Section 18
Provider and Member Incentives

This section includes information on the Primary Care Provider (PCP), Specialist and Member incentive programs offered by the Alliance in 2020. These programs are evaluated by the Alliance on an annual basis to ensure they are achieving their intended outcomes which include improving access, coordination, quality and efficiency of care, and supporting members in making decisions that improve their health outcomes.

Specialist Incentive Program -2020

Specialty Care Incentive Overview

The Specialty Care Incentive (SCI) program compensates participating referral providers for offering Alliance Medi-Cal members access to certain specialty medical services. It is designed to improve Alliance Medi-Cal member access to specialty care services and encourage specialty care physician participation in the Alliance Medi-Cal program.

The Alliance, at its sole discretion, may set aside a pool of money each year from which to pay SCI incentive (SCI Pool). Generally, the portion of the SCI Pool a provider will receive is determined by calculating the portion of the total qualifying referral services provided to Alliance Medi-Cal members, performed by the provider during the calendar year. Information for this incentive program is gathered through claims data.

To participate in SCI, a provider must have had its contract amended by the Alliance to add the SCI addendum. Payment under SCI is made to the entity with whom the Alliance is contracted.

Calculation of SCI Payment

Providers are assigned points for providing qualifying referral visits to Alliance Medi-Cal Members. Initial visits are awarded three points, while additional visits are awarded one point.

Provider's total SCI points are determined by adding all SCI points that the provider earned for initial and subsequent visits during the SCI Term (Provider's Total SCI Points). The portion of the SCI Pool that the provider receives (Provider's SCI Share) is calculated by dividing the Provider's Total SCI Points by the sum of the SCI Points earned by all SCI eligible providers during the SCI Term (Total SCI Points of all Providers). The payment amount that the provider receives under the SCI program is calculated by multiplying Provider's SCI Share by the SCI Pool. Calculation of Provider's SCI Share and Provider's SCI Payment are illustrated on the following page.

Calculation of Provider's SCI Share

Provider's Total SCI Points	÷	Total SCI Points of all Providers	=	Provider's SCI Share

Calculation of Provider's SCI Payment

Provider's SCI Share	x	SCI Pool	=	Provider's SCI Payment

For additional information regarding the SCI program, including definitions, funding, accounting, and distribution of payment, providers participating in SCI should reference the Referral Physician Specialty Care Incentive Program addendum or exhibit added to their Referral Physician Services Agreement.

Primary Care Physician Incentives 2020

Care-Based Incentive Program Overview

The Alliance's Care-Based Incentives (CBI) Program is designed in collaboration with our providers. The CBI Program consists of a set of measures to encourage preventive health services and connecting members with their primary care physicians (PCP). The program offers financial incentives, as well as technical assistance to PCPs to support providers in assisting members to self-manage their care and reduce proximal healthcare costs in the following areas:

- Care Coordination
- Quality of Care
- Performance Targets
- Exploratory (formerly provisionary)
- Practice Management

Although the CBI Program evaluates performance on the Alliance's Medi-Cal line of business, the Alliance encourages quality, cost-efficient care for all your patients.

For a Provider to participate in the CBI program each year, the Provider and the Alliance must execute an amendment adding CBI to the Provider's contract. The description of the CBI program included in this Provider Manual is intended to provide a general overview of the program. It does not modify or alter in any way the terms and conditions of the program for providers contracted to participate in the CBI Program.

For more information about the CBI Program, please see Policy 401-1705 – Care Based Incentive Program.

CBI Programmatic Incentives

Under the CBI Programmatic Incentives, Provider's performance during the CBI term is measured against applicable benchmarks or performance targets and then compared to the performance of other CBI Providers to determine Provider's CBI Programmatic Incentive Payment. The CBI Programmatic Incentive contains three categories of measures: (1) Care Coordination Measures, (2) Quality of Care Measures, and (3) Performance Target Measures. General information regarding CBI Programmatic Incentive measures is provided below. For more information on the CBI measures, including incentive payment amounts, visit our CBI Resources Website page on the Alliance website.

1. **Care Coordination (CC) Measures:** Care Coordination – Hospital & Outpatient Measures, a Provider's performance is compared to the performance of providers within the same comparison group (i.e. Family Practice, Internal Medicine or Pediatrics). Under the Care Coordination–Access Measures, a Provider's performance is based on their rate of achievement under each measure.

   To qualify for the Care Coordination – Access Measures, which include Initial Health Assessment (IHA), Alcohol Misuse Screening and Counseling (AMSC), Developmental Screening in the First Three Years, and Post-Discharge Care measures, providers must have a minimum of 5 eligible linked members at the end of the CBI Term.

   To qualify for the Care Coordination – Hospital Measures, which include Ambulatory Care Sensitive admissions (ACSA), Preventable Emergency Visits, and the 30-Day Readmissions measures, Providers must have 100 eligible linked members, on average, during the 2020 calendar year or 100 linked members as of December 31, 2020. Continuous enrollment requirements also apply to all care coordination measures. California Children's Services (CCS) Members are excluded from Care Coordination measures.

   Visit the CBI Resources page of the Alliance provider website for a list of diagnoses included in the Ambulatory Care Sensitive admissions (ACSA) and the Preventable Emergency visits measures.

2. **Quality of Care (QoC) Measures:** The Quality of Care (QoC) Measures are calculated using the National Committee for Quality Assurance (NCQA) Medicaid benchmarks, following the Healthcare Effectiveness Data and Information Set (HEDIS) methodology. In order for a provider to receive points for a QoC Measure, they must have a minimum of 5 eligible linked members that qualify for the measure based on HEDIS specifications. The 13 QoC Measures for 2020 are shown below.
   - Antidepressant Medication Management
   - Asthma Medication Ratio
   - BMI Assessment: Adult
   - BMI Assessment: Child
   - Cervical Cancer Screening
   - Diabetic HbA1C Poor Control >9.0%
   - Immunizations: Adolescents
   - Immunizations: Children (Combo 10)
   - Maternity Care: Prenatal
   - Maternity Care: Postpartum
   - Well-Adolescent Visit 12 - 21 Years
   - Well-Child Visit 3 - 6 Years

- Well-Child Visits First 15 Months of Life

Performance Target Measure: The Performance Improvement Measure allows providers to receive performance improvement points for every measure they qualify for by either:

- Meeting the plan goal (90th percentile or above), or
- Achieving a 5% improvement compared to the prior year.

3. **Exploratory Measures:** The Exploratory Measures (formerly Provisionary Measures) are a part of the CBI Program to monitor performance and are considerations for possible inclusion as a paid measure in the 2021 CBI Program. These measures do not qualify for payment in 2020. CCS Members are excluded from the 90-Day Referral Completion, Application of Dental Fluoride Varnish, and Breast Cancer Screening measures.. The Exploratory Measures are shown below:

- 90-Day Referral Completion
- Application of Dental Fluoride Varnish
- Breast Cancer Screening
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Immunizations: Adults
- Member Satisfaction

CBI Programmatic Measure Benchmarks

The 2020 Programmatic Benchmarks indicate the rate of performance a provider site must achieve in order to receive points for a measure. Total CBI year end payments are dependent on the total number of points a provider site receives. The final programmatic payment amounts are calculated using: 1) total programmatic points received, total number of eligible member months, and 3) distribution percentages determined by comparison to the totals for CBI Providers of the same comparison group (pediatrics, internal medicine and primary care).

In the event a HEDIS benchmark is not published for a Quality of Care Measure, the Alliance will determine a rate of achievement.

For additional information on the CBI Benchmarks visit the CBI Resources page on the Alliance website.

CBI Fee-For-Service Incentives

Fee-For-Service Measures Overview

In contrast to CBI Programmatic Incentive, which is paid based on provider's performance as compared to applicable benchmarks or performance targets, CBI Fee-for-Service (FFS) Incentives are single payment incentives to PCP sites and require providers to submit an attestation or certification of achievement to qualify for payment. The Alliance is offering three CBI FFS Incentives in 2020 for the measures shown below.

For more information on the CBI measures, including incentive payment amounts, visit our CBI Resources page on the Alliance Website.

- Behavioral Health Integration
- Buprenorphine License (X-License Waiver)
- Patient Centered Medical Home (PCMH) Recognition

CBI Payments

Provider Incentives are paid to qualifying contracted provider sites, including family practice, pediatrics and internal medicine. As noted above, provider incentives are broken into Programmatic and Fee-For-Service (FFS). Programmatic and FFS Measures vary in the frequency which they are paid and the incentive payment calculation methodology.

- Programmatic measures are paid annually based on their rate of performance in each measure.
- Fee-For-Service measures are paid quarterly

CBI Resources

The Alliance's Provider Portal is a resource that offers monthly Quality Reports on claims data received for relevant measures to assist providers in monitoring their patients. The CBI Reports allow providers to view accumulative summaries of both Programmatic and Fee-for-Service measures by quarter.

Note: Claims data is subject to lag and is based upon the Provider's submissions. The measurement of the CBI data is subject to variation, reasonable statistical and operational error.

The Alliance's Data Submission Tool is available on the Provider Portal to allow providers to upload data for a selection of measures to achieve compliance in CBI. The Data Submission Tool Guide, available on the Provider Portal, provides step-by-step instructions, required information, and how to upload the data. If you do not have access to the Provider Portal Data Submission Tool or have additional questions, contact your Provider Relations Representative.

For additional CBI resource information please visit the Alliance's CBI Resources Website, or contact your Provider Relations Representative.

Value-Based Payment Program

The Department of Health Care Services (DHCS) VBP Program is new for 2020. It will be administered through Medi-Cal Managed Care Health plans to provide incentive payments to qualifying providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. Implementation date is July 1, 2019 for all measures.

Value-Based Payment Program Domains and Measures (Not yet finalized)

- Prenatal/Post-partum Care Domain
    - Prenatal Pertussis ('Whopping Cough') Vaccine
    - Prenatal Care Visit

  - Postpartum Care Visit
  - Postpartum Birth Control
- Early Childhood Domain
  - Well Child Visits in First 15 Months of Life
  - Well Child Visits in 3rd-6th Years of Life
  - All Childhood Vaccines for Two Year Olds
  - Blood Lead Screening
  - Dental Fluoride Varnish
- Chronic Disease Management Domain
  - Controlling High Blood Pressure
  - Diabetes Care
  - Control of Persistent Asthma
  - Tobacco Use Screening
  - Adult Influenza ('Flu') Vaccine
- Behavioral Health Integration Domain
  - Screening for Clinical Depression
  - Management of Depression Medication
  - Screening for Unhealthy Alcohol Use
  - Value Based Program Payments

VBP Payments

The VBP is projected to be implemented for at least three years, subject to approved funding through the state and program design by the Centers for Medicare & Medicaid Services (CMS). To address and consider health disparities, an increased payment has been allocated for members diagnosed with substance use disorder, serious mental illness (Schizophrenia, Bipolar Disorder, Other Bipolar Disorder, and Major Depression), or homeless or inadequate housing. **Payments are based on Medi-Cal receiving the encounter data**, with the design to pay providers based on the National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1):

- If the rendering or ordering is not completed, the prescriber fields will be used for NPI for an individual (Type 1).
- If the rendering, ordering, or prescribing criteria is not met, the billing provider that is an NPI for an individual (Type 1) is used. If the encounter data does not include an individual (Type 1) NPI, then no incentive payment will be made for the encounter.

DHCS has not yet finalized the measures nor the payment schedule for 2020. For additional information on VBP program, please see the DHCS VBP website and Alliance website.

Member Incentives 2020

Health Education and Disease Management Programs

Alliance Medi-Cal members who do not have other health insurance are eligible to participate in the Alliance Member Health Rewards Programs. Members need to meet program criteria and must be eligible during the time the service is being provided by their PCP. These incentives are provided in conjunction with the Alliance Health Education and Disease Management programs and are designed to support and encourage members' efforts for engaging in healthy behaviors that improve their health outcomes. The impact of each incentive will be assessed by the Alliance at the end of the year. Please visit the Alliance Health Education and Disease Management Program page of the Alliance provider website for important information, including required program components, program eligibility, and member health rewardsfor the following programs:

- Healthy Weight for Life Program
- Heathy Moms and Healthy Babies Program
- Healthier Living Program

Nurse Advice Line Service

The Nurse Advice Line (NAL) offers 24/7 triage support to direct **all** Alliance members requiring medical attention to the appropriate level of care, in the appropriate time frame, resulting in decreased ED use for avoidable conditions and improved PCP access. Alliance Medi-Cal Members who call the NAL will be entered into a raffle for a chance to win a $50 gift card.