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: $1,296,108,000
   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).

   PROPOSITION 56 DIRECTED PAYMENTS FOR PHYSICIAN SERVICES - PROGRAM YEAR (PY) 6. The State will direct Medi-Cal managed care health plans (MCPs) to make uniform and fixed dollar add-on payments to eligible network providers for every adjudicated claim (contracted services only) for select physician services (see Attachment 1). The State will contractually require MCPs to pay these amounts via All Plan Letter or similar instruction. Payments to MCPs under this arrangement shall be subject to a risk corridor described in Attachment 4.

   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?)

See CY 2023 - Attachment 1 - Prop 56 State Directed Fee Schedules for additional details.

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).

MCP must ensure the payments required by this directed payment arrangement are made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services. These timing requirements apply to payments made directly by the MCP, and by the MCP's subcontractors at the MCP's direction, and may be waived only if agreed to in writing between the MCP, or the MCP's subcontractors, and the rendering provider.

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

The increases align with SPA 21-0004, and the per-procedure fee amounts are consistent with the prior year for applicable procedure codes. See Question No. 28 for additional details.

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:

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

All individual rendering network providers qualified to provide the services specified in Question No. 19b, but excluding provider types that are subject to distinct reimbursement methodologies such as: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Tribal Health Clinics (IHS/MOA), and Cost-Based Reimbursement Clinics (CBRC).

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.

FQHCs, RHCs, IHS/MOAs, and CBRCs are excluded from this directed payment program because they are subject to distinct reimbursement methodologies.

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.

This directed payment arrangement will direct MCPs to make uniform and fixed dollar amount add-on payments for select physician services to eligible network providers (see Questions No. 20a and 20b) based on the utilization and delivery of services for eligible enrollees. The State will implement these enhanced directed payments for certain managed care categories of aid. Subsets of enrollees or categories of aid may be excluded from the enhanced contracted payment arrangement as necessary for actuarial or other reasons.

See CY 2023 - Attachment 1 - Prop 56 State Directed Fee Schedules for additional details.

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. Subset of Codes	62.30%	42.40%			104.70%
b. See PY6 - CY 2023 - Attachment 2 - Prop 56 Physicians - Table 2	0.00%	0.00%			0.00%
c.	0.00%	0.00%			0.00%
d.	0.00%	0.00%			0.00%
e.	0.00%	0.00%			0.00%
f.	0.00%	0.00%			0.00%
g.	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.

CY 2021 Medi-Cal managed care encounter data units and payment amounts were used to calculate the average base reimbursement rates (absent the SDP) for each code. CY 2021 Medicare physician fee schedule for the San Diego-Carlsbad locality in California was used as a reasonable proxy for average statewide Medicare benchmarks. The Medicare fee schedule is only available for a subset of the codes. For this subset of codes, a composite Medi-Cal managed care rate, inclusive of the add-ons as proposed, is then compared to a composite Medicare benchmark rate using CY 2021 encounter data units as weights.

Average CY 2020 California-specific commercial payment data for each code was used as commercial reimbursement benchmarks. A composite Medi-Cal managed care rate, inclusive of the add-ons as proposed, is compared to the composite commercial benchmark rate using CY 2021 encounter data units as weights. The composite rates utilize the full code set for case mix purposes.

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

As shown in Table 2, the total payment levels from plans to providers, after accounting for all applicable SDPs, align with Medicare payment levels (104.7%); and the total payment levels fall below commercial payment levels (87.6%).

The payment levels associated with this directed payment are in alignment with the overall Medi-Cal program goals and viewed across the broad perspective of the program's objectives are reasonable.

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 Payment)

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.

Not applicable.

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: Proposition 56 funds (CA tobacco tax revenues) subject to legislative appropriation.

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.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

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.

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. Keeping families and communities healthy via prevention		Medi-Cal Managed Care Quality Strategy Report, Page 5
b. Providing early interventions for rising risk and patient-centered chronic disease management		Medi-Cal Managed Care Quality Strategy Report, Page 5
c. Providing whole person care for high-risk populations, addressing drivers of health		Medi-Cal Managed Care Quality Strategy Report, Page 5
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.

These directed payments are in addition to the existing contracted payments eligible network providers receive from MCPs, and are expected to enhance quality, including the patient care experience, by supporting physicians and other professional providers in California to deliver effective, efficient, and affordable care, including primary and specialty care.

This SDP addresses preventive care and treatment of chronic conditions along with other clinical focus areas. It addresses the foundations of health (i.e., preventive efforts that have long-lasting impact from infants to seniors) and addresses prevention and care from birth through end of life.

Access to primary care physicians is a vital step in providing care at the appropriate setting. Receiving care in the appropriate setting helps realize our goals of quality, health, improved outcomes, and helping to reduce the cost curve by lowering utilization of emergency departments. This program will support the critical goals of promoting primary care access for the almost 11 million Medi-Cal managed care 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 submitted to MCPs. This information will enable dependable data-driven analysis, issue spotting, and solution design to guide care management and care coordination needs, and identification and mitigation of 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: Prenatal Care	CY 2021	Postpartum Care (81.39%) Prenatal Care (87.57%)	Increase MCAS measure by 1%	NCQA Measure
iii. Controlling High Blood Pressure	CY 2021	60.25%	Increase MCAS measure by 2%	CMS Measure
iv. See PY6 - CY 2023 - Attachment 3 - Prop 56 Physicians - 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 the payment arrangement's impact:
https://www.dhcs.ca.gov/Pages/DPP56-BP-Physicians.aspx

For PY 3, see PY3 - Bridge Period - Prop 56 Physicians Services - Evaluation Report.

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

Attachment 1 – Proposition 56 Physician

Procedure Code	Description	Uniform Dollar Amount
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric diagnostic evaluation	$35.00
90792	Psychiatric diagnostic evaluation w/ medical services	$35.00
99381	Initial comprehensive preventive med E&M (<1 year old)	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	$30.00
99391	Periodic comprehensive preventive med reE&M (<1 year old)	$75.00
99392	Periodic comprehensive preventive med reE&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med reE&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med reE&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med reE&M (18-39 years old)	$27.00

Attachment 2 – Proposition 56 Physician Services – Table 2

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

Prop 56 – Physician Services					
Reimbursement 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)**
Subset of Codes	62.3%	42.4%	N/A	N/A	104.7%

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)**
All Codes	51.3%	36.3%	N/A	N/A	87.6%

ATTACHMENT 3

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

Annual Evaluation Purpose

The purpose of this evaluation is to determine if the proposed directed payments made through the California Department of Health Care Services' (DHCS) contracted Medi-Cal managed care plans (MCPs) to network provider physicians for certain covered outpatient services billed under Current Procedural Terminology (CPT) codes 99202-99205, 99211-99215, 90791-90792, 99381-99385, and 99391-99395 result in preserving or improving access to outpatient physician services for all MCP members.

Stakeholders

- MCPs
- California Medical Association (CMA)
- 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 physician payments, via the proposed Program Year (PY) 6 directed payments, serve to maintain or improve the performance of the Child and Adolescent Well Care Visit Medi-Cal Managed Care Accountability Sets (MCAS) measure?

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

3. Do higher physician payments, via the proposed PY 6 directed payments, serve to maintain or improve performance of the Controlling High Blood Pressure 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 year for comparison will be Measurement Year (MY) 2021. Managed care health plans are required to report MCAS performance measures to DHCS in tandem with submission of performance data to NCQA by June 15 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 plans' MCAS data compilation to ensure that plans are set up to report data in accordance with NCQA specifications as pertains to the performance measures

used to measure quality performance. HSAG distills plan-reported data and formats it into rate sheets that HSAG designs under the direction of the State. These rates sheet serve as tools for performing data checks and analysis. Additionally, these performance rates will be reported in annual External Quality Review Technical Reports and plan-specific evaluation reports. The impact to Medi-Cal managed care enrolled populations measured with these metrics will represent the overall impact of the directed payment program targeting specific subsets of providers.

Timeline

All data necessary for quality measurement will be reported after a sufficient lag period post-PY. The State will use health plan 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 also will be posted on the State's directed payment webpage and Medi-Cal Managed Care Quality Improvement Reports webpage.

ATTACHMENT 4

438.6(c) Proposal – Uniform Dollar Increase for Physician Services and Developmental Screening Services

Risk Corridor
Program Year 6: January 1, 2023 – December 31, 2023 (Physician Services)
Program Year 4: January 1, 2023 – December 31, 2023 (Developmental Screening Services)

Risk Corridor

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

- Proposition 56 Directed Payments for Physician Services;
- Directed Payments for Developmental Screening Services; and
- Directed Payments for Adverse Childhood Experiences (ACEs) 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, applicable categories of aid (see Question No. 21), 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 in accordance with the Applicable Directed Payments arrangements. 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.