Section 438.6(c) Preprint

42 C.F.R. § 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 (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) 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 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2023 - December 31, 2023
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2023
3. Identify the managed care program(s) to which this payment arrangement will apply:
   All County Organized Health System plans, All Geographic Managed Care plans, All Regional Model plans, All Two-Plan Model plans, and AIDS Healthcare Foundation
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $1,982,556,000
   a. Identify the estimated federal share of this state directed payment: 65%
   b. Identify the estimated non-federal share of this state directed payment: 35%

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

July 1, 2017 - June 30, 2018; July 1, 2018 - June 30, 2019; July 1, 2019 - December 31, 2020; January 1, 2021 - December 31, 2021; and January 1, 2022 - December 31, 2022

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(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 should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

DESIGNATED PUBLIC HOSPITAL (DPH) ENHANCED PAYMENT PROGRAM (EPP) - PROGRAM YEAR (PY) 6. The State will direct Medi-Cal managed care health plans (MCPs) to enhance contracted payments for the applicable classes of DPH systems by either uniform percentage or dollar amount add-on increases adjusted for each DPH based on the amount of capitation payments or the acuity of FFS services provided, respectively. Total funding available for these enhanced contracted payments will be limited to a predetermined amount (pool). The pool funding and projected utilization will be assumed in the development of prospective actuarially sound rates.

Upon determination of actual utilization or actual capitation payments, the State will direct MCPs to make enhanced payments for contracted services within specific classes of DPH systems, via All Plan Letter or similar instruction. The State may calculate directed payment amounts based on actual capitation payments or actual utilization, respectively, for two distinct time periods within PY 6 (CY 2023) and direct MCP payments accordingly. Following the issuance of all enhanced payments, the State will notify CMS of the updated actual per-member-per-month (PMPM) increment adjusted for actual utilization and actual capitation amounts paid by MCPs.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

CMS approved the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver on December 29, 2021, and an amendment of the 1115 demonstration on June 29, 2022. The approval letters are linked below:

https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf
https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Asset-Test-Amendment-Approval.pdf
https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-Approval-Letter.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 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.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), 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. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

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

11. 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. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

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

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed 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 below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 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.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

Final uniform dollar amount and uniform percentage increases will be calculated in accordance with the methodology described in Question No. 21.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

A retroactive adjustment done approximately 21 months after the end of the calculation period.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

See Question No. 21. This SDP replaces pre-existing supplemental payment programs under Assembly Bill (AB) 85 (Welfare & Institutions Code (W&I) 14199.1 & 14199.2; Stats 2013, c. 24 (AB 85), 2, eff. June 27, 2013) and Senate Bill (SB) 208 (W&I 14182.15; Stats. 2010, c. 714 (SB 208), 20, eff. Oct. 19, 2010), which have been an integral part of California's managed care program since 2010. The directed payment arrangement will continue to support DPH systems that provide critical services to Medi-Cal managed care. members.

The proposed pool amount increased by only 5.5% to account for cost trend (based on the Consumer Price Index-Urban for Hospital and Related Services) and the transition of select services and populations from the Medi-Cal Fee-for-Service delivery system to Medi-Cal managed care (i.e., a larger denominator) as approved by CMS through the CalAIM Waivers.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☒ outpatient hospital service
- ☒ professional services at an academic medical center
- ☒ primary care services
- ☒ specialty physician services
- ☒ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☒ Other: Emergency Department Services

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Designated public hospitals as defined in CA Welfare & Institutions Code 14184.10(f)

Class A is composed of Santa Clara Valley Medical Center DPH system that holds a risk-based PMPM contract with a Medi-Cal MCP that includes capitation for the provision of most services including inpatient hospital services.

Class B is composed of Los Angeles County DPH system that holds a risk-based PMPM contract with a Medi-Cal MCP that includes capitation for the provision of most services including inpatient hospital services.

Class C is composed of other county-operated or -affiliated DPHs or DPH multi-hospital systems that are predominantly reimbursed by their MCPs on a FFS basis that does not include capitation for hospital inpatient services. These include Alameda Health System Hospitals, Arrowhead Regional Medical Center, Contra Costa Regional Medical Center, Kern Medical Center, Natividad Medical Center, Riverside University Health System Medical Center, San Joaquin General Hospital, San Mateo Medical Center, Ventura County Medical Center, and Zuckerberg San Francisco General.

Class D is composed of University of California (UC) hospital systems. These include UC Davis Medical Center, UC Irvine Medical Center, UC San Diego Medical Center, UC San Francisco Medical Center, and UCLA Medical Center.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The provider type is defined in State law, CA Welfare & Institutions Code § 14184.10(f).

The individual provider classes (A through D) are based on similarity of organizational structure and contracting relationships with Medi-Cal MCPs. The class structure is consistent with the previous program year except that Zuckerberg San Francisco General moved to a fee-for-service (FFS) contractual arrangement as their primary reimbursement effective January 1, 2023, and therefore has shifted from Class A to Class C.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(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.

For each class of providers, the State will establish two pools from which the uniform increases to payments for that provider class will be made. For PY 6 (CY 2023), the two pools will consist of total amounts for:

1) uniform percent increases to payments for capitated contractual arrangements for classes of DPHs that are reimbursed primarily on capitated basis, and
2) uniform dollar amount payments for FFS contractual arrangements for all classes of DPHs, separately for: a) contracted inpatient and long-term care services, and b) contracted non-inpatient (outpatient/emergency department and professional) services.

MCPs that have contracted with an eligible provider, within the designated classes, based on a capitated arrangement (1) will be directed to make uniform percent increases to their contracted capitated payments to these providers for payments associated with assigned Medi-Cal managed care members.

When MCPs have contracted with an eligible provider, within the designated classes, based on a FFS arrangement (2a and 2b), they will be directed to make uniform dollar amount add-on payments for actual FFS utilization of contracted inpatient and non-inpatient services. For the contracted inpatient services sub-pool of the FFS pool (2a), MCPs will be directed to make uniform dollar amount add-on payments to eligible DPHs based on actual utilization of contracted inpatient and long-term care bed days for eligible Medi-Cal managed care members (as adjusted for the acuity of services provided). For the contracted non-inpatient services sub-pool of the FFS pool (2b), MCPs will be directed to make uniform dollar amount add-on payments to the eligible DPHs based on actual utilization of contracted non-inpatient services (as adjusted for the acuity of services provided).

For both the capitated and FFS pools identified above (sub-pools 1, 2a, or 2b), a weighted pro rata redistribution of a particular sub-pool shall be used to distribute each sub-pool's funding based on either the amount of actual capitation or all actual utilization of FFS services, as applicable. For example, if the number of actual FFS inpatient encounters exceed what was initially projected in the rate development, the state will ensure that all eligible encounters in the rate year are accounted for in a weighted pro rata portion of the subpool.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. DPH Class A – Inpatient and Long-Term Care Hospital Services	68.90%	40.00%	13.80%		122.70%
b. DPH Class A – Outpatient Hospital and Emergency Room Services	36.60%	24.40%	22.40%		83.40%
c. DPH Class A – Professional Services	40.30%	28.50%	25.30%		94.10%
d. DPH Class B – Inpatient Hospital Services	30.10%	25.60%	9.20%		64.90%
e. DPH Class B – Outpatient Hospital and Emergency Room Services	16.10%	14.60%	15.50%		46.10%
f. DPH Class B – Professional Services	33.50%	30.40%	32.40%		96.30%
g. See PY6 - CY 2023 - Attachment 1 - EPP - Table 2	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☒ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The average base payment levels from plans to providers as well as the total applicable unit counts are estimated based on unit costs and utilization assumed in the CY 2023 Medi-Cal managed care capitation rates, as well as class-specific unit cost differentials. The class-specific unit cost differentials are as compared to the average unit cost across all providers for each applicable category of service, and are based on a review of plan-submitted supplemental data. This SDP and other SDPs applicable to each provider class are converted to an add-on unit cost based on the sub-pool amounts and the estimated total applicable unit counts.

Percentages represent a comparison to Medicare unit costs for California hospitals. Benchmarking by individual provider class would be difficult and flawed because most of the hospital systems in these classes have little Medicare business as Medicaid occupies the vast majority of the participating hospital system's book of business. The Medicare unit cost benchmarks for the inpatient and outpatient/emergency room service categories are California-specific, sourced from the California Department of Health Care Access and Information (HCAI), formerly known as the Office of Statewide Health Planning and Development (OSHPD), hospital financial and utilization data for CY 2021. The benchmark was calculated using class-specific Medicare data for Class D and county-level Medicare data for all hospitals within applicable counties for Classes A, B, and C. Professional benchmarks leverage the CY 2021 CMS provider detail files and are specific to California and the services provided by the applicable hospital systems. CY 2021 Medicare benchmarks were trended forward to CY 2023 consistent with trend factors utilized in the development of the CY 2023 Medi-Cal managed care capitation rates.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As shown in Table 2, by provider class and service type, the total payment levels from plans to providers, after accounting for all applicable SDPs, fall below Medicare payment levels in most instances. For all other instances, the total payment levels fall below Commercial payment levels.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

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ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Exhibit B, Provision 16. Special Contract Provisions Related to Payement.

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. California_TwoPlan GMC Regional COHS _20230101-20231231_Certification_20221221	12/23/2022	Yes	92-112
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

Not applicable, except the State will submit the rate certification for AIDS Healthcare Foundation by April 30, 2023.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The certification will provide the methodology that will be used by DHCS to allocate actual payments associated with this payment arrangement. The estimated impacts of this payment arrangement on a PMPM basis will be provided in a supporting exhibit, but the estimated PMPM add-ons will not be included in the final rate ranges. A separate payment term is necessary in order to calculate and pay on actual utilization or member assignment. The separate payment term was designed to meet the objectives outlined in the quality strategy to deliver effective, efficient, affordable care.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Alameda Health System	Special District		No	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
ii. City and County of San Francisco	City and County		Yes	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
iii. Contra Costa County	County		Yes	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
iv. County of Los Angeles	County		Yes	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
v. County of Riverside	County		Yes	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
vi. County of San Mateo	County		Yes	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
vii. Kern County Hospital Authority	Special District		No	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
viii. Monterey County	County		Yes	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
ix. UCLA Medical Center	University of California		No	See PY6 - CY 2023 - Attachment 2 - EPP - Table 4	Yes
x. See PY6 - CY 2023 EPP Table 4 for additional					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

The State has yet to enter into any written agreements with potential funding entities relating to the non-federal share of this SDP. The State is not aware of any additional written agreements that may currently exist between healthcare providers and/or related entities to finance the non-federal share specific to this payment arrangement. If this SDP is approved, the State intends to enter into separate agreements with eligible funding entities regarding the voluntary provision of IGTs for this purpose, including a mechanism whereby the transferring entities will certify that the funds are eligible for federal financial participation pursuant to applicable federal regulations.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: "https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf"
- **b.** The effective date of quality strategy. February 4, 2022

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year): Jun-23
- **b.** Note any potential changes that might be made to the goals and objectives.

  Addendum to include quality goals and standards for long-term care and D-SNP/Medi-Cal plans.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Data-driven improvements that address the whole person		DHCS Comprehensive Quality Strategy, Page 5
b. Providing early interventions for rising risk and patient-centered chronic disease management		DHCS Comprehensive Quality Strategy, Page 5
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The State will direct MCPs to make enhanced payments to DPH systems, based on actual capitation payments by MCPs to applicable DPH systems or their utilization of contracted services, as applicable. These directed payments are expected to enhance quality, including the patient care experience, by supporting core safety-net providers in California to deliver effective, efficient, and affordable care, including primary, specialty, and inpatient (both tertiary and quaternary) care.

This SDP addresses children's preventive care, maternity care and birth equity, and behavioral health integration. These clincial areas address the foundations of health (i.e., preventive efforts that have long-lasting impact from infants to seniors). Addressing child and maternal health and behavioral health for all populations will reduce chronic diseases and serious illnesses in the decades to come.

Access to care is the first step in realizing quality, health, and improved outcomes. This program will support the critical goals of promoting access and increasing credibility and accuracy of encounter reporting by the DPHs, which deliver care to millions of Medi-Cal beneficiaries each year. In addition, this SDP creates a robust data monitoring and reporting mechanism with strong incentives for data, especially since this proposal links payments to actual reported encounters. This information will enable dependable data-driven analysis, issue spotting, and solution design to guide care management and care coordination needs, and identify and mitigate social drivers of health to reduce health care disparities.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. 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 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Child and Adolescent Well Care Visits	CY 2021	47.51%	Increase MCAS measure by 2%	NCQA Measure
ii. Prenatal and Postpartum Care	CY 2021	Postpartum Care (81.39%) Prenatal Care (87.57%)	Increase MCAS measure by 1%	NCQA Measure
iii. Depression Screening and FU (Adol/Adults)	CY 2021	Ages 12–17 Years (21.37% Ages 18–64 Years (13.00%)	Increase MCAS measure by 2%	CMS Measure
iv. See PY6 - CY 2023 - Attachment 3 - EPP - Evaluation Plan				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

See website link for prior years, PY1 - PY2, including evaluation findings and discussion of payment arrangement's impact:
https://www.dhcs.ca.gov/services/Pages/DP-DPH-EPP.aspx

For PY 3, see PY3 - Bridge Period - EPP - Evaluation Report.

The PY 4 Evaluation will be completed and submitted to CMS by June 30, 2023.

Mercer Caveats

State of California Department of Health Care Services

December 23, 2022

This Excel file covers reimbursement analyses and other preprint support for CY 2023 CA 438.6(c) state directed payment preprints for EPP.

Documents included in this communication are this Excel file and the associated delivery email.

This Excel file is prepared on behalf of the State of California Department of Health Care Services, and is intended to be relied upon by solely by the State of California Department of Health Care Services. It should be read in its entirely and has been prepared under the direction of Katharina Katterman, ASA, MAAA and Jie Savage, ASA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standards for issuing the statements of actuarial opinion herein. They are available at katharina.katterman@mercer.com and jie.savage@mercer.com if this audience has questions.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Attachment 1 – EPP – Table 2

CY 2023 Medi-Cal 438.6(c) Draft Preprint Support

EPP					
Provider Payment Analysis					
Percentage of Medicare					
Provider Class(es)	**Average Base Payment Level from Plans to Providers (absent the SDP)**	**Effect on Total Payment Level of State Directed Payment (SDP)**	**Effect on Total Payment Level of Other SDPs**	**Effect on Total Payment Level of Pass-Through Payments (PTPs)**	**Total Payment Level (after accounting for all SDPs and PTPs)**
DPH Class A – Inpatient and Long-Term Care Hospital Services	68.9%	40.0%	13.8%		122.7%
DPH Class A – Outpatient Hospital and Emergency Room Services	36.6%	24.4%	22.4%		83.4%
DPH Class A – Professional Services	40.3%	28.5%	25.3%		94.1%
DPH Class B – Inpatient Hospital Services	30.1%	25.6%	9.2%		64.9%

DPH Class B – Outpatient Hospital and Emergency Room Services	16.1%	14.6%	15.5%		46.1%
DPH Class B – Professional Services	33.5%	30.4%	32.4%		96.3%
DPH Class C – Inpatient and Long-Term Care Hospital Services	79.4%	39.2%	33.2%		151.8%
DPH Class C – Outpatient Hospital and Emergency Room Services	28.2%	13.4%	45.6%		87.2%
DPH Class C – Professional Services	24.0%	11.4%	38.9%		74.3%
DPH Class D – Inpatient Hospital Services	61.0%	13.8%	6.0%		80.9%
DPH Class D – Outpatient Hospital and Emergency Room Services	52.0%	15.9%	25.9%		93.8%
DPH Class D – Professional Services	28.3%	8.7%	14.1%		51.0%

Percentage of Commercial					
Provider Class(es)	**Average Base Payment Level from Plans to Providers (absent the SDP)**	**Effect on Total Payment Level of State Directed Payment (SDP)**	**Effect on Total Payment Level of Other SDPs**	**Effect on Total Payment Level of Pass-Through Payments (PTPs)**	**Total Payment Level (after accounting for all SDPs and PTPs)**
DPH Class A – Inpatient and Long-Term Care Hospital Services	20.9%	12.1%	4.2%		37.1%
DPH Class C – Inpatient and Long-Term Care Hospital Services	31.1%	15.4%	13.0%		59.5%

Attachment 2 – EPP – Table 4

Name of Entities transferring funds	Operational Nature of the Transferring Entity	Total Amounts Transferred by this Entity	Does the Transferring Entity Have General Taxing Authority	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, Identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment?
Alameda Health System	Special District	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 6 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify	Yes
City and County of San Francisco	City and County	TBD	Yes		Yes
Contra Costa County	County	TBD	Yes		Yes
County of Los Angeles	County	TBD	Yes		Yes
County of Riverside	County	TBD	Yes		Yes
County of San Mateo	County	TBD	Yes		Yes
Kern County Hospital Authority	Special District	TBD	No		Yes
Monterey County	County	TBD	Yes		Yes
UCLA Medical Center	University of California	TBD	No		Yes
San Bernardino County	County	TBD	Yes		Yes
San Joaquin County	County	TBD	Yes		Yes
Santa Clara Valley Medical Center	County	TBD	Yes		Yes
UC Davis	University of California	TBD	No		Yes
UC Irvine	University of California	TBD	No		Yes
UCSD Medical Center	University of California	TBD	No		Yes
UCSF Medical Center	University of California	TBD	No		Yes

Ventura County Medical Center	County	TBD	Yes	that the transferred funds qualify for federal financial participation.	Yes

ATTACHMENT 3

438.6(c) Proposal – Uniform Dollar or Percentage Increase for DPH Services
Annual Evaluation Plan
Program Year (PY) 6: January 1, 2023 – December 31, 2023

Evaluation Purpose

The purpose of this annual evaluation plan is to determine if the proposed directed payments made through the California Department of Health Care Services' (DHCS) Medi-Cal managed care health plans (MCPs) to Network Provider Designated Public Hospitals (DPHs) to increase Network Provider capitation rates at a fixed percentage and to increase payment for eligible contracted services at a fixed dollar amount result in preserving or improving access to services for all MCP members.

Stakeholders

- MCPs
- California Association of Public Hospitals and Health Systems (CAPH)
- California Association of Health Plans (CAHP)
- Local Health Plans of California (LHPC)
- Medi-Cal Managed Care Advisory Group (MCAG)

Annual Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do higher DPH payments, via the proposed PY 6 directed payments, serve to maintain or improve the performance of the Child and Adolescent Well Care Visits Medi-Cal Managed Care Accountability Sets (MCAS) measure?

2. Do higher DPH payments, via the proposed PY 6 directed payments, serve to maintain or improve the performance of the Prenatal and Postpartum Care: Timeliness of Prenatal Care MCAS measure?

3. Do higher DPH payments, via the proposed PY 6 directed payments, serve to maintain or improve the performance of the Depression Screening and Follow-Up Plan MCAS measure?

Evaluation Design and Data Collection

The State will conduct quality assessments focusing on MCP performance as defined by nationally standardized quality and access to care measures and in the context of the State's Comprehensive Quality Strategy. The baseline for comparison will be Measurement Year (MY) 2021. This directed payment program was specifically designed so that directed payments made to DPHs are determined based on actual utilization data as demonstrated by MCP-submitted encounter data received by DHCS. This design encourages increased collaboration among Network Provider DPHs and MCPs to ensure that the encounter data received by DHCS accurately reflects the actual utilization that has taken place during the defined time period. This will likely result in a substantial increase in encounter reporting for all service categories that

started in PY 1 and will likely continue to improve over time. To that end, the evaluation will compare changes in performance rates, which adjust for volume of service use as reflected in encounter submissions.

MCPs are required to report MCAS performance measures to DHCS in tandem with submission of performance data by NCQA by June 15th for the prior MY. In accordance with federal regulations, external quality review organization (EQRO)—Health Services Advisory Group (HSAG), conducts annual Healthcare Effectiveness Data and Information Set (HEDIS) audits of MCPs' MCAS data compilation to ensure that they are able to report data in accordance with NCQA specifications as it pertains to the performance measures used to measure MCPs' quality performance. HSAG distills MCP-reported data and formats it into rate sheets that HSAG designs under the direction of the State. These rate sheets serve as tools for performing data checks and analysis. Additionally, these performance rates will be reported in annual External Quality Review Technical Report and MCP-specific evaluation reports. The impact to managed care enrolled populations measured with these metrics will represent the overall impact of the directed payment program targeting specific subsets of Network Providers.

Timeline

All data necessary for quality measurement will be reported after a sufficient and appropriate lag period post-PY. The State will use MCP data submitted via MCAS rate sheets to assess the impact of the directed payment program no sooner than 12 months after the PY.

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the State's directed payment webpage and Medi-Cal Managed Care Quality Improvement Reports webpage.