VALUE-BASED PAYMENTS

PROGRAM GUIDE

Contact: ValueBasedPaymentsProgram@iehp.org

Published: October 16, 2023

TABLE OF CONTENTS

Program Overview

This program guide provides an overview of Inland Empire Health Plan's (IEHP) Value-Based Payments (VBP) Program for Providers. The VBP Program is funded by Proposition 56 and was created by the California Department of Health Care Services (DHCS) to encourage Network Providers to deliver key health care services that improve quality of care to Medi-Cal beneficiaries. In this first year of the VBP Program, IEHP will provide incentive payments to Providers that render specific health care services aimed at improving the quality of care for IEHP Members.

For more information on the DHCS VBP Program, visit the DHCS website at ***https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx.***
For additional information on how IEHP is implementing the DHCS VBP Program, visit the IEHP website at ***www.iehp.org***, or email the Quality Team at ***ValueBasedPaymentsProgram@iehp.org***, or call the IEHP Provider Relations Team at **(909) 890-2054**.

Program Eligibility and Participation

All IEHP Medi-Cal Network Providers are automatically eligible to participate in the DHCS VBP Program. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Individual Health Care Plans (IHCPs) and Cost Based Reimbursement Clinics (CBRCs) are not eligible for VBP Program participation.

Financial Overview

The VBP Program will reward Providers through a pay-per-event payment process. All services must be captured through an encounter/claim for payment disbursement. Providers must report all encounters through normal reporting channels with their assigned IPA. IEHP is required to submit all VBP Program encounters to DHCS for reporting purposes.

IEHP will not pay for any services performed by a Provider who is not eligible to receive payment through this program.

Subject to federal approval, the projected value of the directed payments will be accounted for in IEHPs certified, risk-based capitation rates.

NOTE: IEHP Cal MediConnect Members (Dual Choice) will be excluded from payment for the VBP services.

VBP Payment Schedule – Performance Period (July 2020- June 2022)		
DATE OF SERVICE:	**CLAIM PAID/ ENCOUNTER RECEIVED:**	**PAYMENT DATE:**
7/1/20 - 5/31/21	6/30/21	7/20/21
8/1/20 - 6/30/21	7/31/21	8/20/21
9/1/20 - 7/31/21	8/31/21	9/20/21
10/1/20 - 8/31/21	9/30/21	10/20/21
11/1/20 - 9/30/21	10/31/21	11/20/21
12/1/20 - 10/31/21	11/30/21	12/20/21
1/1/21 - 11/30/21	12/31/21	1/20/22
2/1/21 - 12/31/21	1/31/22	2/20/22
3/1/21 - 1/31/22	2/28/22	3/20/22
4/1/21 - 2/28/22	3/31/22	4/20/22
5/1/21 - 3/31/22	4/30/22	5/20/22
6/1/21 - 4/30/22	5/31/22	6/20/22
7/1/21 - 5/31/22	6/30/22	7/20/22
8/1/21 - 6/30/22	7/31/22	8/20/22

NOTE: Timeliness of data submission can be modified on a case-by-case scenario.

APPENDIX 1: Program Services

Appendix 1 provides a list of 17 services included in the VBP Program. These services have been categorized into four domains: Chronic Disease Management, Early Childhood, Prenatal/Postpartum Care, and Behavioral Health Integration.

Most services included in the VBP Program domains align to Healthcare Effective Data and Information Set (HEDIS) measures that are based on specifications published by the National Committee for Quality Assurance (NCQA). Other services support additional quality performance measures that are part of the CMS Child and Adult Core Measure Sets.

Below is a list of the services included in the VBP Program by domain.

Chronic Disease Management

- Controlling High Blood Pressure
- Diabetes Care
- Controlling Persistent Asthma
- Tobacco Use Screening
- Adult Influenza Vaccine

Early Childhood

- Well-Child Visits in First 15 Months of Life
- Well-Child Visits in 3rd – 6th Years of Life
- All Childhood Vaccines for Two Year Olds
- Blood Lead Screening
- Dental Fluoride Varnish

Prenatal/Postpartum Care

- Prenatal Pertussis Vaccine
- Prenatal Care Visit
- Postpartum Care Visits
- Postpartum Birth Control

Behavioral Health Integration

- Screening for Clinical Depression
- Management of Depression Medication
- Screening for Unhealthy Alcohol Use

APPENDIX 2: Financial Earnings

All IEHP Medi-Cal network Providers are automatically eligible to participate in the DHCS VBP Program. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Individual Health Care Plans (IHCPs) and Cost Based Reimbursement Clinics (CBRCs) are not eligible for VBP Program participation.

Value-Based Payment Per Service			
DOMAIN	**SERVICE**	**AMOUNT**	**AT-RISK AMOUNT***
Prenatal/Postpartum Care	Prenatal Pertussis Vaccine	$ 25.00	$ 37.50
Prenatal/Postpartum Care	Prenatal Care Visit	$ 70.00	$ 105.00
Prenatal/Postpartum Care	Postpartum Care Visits	$ 70.00	$ 105.00
Prenatal/Postpartum Care	Postpartum Birth Control	$ 25.00	$ 37.50
Early Childhood	Well Child Visits in First 15 Months of Life	$ 70.00	$ 105.00
Early Childhood	Well Child Visits in 3rd- 6th Years of Life	$ 70.00	$ 105.00
Early Childhood	All Childhood Vaccines for Two Year Olds	$ 25.00	$ 37.50
Early Childhood	Blood Lead Screening	$ 25.00	$ 37.50
Early Childhood	Dental Fluoride Varnish	$ 25.00	$ 37.50
Chronic Disease Management	Controlling High Blood Pressure	$ 40.00	$ 60.00
Chronic Disease Management	Diabetes Care	$ 80.00	$ 120.00
Chronic Disease Management	Control of Persistent Asthma	$ 40.00	$ 60.00
Chronic Disease Management	Tobacco Use Screening	$ 25.00	$ 37.50
Chronic Disease Management	Adult Influenza Vaccine	$ 25.00	$ 37.50
Behavioral Health Integration	Screening for Clinical Depression	$ 50.00	$ 75.00
Behavioral Health Integration	Management of Depression Medication	$ 40.00	$ 60.00
Behavioral Health Integration	Screening for Unhealthy Alcohol Use	$ 50.00	$ 75.00

*At-Risk Denotes Serious Mental Illness, Substance Use Disorder, or Homeless Conditions. For a listing of the ICD-10 codes used to identify these conditions, please see the IEHP VBP Website: ***https://iehp.org/en/providers/p4p-prop56-gemt?target=prop56-vbp***

APPENDIX 3: Services Overview

Domain: Chronic Disease Management

Controlling High Blood Pressure ($40)

Supports CMS Adult Core Set Measure

Service Description: Incentive payment to Provider for each event of adequately controlled blood pressure for Members 18 to 85 years of age who are seen by the Provider for the treatment of hypertension.

- Payment to each rendering Provider for a non-urgent outpatient, or remote monitoring event, that documents 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 (see code options below)
- Member must be between the ages of 18 and 85 at the time of the visit

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid for each adequately controlled blood pressure encounter in the year.

Codes to Identify Blood Pressure Screening			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Blood Pressure Screening	CPT-CAT-II	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM), (HTN, CKD, CAD)
Blood Pressure Screening	CPT-CAT-II	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)
Blood Pressure Screening	CPT-CAT-II	3078F	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT-CAT-II	3079F	Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)

Codes to Identify Hypertension			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Blood Pressure Screening	ICD-10	I10	Essential (primary) hypertension

Diabetes Care ($80)

Supports CMS Adult Core Set Measure

Service Description: Incentive payment to Provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that includes the results of the tests 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 includes the results for Members 18 to 75 years of age using one of the following codes below
- No more than four payments per year
- Diabetes HbA1c tests must be at least 60 days apart
- Diabetes diagnosis is not required to allow for screening of Members at increased risk of diabetes

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid up to four times in the year for HbA1c tests completed per Member per year.

Codes to Identify HbA1c Tests			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
HbA1c Test	CPT-CAT-II	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
HbA1c Test	CPT-CAT-II	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
HbA1c Test	CPT-CAT-II	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
HbA1c Test	CPT-CAT-II	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)

Control of Persistent Asthma ($40)

Supports CMS Child and Adult Core Set Measure

Service Description: Incentive payment to Provider for each Member between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications.

- Payment to each Provider who prescribed controller asthma medications during the year for Members 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 Member
- Members must be between the ages of 5 and 64 years at the time of the visit

Payment Description: In-network Providers who prescribe a controller medication for the eligible population mentioned above will be paid once per Member per year.

Asthma Value Set Codes			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Persistent Asthma	ICD-10	J45.20	Mild intermittent asthma, uncomplicated
Persistent Asthma	ICD-10	J45.21	Mild intermittent asthma with (acute) exacerbation
Persistent Asthma	ICD-10	J45.22	Mild intermittent asthma with status asthmaticus
Persistent Asthma	ICD-10	J45.30	Mild persistent asthma, uncomplicated
Persistent Asthma	ICD-10	J45.31	Mild persistent asthma with (acute) exacerbation
Persistent Asthma	ICD-10	J45.32	Mild persistent asthma with status asthmaticus
Persistent Asthma	ICD-10	J45.40	Moderate persistent asthma, uncomplicated
Persistent Asthma	ICD-10	J45.41	Moderate persistent asthma with (acute) exacerbation
Persistent Asthma	ICD-10	J45.42	Moderate persistent asthma with status asthmaticus
Persistent Asthma	ICD-10	J45.50	Severe persistent asthma, uncomplicated
Persistent Asthma	ICD-10	J45.51	Severe persistent asthma with (acute) exacerbation
Persistent Asthma	ICD-10	J45.52	Severe persistent asthma with status asthmaticus
Persistent Asthma	ICD-10	J45.901	Unspecified asthma with (acute) exacerbation
Persistent Asthma	ICD-10	J45.902	Unspecified asthma with status asthmaticus
Persistent Asthma	ICD-10	J45.909	Unspecified asthma, uncomplicated
Persistent Asthma	ICD-10	J45.990	Exercise-induced bronchospasm
Persistent Asthma	ICD-10	J45.991	Cough variant asthma
Persistent Asthma	ICD-10	J45.998	Other asthma

Asthma Controller Medications			
DESCRIPTION	**PRESCRIPTION**		
Anti-Asthmatic Combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody Inhibitors	• Omalizumab		
Anti-interleukin-5	• Mepolizumab	• Reslizumab	
Inhaled Steroid Combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Fluticasone-vilanterol • Mometasone-formoterol	
Inhaled Corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	
Leukotriene Modifiers	• Montelukast	• Zafirlukast	• Zileuton
Methylxanthines	• Dyphylline	• Theophylline	

Asthma Reliever Medications		
DESCRIPTION	**PRESCRIPTION**	
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol

Tobacco Use Screening ($25)

Supports NCQA

Service Description: Incentive payment to Provider for tobacco use screening or counseling provided to Members 12 years of age and older.

- Payment to the rendering Provider for any of the following CPT codes listed below
- No more than one payment per Provider per Member per year
- Must be an outpatient visit

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid one payment per Member per year for tobacco use screening.

Codes to Identify Tobacco Use Screening			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Tobacco Use Screening	CPT	99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
Tobacco Use Screening	CPT	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
Tobacco Use Screening	CPT-CAT-II	4004F	Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (PV, CAD)
Tobacco Use Screening	CPT-CAT-II	1036F	Current tobacco non-user (CAD, CAP, COPD, PV) (DM) (IBD)

Adult Influenza Vaccine ($25)

Supports the American Medical Association Physician Consortium for Performance Improvement Measure

Service Description: Incentive payment to the Provider for ensuring influenza vaccine was administered to Members 19 years of age and older.

- Payment to rendering or prescribing Provider for up to two flu shots given throughout the year for Members 19 years of age and older at the time of the flu shot
- No more than one payment per Member 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

Payment Description: One in-network Provider who administers the influenza vaccine will be paid one payment per Member per quarter. One payment in Quarter One (January – March) and one payment in Quarter Four (October – December) of the calendar year.

Domain: Early Childhood

Well-Child Visits in First 15 Months of Life ($70)

Supports CMS Child Core Set Measure

Service Description: Separate incentive 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 of age.

- 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-Child Visit between 172 and 263 days of life
    - 9-month visit: the first Well-Child Visit between 264 days and 355 days of life
    - 12-month visit: the first Well-Child Visit between 356 and 447 days of life
- Three payments per child are eligible for payment
- Any of the following codes below meet the Well-Child Visit definition

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid up to three payments per Member per year for Well-Child 6th, 7th and 8th visits.

Codes to Identify Well-Care Visits			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Well-Care Visit	CPT	99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
Well-Care Visit	CPT	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
Well-Care Visit	CPT	99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
Well-Care Visit	CPT	99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)

Codes to Identify Well-Care Visits *(continued)*			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Well-Care Visit	CPT	99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
Well-Care Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
Well-Care Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
Well-Care Visit	ICD-10CM	Z00.110	Health examination for newborn under 8 days old
Well-Care Visit	ICD-10CM	Z00.111	Health examination for newborn 8 to 28 days old
Well-Care Visit	ICD-10CM	Z00.121	Encounter for routine child health examination with abnormal findings
Well-Care Visit	ICD-10CM	Z00.129	Encounter for routine child health examination without abnormal findings
Well-Care Visit	ICD-10CM	Z76.1	Encounter for health supervision and care of foundling
Well-Care Visit	ICD-10CM	Z76.2	Encounter for health supervision and care of other healthy infant and child

Well-Child Visits in 3rd- 6th Years of Life ($70)

Supports CMS Child Core Set Measure

Service Description: Separate payment to each rendering Provider for successfully completing each of the annual Well-Child Visits at ages 3, 4, 5, and 6 years.

- Payment for the first Well-Child Visit in each year age group (3, 4, 5, or 6 years old)
- Any of the following codes below meet the Well-Child Visit definition

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid one payment per Member age group per year.

Codes to Identify Well-Care Visits			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Well-Care Visit	CPT	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
Well-Care Visit	CPT	99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
Well-Care Visit	CPT	99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
Well-Care Visit	CPT	99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
Well-Care Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
Well-Care Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
Well-Care Visit	ICD-10CM	Z00.121	Encounter for routine child health examination with abnormal findings
Well-Care Visit	ICD-10CM	Z00.129	Encounter for routine child health examination without abnormal findings

Codes to Identify Well-Care Visits *(continued)*			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Well-Care Visit	ICD-10CM	Z02.5	Encounter for examination for participation in sports
Well-Care Visit	ICD-10CM	Z76.1	Encounter for health supervision and care of foundling
Well-Care Visit	ICD-10CM	Z76.2	Encounter for health supervision and care of other healthy infant and child

All Childhood Vaccines for Two Year Olds ($25)

Supports CMS Child Core Set Measure

Service Description: Incentive payment to a Provider when last dose in any of the multiple dose vaccine series is given on or before the Member's second birthday.

- Payment to each rendering Provider for each final vaccine administered in a series to children turning 2 years old 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
- Provider may receive up to seven payments per year per Member
- A two-year look back is required for each Member to capture the series of vaccines and identify the last vaccine in the series
- Provider must submit all antigens given to Member through encounter data reporting AND into the California Immunization Registry (CAIR2). Determination of the series given will be based on the count of antigens submitted in encounter data and CAIR2 systems.

Payment Description: In-network Providers who administer the final vaccine in a series can be paid up to seven times per Member per year.

CHILDHOOD IMMUNIZATION CODE SET:			
ANTIGEN	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
DTaP	CPT	90698	Diphtheria Tetanus Toxoids and Acellular Pertussis Vaccine and Hemophilus Influenza B Vaccine and Activated Poliovirus Vaccine, (DTaP-IPV/Hib), for Intramuscular Use
DTaP	CPT	90700	Diphtheria Tetanus Toxoids and Acellular Pertussis Vaccine (DTaP) for Intramuscular Use
DTaP	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), for Intramuscular Use
IPV	CPT	90698	Diphtheria Tetanus Toxoids and Acellular Pertussis Vaccine and Hemophilus Influenza B Vaccine and activated poliovirus vaccine, (DTaP-IPV/HiB), for Intramuscular Use
IPV	CPT	90713	Poliovirus Vaccine Inactivated (IPV) for Subcutaneous Use
IPV	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), for Intramuscular Use
HiB	CPT	90644	Meningococcal Conjugate Vaccine, Serogroups C & Y and Hemophilus Influenzae Type B Vaccine (HiB-mency), four dose schedule, when administered to children six weeks-18 months of age, for Intramuscular Use
HiB	CPT	90647	Hemophilus Influenza B Vaccine (HiB) Prp-omp Conjugate (Three Dose Schedule) for Intramuscular Use
HiB	CPT	90648	Hemophilus Influenza B Vaccine (HiB) prp-t Conjugate (Four Dose Schedule) for Intramuscular Use
HiB	CPT	90698	Diphtheria Tetanus Toxoids And Acellular Pertussis Vaccine and Hemophilus Influenza B Vaccine and activated poliovirus vaccine, (DTaP-IPV/HiB), for Intramuscular Use
HiB	CPT	90748	Hepatitis B and Hemophilus Influenza B Vaccine (HepB-HiB) for Intramuscular Use
HepB	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated Poliovirus Vaccine (DTaP-HepB-IPV), for Intramuscular Use
HepB	CPT	90740	Hepatitis B Vaccine Dialysis or Immunosuppressed Patient Dosage (Three Dose Schedule) for Intramuscular Use

CHILDHOOD IMMUNIZATION CODE SET *(continued)*:			
ANTIGEN	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
HepB	CPT	90744	Hepatitis B Vaccine Pediatric/adolescent Dosage (Three Dose Schedule) for Intramuscular Use
HepB	CPT	90747	Hepatitis B Vaccine Dialysis or Immunosuppressed Patient Dosage (Four Dose Schedule) for Intramuscular Use
HepB	CPT	90748	Hepatitis B and Hemophilus Influenza B Vaccine (HepB-HiB) for Intramuscular Use
HepB	HCPCS	G0010	Administration of Hepatitis B Vaccine
PCV	CPT	90670	Pneumococcal Conjucate Vaccine 13 Valent for Intramuscular Use
PCV	HCPCS	G0009	Administration of Pneumococcal Vaccine
Rotavirus - Two Dose	CPT	90681	Rotavirus Vaccine Human Attenuated Two Dose Schedule Live for Oral Use
Rotavirus - Three Dose	CPT	90680	Rotavirus Vaccine Tetravalent Live for Oral Use
Flu	CPT	90655	Influenza Virus Vaccine, Trivalent (IIV3), Split Virus, Preservative Free, 0.25ml Dosage, for Intramuscular Use
Flu	CPT	90657	Influenza Virus Vaccine, Trivalent (IIV3), Split Virus, 0.25 mL Dosage, for Intramuscular Use
Flu	CPT	90661	Influenza Virus Vaccine Derived from Cell Cultures Subunit Preservative And Antibiotic Free for Intramuscular Use
Flu	CPT	90673	Influenza Virus Vaccine Trivalent Derived from Recombinant DNA (RIV3) Hemagglutinin (HA) Protein Only Preservative and Antibiotic
Flu	CPT	90685	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus Preservative Free, 0.25 mL Dosage, for Intramuscular Use
Flu	CPT	90686	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus Preservative Free, 0.5 mL Dosage, for Intramuscular Use
Flu	CPT	90687	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus, 0.25 mL Dosage, for Intramuscular Use
Flu	CPT	90688	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus, 0.5 mL Dosage, for Intramuscular Use
Flu	HCPCS	G0008	Administration of Influenza Virus Vaccine

Blood Lead Screening ($25)

Supports HEDIS

Service Description: Incentive payment to a Provider for completing a blood lead screening in children up to 2 years of age.

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

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid.

Codes to Identify Blood Lead Screening			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Blood Lead Screening	CPT	83655	Lead

Dental Fluoride Varnish ($25)

Supports the American Dental Association (ADA)

Service Description: Incentive payment to Provider when oral fluoride varnish application is rendered to children ages 6 months through 5 years.

- Payment to each rendering Provider for each occurrence of dental fluoride varnish for children younger than 6 years old *(See codes below)*
- Payment for the first four visits in a 12-month period

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes can be paid up to four times per Member per year.

Codes to Identify Fluoride Varnish			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Fluoride Varnish	CPT	99188	Application of topical fluoride varnish by a Physician or other qualified health care professional
Fluoride Varnish	CDT	D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

Domain: Prenatal/Postpartum Care

Prenatal Pertussis Vaccine ($25)

Supports HEDIS

Service Description: Incentive 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 with an ICD-10 code for pregnancy supervision (O09 or Z34 series) anytime in the measurement year *(See code below)*
- Payment may occur once per delivery per Member
- Multiple births: Women who have had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes can be paid up to two times per Member per year.

Codes to Identify Pertussis Vaccine			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Tdap Vaccine	CPT	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use

Prenatal Care Visit ($70)

Supports CMS Child Core Set Measure

Service Description: Incentive payment to the Provider for ensuring that pregnant women come in for an initial prenatal visit.

- Payment to rendering Provider for provision of prenatal and preventive care on a routine, outpatient basis – not intended for emergent event
- No more than one payment per pregnancy per Plan after enrollment with IEHP
- Payment for the first visit for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code pregnancy supervision with a 992xx CPT code on the encounter *(See codes below)*
- DHCS understands that Members may change Providers and Health Plans during a pregnancy. Therefore, the first visit that occurs in a specific Plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes can be paid one time per pregnancy per Plan after enrollment with IEHP.

Codes to Identify Prenatal Visit			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Prenatal Visit	ICD-10	O09	Supervision of high-risk pregnancy
Prenatal Visit	ICD-10	Z34	Encounter for supervision of normal pregnancy

Postpartum Care Visits ($70)

Supports CMS Child Core Set Measure

Service Description: Incentive payment for completion of recommended postpartum care visits after a woman gives birth.

- Payment to rendering Provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering Provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- 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 the use of 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.

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid one time per Member per year for an early postpartum visit, and one time per year per Member for a late postpartum visit.

Codes to Identify Postpartum Visit			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Postpartum Visit	ICD-10	Z39.2	Encounter for routine postpartum follow-up

Postpartum Birth Control ($25)

Supports CMS Child Core Set Measure

Service Description: Incentive 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 regardless of delivery outcome
- Delivery date is required for this service to determine the timing of the postpartum visit

Payment Description: In-network Providers can be paid one time per Member per delivery.

- IEHP will determine payment based on filled prescriptions. No additional reporting is required for payment.

Domain: Behavioral Health Integration

Screening for Clinical Depression ($50)

Supports CMS Core Set Measure

Service Description: Incentive payment to Provider for conducting screening for clinical depression (using a standardized screening tool) for Members 12 years and older.

- Payment to rendering Provider for any of the following CPT codes for screening for clinical depression *(See codes below)*
- No more than one payment per Provider per Member per year
- Must be an outpatient visit

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes can be paid up to one time per Member per year.

Codes to Identify Depression Screening			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Depression Screening	HCPCS	G8431	Screening for depression is documented as being positive and a follow-up plan is documented
Depression Screening	HCPCS	G8510	Screening for depression is documented as negative, a follow-up plan is not required

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the Member population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**: Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2

- **Adult Screening Tools (18 years and older)**: Patient Health Questionnaire (PHQ-9 or PHQ-2), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Management of Depression Medication ($40)

Supports CMS Adult Core Set Measure

Service Description: Incentive payment to Provider for each Member 18 years and older with a new 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 Provider for the Effective Acute Phase Treatment for Members 18 years and older with a new diagnosis of major depression
- Effective Treatment is defined as Member remaining on anti-depressant medication for at least 84 days during 12 weeks of treatment beginning on the Index Prescription Start Date (IPSD) through 114 days after the IPSD (115 total days)
- Payment to each prescribing Provider that prescribed anti-depressant medication during Effective Acute Phase Treatment per year
- No more than one Effective Treatment per year

Payment Description: In-network Providers who prescribe anti-depressant medications during the Effective Treatment period will be paid.

- IEHP will determine payment based on filled prescriptions. No additional reporting is required for payment.

Management of Depression Medication - Timeline						
MONTH RUN	**INTAKE START**	**INTAKE END**	**PRESCRIPTION START DATE**	**PRESCRIPTION END DATE**	**TREATMENT DAYS START**	**TREATMENT DAYS END**
1/1/21	7/1/19	6/30/20	7/1/19	6/30/20	7/1/19	10/22/20
2/1/21	8/1/19	7/31/20	8/1/19	7/31/20	8/1/19	11/22/20
3/1/21	9/1/19	8/31/20	9/1/19	8/31/20	9/1/19	12/23/20
4/1/21	10/1/19	9/30/20	10/1/19	9/30/20	10/1/19	1/22/21
5/1/21	11/1/19	10/31/20	11/1/19	10/31/20	11/1/19	2/22/21
6/1/21	12/1/19	11/30/20	12/1/19	11/30/20	12/1/19	3/24/21
7/1/21	1/1/20	12/31/20	1/1/20	12/31/20	1/1/20	4/24/21
8/1/21	2/1/20	1/31/21	2/1/20	1/31/21	2/1/20	5/25/21
9/1/21	3/1/20	2/28/21	3/1/20	2/28/21	3/1/20	6/22/21
10/1/21	4/1/20	3/31/21	4/1/20	3/31/21	4/1/20	7/23/21
11/1/21	5/1/20	4/30/21	5/1/20	4/30/21	5/1/20	8/22/21
12/1/21	6/1/20	5/31/21	6/1/20	5/31/21	6/1/20	9/22/21
1/1/22	7/1/20	6/30/21	7/1/20	6/30/21	7/1/20	10/22/21
2/1/22	8/1/20	7/31/21	8/1/20	7/31/21	8/1/20	11/22/21
3/1/22	9/1/20	8/31/21	9/1/20	8/31/21	9/1/20	12/23/21
4/1/22	10/1/20	9/30/21	10/1/20	9/30/21	10/1/20	1/22/22
5/1/202	11/1/20	10/31/21	11/1/20	10/31/21	11/1/20	2/22/22
6/1/22	12/1/20	11/30/21	12/1/20	11/30/21	12/1/20	3/24/22

Screening for Unhealthy Alcohol Use ($50)

Supports the National Quality Forum Measure

Service Description: Incentive payment to Provider for screening for unhealthy alcohol use using standardized screening tool for Members 18 years and older.

- Payment to rendering Provider for any of the CPT codes listed below
- No more than one payment per Provider per Member per year

Payment Description: In-network Providers who bill the following codes through normal encounter data or claims billing processes will be paid for one time per Member per year.

Codes to Identify Substance Use			
SERVICE	**CODE TYPE**	**CODE**	**CODE DESCRIPTION**
Substance Use Screening	CPT	99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
Substance Use Screening	CPT	99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
Substance Use Screening	HCPCS	H0049	Alcohol and/or drug screening
Substance Use Screening	HCPCS	G0442	Annual alcohol misuse screening, 15 minutes
Substance Use Screening	HCPCS	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Substance Use Screening	HCPCS	H0050	Alcohol and/or drug services, brief intervention, per 15 minutes

APPENDIX 4: Additional Program Conditions

- The payments issued to eligible Providers in the Value Based Payments Program will be in addition to other payments that the Provider would normally receive from IEHP, or IEHP Subcontractors. Services performed after June 30, 2022, are not eligible to receive payments in the Value Based Payments Program.

- Providers must meet the following to be eligible to participate in the Value Based Payments Program:
    - Must have a Medi-Cal contract with IEHP.
    - Network Provider must have an individual National Provider Identifier (NPI) and Practices within their practice scope.
    - Providers participating in the Value Based Payments Program must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guide" that can be found on the DHCS Directed Payment-Proposition 56 website.
        - NOTE: The IEHP Value Based Payments Program Guide has been written based on the DHCS Technical Specifications and closely aligns with the requirements in the DHCS Value Based Payment Program.

- IEHP will ensure the payments related to the DHCS Value Based Payments Program will be made in accordance with the timely payment standards in the contract for clean claims or acceptable encounters that are received by IEHP, or IEHP Subcontractor, no later than one year after the date of service.

- IEHP has the obligation to communicate and provide clear policies and procedures to IEHP Network Providers with respect to the Plan's claims or encounter submission processes, including what constitutes to a clean claim or an acceptable encounter.
    - If a Network Provider does not adhere to IEHP claims and encounter policies and procedures, IEHP is not required to distribute payments for claims or encounters submitted one year following the date of service.
        - These timing requirements can be waived through an agreement in writing between IEHP (or IEHP Subcontractors) and the Network Provider.

- IEHP, or IEHP Subcontractors, must not pay any amount for any services or items, other than Emergency Services, to a Provider who is not eligible to receive incentive payments in the Value Based Payments Program.
    - This prohibition must apply to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS failed to suspend payment, while pending an investigation of a credible allegation of fraud.

- IEHP must have a formal procedure for the acceptance, acknowledgement, and resolution of Network Provider grievances/disputes related to the processing or non-payment of a directed payment required by DHCS.

- IEHP must have a process to communicate the requirements of the DHCS Value Based Payments Program to Network Providers and must, at a minimum, include a description of the minimum requirements for a qualifying service, how the payments will be processed, how to file a dispute/grievance, and how to identify the responsible payer.
    - Grievance/dispute forms for the IEHP Value Based Payments Program can be found on the IEHP website at: ***https://www.providerservices.iehp.org/en/provider-central/provider-incentive-programs/proposition-56-value-based-payment***
    - IEHP will provide the Network Provider an itemization of payments made to the Network Provider (in the form of a Remittance Advice) in accordance with DHCS requirements and must include sufficient information to uniquely identify the qualifying service for which payment was made, be provided upon the Network Provider's request unless IEHP has established a periodic dissemination schedule and be made available in electronic format when feasible.

NOTES

A Public Entity
Inland Empire Health Plan
www.iehp.org

Provider Relations Team
(909) 890-2054
Monday – Friday, 8am – 5pm

Follow us: