

State of California—Health and Human Services Agency
Department of Health Care Services



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DATE: October 10, 2022

ALL PLAN LETTER 22-019
SUPERSEDES ALL PLAN LETTER 20-014

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED
PAYMENTS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care. This APL supersedes APL 20-014.

BACKGROUND:

On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-103-3305 appropriated Proposition 56 funds pursuant to Welfare and Institutions Code (WIC) section 14188.1, including a portion to be used according to the DHCS-developed payment methodology outlined below.¹

Senate Bill 78 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) added Article 5.8 (commencing with section 14188) to WIC. This article requires DHCS to develop a Value-Based Payment (VBP) program for the managed care delivery system to provide payments to Network Providers aimed at improving health care in the domains of prenatal and postpartum care, early childhood prevention, chronic disease

¹ California law and legislation are searchable at <https://leginfo.legislature.ca.gov/faces/home.xhtml>.

management, and behavioral health care.² DHCS is implementing this program in the form of a directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR) section 438.6(c).³

On January 17, 2019, DHCS issued APL 19-001, “Medi-Cal Managed Care Health Plan Guidance on Network Provider Status,” which describes how DHCS evaluates Network Provider status and establishes requirements that must be satisfied in order for Network Providers to be eligible for directed payments.⁴ Thereafter, on June 21, 2019, DHCS released the VBP program specifications outlining the measures and payment triggers for each domain on the “Value Based Payment Program” webpage on the DHCS website.⁵ The specifications provide an explanation for each VBP program measure, the source for each measure, and the appropriate procedure codes.⁶ DHCS selected the measures in each domain in coordination with various professional and medical organizations, and considered several factors, including but not limited to, stakeholder and advocate feedback, whether or not a measure aligns with DHCS’ quality efforts, the number of impacted Members, and whether or not sufficient administrative support is available for the measure.

On June 30, 2019, DHCS requested approval from the Centers for Medicare and Medicaid Services (CMS) to implement this directed payment arrangement, in accordance with Title 42 of the Code of Federal Regulations (CFR) section 438.6(c)(2). DHCS originally obtained approval from CMS to implement this directed payment arrangement on May 5, 2020. DHCS subsequently received approval for a technical amendment to this directed payment arrangement from CMS on March 8, 2022 to accommodate the level of appropriated funds from the State Legislature. DHCS has made the CMS-approved preprint available on the “Directed Payments Program” webpage on the DHCS website.⁷

² WIC sections 14188 –14188.4.

³ The CFR is searchable at:

<https://www.ecfr.gov/cgi-bin/ECFR?page=browse>.

⁴ For more information, please see APL 19-001, “Medi-Cal Managed Care Health Plan Guidance on Network Provider Status,” or any future iteration of this APL. APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

⁵ DHCS’ VBP Program website is available at:

https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx.

⁶ The VBP program specifications are outlined in the Value Based Payment Program Performance Measures specifications, available at:

<https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-05.07.20.pdf>.

⁷ The CMS-approved preprint is available at:

<https://www.dhcs.ca.gov/services/Documents/DirectedPymts/070119-063022-P56-VBP-Program-Directed-Payment-Preprint.pdf>.

The Proposition 56 VBP directed payment program ended on June 30, 2022.

POLICY:

MCPs, either directly or through their Subcontractors, must make directed payments for qualifying VBP program services (as defined below) for dates of service from July 1, 2019 through June 30, 2022, in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments must be in addition to whatever other payments eligible Network Providers would normally receive from the MCP or the MCP’s Subcontractors. Services performed after June 30, 2022, are not eligible to receive VBP enhanced payments.

VBP Program Domains, Measures, and Qualifying Services

MCPs must make value-based directed payments to eligible Network Providers for specific qualifying services tied to performance across four domains with dates of service from July 1, 2019 through June 30, 2022, as set forth in the VBP program specifications and the valuation summary.⁸ The domains and measures eligible for directed payments and the corresponding amounts for qualifying services are:

Domain	Measure	Add-On Amount for Non-At-Risk Members	Add-On Amount for At-Risk Members ⁹
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	\$25.00	\$37.50
	Prenatal Care Visit	\$70.00	\$105.00
	Postpartum Care Visits	\$70.00	\$105.00
	Postpartum Birth Control	\$25.00	\$37.50

⁸ The VBP valuation summary is outlined in the “Proposition 56 Value Based Payment Program Measure Valuation Summary,” available at: <https://www.dhcs.ca.gov/provgovpart/Documents/VBP-VS.pdf>.

⁹ For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members.

Domain	Measure	Add-On Amount for Non-At-Risk Members	Add-On Amount for At-Risk Members ¹⁰
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	\$70.00	\$105.00
	Well Child Visits in 3rd – 6th Years of Life	\$70.00	\$105.00
	All Childhood Vaccines for Two Year Olds	\$25.00	\$37.50
	Blood Lead Screening	\$25.00	\$37.50
	Dental Fluoride Varnish	\$25.00	\$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	\$40.00	\$60.00
	Diabetes Care	\$80.00	\$120.00
	Control of Persistent Asthma	\$40.00	\$60.00
	Tobacco Use Screening	\$25.00	\$37.50
	Adult Influenza ('Flu') Vaccine	\$25.00	\$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	\$50.00	\$75.00
	Management of Depression Medication	\$40.00	\$60.00
	Screening for Unhealthy Alcohol Use	\$50.00	\$75.00

¹⁰ For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members.

A qualifying service is a specific service, as set forth in the VBP program specifications, that is provided by an eligible Network Provider (see below) from July 1, 2019, through June 30, 2022, to a Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). MCPs must ensure that qualifying services reported using the procedure codes indicated in the VBP program specifications are appropriate for the services being provided. Additionally, MCPs must report the qualifying services using the appropriate procedure codes in their encounter data submissions and provider network data submissions to DHCS.^{11,12} As MCPs are required to periodically report Member specific immunization information to an immunization registry, the California Immunization Registry (CAIR) will be used as a supplemental data source for the vaccine-related measures.^{13,14}

MCPs must make VBP directed payments for qualifying services provided by eligible Network Providers with dates of service from July 1, 2019, through June 30, 2022, in accordance with the requirements outlined within the VBP program specifications. If applicable, for purposes of VBP directed payments, the “measurement year” for a given service is the calendar year in which that service was provided.

In view of the termination of Proposition 56 funding, qualifying services performed after June 30, 2022, will not be eligible to receive VBP directed payments.

Network Providers Eligible for VBP Program Payments

Individual rendering Network Providers qualified to provide the VBP program services are eligible to receive VBP directed payments. In addition to the requirements outlined in APL 19-001, “Medi-Cal Managed Care Health Plan Guidance on Network Provider Status,” Network Providers must meet the following criteria to be eligible for the payments outlined above:

- Possess an individual (Type 1) National Provider Identifier (NPI); and
- Be practicing within their practice scope.

Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics (as defined in Supplement 5

¹¹ For more information on encounter data, please see APL 14-019: “Encounter Data Submission Requirements,” or any future iteration of that APL.

¹² For more information on provider network data, please see APL 16-019: “Managed Care Provider Data Reporting Requirements,” or any future iteration of that APL.

¹³ For more information on immunization requirements, please see APL 18-004: “Immunization Requirements,” or any future iteration of that APL.

¹⁴ The CAIR website is available at: <http://cairweb.org/>

to Attachment 4.19-B of California's Medicaid State Plan and WIC section 14105.24) are not eligible Network Providers for the purposes of the VBP program. Services provided at or by these ineligible provider types are not eligible to receive VBP directed payments.¹⁵

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, VBP measure, service month, payer (i.e., MCP or Subcontractors), and the Provider's NPI. DHCS may require additional data as deemed necessary. All reports must be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCO) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL 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 year after the date of service.¹⁶ MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying VBP program services received by the MCP more than one 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 Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of a directed payment required by

¹⁵ Attachment 4.19-B of California's Medicaid State Plan is available at:
<https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-B.aspx>.

¹⁶ A "clean claim" is defined by 42 CFR section 447.45(b).

this APL.¹⁷ In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying service, how payments will be processed, how to file a grievance, and how to identify the responsible payor.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement must be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are responsible for ensuring that their Subcontractors comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.¹⁸ These requirements must be communicated by each MCP to all Subcontractors. If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original signed by Dana Durham.

Dana Durham, Chief
Managed Care Quality and Monitoring Division

¹⁷ MCP Contracts are available at:

<https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

¹⁸ For more information on Subcontractors and Network Providers, including the definition and applicable requirements, please see APL 19-001 or any future iteration of that APL.