
Update on Action Plan				
Final Action Plan				
QI PROGRAM CONTACT NAMES				
QI Manager				

Approved by <INSERT IPA NAME>:

_____ _____

NAME LAST NAME Date

TITLE (e.g. Chief Executive Officer/President)

Approved by <INSERT MSO NAME>:

_____ _____

NAME LAST NAME Date

TITLE (e.g. Performance Improvement Manager)

NOTES:

For All of L.A.

ELEVATING HEALTHCARE
IN LOS ANGELES COUNTY
SINCE 1997