Section 438.6(c) Preprint

Section 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. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) 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 section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

July 1, 2017 through June 30, 2018

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

July 1, 2017

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

5-years (SFY 2017-18 and SFY 2021-22)

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §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. *Check all that apply; if none are checked, proceed to Question 6.*

Not Applicable

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

5. 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 (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

Not Applicable

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), 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. *Check all that apply; if none are checked, proceed to Question 10.*

☐ Minimum Fee Schedule
☐ Maximum Fee Schedule
☒ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

☐ The State is proposing to use an approved State plan fee schedule
☐ The State is proposing to use a Medicare fee schedule
☒ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

The State does not concur with the characterization that this payment arrangement constitutes a fee schedule. Nonetheless, the state is providing an answer to this question based on the assumption that CMS is requiring an answer for question 8 for uniform dollar increments under $438.6(c)(1)(iii)(B).

This proposal will direct Medi-Cal Managed Care Plans (MCPs) to pay uniform and fixed dollar amount add-on payments for specific services (discussed in our response to Question 12) to eligible providers (defined in our response to Question 11) based on their utilization. This time-limited directed payment arrangement has been developed pursuant to the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), a ballot proposition to increase the excise tax rate on cigarettes and other tobacco products for the purpose of funding expenditures, including excising programs administered by the Department.

Assembly Bill 120 (Stats. 2017, ch. 22, § 3, Item 4260-101-3305) appropriates Proposition 56 funds in the 2017-18 state fiscal year for specified DHCS directed payment expenditures. DHCS has developed the required directed payment methodology outlined in this Preprint to compensate providers eligible to provide and bill for the CPT codes set forth in Question 12. However, unlike the Hospital directed payment proposals this proposal does not include a pooled amount.

Lastly, these codes were selected because of their focus in the outpatient setting and the high frequency for which they are used, specifically by primary care and specialty physicians.

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

Not Applicable

☐ In accordance with §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.

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(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 may also provide an attachment).

MCPs will be directed to pay a uniform, fixed, add-on payment for every adjudicated claim (contracted services only) for the identified 13 procedure codes, to all eligible providers.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

Class of Providers
1) All Primary Care, Specialty Physician, and Mental Health Outpatient provider types used in rate development, but excluding provider types within these categories that are subject to distinct reimbursement methodologies such as Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Clinics, and Cost-Based Reimbursement Clinics.

12. In accordance with §438.6(c)(2)(i)(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 (the State may also provide an attachment).

Procedure Code		
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric diagnostic evaluation	$35.00
90792	Psychiatric diagnostic evaluation w/ medical services	$35.00
90863	Pharmacologic management	$5.00

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2017.pdf

b. Date of quality strategy (month, year):

January 2017

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	**Quality strategy page**
Enhance quality, including the patient care experience, in all DHCS programs	Deliver effective, efficient, affordable care	2017 Medi-Cal Quality Strategy, page 2
If additional rows are required, please attach.		

Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this

both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

The State will direct MCPs to make the directed payments to all eligible providers that utilize the 13 procedure codes identified in Question 12. These directed payments are in addition to their existing contracted payments received from MCPs. These directed payments to physicians are expected to enhance quality, include the patient care experience, by ensuring that physicians in California receive adequate payment to deliver effective, efficient, affordable care, including primary and specialty care.

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.

The directed payment proposal creates a robust data monitoring and reporting mechanism with strong incentives for quality data—especially, since this proposal links payments to actual reported encounters. This information will enable dependable data-driven analysis, issue spotting and solution design.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. 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 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

For year one, DHCS proposes to establish benchmark metrics to measure encounter data quality. Encounter data quality would be measured through several different domains, including:

- Reasonability:
  - Denied Encounters Turnaround Time – this measure addresses how quickly denied encounters are corrected and resubmitted.
  - Denied Encounters as a Percent of Total - this measure reports the percentage of total encounters that are denied each month of submission.
  - Review of Rendering Provider Identifier - this measure reports the percentage of providers with a valid rendering provider ID.

- Timeliness:
  - Lagtime - This measure reports the lagtime for submitting Professional encounter data. Lagtime is the time, in days, between the Date of Services and the Submission Date to DHCS. The benchmark for lagtime is as follows:

	Lag of 0 to 90 Days	**Lag of 0 to 180 Days**	**Lag of 0 to 365 Days**	**Lag > 365 Days**
Professional	65%	80%	95%	5%

- Accuracy:
  - Encounter Data Validation Study - the Encounter Data Validation study is to examine the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs through a review of medical records. Through a comparative analysis between the encounter data in the DHCS data warehouse and the data in the medical records, DHCS can validate whether specific data elements match within data found in both the medical records and DHCS encounter data.

For years two through five, DHCS proposes to establish quality benchmarks that prioritize improved health outcomes and/or other goals or objectives contained in the yet-to-be-finalized Managed Care Quality Strategy pursuant to 42 CFR §438.340. As the quality of encounter data submitted to DHCS improves, DHCS believes that this will lead to improvements in its quality performance metrics, known as its External Accountability Set or EAS. DHCS' EAS is composed primarily of Health Effectiveness Data and Information Set (HEDIS) measures from the National Committee for Quality Assurance (NCQA).

(CONTINUED ON NEXT PAGE)

In its Annual Managed Care Quality Strategy, DHCS sets goals for quality metric performance. As the MCPs and DHCS have more reliable data on which to base their assessments, DHCS and MCPs will be better able to target those areas where improved performance will have the greatest effect on health outcomes.

Upon finalizing the Managed Care Quality Strategy for use in contract periods on or after July 1, 2018, DHCS will submit proposed revisions to this Evaluation Plan as necessary to establish and refine goals and objectives to be measured in years 2-5 of this directed payment initiative.

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

California is proposing to 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.

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

Not applicable.

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

Not applicable.

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

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

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

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

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the 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 above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

Not applicable

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

Not applicable

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

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
1					
2					
3					
4					
5					
6					
If additional rows are required, please attach.					

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

Not applicable

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

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

Not applicable

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

Not applicable

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