



DHCS Value Based Payment (VBP) Program



Key Topics

1. About the Program
2. Measures: 1-17
3. Disclosures
4. Frequently Asked Questions (FAQs)



About the VBP 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

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



Proposed Value Based Payments Program Measures & Reimbursements

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

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

DHCS VBP Measures #1-17





Measure 1 - Prenatal Pertussis (“Tdap”) Vaccine

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 Tdap 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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Delivery Date Required Claim Remarks Field	Frequency
\$ 25.00	\$ 37.50	90715	O09 or Z34 series	11, 22	1500	No	▪ once per delivery per patient



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 Z1032 or outpatient visit code series 992xx CPT code on the encounter

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Additional Claim Requirements	Frequency
\$ 70.00	\$ 105.00	Z1032* , 99201-05, 99211-15, 99241-45	O09, or Z34 series	11, 22	1500	LMP in Box 14	▪ No more than one payment per pregnancy per plan

*preferred CPT code for measure



Measure 2 - Prenatal Care Visit

Additional HPSJ Billing Requirements:

- Patient must be seen by physician or nurse must be supervised by physician

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 (Early/Late) Care Visit

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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Additional Claim Requirements	Frequency
\$ 70.00	\$ 105.00	Z1038* , 99201-05, 99211-15, 99241-45	Z39.2	11, 22	1500	Delivery Date in Box 15	▪ No more than one payment per time period (Early or Late)

*preferred CPT code for measure



Measure 3 - Postpartum (Early/Late) Care Visit

Additional HPSJ Billing Requirements:

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

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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 25.00	\$ 37.50	Valid contraceptive code (refer to next page for link to codes)		11, 22	1500	▪ No more than one payment per delivery



Measure 4 - Postpartum Birth Control

Additional HPSJ Billing Requirements:

- 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>

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 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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 70.00	\$ 105.00	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	<ul style="list-style-type: none"> ▪ Three payments per child are eligible for measure, if occurring within valid timeframes

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)

Add-On Amount	At-Risk Add-On ¹ Amount	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 70.00	\$ 105.00	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	<ul style="list-style-type: none"> ▪ One payment per child per year per first well-child visit for ages 3-6



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.

- 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

Add-On Amount	At-Risk Add-On Amount ¹	Vax Desc.	CPT Codes	CPT Combo	# in Series
\$25.00	\$37.50	TDaP	90700	90723, 90698	4
\$25.00	\$37.50	IPV	90713	90723, 90698	3
\$25.00	\$37.50	Hep B	90740,90744, 90747, 90748	90723	3
\$25.00	\$37.50	HIB	90644-90648, 90748	90698	3
\$25.00	\$37.50	Pneumococcal	90670		4
\$25.00	\$37.50	Rotavirus (2 dose)	90681		2
\$25.00	\$37.50	Rotavirus (3 dose)	90680		3
\$25.00	\$37.50	Influenza	90655,90657, 90662, 90673, 90685, 90868, 90688, 90689		2



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.

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 25.00	\$ 37.50	83655		11, 22	1500	<ul style="list-style-type: none">▪ Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday

Measure 8 – Blood Lead Screening



Additional HPSJ Billing Requirements:

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.



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)

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 25.00	\$ 37.50	99188 or D1206		11, 22	1500	▪ Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six

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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 40.00	\$ 60.00	3074F, 3075F, 3078F, 3079F	I10 (essential hypertension)	02, 11, 22	1500	<ul style="list-style-type: none"> ▪ Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents patients’-controlled blood pressure

Measure 10 – Controlling High Blood Pressure



Additional HPSJ Billing Requirements:

N/A

Other claim related specifications:

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)



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%
- 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.

Add-On Amount (use modifier: "SE")	At-Risk Add-On Amount ¹ (use modifier: "SK")	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 80.00	\$ 120.00	3044F, 3051F, 3052F, 3046F		11, 22	1500	▪ No more than four payments per year



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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 40.00	\$ 60.00	99201-05, 99211-15, 99241-45	One of the DX from Asthma Value Set	11, 22	1500	▪ Each provider is paid once per year per “pay to group” or “provider” per patient

Measure 12 – Control of Persistent Asthma



Additional HPSJ Billing Requirements:

N/A

Other claim related specifications:

▪ 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 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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Diagnosis	Place of Service	Form Type	Frequency
\$ 25.00	\$ 37.50	99406 or 99407		11, 22	1500	▪ No more than one payment per provider per patient per year

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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	DX	Place of Service	Form Type	Frequency
\$ 25.00	\$ 37.50	90630, 90654, 90655, 90656, 90657, 90658, 90660, 90662, 90673, 90674, 90682, 90685, 90686, 90688, 90689, 90756		11, 22	1500	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)



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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	DX	Place of Service	Form Type	Frequency
\$ 50.00	\$ 75.00	G8431 or G8510		11, 22	1500	<ul style="list-style-type: none">▪ No more than one payment per provider per patient per year

Measure 15 – Screening for Clinical Depression



Additional HPSJ Billing Requirements:

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.

Other claim related specifications:

- N/A



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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	DX	Form Type	Frequency
\$ 40.00	\$ 60.00	99201-05, 99211-15, 99241-45	Major depression DX	1500	▪ No more than one Effective Acute Phase Treatment per year

Measure 16 – Management of Depression Medication



Additional HPSJ Billing Requirements:

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
3	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

**note: measure year dependent on DHCS budgetary approvals*

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).

[measure continued on next page]

Measure 16 – Management of Depression Medication



Additional HPSJ Billing Requirements:

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/ .

Other claim related specifications:

- N/A



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

Add-On Amount	At-Risk Add-On Amount ¹	CPT Codes	Modifier	DX	Place of Service	Form Type	Frequency
\$ 50.00	\$ 75.00	G0442 or G0443	59 (per NCCI guidelines)		11, 22	1500	▪ No more than one payment per provider per patient per year



Frequently Asked Questions (FAQs)

Q: The service is delivered / documented in the medical record, but no encounter is submitted or received?

A: A claim must be received, and qualifying measure line paid in order to qualify.

Q: What if I have a VBP or Prop 56 claims question?

A: If you have a claims questions please utilize the following email address:

supplementalpayments@hpsj.com

Q: I believe that a claim should have qualified for a VBP supplemental payment?

A: 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's a VBP dispute and advise which measure you feel the claim should have qualified for (example : VBP – Measure 2). As a reminder, in order for a claim to qualify for the VBP supplemental payment, the claim must: (a) Meet all qualifying identifiers of the measure and (b) Be in a PAID status (*denied claims and/or claim lines do not qualify for the supplemental payment*)



DHCS VBP Program Disclosures

- Helpful hints
- Program exclusions
- Enhanced Supplemental Payments
- Payments
- Corrected Claims
- Auditing
- Provider Dispute Resolution





Helpful Hints and Tips

1. Providers will need to submit DHCS VBP measures on a CMS 1500 form
2. Provider will receive one supplemental amount for each qualified measure, providing all requirements listed in this manual for each measure are documented appropriately
3. Measurement year is equivalent to a calendar year



Program's Exclusions

Exclusions to DHCS VBP program participation criteria include the following:

- a) Providers **NOT** contracted with Health Plan of San Joaquin
- b) Beneficiaries with Medicare Part B
- c) Encounters occurring at Federally Qualified health Centers (FQHCs)
- d) Rural Health Clinics
- e) American Indian Health Clinics
- f) Cost Based Reimbursement Clinics will be excluded from payment
- g) Planned Parenthood



Applicable “Place of Service”

A. 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



“ At Risk ” Supplemental Payments

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):

A. Substance Use Disorder - F1x series

B. Serious Mental Illness

- Schizophrenia – F20-F29 series
- Bipolar Disorder – F31 series
- Major Depression – F33 series

C. Homelessness

- Homelessness – Z59.0
- Inadequate housing – Z59.1

Claims without this information will not qualify for the At-Risk add-on, please submit a dispute with supporting documentation. DO NOT submit a corrected claim for at-risk only.

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
- Initial VBP payments on 8/21/20 for measures: 1-6, 8-9, 11, 13-15, 17

Note: Some measures—e.g. Measure 12, Measure 16—will be paid less frequently due to measurement requirements



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.



Provider Dispute Resolution

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 description indicates it's a VBP dispute and advise which measure you feel the claim should have qualified for (example : VBP – Measure 2).

As a reminder, 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*)

Dispute Resolution procedure available at:

<https://provider.hpsj.com/dre/default.aspx>



PDR vs 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



Audit/Integrity Component

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.



1. HPSJ “DHCS Value Based Payments website:
 - HPSJ.com> “I am a provider”> select banner for Learn more for “DHCS Value Based Payments Program”
 - <https://www.hpsj.com/value-based-payments/>
 - Use this site for obtaining DHCS VBP materials including:
 - Provider Handbook, Cheat Sheet, FAQs (upcoming), and communication archive
2. 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

THANK YOU

