Value-Based Payment (VBP) Program
Frequently Asked Questions

December 4, 2020

This document provides additional guidance, information, and clarification to Medi-Cal managed care health plans (MCPs) and Providers regarding the Department of Health Care Services (DHCS) VBP Program. VBP provides incentive payments to Providers who meet specific measures aimed at improving care for specific high-cost or high-need populations. The VBP Program began implementation on July 1, 2019, excluding the Behavioral Health Integration Incentive Program component. This document will be continuously updated. All revisions or newly added questions will have a note in red font next to the question and the version date above will be updated.

Contents

A. VBP Program Information/Policy/Resources

1. Where can policy and instructions be found?

Answer: New and updated VBP Program information, presentations, and resource documents can be found on the DHCS website on the VBP Program main page and requirement information can be found on the VBP Technical Specifications link. Additional information can also be found in All Plan Letter 20-014 and on the Proposition 56 page.

B. Providers/Participants

2. How do Providers participate in the VBP Program?

Answer: The VBP Program is designed for individual Providers, rather than clinics or health systems, and is administered through the managed care delivery system only. Provider payments are received through the MCP, and Providers must be contracted

with a MCP to participate. To participate in the VBP Program, Providers should contact their MCP.

3. **Are VBP incentive payments to go directly to the rendering Provider at their practice address, or can it be paid to the medical group at the group's associated address? [NEW]**

   Answer: The billing Provider must have a practice linkage with the eligible rendering Provider and a mechanism in place to reimburse the eligible rendering Provider for qualifying services as shown on the claim. To be an eligible Provider and to receive payment for the qualifying services, the rendering Provider must (1) possess an individual (Type 1) National Provider Identifier (NPI); and (2) be practicing within their scope of practice. (See All Plan Letter 20-014, pages 3-5)

4. **Is the attending NPI also considered the rendering NPI?**

   Answer: If an encounter is attributed to and associated with an individual NPI, the Physician delivering the services is considered the rendering Physician.

5. **What reporting requirements do MCPs need to follow for the VBP Program payment?**

   Answer: Please reference the technical guidance for MCPs document, *File Specifications Proposition 56 Expenditures*, for an outline of the requirements. If you do not have a copy, please contact your MCP contract manager.

C. Billing/Payment/Reimbursement

6. **If a patient receives an immunization through an RN with a type 1 NPI, will the visit be eligible for the VBP incentive?**

   Answer: Type 1 NPI Providers on the claims/encounters, practicing within their scope of licensures, will receive payment.

7. **Are Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program entities eligible for the VBP Program?**

   Answer: The VBP Program is designed for individual Providers, rather than clinics or health systems, and is administered through the managed care delivery system only. An entity like a hospital system is not eligible for VBP payment. To receive the VBP payment, the contracted Provider (doctor, nurse practitioner, etc.) must have a type 1 NPI (the NPI a doctor has, not their clinic NPI) with the encounter that is submitted to their MCP. Non-contracted Providers are not eligible for VBP payment.

8. **Is the VBP incentive in addition to the Proposition 56 supplemental payment program?**

   Answer: The VBP incentive is one of multiple programs available under Proposition 56. Providers may participate in more than one Proposition 56 program. Please see the Proposition 56 website for more information.

9. **Can an eligible Provider be reimbursed for two (2) Proposition 56 programs if there is an overlap in codes? [NEW]**

   Answer: Proposition 56 programs that authorize supplemental payments to eligible Providers may have an overlap in reimbursable codes. MCPs are required to review the respective program requirements and determine if eligible Providers satisfy the criteria for supplemental payments under the Proposition 56 programs. To the extent that an eligible Provider satisfies applicable program requirements, there may be circumstances when Providers are eligible to receive supplemental payments under multiple Proposition 56 programs.

10. **How does the MCP identify which physicians are eligible for payment for the management of depression medication measure?**

    Answer: Payments are made to prescribing Providers that prescribed antidepressant medications during the Effective Acute Phase Treatment period for patients 18 years or older with a diagnosis of major depression. Please refer to the VBP Technical Specifications on the DHCS website for additional requirements applicable to this measure.

11. **Is payment tied to the date of service or the measurement year? [NEW]**
    Answer: Payment is tied to the date of service, however please review the specifications document for additional payment criteria for each measure.

12. **When will Providers receive payment? [NEW]**
    Answer: MCPs must ensure VBP program payments are made within 90 calendar days of receiving a clean claim or accepted encounter for a qualifying VBP program service, for which the clean claim or accepted encounter is received by the MCP no later than one (1) year after the date of service. MCPs are not required to make the VBP program payments for clean claims or accepted encounters for qualifying VBP program services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

D. Technical Support/Billing Codes/Data Sources

13. Is there a maximum number of times a Provider may test and be paid for controlled blood pressure tests?

Answer: There is no limitation on the number of controlled blood pressure tests performed, in accordance with accepted clinical practice, and paid through the VBP Program. However, as in all instances, if a Provider is billing for services at a frequency outside standards of practice, DHCS expects the MCPs to conduct appropriate utilization management and pay only if the utilization is appropriate.

14. For measures that require administration of medication, is the VBP incentive payment based on prescribing the controller medication to the patient or the controller medication being dispensed to the patient?

Answer: Payment is based on the controlled medication being dispensed to the patient.

15. Is the measure and at-risk add-on tied to a beneficiary's current situation during a single visit or is there is a look back period for at-risk diagnoses?

Answer: The substance use disorder and serious mental illness at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the payment quarter or the three (3) previous quarters. The diagnosis of homeless should be on the encounter for the VBP eligible service. Payment is made for dates of service starting July 1, 2019, forward.

16. If the date of VBP service must be on or after July 1, 2019, would the prescribing Provider have to have prescribed medication during an *effective treatment period* on or after July 1, 2019? [NEW]

Answer: The look back period can go back prior to July 1, 2019, however, the VBP service being paid for must occur on or after July 1, 2019. Payment is based on the prescribing event which must occur on or after July 1, 2019.

17. Will county-administered behavioral health systems provide data to MCPs on beneficiaries with a serious mental illness diagnosis for the additional VBP payment?

Answer: Applicable diagnosis codes are on encounters received by the MCPs. Please refer to APL 18-015 for more information regarding data sharing between Mental Health Plans in each county and MCPs.

18. **How should physicians code for each measure and indicate that a patient will qualify for the additional at-risk amount?**

    Answer: Every VBP measure is derived directly from health plan encounter data, not from chart review. If a practitioner performs a qualifying service and records the appropriate diagnosis code for submission to the health plan, they will be eligible for payment.

19. **For the dental fluoride varnish measure, is the measurement period the first four (4) visits in a 12-month period? [NEW]**

    Answer: Yes. Furthermore, the measurement period is once per quarter and four (4) times per year.

20. **Does a diagnosis and procedure code (CPT code) for services rendered have to exist on the same claim line?**

    Answer: The diagnosis and procedure code for services rendered must have same date of service on the claim. Please refer to the VBP Technical Specifications on the DHCS website for more information.

21. **When will MCPs receive a connection to the California Department of Public Health's (CDPH) Blood Lead Registry for payment?**

    Answer: VBP Program payment is based on the encounter received by the MCP. Although MCP connection to the registry is in process, payment for services is made based on the CPT code in the encounter.

22. **Will DHCS be using local immunization registries besides the California Immunization Registry (CAIR) as a supplemental data source?**

    Answer: DHCS will use CAIR as a supplemental data source. MCPs may use other local registries to verify the service for payment; however, full integration of the local registries with CAIR is expected by the end of calendar year 2020. The integration will provide historical data as well as ongoing current data between the local registries and the state registry.

23. **How should MCPs use the California Immunization Registry (CAIR) and RIDE Immunization Registry (RIDE) for VBP payment? [NEW]**
    Answer: The expectation is that CAIR and RIDE will be used as supplemental data sources. Payment is based on the final encounter of a vaccination series.

24. How will a physician indicate or a MCP know that the last dose of the vaccine was provided?

Answer: A two-year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series. For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source to verify an encounter is the last vaccine in the series.

25. Can Z codes be used for billing even though the technical specifications metric says to use CPT codes?

Answer: Z codes can be used to the extent they are included in the VBP Technical Specifications.

E. Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

26. Are FQHCs/RHCs eligible for the VBP Program?

Answer: No.