California Department of Health Care Services
Value Based Payment Program
Training Handbook

(Version 05/15/20 – V1)
(Version 08/18/20 – V2)
(Version 08/18/20 – V3)

Contents

About the Value Based Payment Program

The California Department of Health Care Services (DHCS) Value Based Payment Program (VBP) program will provide supplemental payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. Supplemental payments are for DHCS VBP measures in the following areas:

- Behavioral Health Integration
- Chronic Disease Management
- Prenatal/Post-Partum Care
- Early Childhood Prevention

Department of Health Care Services (DHCS) initially indicated that the VBP program would be for 3 years—effective 7/1/19—subject to 2019 approved budget.

Program Duration: 7/1/19-6/30/21 (uncertain beyond date)

To address and consider health disparities, DHCS will pay an increased supplemental amount for events tied to beneficiaries diagnosed as having a substance use disorder or serious mental illness, or who are homeless.

Proposed Value Based Payments Program Measures & Reimbursements

Note: Reimbursements subject to change, including program discontinuance, at the sole discretion of Department of Health Care Services.

Domain	Measure	Add-On Amount	At-Risk Add-On Amount
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$ 25.00	$ 37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$ 70.00	$ 105.00
Prenatal/Postpartum Care Bundle	Postpartum Care (Early or Late) Visits	$ 70.00	$ 105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$ 25.00	$ 37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$ 70.00	$ 105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$ 70.00	$ 105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$ 25.00	$ 37.50
Early Childhood Bundle	Blood Lead Screening	$ 25.00	$ 37.50
Early Childhood Bundle	Dental Fluoride Varnish	$ 25.00	$ 37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$ 40.00	$ 60.00
Chronic Disease Management Bundle	Diabetes Care	$ 80.00	$ 120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$ 40.00	$ 60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$ 25.00	$ 37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$ 25.00	$ 37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$ 50.00	$ 75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$ 40.00	$ 60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$ 50.00	$ 75.00

Measure 1 - Prenatal/Postpartum Care

Prenatal Pertussis ("Tdap") Vaccine – Supplemental payment to the provider for the administration of the pertussis vaccination to women who are pregnant.

- Payment to rendering or prescribing provider for DTaP vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may be eligible twice

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
90715	O09 or Z34 series	11, 22	1500

Measure 2 - Prenatal Care Visit

Supplemental payment to the provider for ensuring that the woman comes in for her initial prenatal visit.

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis, not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by using the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a CPT codes of **Z1032*,** 99201-05, 99211-15, 99241-45 on the encounter

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type	Additional Claim Requirements
Z1032*, 99201-05, 99211-15, 99241-45	O09 or Z34 series	11, 22	1500	LMP in Box 14

*preferred CPT code for measure

Other claim related specifications:

- Utilize "Box 14" – LMP Date
    - If you are not currently billing with the LMP in Box 14 of the CMS-1500 form, please ensure you are indicating this information moving forward. The absence of the LMP may delay your VBP payments.

Measure 3 - Postpartum Care Visits

Supplemental payment for completion of recommended postpartum care visits after a woman gives birth.

- Payment to rendering provider for provision of an Early Postpartum Visit
- Payment to rendering provider for provision of a Late Postpartum Visit
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by using the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.
Definitions:

- Early Postpartum Visit - A postpartum visit on or between 1 and 21 days after delivery
- Late Postpartum Visit - A postpartum visit on or between 22 and 84 days after delivery

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type	Additional Claim Requirements
Z1038*, 99201-05, 99211-15, 99241-45	Z39.2	11, 22	1500	Delivery Date in Box 15

*preferred CPT code for measure

Other claim related specifications:

- Utilize “Box 15” – Delivery Date
    - While HPSJ will make every effort to validate the delivery date from the delivery claim providers should start indicating the delivery date in box 15 of the CMS-1500 form, to expedite the validation process and subsequent supplemental payment.

Measure 4 - Postpartum Birth Control

Supplemental payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery.

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.
The codes used to calculate this measure are available in Tables CCP-C through CCP-D at:
https://www.medicaid.gov/license/form/1541/3741

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
Valid contraceptive code		11, 22	1500

Measure 5 - Early Childhood (Well-Child Visits in First 15 Months of Life)

Separate supplemental payment to a provider for each of the last three well-child visits out of eight total--6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months). Encounters for the first 5 must be received to count for the 6th through 8th.

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6-month visit – the first well care visit between 172 and 263 days of life
  - 9-month visit – the first well care visit between 264 and 355 days of life
  - 12-month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for measure, if occurring within above time period

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
99381, 99382, 99391, 99392	Z00.121, Z00.129, Z00.8, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	11, 22	1500

Measure 6 - Well Child Visits (3rd – 6th Years of Life)

Separate payment to the first rendering provider who successfully completes each of the annual well child visits at age 3, 4, 5, and 6.

- Payment for the first well-child visit in each year age group (3, 4, 5, or 6-year old's)

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
99382, 99383, 99392, 99393	Z00.121, Z00.129, Z00.8, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	11, 22	1500

Measure 7 - All Childhood Vaccines for Two Year Old's

For two-year-old children, pay an supplemental payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday. Therefore, the entire series must be received in order to receive credit for the final vaccination in the series. It is highly recommended that the provider submits claims to ensure appropriate credit for the vaccines.

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient

HPSJ Billing Requirements:

Vaccine Description	**# in Series**	**CPT**	**CPT Combo**
TDaP	4	90700	90723, 90698
IPV	3	90713	90723, 90698
Hep B	3	90740,90744, 90747, 90748	90723
HIB	3	90644-90648, 90748	90698
Pneumococcal	4	90670	
Rotavirus (2 dose)	2	90681	
Rotavirus (3 dose)	3	90680	
Influenza	2	90655,90657, 90662, 90673, 90685, 90868, 90688, 90689	

- Place of Service 11, 22 using Form Type 1500

Measure 8 - Blood Lead Screening

Supplemental payment to a provider for completing a blood lead screening in children up to two years of age.

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment
- Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses 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.

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
83655		11, 22	1500

Measure 9 - Dental Fluoride Varnish

Supplemental payment to provider if provides oral fluoride varnish application for children 6 months through 5 years of age.

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12-month period (quarterly)

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
99188 or D1206		11, 22	1500

Measure 10 - Controlling High Blood Pressure

Supplemental payment to provider for each event of adequately controlled blood pressure.

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents patient's controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day
- Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

• Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130)
  - CPT 3075F (systolic blood pressure less than 130-39)

• Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80)
  - CPT 3079F (diastolic blood pressure less than 80-89)

• Hypertension: – ICD-10: I10 (essential hypertension)

HPSJ Billing Requirements:

CPT/HCPCS	**Diagnosis**	**Place of Service**	**Form Type**
3074F, 3075F, 3078F, 3079F	I10	02, 11, 22	1500

Measure 11 - Diabetes Care

Supplemental payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age.

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3051F most recent HbA1c 7.0-7.9%
  - CPT 3052F most recent HbA1c 8.0-9.0%
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

HPSJ Billing Requirements:

CPT/HCPCS	**Diagnosis**	**Place of Service**	**Form Type**
3044F, 3051F, 3052F, 3046F		11, 22	1500

Measure 12 - Control of Persistent Asthma

Supplemental payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications.

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per "pay to group" or "provider" per patient
- Ages 5 to 64 at the time of the visit with persistent asthma and a ratio of controller medications to total asthma medications of 0.5 or greater

The Asthma Value Set includes the following diagnosis codes:

- J45.20 Mild intermittent asthma, uncomplicated
- J45.21 Mild intermittent asthma with (acute) exacerbation
- J45.22 Mild intermittent asthma with status asthmaticus
- J45.30 Mild persistent asthma, uncomplicated
- J45.31 Mild persistent asthma with (acute) exacerbation
- J45.32 Mild persistent asthma with status asthmaticus
- J45.40 Moderate persistent asthma, uncomplicated
- J45.41 Moderate persistent asthma with (acute) exacerbation
- J45.42 Moderate persistent asthma with status asthmaticus
- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation
- J45.52 Severe persistent asthma with status asthmaticus
- J45.901 Unspecified asthma with (acute) exacerbation
- J45.902 Unspecified asthma with status asthmaticus
- J45.909 Unspecified asthma, uncomplicated
- J45.990 Exercise induced bronchospasm
- J45.991 Cough variant asthma
- J45.998 Other asthma

(measure continued on next page)

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
99201-05, 99211-15, 99241-45	One of the DX listed above	11, 22	1500

Measure 13 - Tobacco Use Screening

Supplemental payment to provider for tobacco use screening or counseling provided to members 12 years and older.

- Payment to rendering provider for any of the following CPT codes: 99406 or 99407
- No more than one payment per provider per patient per year
- Must be an outpatient visit

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
99406 or 99407		11, 22	1500

Measure 14 - Adult Influenza ('Flu') Vaccine

Supplemental payment to a provider for ensuring influenza vaccine administered to members 19 years and older.

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
90630, 90654, 90655, 90656, 90657, 90658, 90660, 90662, 90673, 90674, 90682, 90685, 90686, 90688, 90689, 90756		11, 22	1500

Measure 15 - Screening for Clinical Depression

Supplemental payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older.

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

HPSJ Billing Requirements:

CPT/HCPCS	Modifier	Diagnosis	Place of Service	Form Type
G8431 or G8510			11, 22	1500

Measure 16 - Management of Depression Medication

Supplemental payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks.

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the Index Prescription Start Date (IPSD) -115 total days.
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

HPSJ Billing Requirements:

CPT/HCPCS	Diagnosis	Place of Service	Form Type
99201-05, 99211-15, 99241-45	One of the DX listed above	11, 22	1500

Measurement Years/Intake Periods:

Measure Year	Qualified Month in Measure Year	Qualified Intake Period (in months)
1	07/01/2019 to 12/31/2019	05/01/2018 to 04/30/2019
2	01/01/2020 to 12/31/2020	05/01/2019 to 04/30/2020
2	01/01/2021 to 12/31/2021	05/01/2020 to 04/30/2021
4	01/01/2022 to 6/30/2022	05/01/2021 to 04/30/2022

Example:

- ❖ In the Intake Period#1 (05/01/2018 to 04/30/2019), SAY the member's earliest antidepressant prescription is 09/01/2018. Therefore, the **IPSD=07/01/2018**

- In the above example **IPSD=07/01/2018** only when there are no pharmacy claims for an antidepressant medication after **03/18/2018** (which is **105 days** prior to **07/01/2018**).
- In the above example **IPSD=07/01/2018**. This member must have at least **84+ DAYSFILLS** for an antidepressant medication before **10/23/2018** (which is **114 days** from the **IPSD** date).

Definitions	
Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment Days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major Depression Diagnosis Code	ICD10: F32.0, F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9
Antidepressant Medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.

Measure 17 - Screening for Unhealthy Alcohol Use

Supplemental payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older.

- Payment to rendering provider for any the following CPT codes: G0442 or G0443 (equivalent payment for both codes)
- No more than one payment per provider per patient per year

HPSJ Billing Requirements:

CPT/HCPCS	Modifier	Diagnosis	Place of Service	Form Type
G0442 or G0443	59		11, 22	1500

Disclosures

Value Based Payments Program

For State Fiscal Year (SFY) 19-20 the Governor's Budget proposed state funds to be passed through Medi-Cal managed care health plans (MCPs) that would provide supplemental payments to providers for meeting Department of Health Care Services (DHCS) Value Based Payment (VBP) program specific measures aimed at improving care for certain high-cost or high-need populations. The supplemental payments will be focused on physicians that meet performance specific functions on metrics targeting areas such as behavioral health integration, chronic disease management, prenatal/post-partum care, and early childhood prevention. DCHS VBP payments will begin once funding from the State is received and will be retrospective to services rendered beginning 7/1/19. Based on the international COVID-19 public health crisis response there may be Department of Health Care Services directed changes to the VBP program.

Helpful Hints and Tips

- Providers will need to submit DHCS VBP measures on a CMS 1500 form
- Provider will receive one supplemental amount for each qualified measure, providing all requirements listed in this manual for each measure are documented appropriately
- The supplemental amount depends on the modifier billed for each qualifying claim and/or claim line
- Measurement year is equivalent to a calendar year

Applicable "Place of Service"

- Place of Service codes:
    - "11" Office Visit
    - "22" Outpatient Visit
    - "02" Remote Telehealth Visit
        - Measure 10 (always)
        - All other measures, where applicable, during the COVID-19 pandemic

Exclusion Criteria

Exclusions to DHCS VBP program participation criteria include the following:

- Providers **NOT** contracted with Health Plan of San Joaquin
- Services for beneficiaries with Medicare Part B will be excluded
- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics and Cost Based Reimbursement Clinics will be excluded from VBP payment
- Planned Parenthood

Enhanced Payment Factors - At Risk Add-On

At Risk members for the purpose of the DHCS VBP supplemental (add -on payment) are identified by using one of the following conditions when billed with the proper diagnosis code(s):

- **Substance Use Disorder** - F1x series
- **Serious Mental Illness**
    - Schizophrenia – F20-F29 series
    - Bipolar Disorder – F31 series
    - Major Depression – F33 series
- **Homelessness**
    - Homelessness – Z59.0
    - Inadequate housing – Z59.1

Note: Post utilization monitoring will be performed to ensure overuse of services is not occurring.

Payments

DHCS VBP payments will NOT be reflected in your normal check run cycles. Each month HPSJ will capture DHCS VBP qualified claims in finalized PAID status (regardless of an actual dollar amount paid on the claim) from the month prior and process for DHCS VBP payment. These payments will come monthly, in the same manner as The Prop 56 Supplemental payments.

Process for Identifying VBP Qualified Claims

Within the first week of each month we will run all claims finalized in the month prior through a screening process to identify DHCS VBP qualified claims (based on

each of the 17 measures). Qualified claims in a PAID status, regardless of an actual dollar amount paid; will pay out the add-on amounts.

Corrected Claim Submission

If you are re-billing a claim previously submitted and PAID (as a FFS or Capitated claim) in accordance with the guidelines above for the purpose of DHCS VBP reimbursement, please use a "7" in box 22 (Resubmission Code) of the claim form. This will help avoid unnecessary denials.

PDR Versus Corrected Claim

If you identify a qualified service was provided, but not billed:

- Submit a corrected claim
- DO NOT submit a dispute

If you received a VBP supplemental payment, that you believe qualified for the "at-risk" supplemental amount, please:

- Submit a dispute with supporting documentation
- DO NOT submit a corrected claim for at-risk only

Disputing "non-payment" of VBP Supplemental Payment

In the event you feel a claim qualified but did not receive a supplemental payment, please file a dispute through the normal dispute process. Please ensure the dispute indicates it is a VBP dispute and advise which measure you feel the claim should have qualified for (example: VBP – Measure 2).

Remember, for a claim to qualify for the VBP supplemental payment, the claim must:

- Meet all qualifying identifiers of the measure
- Be in a PAID status (*denied claims and/or claim lines do not qualify for the supplemental payment*)

VBP Claims Questions

If you have questions or concerns pertaining to the DHCS VBP program and/or claims you believe qualified for the DHCS VBP program, please contact the HPSJ Claims Department via email at: SUPPLEMENTALPAYMENTS@HPSJ.COM

Provider Dispute Resolution

Dispute Resolution procedure available at:
https://provider.hpsj.com/dre/default.aspx

Auditing

Health Plan of San Joaquin at any point may conduct random medical records auditing of DHCS VBP claims received as part of its ongoing Fraud, Waste, and Abuse Compliance Program.