DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

Proposition 56 Directed Payments Expenditures File Technical Guidance

Change Log

DATE	UPDATE
5/1/2018	Initial Proposition 56 Directed Payments document (APL 18-010[1]) for State Fiscal Year (SFY) 2017-18 published on the Department of Health Care Services (DHCS) website
10/9/2018	Initial document
5/10/2019	Transmission Method updated
6/13/2019	Updated with APL 19-006 requirements
10/17/2019	Updated with APL 19-013 requirements
12/24/2019	Updated with APL 19-015 requirements
12/26/2019	Updated with APL 19-016 and APL 19-018 requirements
5/13/2020	Updated with APL 20-013 requirements
5/15/2020	Updated with APL 20-014 requirements
6/23/2022	Updated with APL 22-011 requirements
10/10/2022	Updated with APL 22-019 requirements
3/1/2023	Updated with Technical Guidance for data reporting requirements
5/8/2023	Corrected error in VBP Risk example table
5/30/2023	Updated Appendix F ICD-10 Code. Added Z02.5.
10/23/2023	Updated the “Data Format” section. Added “CCN” column header. Updated appendices.
11/03/2023	Various corrections in the document
12/22/2023	Updated historical reporting requirements and to align with Targeted Provider Rate Increases and Investments[2] effective January 1, 2024

Data Reporting Requirements

General Information

Managed Care Plans (MCPs) must report to DHCS by the 15th of each May and November (bi-annual reports) all directed payments made pursuant to APLs 23-008, 23-

[1] All Plan Letters (APLs) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[2] More information about the Medi-Cal Targeted Provider Rate Increases and Investments can be found here: https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx.

014, 23-015, 23-016, 23-017, and 23-019 either directly by the MCP or by the MCP's Subcontractors at the MCP's direction. Reports must be cumulative and include all directed payments made for dates of service as specified below.

APL	Directed Payment	Start Date	End Date
23-017	ACE Screening Services	1/1/2020	No End Date
23-016	Developmental Screening Services	1/1/2020	No End Date
23-008	Family Planning Services	7/1/2019	No End Date
23-015	Private Services	7/1/2017	No End Date
23-019	Physician Services	7/1/2017	12/31/2023
23-014	VBP Program Services	7/1/2019	6/30/2022

MCPs must provide these reports in the format specified in this document. DHCS may require additional data as deemed necessary. All reports must be submitted in a consumable file format (i.e., text file) specified by DHCS to the MCP's Capitated Rates Development Division (CRDD) Rate Liaison.

Submission Frequency to DHCS

MCPs must submit bi-annual reports to DHCS by the 15th of each May and November, or more frequently when required by DHCS. DHCS may require MCPs with identified data quality gaps to report on a quarterly basis until the gaps are resolved to DHCS' satisfaction.

File Name

MCPs must submit their Directed Payments Expenditures files using the naming convention detailed below.

The format of the file name must be "**[plan name]**.Prop56.**yyyymm**.txt" where

[plan name] = Health plan name (up to 30 characters)
yyyymm = 4-digit year and 2-digit month of submission

File Format

MCPs must submit all data in either a tab-delimited or comma-delimited text file. MCPs must strive to submit a single, comprehensive text file of data for Adverse Childhood Experiences (ACE) Screenings, Developmental Screenings, Family Planning Services, Private Services, Physician Services, and Value Based Payments (VBP) Program Services; multiple text files may be submitted if the data cannot fit into text file. The submission files must build upon one another, including all current and historical program years where the final Medical Expenditure Percentage (MEP) has not been

finalized. MCPs must continually update, correct as necessary, and add new program data to an established file rather than submitting a segment of new data each period.

Data Format

All files must have the following columns, matched in both naming and order:

COLUMN HEADERS											
HPC	PROCEDURE CODE	PROGRAM	DOS	PAYOR	CIN	NPI	VBP MEASURE	VBP RISK 1	VBP RISK 2	VBP RISK 3	CCN

HPC:

- Health Plan Code – a three-digit numerical code designating the MCP's county of operation

PROCEDURE CODE:

- Procedure Code – a code of varying alpha-numeric length (seven characters maximum) associated with a qualifying Medi-Cal service

- Procedure codes may include Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), CPT-4, etc. A HCPCS code consists of five characters that are associated with a qualifying Medi-Cal service. It begins with one alphabet letter, then is followed by a four-digit numerical code. CPT and CPT-4 codes are five-digit numerical codes associated with a qualifying Medi-Cal services. Applicable modifiers should be included and are listed in the applicable appendices for each program.

- A list of applicable procedure codes for each Directed Payments program is located in the following appendices:

ACE Screening Services	Appendix A
Developmental Screening Services	Appendix B
Family Planning Services	Appendix C
Private Services	Appendix D
Physician Services	Appendix E
VBP Program Services	Appendix F

- For VBP Program Services, a valid procedure code is not required. MCPs can use "0" in the "Procedure Code" column for VBP Program Services.

PROGRAM:

- Directed Payments Program – a single-digit number indicating the directed payments arrangement to which that particular data entry aligns with

PROGRAM #	PROGRAM NAME
1	ACE Screening Services
2	Developmental Screening Services
3	Family Planning Services
4	Private Services
5	Physician Services
6	VBP Program Services

DOS:

- Date of Service – a ten-character long entry corresponding to the month, day, and year on which a Medi-Cal service was provided, written as MM/DD/YYYY

PAYOR:

- Payor – a character entry of varying length indicating the MCP or the MCP's Subcontractor that issued payment to the eligible Provider for that particular Medi-Cal service

CIN:

- Client Index Number – a unique nine-digit numerical code pertaining to an individual Medi-Cal recipient

NPI:

- National Provider Identifier – a ten-digit numerical code that uniquely identifies the rendering provider

VBP MEASURE:

- VBP Program Measure – a double-digit number indicating which VBP Program Measure that particular data entry aligns with

VBP MEASURE #	VBP MEASURE
00[3]	Not Applicable
01	Prenatal Pertussis "Whooping Cough" Vaccine
02	Prenatal Care Visit
03	Postpartum Care Visits
04	Postpartum Birth Control
05	Well Child Visits in First 15 Months of Life
06	Well Child Visits in 3rd – 6th Years of Life
07	All Childhood Vaccines for Two Year Olds
08	Blood Lead Screening
09	Dental Fluoride Varnish
10	Controlling High Blood Pressure
11	Diabetes Care
12	Control of Persistent Asthma
13	Tobacco Use Screening
14	Adult Influenza "Flu" Vaccine
15	Screening for Clinical Depression
16	Management of Depression Medication
17	Screening for Unhealthy Alcohol Use

VBP RISK 1-3:

- VBP Program Beneficiary Risk Status – a single-digit number indicating whether that particular Medi-Cal member was determined to be additionally at-risk

VBP RISK #	VBP RISK[4]
0[5]	Not Applicable
1	No additional risk identified
2	At risk: Serious Mental Illness diagnosis[6]
3	At risk: Substance Use Disorder diagnosis[5]
4	At risk: Insufficient Housing[7]

Please note that the MCP is required to key in a "VBP Risk #" for all "VBP Risk" columns. For non-VBP Program Services, all "VBP Risk" columns should read as "0." For VBP Program Services, the "VBP Risk" columns can have a combination

[3] For all non-VBP Program services, it is mandatory to use "00" for the "VBP Measure" column
[4] More information regarding the 2022 adult core set value sets is available here: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html.
[5] For non-VBP Program services, it is mandatory to use "0" for all of the "VBP Risk" columns.
[6] Value sets for a Serious Mental Illness diagnosis and a Substance Use Disorder diagnosis are available here: https://www.medicaid.gov/license/form/7436/137571.
[7] "Insufficient Housing" must meet the Homeless ICD-10 Diagnosis codes of Z59.0 (Homeless) or Z59.1 (Inadequate Housing).

of VBP Risk numbers, dependent on the provider's assessment of the beneficiary. Please see the examples below.[8]

VBP RISK 1	VBP RISK 2	VBP RISK 3
0	0	0
1	1	1
2	1	1
3	4	1
2	3	4

CCN:

- Client Control Number – An alpha-numeric combination where the first three characters must be the three-digit HPC number of the MCP the beneficiary was enrolled in at the time of the rendered service.

- On an 837 file, the CCN is the same as the "CLM01" field.

- For VBP Program Services, a valid CCN is not required. MCPs can use their three-digit HPC in the "CCN" column for VBP Program Services.

Submission Process

All reports must be submitted in a consumable text file format (see *File Format* section for requirements) through the DHCS secure file transfer protocol (SFTP) site.[9] DHCS' SFTP site can be accessed either through Microsoft Edge or the Google Chrome web browser. DHCS has created SFTP accounts for each MCP.

MCPs must designate individuals from their staff who will be granted access to DHCS' SFTP site. DHCS will email each MCP every six months to confirm the contact information DHCS has on file, and to request any new contact information and provide SFTP access for additional staff. MCPs must respond to DHCS' email by the due date indicated in the email request. Once designations are received, DHCS will process and provide SFTP login credentials to each designated individual.

Each bi-annual report must be a replacement of all prior submissions and include an attestation that the MCP considers the report complete. If no new information is available for the bi-annual report, MCPs must submit an attestation in lieu of the bi-annual report explaining the reason that no new information is available.

[8] These "VBP Risk" examples do not encompass all possible combinations for the "VBP Risk" columns.
[9] The DHCS SFTP website is available at: https://etransfer.dhcs.ca.gov

Reports must be uploaded to the following SFTP path: DHCS-CRDD-Prop56/*PlanName*

File Layout

Reports must be submitted in the format specified in the *Data Format* section. Below is a comprehensive table of the formation requirements.

Directed Payments Expenditure Data Record

FIELD	FORMAT	NUMBER OF CHARACTERS
HPC-CODE	Numeric	3
PROCEDURE-CODE	Alpha-Numeric	7
PROGRAM	Numeric	1
DOS	Numeric	10
PAYOR	Alpha-Numeric	50
CIN	Numeric	9
NPI	Numeric	10
VBP-MEASURE[10]	Numeric	2
VBP-RISK-1	Numeric	1
VBP-RISK-2	Numeric	1
VBP-RISK-3	Numeric	1
CCN	Alpha-Numeric	38

[10] The VBP-MEASURE and VBP-RISK 1-3 fields are only required for data related to APL 23-014. Please input “00” (for VBP-MEASURE) or “0” (for VBP-RISK) in the appropriate fields for data related to APLs 23-008, 23-015, 23-016, 23-017, and 23-019.

APPENDIX A

Adverse Childhood Experiences (ACE) Screening Services

To report ACE Screening Services for dates of service on or after January 1, 2020, the below procedure codes must be used.

CODE	CODE SET	DESCRIPTION	EFFECTIVE DATES
G9919	HCPCS	Screening performed – results positive and provision of recommendations provided	1/1/2020 – Ongoing
G9920	HCPCS	Screening performed – results negative	1/1/2020 – Ongoing

Additional information about the Directed Payments programs for ACE Screening Services can be found on the DHCS APL website.[11]

[11] All Plan Letters (APLs) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

APPENDIX B

Developmental Screening Services

To report Developmental Screening Services for dates of service on or after January 1, 2020, the below procedure code must be used.

CODE	CODE SET	DESCRIPTION	EFFECTIVE DATES
96110 without modifier KX	CPT	Developmental screening, with scoring and documentation, per standardized instrument	1/1/2020 – Ongoing

Additional information about the Directed Payments program for Developmental Screening Services can be found on the DHCS APL website.[12]

[12] All Plan Letters (APLs) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

APPENDIX C

Family Planning Services

To report Family Planning Services, the below procedure codes must be used.

CODE	CODE SET	DESCRIPTION	EFFECTIVE DATES
J7294	CPT	CONTRACEPTIVE VAGINAL RING; SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	1/1/2022 – Ongoing
J7295	CPT	CONTRACEPTIVE VAGINAL RING; ETHINYL ESTRADIOL AND ETONOGESTREL	1/1/2022 – Ongoing
J7296	CPT	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	7/1/2019 – Ongoing
J7297	CPT	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	7/1/2019 – Ongoing
J7298	CPT	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	7/1/2019 – Ongoing
J7300	CPT	INTRAUTERINE COPPER CONTRACEPTIVE	7/1/2019 – Ongoing
J7301	CPT	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	7/1/2019 – Ongoing
J7303	CPT	CONTRACEPTIVE VAGINAL RING	7/1/2019 – 12/31/2021
J7304	CPT	CONTRACEPTIVE PATCH	7/1/2019 – 12/31/2021
J7304U1	CPT	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	1/1/2022 – Ongoing
J7304U2	CPT	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	1/1/2022 – Ongoing
J7307	CPT	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	7/1/2019 – Ongoing
J3490U5	CPT	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	7/1/2019 – Ongoing
J3490U6	CPT	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	7/1/2019 – Ongoing
J3490U8	CPT	DEPO-PROVERA	7/1/2019 – Ongoing
11976	CPT	REMOVE CONTRACEPTIVE CAPSULE	7/1/2019 – Ongoing
11981	CPT	INSERT DRUG IMPLANT DEVICE	7/1/2019 – Ongoing
55250	CPT	REMOVAL OF SPERM DUCT(S)	7/1/2019 – Ongoing
58300	CPT	INSERT INTRAUTERINE DEVICE	7/1/2019 – Ongoing

CODE	CODE SET	DESCRIPTION	EFFECTIVE DATES
58301	CPT	REMOVE INTRAUTERINE DEVICE	7/1/2019 – Ongoing
58340	CPT	CATHETER FOR HYSTEROGRAPHY	7/1/2019 – Ongoing
58555	CPT	HYSTEROSCOPY DX SEP PROC	7/1/2019 – 12/31/2019
58565	CPT	HYSTEROSCOPY STERILIZATION	7/1/2019 – 12/31/2019
58600	CPT	DIVISION OF FALLOPIAN TUBE(S)	7/1/2019 – Ongoing
58615	CPT	OCCLUDE FALLOPIAN TUBE(S)	7/1/2019 – Ongoing
58661	CPT	LAPAROSCOPY REMOVE ADNEXA	7/1/2019 – Ongoing
58670	CPT	LAPAROSCOPY TUBAL CAUTERY	7/1/2019 – Ongoing
58671	CPT	LAPAROSCOPY TUBAL BLOCK	7/1/2019 – Ongoing
58700	CPT	REMOVAL OF FALLOPIAN TUBE	7/1/2019 – Ongoing
81025	CPT	URINE PREGNANCY TEST	7/1/2019 – Ongoing

Additional information about the Directed Payments program for Family Planning Services can be found on the DHCS APL website.[13]

[13] All Plan Letters (APL) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

APPENDIX D

Private Services

To report Private Services for dates of service on or after July 1, 2017, the below procedure codes must be used.

CODE	CODE SET	DESCRIPTION	EFFECTIVE DATES
59840	CPT-4	INDUCED ABORTION (BY DILATION AND CURETTAGE)	7/1/2017 – Ongoing
59841	CPT-4	INDUCED ABORTION (BY DILATION AND EVACUATION)	7/1/2017 – Ongoing

Additional information about the Directed Payments program for Private Services can be found on the DHCS APL website.[14]

[14] All Plan Letters (APLs) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

APPENDIX E

Physician Services

To report Physician Services for dates of service before or on December 31, 2023, the below procedure codes must be used. Due to the implementation of the Medi-Cal Targeted Provider Rate Increases and Investments,[15] Prop 56 Physician Services expenditure data will no longer be required to be reported for dates of services on or after January 1, 2024. All Prop 56 Physician Services directed payments have been incorporated into the Targeted Provider Rate Increases and Investments Fee Schedule.

CODE	CODE SET	DESCRIPTION	EFFECTIVE DATES
99201	CPT	Office/Outpatient Visit New	7/1/2017 – 12/31/2021
99202	CPT	Office/Outpatient Visit New	7/1/2017 – 12/31/2023
99203	CPT	Office/Outpatient Visit New	7/1/2017 – 12/31/2023
99204	CPT	Office/Outpatient Visit New	7/1/2017 – 12/31/2023
99205	CPT	Office/Outpatient Visit New	7/1/2017 – 12/31/2023
99211	CPT	Office/Outpatient Visit Est	7/1/2017 – 12/31/2023
99212	CPT	Office/Outpatient Visit Est	7/1/2017 – 12/31/2023
99213	CPT	Office/Outpatient Visit Est	7/1/2017 – 12/31/2023
99214	CPT	Office/Outpatient Visit Est	7/1/2017 – 12/31/2023
99215	CPT	Office/Outpatient Visit Est	7/1/2017 – 12/31/2023
90791	CPT	Psychiatric Diagnostic Eval	7/1/2017 – 12/31/2023
90792	CPT	Psychiatric Diagnostic Eval with Medical Services	7/1/2017 – 12/31/2023
90863	CPT	Pharmacologic Management	7/1/2017 – 12/31/2020
99381	CPT	Initial Comprehensive Preventive Med E&M (<1 Year Old)	7/1/2018 – 12/31/2023
99382	CPT	Initial Comprehensive Preventive Med E&M (1-4 Years Old)	7/1/2018 – 12/31/2023
99383	CPT	Initial Comprehensive Preventive Med E&M (5-11 Years Old)	7/1/2018 – 12/31/2023
99384	CPT	Initial Comprehensive Preventive Med E&M (12-17 Years Old)	7/1/2018 – 12/31/2023
99385	CPT	Initial Comprehensive Preventive Med E&M (18-39 Years Old)	7/1/2018 – 12/31/2023
99391	CPT	Periodic Comprehensive Preventive Med E&M (<1 Year Old)	7/1/2018 – 12/31/2023
99392	CPT	Periodic Comprehensive Preventive Med E&M (1-4 Years Old)	7/1/2018 – 12/31/2023

[15] More information about the Medi-Cal Targeted Provider Rate Increases and Investments can be found here: https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx.

99393	CPT	Periodic Comprehensive Preventive Med E&M (5-11 Years Old)	7/1/2018 – 12/31/2023
99394	CPT	Periodic Comprehensive Preventive Med E&M (12-18 Years Old)	7/1/2018 – 12/31/2023
99395	CPT	Periodic Comprehensive Preventive Med E&M (19-39 Years Old)	7/1/2018 – 12/31/2023

Additional information about the Directed Payments program for Physician Services can be found on the DHCS APL website.[16]

[16] All Plan Letters (APLs) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

APPENDIX F

Value Based Payment (VBP) Program Services

For dates of service between July 1, 2019 and June 30, 2022, the below VBP Program services are eligible for directed payments.

DOMAIN	MEASURE	CODE(S)	CONDITIONS
Prenatal/Postpartum Care Bundle	Prenatal/Pertussis ('Whooping Cough') Vaccine	CPT: 90715	• 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 count twice
	Prenatal Care Visit	CPT: 992xx	• 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 the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34'

DOMAIN	MEASURE	CODE(S)	CONDITIONS
			series) with a 992xx CPT code on the encounter
	Postpartum Care Visits	ICD-10: Z39.2	• 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) • Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births. • For definitions, see *Value Based Payment Program Performance Measures* specifications[17]
	Postpartum Birth Control	The codes are listed in a directory[18]	• 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

[17] The *Value Based Payment Program Performance Measures* specifications are available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-9.30.20.pdf

[18] The codes used to calculate this measure are available in Tables CCP-C through CCP-D at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-non-hedis-value-set-directory.zip

DOMAIN	MEASURE	CODE(S)	CONDITIONS
			• 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.

Early Childhood Bundle	Well Child Visits in First 15 Months of Life	Any of the following:
		
		CPT:
		99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
		
		ICD-10:
		Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
			• 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 payment

	Well Child Visits in 3rd through 6th Years of Life	Any of the following: CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439	• Payment for the first well child visit in each year age group (3, 4, 5, or 6 years old)

DOMAIN	MEASURE	CODE(S)	CONDITIONS
		ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2	

	All Childhood Vaccines for Two Year Olds	Each of the following final vaccines:
		
		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
			• 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
			• A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

DOMAIN	MEASURE	CODE(S)	CONDITIONS
	Blood Lead Screening	CPT: 83655	• 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 executed if a child is diagnosed with lead toxicity
	Dental Fluoride Varnish	CPT: 99188 or CDT: D1206	• Payment to each rendering provider 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

Chronic Disease Management Bundle	Controlling High Blood Pressure	• Controlled Systolic:
		  ○ CPT 3074F (systolic blood pressure less than 130)
		  ○ CPT 3075F (systolic blood pressure less than 130-139)
		• Controlled Diastolic:
		  ○ CPT 3078F (diastolic blood pressure less than 80)
		  ○ CPT 3079F (diastolic blood pressure less than 80-89)
			• Payment to each rendering provider for a non-emergent outpatient visit, 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
			• Ages 18 to 85 at the time of visit
			
			*Hypertension:
			• ICD-10: I10 (essential hypertension)

DOMAIN	MEASURE	CODE(S)	CONDITIONS
	Diabetes Care	• For dates of service prior to October 1, 2019: ○ CPT 3044F most recent HbA1c <7.0% ○ CPT 3045F most recent HbA1c 7.0-9.0% ○ CPT 3046F most recent HbA1c >9.0% • For dates of service on or after October 1, 2019: ○ 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%	• 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 (see codes to the left) • 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
	Control of Persistent Asthma	Diagnosis Codes: • J45.20 Mild intermittent asthma, uncomplicated	• Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based

DOMAIN	MEASURE	CODE(S)	CONDITIONS
		• 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	on the Asthma Value Set, in the measurement year of the year prior to the measurement year • Each provider is paid once per year per patient • Ages 5 to 64 at the time of visit

DOMAIN	MEASURE	CODE(S)	CONDITIONS
		• 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	
	Tobacco Use Screening	CPT: • 99406 • 99407 • 4004F • 1036F	• Payment to rendering provider for any of the following CPT codes (see CPT codes to the left) • No more than one payment per provider per patient per year • Must be an outpatient visit
	Adult Influenza ('Flu') Vaccine	Up to two flu shots given throughout the year for patients 19 years and older at the time of the flu shot following the appropriate conditions	• Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 years 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

DOMAIN	MEASURE	CODE(S)	CONDITIONS
Behavioral Health Integration Bundle	Screening for Clinical Depression	CPT: • G8431 • G8510	• Payment to rendering provider for any of the following CPT codes for screening for clinical depression (see codes to the left) • Beneficiaries must be 12 years and older • No more than one payment per provider per patient per year • Must be an outpatient visit
	Management of Depression Medication	ICD-10: • F32.0 • F32.1 • F32.2 • F32.3 • F32.4 • F32.9 • F33.0 • F33.1 • F33.2 • F33.3 • F33.41 • F33.9	• 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 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 • For definitions, see *Value Based Payment Program Performance Measure* specifications[15] *NCQA's 2022 Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at:

DOMAIN	MEASURE	CODE(S)	CONDITIONS
			https://store.ncqa.org/hedis-my-2022-medication-list-directory.html
	Screening for Unhealthy Alcohol Use	CPT: • 99408 • 99409 • G0396 • G0397 • G0442 • G0443 • H0049 • H0050	• Payment to rendering provider for any of the following CPT codes (see codes to the left) • For beneficiaries 18 years and older • No more than one payment per provider per patient per year

Additional information about the Directed Payments program for VBP Program services can be found on the DHCS APL website.[19]

[19] All Plan Letters (APLs) are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.