DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 9, 2023

ALL PLAN LETTER 23-014
(SUPERSEDES ALL PLAN LETTER 22-019)

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.

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 California 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 management, and behavioral health care.[2] DHCS is implementing this program in the

[1] California law and legislation are searchable at https://leginfo.legislature.ca.gov/faces/home.xhtml.
[2] WIC sections 14188 –14188.4.

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.

The Centers for Medicare and Medicaid Services (CMS) approved this directed payment arrangement on May 5, 2020. CMS subsequently approved a technical amendment to this directed payment arrangement on March 8, 2022, to accommodate the level of appropriated funds from the California Legislature. DHCS has made the CMS-approved preprint available on the "Directed Payments Program" webpage on the DHCS website.[7]

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

POLICY:

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[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, and are 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.

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 directed 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] 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. The domains and measures eligible for directed payments and the corresponding amounts for qualifying services are found in Appendix A.

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.[9,10] 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.[11,12]

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[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 more information on Encounter Data, please see APL 14-019: "Encounter Data Submission Requirements," or any future iteration of that APL.
[10] 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.
[11] For more information on immunization requirements, please see APL 18-004: "Immunization Requirements," or any future iteration of that APL.
[12] The CAIR website is available at: http://cairweb.org/

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 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.[13]

Data Reporting

MCPs must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guidance" document available on the DHCS Directed Payment - Proposition 56 website, which is hereby incorporated herein by reference.[14]

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made in accordance with the timely payment standards in the Contract for clean claims or accepted encounters that are received by the MCP or Subcontractor no later than one year after the date of

[13] Attachment 4.19-B of California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-B.aspx.
[14] DHCS' Directed Payments Program webpage is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

service. [15] The Contract specifies the requirements pertaining to timely payment in Exhibit A, Attachment 8, Provision 5.[16]

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

MCPs or their Subcontractors must not pay any amount for any services or items, other than Emergency Services, to an excluded Provider as defined in the "Definitions" section of the Contract.[17] 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 has failed to suspend payment while pending an investigation of a credible allegation of fraud.

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 this APL. 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 payer. In addition, MCPs must make available to a Network Provider, an itemization of payments made to the Network Provider in accordance with this APL. The itemization must include sufficient information to uniquely identify the qualifying service for which payment was made, be provided upon the Network Provider's request unless the MCP has established a periodic dissemination schedule, and be made available in electronic format when feasible.

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[15] A "clean claim" is defined by 42 CFR section 447.45(b).
[16] MCP boilerplate Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP contracts and amendments executed thereto.
[17] Boilerplate MCP Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs should also review their own MCP contracts, as amended.

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, which will be made available on the DHCS' Directed Payments Program website upon CMS approval. 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.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers 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 applicable Subcontractors and Network Providers. DHCS may impose corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a Corrective Action Plan and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

[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.

Sincerely,

Original Signed Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

APPENDIX A

Dates of service between July 1, 2019 and June 30, 2022

MCPs must ensure the payments required by this APL are made in accordance with the timely payment standards in the Contract for Clean Claims[19] or accepted encounters that are received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for Clean Claims or accepted encounters received by the MCP more than one year after the date of service. These timing requirements may be waived through an agreement in writing between the MCP (or the MCO's Subcontractors) and the Network Provider.

Domain	Measure	Add-on Amount for Non-At-Risk Members	Add-on Amount for At-Risk Members
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
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

[19] A "clean claim" is defined by 42 CFR section 447.45(b).

Domain	Measure	Add-on Amount for Non-At-Risk Members	Add-on Amount for At-Risk Members
	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