DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**
**State Demonstrations Group**

March 21, 2016

Mari Cantwell
Chief Deputy Director
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

This letter is to inform you that the following attachments to the Special Terms and Conditions (STCs) for California's section 1115(a) demonstration, entitled "California Medi-Cal 2020 Demonstration" (11-W-00193/9), are approved as submitted by the state and as modified through our discussions.

- GPP Funding and Mechanics Protocol (Attachment EE)
- Global Payment Program (GPP) Valuation Methodology Protocol (Attachment FF)

CMS finds these protocols to be in accordance with the STCs for the demonstration, and has no further questions or comments at this time.

Copies of the approved attachments are enclosed. They will replace the corresponding attachments in the STCs.

We look forward to continuing to work with you and your staff on the California Medi-Cal 2020 Demonstration. If you have any questions, please contact your project officers, Ms. Mehreen Hossain, at either 410-786-0938 or by email at Mehreen.Hossain@cms.hhs.gov, and Ms. Heather Ross, at either 410-786-3666 or by email at Heather.Ross@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/
Angela D. Garner
Director Division of System Reform Demonstrations

Enclosure

cc: Henrietta Sam-Louie, Acting ARA Region IX

**Attachment EE: Global Payment Program Funding and Mechanics Protocol**

A. Public Health Care Systems (PHCS)

GPP Payments are available for PHCS, which are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment C. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C.

The GPP provides support for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS will provide an assurance that, to the extent the GPP exceeds the amount that is attributable to the state's Adjusted DSH (determined pursuant to STC 167), a percentage of GPP points earned by each PHCS will be associated with care and activities that are furnished through charity care and discount payment policies for financially qualified, uninsured individuals that adhere to California state law ability-to-pay requirements. The required percentage is equal to the amount of the GPP that is in excess of the Adjusted DSH divided by the total GPP for the year. For the first year of the GPP, each PHCS is required in the aggregate to satisfy the above assurance for at least 21.4% of GPP points earned.

Each PHCS shall identify to DHCS the affiliated and contracted providers that will constitute the PHCS, and shall notify DHCS of changes.

B. Determination of GPP Annual Limits

For each GPP PY, DHCS shall work with CMS to determine the annual limit for the GPP consistent with STC 167. The annual limit shall be calculated as the sum of the Adjusted DSH allotment and the Uncompensated Care Component. The Adjusted DSH allotment shall be determined consistent with the provisions of Attachment NN (DSH Coordination Methodology).

C. Establishment of Participating PHCS global budgets

DHCS will determine for each PHCS a global budget for each GPP PY, which is the total amount of funding each PHCS will earn if it meets or exceeds its applicable threshold. Threshold amounts for each PHCS for GPP PY1 are set forth in Attachment FF, section B. Threshold amounts for subsequent GPP PYs will be calculated through adjustments in proportion to changes in the size of the aggregate GPP annual limits, as set forth in Attachment FF, section B.

To determine a PHCS' global budget for a GPP year, DHCS shall calculate the PHCS' allocation percentage, which is the PHCS's point threshold for a GPP PY divided by the sum of all PHCS point thresholds for the same GPP PY. The PHCS's global budget shall equal the allocation percentage multiplied by the total computable annual limit for the GPP, as set forth in ¶ 167 of the Special Terms and Conditions ("Funding and Annual Limits").

DHCS shall determine an initial total computable annual limit for a GPP PY based on the initial CA DSH allotment published by CMS for the applicable GPP PY and any uncompensated care funding allocated under the Medi-Cal 2020 Waiver. DHCS shall determine initial threshold amounts and annual budgets for each PHCS based on this information and publish the information on its GPP webpage within 10 days of the determination. DHCS shall determine the final total computable annual limit for a GPP PY once

the final CA DSH allotment is published by CMS and shall publish the final amounts, and associated PHCS threshold amounts and annual budgets within 10 days of such determination.

D. Reporting Requirements

By August 15th following each GPP PY, each PHCS shall submit an interim year-end summary report summarizing the aggregate number of uninsured units of service provided during the GPP PY, broken out by the service categories, tiers, and types as defined in Attachment FF (Valuation Protocol). The summary report will also compute the number of points earned based on the corresponding point valuations for the services provided, and the payments due to the PHCS (net of any payments previously received for the GPP PY). Data contained in the interim year-end summary report will be based on the best data available through the close of the GPP PY. Revisions to the interim data will be reflected in the final reconciliation report.

By March 31st following the close of each GPP PY, each PHCS shall submit a final year-end reconciliation summary report in the same format as the interim year-end summary report referenced above that includes the PHCS final submission with regard to the services, points, and funds earned for the GPP PY. The final reconciliation summary report shall reflect any necessary revisions to the interim data and shall serve as the basis for the final reconciliation of GPP payments for the GPP PY.

Starting with GPP PY 2, each PHCS shall submit encounter-level data on their uninsured services in order to provide auditable verification that the reported uninsured services were provided. For this purpose, encounter-level data may include line-level encounters or documentation of claims or other reliable methods for determining the number of contracted units of service to the uninsured by contracted providers. Such reporting shall be provided at the time of the final reconciliation summary reports. All reports shall be submitted in a manner and format as set forth by DHCS. In addition, for all GPP PYs, PHCS shall maintain documentation of services and shall make such information available to DHCS or CMS upon request.

DHCS shall review all summary reports and data submitted for accuracy and compliance with established procedures, and perform tests for reasonableness. If discrepancies or inconsistencies are identified, DHCS shall work directly with PHCS staff to promptly resolve issues and correct data and reporting. PHCS shall provide a formal response to DHCS inquiries within five (5) business days of receipt of an inquiry or question; additional time to respond may be requested by the PHCS and approved by DHCS.

The interim year-end summary report and the final year-end reconciliation summary report shall be due at the times specified in Table 1 below. If the identified date falls on a weekend or holiday, the report shall be due at the close of the following business day.

**Table 1: Reporting timeline**

| **Report name** | **Reporting period** | **Report due date to DHCS** | | |
|---|---|---|---|---|
| Interim year-end summary report | July 1 – June 30 | August 15 (following program year) | | |
| Final year-end reconciliation summary report | July 1 – June 30 | March 31 (following program year) | | |

E. Payment schedule.

*Interim Payments*

PHCS shall receive interim quarterly GPP payments based on 25% of their annual global budget for the first three quarters of the GPP PY. DHCS will notify PHCS of the IGT due dates and payment dates according to Table 2. Payments will be made within 15 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Table 2. For a PHCS that is comprised of more than one DPH, payments will be made to the health system under which the DPHs operate.

For the fourth quarter of each GPP PY, an interim payment shall be made to each PHCS that is sufficient to bring the PHCS' interim payments for the GPP PY to the amount earned by the PHCS based on its interim year-end summary report. The total Interim payments earned by a PHCS shall be determined by multiplying the PHCS's annual global budget by the ratio of the value of the points earned during the GPP PY to the PHCS's threshold, as reported in the interim year-end summary report; however, no PHCS may earn more than its annual global budget prorated by the number of months in the reporting period. The fourth quarter interim payment shall be calculated based on the amount earned by the PHCS for the GPP PY, net of any GPP payments previously received by the PHCS for the GPP PY. If the PHCS' interim year-end summary report reflects an annual payment that is less than 75% of its total annual budget, no additional interim payment shall be made for the fourth quarter. DHCS shall calculate the amount of the required IGTs for the fourth quarter and make GPP IGT notifications to all PHCS no later than 30 calendar days after submission of the interim year-end summary report, as shown in Table 2. PHCS shall submit IGTs within 7 days of receiving notification. Interim payments will be made to all PHCS no later than one month following their respective IGT notification date, if IGTs are received within the required 7 days.

*Final Reconciliation and Redistribution Process*

There will be a final reconciliation annually following the submission of each PHCS' final reconciliation summary report and (beginning with GPP PY 2) the required supporting encounter data. DHCS shall determine the amount earned by each PHCS based on the total number of points earned by each PHCS for the GPP PY, as reported in the final year-end reconciliation summary reports. For PHCS that exceeded their threshold for the GPP PY, the amount earned is subject to adjustment in accordance with the following redistribution process set forth below.

DHCS will identify any GPP global budget amounts that PHCS were individually unable to claim and redistribute such unclaimed amounts to the PHCS that exceeded their point thresholds for the applicable GPP PY. To determine redistribution amounts, DHCS shall first calculate a dollar amount of funding per GPP point by dividing the total GPP annual limit for the GPP PY by the aggregate threshold points for all PHCS. DHCS will then multiply this dollar amount by the amount by which each PHCS has exceeded its threshold to determine the PHCS's maximum redistribution amount. Each PHCS that has exceeded its threshold will receive its maximum redistribution amount if there are sufficient unused funds for the year from other PHCS. If there are insufficient unused funds to pay all PHCS that exceeded their thresholds their maximum redistribution amount, then each PHCS will receive an adjusted redistribution amount, prorating the amount of unused funds available by the number of points each PHCS is above its applicable threshold. The redistributed amounts following this determination shall be added to the GPP amounts earned by the applicable PHCS for the purposes of the final reconciliation.

Based on the final reconciliation amounts determined as set forth above, DHCS shall adjust, as necessary, the interim payments previously made to the PHCS for the GPP PY. Within 90 calendar days of receiving

the final reconciliation summary reports from the PHCS DHCS shall calculate the amount of the required IGTs for the reconciliation and make GPP IGT notifications to all PHCS, as shown in Table 2 above. PHCS shall submit IGTs within 14 days of receiving notification. Final payments will be made to all PHCS no later than 45 days following their respective IGT notification date, if PHCS have submitted the IGTs within the 14 day requirement. If the necessary IGTs are submitted past the 14 day requirement, final payments, as well as any other associated payments, will be made no later than 45 days following submission of the necessary IGT amounts. If, at the end of the reconciliation process, it is determined that the interim GPP funds for a GPP PY exceeded the amounts due upon final reconciliation, DHCS shall recoup the amounts from the appropriate PHCS. In the event of any recoupments, DHCS shall return the associated IGT funds to the transferring entity within 14 calendar days.

*Payment Summary Report to CMS*

For each GPP PY, DHCS will submit a Payment Summary Report to CMS (following the schedule in Table 2) that summarizes all GPP transactions to date which pertain to that GPP PY and includes a list of entities that have provided IGTs during the report period and the amount of the IGTs provided. Transactions include interim payments, final payments, and recoupments. Each transaction record will include the name of the PHCS to which the transaction pertains, whether the transaction is an interim, reconciliation, or redistribution payment, the interim year-end Summary Report or Final Reconciliation Summary Report that supports the transaction, and the Quarterly Expenditure Report on which the transaction was or will be reported. The Payment Summary Report following the Final Reconciliation Summary Report will show how the sum of all transactions for each PHCS matches the PHCS final reconciliation amount.

**Table 2: Interim and Final Payment timeline**

| **Payment** | **Payment Amount** | **Payment Amount & IGT Notification Date** | **IGT Due Date** | **Payment Date** | **Payment Summary Report to CMS** |
|---|---|---|---|---|---|
| Interim Quarter 1 | 25% of Annual | September 15 | September 22 | October 15 | November 15 |
| Interim Quarter 2 | 25% of Annual | December 15 | December 22 | January 15 | February 15 |
| Interim Quarter 3 | 25% of Annual | March 15 | March 22 | April 15 | May 15 |
| Interim Quarter 4 | Final Interim based on interim year-end summary report | September 15 following the GPP PY end | September 22 following the GPP PY end | October 15 following GPP PY end | November 15 following GPP PY end |
| Final Reconciliation | Final reconciled amount | June 30 following the GPP PY end | July 14 after notification date | August 15 after notification date | September 15 after notification date |

**Attachment FF: Global Payment Program Valuation Protocol**

A. Valuation of Services

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points based on this protocol. Each service has an identical point value for every PHCS, but the assigned point values per service shall vary by GPP Program Year (GPP PY) as described in detail below.

1. Categories and tiers of service

Services associated with points in the GPP are shown in Table 1 below, grouped into both categories (1-4) and tiers within categories (A-D). These groupings can contain both traditional and non-traditional services. The groupings were intended to better display the full range of services that may be provided to the uninsured under the GPP, to help develop initial point values for non-traditional services (for which cost data is not available), and to clarify which service types it made sense to revalue up or down for GPP purposes over time.

Categories 1 through 4 are groupings of health care services that are organized according to their similar characteristics. For example, Category 1 contains outpatient services in traditional settings, mostly "traditional" services provided by licensed practitioners. Category 2 is made up of a range of outpatient services provided by non-provider care team members, both inside and outside of the clinic, including health education, health coaching, group and mobile visits, etc. Category 3 services are technologically-mediated services such as real-time video consultations or e-Consults between providers. Category 4 services are those involving facility stays, including inpatient and residential services.

Grouping of services into tiers was based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in-person, electronic, etc.). Generally speaking, within each category, tier D is the most intensive and/or costly, and often requires individuals with the most advanced training or certifications, resulting in higher initial point values on average, whereas tier A is on the other end of the spectrum in intensity and resource use. However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.

The services whose values would decline over time under the GPP (as described in section 4 below) are most service types in categories 1C (emergent outpatient) and 4B (inpatient medical/surgical and mental health), which are higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care.

**Table 1: GPP Service Types by Category and Tier, with Point Values**

| Category and description | Tier | Tier description | Service type | Traditional / non-traditional | Initial point value |
|---|---|---|---|---|---|
| 1: Outpatient in traditional settings | A | Care by Other Licensed or Certified Practitioners | RN-only visit | NT | 50 |
| | | | PharmD visit | NT | 75 |
| | | | Complex care manager | NT | 75 |
| | B | Primary, specialty, and other non-emergent care (physicians or other licensed independent practitioners) | Primary/specialty **(benchmark)** | T | 100 |
| | | | Contracted primary/specialty (contracted provider) | T | 19 |
| | | | Mental health outpatient | T | 38 |
| | | | Substance use outpatient | T | 11 |
| | | | Substance use: methadone | T | 2 |
| | | | Dental | T | 62 |
| | C | Emergent care | OP ER | T | 160 |
| | | | Contracted ER (contracted provider) | T | 70 |
| | | | Mental health ER / crisis stabilization | T | 250 |
| | D | High-intensity outpatient services | OP surgery | T | 776 |
| 2: Complementary patient support and care services | A | Preventive health, education and patient support services | Wellness | NT | 15 |
| | | | Patient support group | NT | 15 |
| | | | Community health worker | NT | 15 |
| | | | Health coach | NT | 15 |
| | | | Panel management | NT | 15 |
| | | | Health education | NT | 25 |
| | | | Nutrition education | NT | 25 |
| | | | Case management | NT | 25 |
| | | | Oral hygiene | NT | 30 |
| | B | Chronic and integrative care services | Group medical visit | NT | 50 |
| | | | Integrative therapy | NT | 50 |
| | | | Palliative care | NT | 50 |
| | | | Pain management | NT | 50 |
| | C | Community-based face-to-face encounters | Home nursing visit | NT | 75 |
| | | | Paramedic treat and release | NT | 75 |
| | | | Mobile clinic visit | NT | 90 |
| | | | Physician home visit | NT | 125 |
| 3: Technology-based outpatient | A | Non-provider care team telehealth | Texting | NT | 1 |
| | | | Video-observed therapy | NT | 10 |
| | | | Nurse advice line | NT | 10 |
| | | | RN e-Visit | NT | 10 |
| | B | eVisits | Email consultation with PCP | NT | 30 |
| | C | Store and | Telehealth (patient - provider) | NT | 50 |

| | | | | | |
|---|---|---|---|---|---|
| | | forward telehealth | - Store & Forward | | |
| | | | Telehealth (provider - provider) – eConsult / eReferral | NT | 50 |
| | | | Telehealth – Other Store & Forward | NT | 65 |
| | D | Real-time telehealth | Telephone consultation with PCP | NT | 75 |
| | | | Telehealth (patient - provider) - real time | NT | 90 |
| | | | Telehealth (provider - provider) - real time | NT | 90 |
| 4: Inpatient | A | Residential, SNF, and other recuperative services, low intensity | Mental health / substance use residential | T | 23 |
| | | | Sobering center | NT | 50 |
| | | | Recuperative / respite care | NT | 85 |
| | | | SNF | T | 141 |
| | B | Acute inpatient, moderate intensity | Medical/surgical | T | 634 |
| | | | Mental health | T | 341 |
| | C | Acute inpatient, high intensity | ICU/CCU | T | 964 |
| | D | Acute inpatient, critical community services | Trauma | T | 863 |
| | | | Transplant/burn | T | 1,131 |

2. Valuation of traditional services

Services for which payment typically is made available upon provision of the service, referred to herein as “traditional” services, will receive initial point valuations based on their cost per unit of service in the historical year SFY2013-14. These traditional services are grouped into categories that reflect generally where care is being provided and intensity. Gross costs incurred for services provided to the uninsured by PHCS in SFY 2013-14, as determined under the applicable claiming methodologies, are summed across all PHCS by service type, using the most complete and reliable data when available, to obtain an average cost per unit for each traditional service. All traditional services are assigned point values based on their relative cost compared to an outpatient primary and specialty visit, which serves as the benchmark traditional service. These initial points are shown in table 1; the relative costs per unit of service are shown in Appendix 1.

3. Valuation, non-traditional services

Non-traditional services typically are not directly or separately reimbursed by Medicaid or other payors, and are often provided as substitutes for or complementary to traditional services. These services are

assigned initial point values based on their estimated relative cost compared to the benchmark traditional service, and their value in enhancing the efficiency and effectiveness of traditional services.

The non-traditional services in the table 1 provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, by improving uninsured individuals' access to the right care, at the right time, in the right place. For example, instead of needing to go to the emergency department, an uninsured individual could have telephone access to his or her care team, which would both help address and treat the presenting condition, as well as help connect the patient back to the entire breadth of primary care services. Likewise, a PHCS deploying eReferral/eConsult services would be able to better prioritize which uninsured individuals need early access to face-to-face specialty care expertise, or which can benefit from receipt of specialty care expertise via electronic collaboration between their PCP and a specialist. This collaboration enhances the PCPs' capacity to provide high-quality, patient-centered care, and allows the individual receiving that care to avoid specialty care wait times and the challenges of travelling to an additional appointment to a specialist who may be located far from where they live. This increased ability to provide timely access to specialty expertise will result in earlier treatment of complex conditions and help uninsured individuals avoid the need to seek emergent or acute care for untreated or partially treated sub-acute and chronic conditions. More detail on non-traditional services, including codes where available and descriptions, is in Appendix 2.

Individuals will be considered uninsured with respect to a non-traditional service if he or she has no source of third party coverage for a comparable traditional service. For example, an individual with coverage for outpatient visits would not be considered uninsured with regard to technology-based outpatient services, even if his or her insurance does not cover those services. DHCS shall, in consultation with the DPH systems, issue guidance letters addressing whether individuals shall be considered uninsured in specific factual circumstances, to ensure that the requirements are consistently applied.

4. Point revaluation over time

Point values for services will be modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value. The provision of general medical/surgical acute inpatient services and emergent services will receive fewer points over time,. The changing point structure will be designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible.

Point revaluation will be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if utilization and the mix of services provided remained constant. Specifically, for any PHCS, if its utilization and mix of services does not change from the baseline year of SFY 2014-15, it will not earn any more points in GPP PY 1 than it earned under the baseline year, and in subsequent GPP PYs shall earn fewer points.

As points for certain services are revalued over the course of the GPP, PHCS will be incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation will be phased in over time to enable PHCS to adapt to the change in incentives. In GPP PY 1, points will be identical to the initial cost-based point values. In GPP PY 2, 20% of the full change will be made to point values. In GPP PY 3, an additional 30% of the revaluation will be phased in, with the final 50% change occurring in GPP PY 4. This phase-in is illustrated in Table 2.

Point values will not vary from their initial cost-based amounts by more than 40% at any time during the GPP.

**Table 2: Revaluations to categories of service, by year, compared to initial point value**

| **Category of service** | Initial point value (cost-based) | Point value (% change), GPP PY 1 | Point value (% change), GPP PY 2 | Point value (% change), GPP PY 3 | Point value (% change), GPP PY 4 | Point value (% change), GPP PY 5 |
|---|---|---|---|---|---|---|
| OP ER | 160 | 160 (0%) | 158 (-1%) | 156 (-2.5%) | 152 (-5%) | 152 (-5%) |
| Mental health ER / crisis stabilization | 250 | 250 (0%) | 248 (-1%) | 244 (-2.5%) | 238 (-5%) | 238 (-5%) |
| IP med/surg | 634 | 634 (0%) | 630 (-0.6%) | 624 (-1.5%) | 615 (-3%) | 615 (-3%) |
| IP mental health | 341 | 341 (0%) | 339 (-0.6%) | 336 (-1.5%) | 331 (-3%) | 331 (-3%) |

Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

B. PHCS-Specific Point Thresholds

DHCS established GPP PY 1 point thresholds for each PHCS by collecting utilization data for all traditional uninsured services (by each traditional table 1 category) provided in SFY 2014-15, and then multiplying those service counts by corresponding initial point values. The thresholds for PY1 are shown in Table 3.

For GPP PY 2 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 167, compared to the total GPP funds available in GPP PY 1, e.g. if total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%.

**Table 3: GPP PY 1 PHCS Thresholds, Based on FY2014-15 Uninsured Services**

| **Public Health Care System** | **System Threshold, GPP PY1** |
|---|---|
| Los Angeles County Health System | 101,573,445 |
| Alameda Health System | 19,151,753 |
| Arrowhead Regional Medical Center | 7,525,819 |
| Contra Costa Regional Medical Center | 5,674,651 |
| Kern Medical Center | 3,633,669 |
| Natividad Medical Center | 2,959,964 |
| Riverside University Health System – Medical Center | 8,066,127 |
| San Francisco General Hospital | 12,902,913 |
| San Joaquin General Hospital | 3,021,562 |
| San Mateo County General Hospital | 8,733,292 |
| Santa Clara Valley Medical Center | 19,465,293 |
| Ventura County Medical Center | 9,213,731 |

**Appendix 1**

**Table 4: Categories of Service and Point Values, Traditional**

| Category | Tier | Service Name | Cost/unit | Initial point value |
|---|---|---|---|---|
| 1: Outpatient | B | OP Primary / Specialty (**benchmark, 100)** | 587 | **100** |
| | B | Dental | 365 | **62** |
| | B | MH Outpatient | 225 | **38** |
| | B | SU Outpatient | 62 | **11** |
| | B | SU Methadone | 11 | **2** |
| | B | Contracted Prim/Spec | 110 | **19** |
| | C | OP ER | 942 | **160** |
| | C | Contracted ER | 411 | **70** |
| | C | MH ER/Crisis Stabilization | 1,470 | **250** |
| | D | OP Surgery | 4,554 | **776** |
| 4: Inpatient | A | SNF | 829 | **141** |
| | A | MH/SU Residential | 138 | **23** |
| | B | Med/surg | 3,721 | **634** |
| | B | MH Inpatient | 2,000 | **341** |
| | C | ICU/CCU | 5,663 | **964** |
| | D | Trauma | 5,069 | **863** |
| | D | Transplant/Burn | 6,644 | **1,131** |

**Table 5: Categories of Service and Point Values, Non-Traditional**

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| **Service Category 1: Outpatient** | | | | |
| A | RN Visit[12] (includes Wound Assessment visits) | **99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. | | 50 |
| A | PharmD Visit[3] | **99605, 99606, 99607** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment, and intervention if provided; | | 75 |
| A | Complex Care Manager[4] | **99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:<br>• Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,<br>• Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,<br>Comprehensive care plan established, implemented, revised, or monitored. | | 75 |
| Service Category 2: Complementary Patient Support and Care Services | | | | |
| A | Wellness[5,6] | G0438 Annual wellness visit; includes a | | 15 |

[1] CMS Source: https://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99211&RangeEnd=99215, Accessed 11/14/2015

[2] Understanding When to Use 99211, Family Practice Management, http://www.aafp.org/fpm/2004/0600/p32.html, Accessed 11/10/2015

[3] Pharmacist Services Technical Advisory Coalition, http://www.pstac.org/services/mtms-codes.html, accessed 11/15/2015

[4] CMS Medicare Learning Network, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf, Accessed 11/15/2015

[5] https://www.careimprovementplus.com/pdf/PROVIDER_COMMUNICATION_WELLNESS_AND_PHYSICAL_EXAMINATION_CODES.pdf

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| | | personalized prevention plan of service (PPPS), initial visit<br>G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit<br>**S5190** Wellness assessment, performed by non-physician<br>**Z00.00, Z00.01x`** | | |
| A | Patient Support Group | **Non-physician Health Care Professional CPT Code**<br>**98961** Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/ Family) 2-4 Patients<br>**98962** Education And Training as above; 5-8 Patients | | 15 |
| A | Community Health Worker (CHW) | | Encounters in which a Community Health Worker assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs[7] | 15 |
| A | Health Education | | Services provided for the purpose of promoting health and preventing illness or injury. These include risk factor reduction interventions, preventive medicine counseling and behavior change interventions. | 25 |

[6] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

[7] Bureau of Labor and Statistics, Standard Occupational Classification: 21-1094 Community Health Workers. http://www.bls.gov/soc/2010/soc211094.htm, Accessed 11/24/2015

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| A | Nutrition Education[8,9] | **97802** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient<br>**97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient | | 25 |
| A | Case management | | Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.[10]<br><br>**Case manager is assigned** to the patient and engages in direct care **OR** coordination of care **OR** manages patient's access to care **OR** initiates and/or supervises other health care services needed by the patient[11] | 25 |
| A | Health coach | | Health and behavior intervention performed by non-provider member of the health care team to build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Includes motivational interviewing, self-management goal setting, patient education and activation and chronic disease support[12] | 15 |

[8] National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1), https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=252&ncdver=1&NCAId=53&NcaName=Medical+Nutrition+Therapy+Benefit+for+Diabetes+%2526+ESRD&IsPopup=y&bc=AAAAAAAAIAAA&, Accessed 11/24/2015

[9] CMS, DHHS: Medical Nutrition Therapy (MNT) Services for Beneficiaries With Diabetes or Renal Disease - POLICY CHANGE, November 1, 2002. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A02115.pdf, Accessed 11/10/2015

[10] Case Management Society of America, http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx, Accessed 11/15/2015

[11] Oregon APM Patient Touches, direct communication with Oregon Health Authority

[12] Per 11/30/2015 communication with Dr. Nwando J. Olayiwola, Associate Professor, Department of Family and Community Medicine, and Director of the Center for Excellence in Primary Care (CEPC), University of California San Francisco. CEPC is a recognized national leader in Health Coach training.

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| A | Panel management | | Document in patient's medical record when staff proactively reach out to a patient and speak with them regarding preventive services, chronic illness management, their care plan, problem list, health goals, and/or treatment options[13] | 15 |
| A | Oral Hygiene Encounters | | Adult and Pediatric oral health services including dental varnishing, oral health education and other prevention services provided by dental hygienists | 30 |
| B | Group medical visits | **99411-99412** Preventive medicine counseling and/or risk factor reduction provided to individuals in a group setting<br><br>**99078** Physician educational services rendered to patients in a group setting (eg, obesity or diabetic instructions) | | 50 |
| B | Integrative medical therapies | **97810-97811:** Acupuncture, one or more needles, without electrical stimulation, personal one-on-one contact with the patient | | 50 |
| B | Palliative Care | **0690-0699 Pre-hospice/Palliative Care Services**: Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration.<br><br>Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists. Unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters. | Encounters with non-provider care team members that focus on preventing and relieving suffering, and improveing the quality of life of patients and their families facing serious illness. Palliative care is provided by an interdisciplinary team which works with primary and specialty care providers to identify and treat pain and other distressing symptoms, provide psychosocial and spiritual support, and assist in complex decision-making and advance care planning. | 50 |
| B | Pain management | | Encounter provided by a non-provider caregiver or care team focused on enhancing self-management of chronic pain, implementing behavioral strategies for managing pain, discussing medication effectiveness and side effects, assessing treatment | 50 |

[13] Oregon APM Patient Touches

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| | | | effectiveness, and adjusting treatment plan and goals. Chronic pain visits may also include assessment for signs of substance use or mental health disorder as well as motivational interviewing or other treatment strategies for these disorders | |
| C | Physician Home Visits[14] | **99341 - 99347** Home visit, new patient;<br>**99347 - 99350** Home visit, established patient | | 125 |
| C | Home nursing visits | **G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting) | Visits by RNs to patients at home for acute or chronic disease management. May include history taking, physical exam, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level, or medications. | 75 |
| C | Mobile Clinic Visits | **CPT Physician Code**<br>**99050** Service(s) provided in office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service<br>**99051** Service(s) provided in the office during regularly scheduled evening, weekend or holiday hours, in addition to basic service<br>**99056** Services typically provided in the office, provided out of the office at request of patient, in addition to basic service<br><br>Use POS code 15 with the above codes to signify a services provided in a mobile setting[15] | | 90 |
| C | Paramedic treat and release | | Paramedic assessment, treatment if appropriate, and discharge of a patient without ambulance transport[16] | 75 |
| Service Category 3: Technology-Based Outpatient[17] | | | | |

[14] CMS Billing and Coding Guidelines - L31613 PHYS-081 - Home and Domiciliary Visits: https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31613_1/L31613_PHYS081_CBG_050111.pdf, Accessed 11/10/2015

[15] https://www.supercoder.com/my-ask-an-expert/topic/mobile-clinic

[16] Millin, M. et al. EMS provider determinations of necessity for transport and reimbursement for ems response, medical care, and transport: Combined resource document for the national association of EMS physicians position statements, http://www.naemsp.org/Documents/Position%20Papers/POSITION%20Determinationoftransport-Resource%20Doc-PEC_2011.pdf, Accessed 11/24/2015

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| A | Texting | | Texting services provided by the care team to an established patient, parent, or guardian to support care management. Cannot focus on administrative tasks such as scheduling appointments. Must not originate from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment | 1 |
| A | Video Observed Therapy | | Observation of patients taking their tuberculosis medication in their homes. Observation is done using a live video telephone on both the patient and provider ends[18] | 10 |
| A | Nurse advice line[19,20] | **98966, 98967, 98968** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment | | 10 |
| A | RN e-Visit[21] | **98969** Online evaluation and management service provided by a qualified non-physician | | 10 |

[17] General resource for this section is the American Telemedicine Association Letter to CMS on Telehealth Services, December 31, 2013. http://www.americantelemed.org/docs/default-source/policy/medicare-code-request-for-2015.pdf?sfvrsn=4, Accessed 10/28/2015

[18] California Department of Public Health Tuberculosis Control Branch - Guidance for Developing a Video Observed Therapy (VOT) - Policy and Procedures. https://www.cdph.ca.gov/programs/tb/Documents/TBCB-SPM-Cert-Guidance-VOT-Policy-And-Procedures.doc, Accessed 11/24/15

[19] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

[20] American Academy of Pediatrics, Charging for Nurse Telephone Triage. https://www.aap.org/en-us/professional-resources/practice-support/Telephone-Care/pages/Charging-for-Nurse-Telephone-Triage.aspx, Accessed 10/20/2015

[21] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| | | health care professional to an established patient, guardian or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network | | |
| B | Email consultation with PCP[22] | **99444** Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network | | 30 |
| C | Telehealth (patient - provider) - Store & Forward[23,24] | Digital Retinal Screening<br><br>**92250** (global) Fundus photography with interpretation and report | | 50 |
| C | Telehealth – Store & Forward | +GQ modifier for distant site:<br>**99241-99243** Office consultation, new or established patient<br>**99251-99253** Initial inpatient consultation<br>**99211-99214** Office or other outpatient visit<br>**99231-99233** Subsequent hospital care<br>OR<br>**99446-99449**: Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations | Store and Forward services that include images, such as Teleophthalmology and Teledermatology | 65 |
| C | Telehealth (provider - provider) – eConsult/ eReferral[25] | **99446-99449**, the new "Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations<br>OR<br>**99241-5** with GT modifer for distant site | | 50 |

[22] *Ibid*

[23] July 2015, Medi-Cal Ophthalmology Update. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ophthal_m01o03.doc, Accessed 10/15/2015

[24] communication with Jorge Cuadros, OD, PhD, Director of Clinical Informatics Research, UC Berkeley School of Optometry, CEO of EyePacs

[25] RTR- ECONSULT CPT CODES, UC Davis. https://static1.squarespace.com/static/52d9c6c5e4b021f2d93416db/t/534c2d9fe4b0d8fffdf288f5/1397501343957/CPT+Codes.pdf, plus communication 10/27/2015 with Timi Leslie, BluePath Health and Rachel Wick, Blue Shield of CA Foundation in reference to BSCF eConsult grant program.

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| D | Telephone consultation with PCP[26] | **CPT Physician Code** **99441** through 99443. Telephone E&M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment | ALTERNATIVE DESCRIPTION: PCP speaks via telephone with patient about medical/dental/MH/substance use condition or medications AND discusses or creates care plan OR discusses treatment options | 75 |
| D | Telehealth (patient - provider) - real time[27,28] | **99201-99215** with modifier **GT** "Office or other outpatient visits" Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" | | 90 |
| D | Telehealth (provider - provider) - real time[29] | | Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems | 90 |
| Service Category 4: Inpatient | | | | |
| A | Sobering Center[30] | | Nurse assessment and monitoring, to determine and ensure safety for individuals found intoxicated in public[31] | 50 |
| A | Recuperative/Respite Care[32] | | Provision of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Services may include recuperative care, completion of therapy | 85 |

[26] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

[27] CMS Medicare Learning Network: Telehealth Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, Accessed 10/28/2015

[28] Medi-Cal Provider Manual: Telehealth, December 2013. http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc, Accessed 10/28/2015

[29] *Ibid*

[30] San Francisco Department of Public Health, Housing and Urban Health, Medical Respite and Sobering Center. https://www.sfdph.org/dph/comupg/oprograms/HUH/medrespite.asp, Accessed 11/25/2015

[31] 12/23/2015 communication with Dr. Hali Hammer, Medical Director for Ambulatory Services, San Francisco Health Network.

[32] National Health Care *for the* Homeless Council, definition of Recuperative Care https://www.nhchc.org/ accessed 11/24/2015

| Tier | Service | Relevant codes and description if available (CPT, ICD) | Definition [source] Where no nationally recognized code exists | Relative Points |
|---|---|---|---|---|
| | | | (e.g, antibiotics, wound care), temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults[33] | |

[33] Ibid 12/23/2015 communication with Dr. Hammer.