PROPOSITION 56 DIRECTED PAYMENTS FOR ADVERSE CHILDHOOD EXPERIENCES SCREENING SERVICES (PY 1)

Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

Rating Period (RP) 2019-20: July 1, 2019 through December 31, 2020

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

January 1, 2020

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

Program Year 1 (PY 1, CY 2020) through PY 3 (CY 2022), contingent on appropriation of funds by the California Legislature for this purpose

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

   Not applicable

   ☐ Quality Payments / Pay for Performance (Category 2 APM, or similar)
   ☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
   ☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
   ☐ Multi-Payer Delivery System Reform
   ☐ Medicaid-Specific Delivery System Reform
   ☐ Performance Improvement Initiative
   ☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

Not applicable

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

   ☒ Minimum Fee Schedule
   ☐ Maximum Fee Schedule
   ☐ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

   ☒ The State is proposing to use an approved State plan fee schedule
   ☐ The State is proposing to use a Medicare fee schedule
   ☐ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

This arrangement will direct MCPs to pay no less than a minimum fee schedule payment for specific Adverse Childhood Experiences Screening services (see Question 12) to eligible network providers (see Question 11) based on the utilization and delivery of services for eligible enrollees (see Question 14.b) covered under the contract.

This time-limited directed payment arrangement has been developed pursuant to the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), a ballot proposition to increase the excise tax rate on cigarettes and other tobacco products for the purpose of funding certain State expenditures, including existing health care programs administered by DHCS. The Budget Act of 2019 allocated a specified portion of Proposition 56 revenue to DHCS for use as the nonfederal share of Medi-Cal expenditures in RP 2019-20, including the directed payment arrangement for Adverse Childhood Experiences Screening services described herein.

Payments to MCPs under this arrangement shall be subject to a two-sided risk corridor, which will be calculated retrospectively by the State. Please see Attachment 1 for more details.

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

   Not applicable

   ☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

MCPs will be directed to pay to eligible network providers (see Question 11) a minimum fee schedule add-on payment for every adjudicated claim (contracted services only) for specific Adverse Childhood Experiences Screening services (see Question 12). DHCS will contractually require MCPs to pay these amounts via All Plan Letter or similar instruction.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

Class of Providers
1) All network providers qualified to provide the services specified in Question 12.

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

Procedure Code	Description	Minimum Fee Amount
G9919	Screening performed – results positive and provision of recommendations provided	$29.00
G9920	Screening performed – results negative	$29.00

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf

b. Date of quality strategy (month, year):

June 2018

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	**Quality strategy page**
• Improve the health of all Californians • Enhance quality, including the patient care experience, in all DHCS programs	• Deliver effective, efficient, affordable care • Advance prevention	Medi-Cal Managed Care Quality Strategy Report, Page 6

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

The State is using an approved State plan fee schedule to ensure access to care for Medi-Cal managed care enrollees.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

The State is using an approved State plan fee schedule to ensure access to care for Medicaid managed care enrollees; the State will ensure routine monitoring of access to care as required under §§ 438.66, 438.206, and 438.207.

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

California is proposing to implement this directed payment arrangement for certain managed care categories of aid. Subsets of enrollees or categories of aid may be excluded from the payment arrangement as necessary for actuarial or other reasons.

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

Not applicable

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

Not applicable

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

Not applicable

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
1.					
2.					
3.					
4.					
5.					
6.					
If additional rows are required, please attach.					

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

Not applicable

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

18. Use the checkboxes below to make the following assurances:

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

ATTACHMENT 1

438.6(c) Proposal – Minimum Fee Schedule for Adverse Childhood Experiences Screening Services
Risk Corridor
Program Year 1: January 1, 2020 – December 31, 2020

Risk Corridor

A two-sided risk corridor shall be in effect for capitation payments to MCPs for the following directed payment arrangements (the Applicable Directed Payments):

- Proposition 56 Directed Payments for Physician Services,
- Proposition 56 Directed Payments for Developmental Screening Services, and
- Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services.

The two-sided risk corridor shall be based on the aggregated Multi-Preprint Medical Expenditure Percentage (MEP) achieved by each MCP, as calculated by DHCS. The Multi-Preprint MEP shall be calculated for each MCP in aggregate across all Applicable Directed Payments, all applicable categories of aid (see Question 14.b), and rating regions where the MCP operates for dates of service within the Program Year (PY). DHCS will perform this risk corridor calculation no sooner than 12 months after the end of the PY.

DHCS will calculate the numerator of the Multi-Preprint MEP utilizing a MCP's submitted encounters that have been accepted by DHCS in accordance with its policies, for services eligible to receive an Applicable Directed Payment add-on amount, multiplied by the Applicable Directed Payment add-on amount for each encounter. The resulting amount will be considered the "actual amount" of Applicable Directed Payment expenditures issued by the MCP to its eligible network providers in accordance with this preprint for dates of service within the PY. The denominator of the Multi-Preprint MEP shall be equal to the total of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's capitation payment revenues for the PY pursuant to the Applicable Directed Payments.

The risk corridor will consist of the following bands:

- If the aggregate Multi-Preprint MEP is less than or equal to 98 percent, the MCP will remit to DHCS within 90 days of notice the difference between 98 percent of the medical portion of the MCP's capitation payment revenues pursuant to the Applicable Directed Payments and the aggregate amount of the MCP's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Applicable Directed Payments.
- If the aggregate Multi-Preprint MEP is greater than 98 percent but less than 102 percent, the MCP will retain all gains or losses, with no reconciliation payments from DHCS to the MCP, or vice versa.
- If the aggregate Multi-Preprint MEP is greater than or equal to 102 percent, DHCS will remit to the MCP the difference between 102 percent of the medical portion of the MCP's capitation payment revenues for the Applicable Directed Payments and the aggregate amount of the MCP's MEP numerator, plus a proportional amount for the non-

medical portion of the capitation payments aligned with the Applicable Directed Payments.