
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: \$418,634,000
 - a. Identify the estimated federal share of this state directed payment: 90%
 - b. Identify the estimated non-federal share of this state directed payment: 10%

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, 2019 - December 31, 2020; January 1, 2021 - December 31, 2021; and January 1, 2022 - December 31, 2022 (Pending)
 - 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 FAMILY PLANNING SERVICES - PROGRAM YEAR (PY) 4. The State will direct Medi-Cal managed care health plans (MCPs) to make uniform and fixed dollar amount add-on payments to eligible contracted and non-contracted providers for every adjudicated claim for select family planning 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
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
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.

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?)
- 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 directed payments required by this preprint are made within 90 calendar days of receiving a clean or accepted encounter claims for qualifying services but no later than year after service. These timing requirements apply to payments made directly by the MCP, and/or 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 21-0034, 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: All network and non-network providers qualified to provide the services specified in response to Question No. 19b.

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

All network and non-network providers qualified to provide the services specified in Question No. 19b, but excluding provider types within these categories 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.

FQHC, RHC, IHS/MOA, and CBRC 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 family planning services to eligible contracted and non-contracted 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)
<i>Ex: Rural Inpatient Hospital Services</i>	80%	20%	N/A	N/A	100%
a. All Professional Services	75.80%	17.00%			92.80%
b. See PY4 - CY 2023 - Attachment 2 - Prop 56 Family Planning - 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.

Many of the codes that receive uniform increases do not have values in Medicare. The subset of codes that exist in Medicare only represented 20% of base payment expenditures. It is important to note that the types of providers that deliver the services specified by the codes (primary care, specialists, OB/GYN physicians) also deliver a large variety of other services. In fact, the specific codes covered in this proposal make up a minority of all services provided by the “class of providers” in question. Therefore, comparisons for this small subset of total codes/services provided by the “class of providers” would not necessarily be reflective of the total reimbursement levels to physicians through Medicare or commercial insurance.

Our perspective on these payment levels needs to be viewed across the entirety of the payments involved for these providers. As a more appropriate comparative provider payment analysis, the impact on payment level is calculated for all Proposition 56/General Fund SDPs combined, which include SDPs for ACEs Screening, Developmental Screening, Proposition 56 Family Planning services, and Proposition 56 Physician services.

The average base payment levels from MCPs 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 for all professional services. The total SDP add-on dollars are converted to an add-on unit cost based on the total applicable unit counts.

Benchmarks for professional services leverage the CY 2020 CMS provider detail files that are specific to California and for the services provided in appropriate settings. CY 2020 Medicare benchmarks were trended forward to CY 2023 consistent with the 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.

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.

It is important to note that the types of providers that deliver the services specified by the codes (primary care, specialists, OB/GYN physicians) also deliver a large variety of other services. In fact, the specific codes covered in this proposal make up a minority of all services provided by the “class of providers” in question. Therefore, the comparisons for this small subset of total codes/services provided by the “class of providers” would not necessarily be reflective of the total reimbursement levels to physicians through Medicare or commercial insurance.

We believe the proposed payment levels are appropriate and enhance the quality of patient care by contributing to adequate and timely access to family planning services, which are a key component of beneficiary and population health. Please note, CMS has approved these payment levels in the FFS delivery system via SPA 19-0027.

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?

Package 69

- 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 hyperlink to State’s most recent quality strategy: "<https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf>"
 - 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 target date for submission of the revised quality strategy (month and year): Jun-23
 - 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
<i>Example: Improve care coordination for enrollees with behavioral health conditions</i>	<i>Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%</i>	5
a. Keeping families and communities healthy via prevention		DHCS Comprehensive Quality Strategy, Page 5
b.		
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.

These directed payments are in addition to the existing payments eligible providers receive from MCPs, and are expected to enhance quality, including the patient care experience, by supporting providers in California who offer family planning services to deliver effective, efficient, and affordable care.

Adequate and timely access to family planning services is a critical component of beneficiary and population health, keeping families and communities healthy by allowing adequate birth spacing to improve maternal and infant health, and preventing undesired (and potentially dangerous) childbirth. This program is designed to incentivize access to the following Family Planning Services:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

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, 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
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
i. Contraceptive Care—All Women: Most or Moderately Effective Contraception	CY 2021	Most or Moderately Effective Contraception—Ages 15–20 Years (13.89%) Most or Moderately Effective Contraception—Ages 21–44 Years (23.21%)	Increase MCAS measure by 2%	CMS Measure
ii. Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CY 2021	Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years (35.88%) Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (35.18%)	Increase MCAS measure by 2%	CMS Measure
iii. See PY4 - CY 2023 - Attachment 3 - Prop 56 Family Planning - Evaluation Plan				
iv.				

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.

For PY 1, see PY1 - Bridge Period - Prop 56 Family Planning - Evaluation Report.

The PY 2 Evaluation will be completed and submitted to CMS by June 30, 2023.

Attachment 1 – Proposition 56 Family Planning

Procedure Code	Description	Supplemental Payment
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	\$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	\$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	\$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	\$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	\$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	\$2,671.00
J3490U8	DEPO-PROVERA	\$340.00
J7294	CONTRACEPTIVE VAGINAL RING: SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	\$301.00
J7295	CONTRACEPTIVE VAGINAL RING: ESTRADIOL	\$301.00
J7304U1	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	\$110.00
J7304U2	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	\$110.00
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 mg	\$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 mg (2) & 1.5 mg (1)	\$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	\$399.00
11981	INSERT DRUG IMPLANT DEVICE	\$835.00
58300	INSERT INTRAUTERINE DEVICE	\$673.00
58301	REMOVE INTRAUTERINE DEVICE	\$195.00
81025	URINE PREGNANCY TEST	\$6.00
55250	REMOVAL OF SPERM DUCT(S)	\$521.00
58340	CATHETER FOR HYSTEROGRAPHY	\$371.00
58600	DIVISION OF FALLOPIAN TUBE	\$1,515.00
58615	OCCLUDE FALLOPIAN TUBE	\$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	\$978.00
58670	LAPAROSCOPY TUBAL CAUTERY	\$843.00
58671	LAPAROSCOPY TUBAL BLOCK	\$892.00
58700	REMOVAL OF FALLOPIAN TUBE	\$1,216.00

Attachment 2 – Prop 56 Family Planning – Table 2

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

Prop 56 – Family Planning 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)
All Professional Services	75.8%	17.0%	N/A	N/A	92.8%

ATTACHMENT 3

438.6(c) Proposal – Uniform Dollar Increase for Family Planning Services

Annual Evaluation Plan

Program Year (PY) 4: January 1, 2023 – December 31, 2023

Annual 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) contracted Medi-Cal managed care health plans (MCPs) to Network Providers for family planning services billed under the specified codes as outlined in Attachment 1 lead to improved access to family planning services for 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 provider payments for family planning services, via the proposed PY 4 directed payments, serve to maintain or improve the performance of the Contraceptive Care—All Women Ages 15 to 44 measure (CCW-CH + CCW-AD) for the sub-rate of most effective or moderately effective method of contraception?
2. Do higher provider payments for family planning services, via the proposed PY 4 directed payments, serve to maintain or improve the performance of the Contraceptive Care—All Women Ages 15 to 44 measure (CCW-CH + CCW-AD) for the sub-rate of long-acting reversible method of contraception (LARC)?

Evaluation Design and Data Collection

The State will conduct quality assessments focusing on MCP performance measures 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 Managed Care Accountability Sets (MCAS) performance measures to DHCS in tandem with submission 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 the plans are set up to report data in accordance with NCQA specifications as pertains to the performance measures used to measure plans' 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 Report and plan-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 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 Family Planning Services

Risk Corridor

Program Year (PY) 4: January 1, 2023 – December 31, 2023

Risk Corridor

A two-sided risk corridor shall be in effect for Proposition 56 Directed Payments for Family Planning Services capitation payments to MCPs. The risk corridor shall be based on the Medical Expenditure Percentage (MEP) achieved by each MCP, as calculated by DHCS. The MEP shall be calculated in aggregate across all 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 the risk corridor calculation no sooner than 12 months after the end of the PY.

DHCS will calculate the numerator of the MEP using an MCP's submitted encounters that have been accepted by DHCS, in accordance with its policies, for services eligible to receive a Proposition 56 Directed Payments for Family Planning Services 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 Proposition 56 Directed Payments for Family Planning Services expenditures issued by the MCP to its eligible network providers in accordance with this preprint for date of service within the PY. The denominator of the MEP, shall be equal to the total of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's Proposition 56 Directed Payments for Family Planning Services capitation payment revenues for the PY, as calculated by DHCS.

The risk corridor will consist of the following bands:

- If the aggregate 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 Proposition 56 Directed Payments for Family Planning Services capitation payment revenues 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 Proposition 56 Directed Payments for Family Planning Services.
- If the aggregate 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 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 Proposition 56 Directed Payments for Family Planning Services capitation payment revenues 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 Proposition 56 Directed Payments for Family Planning Services.