PROPOSITION 56 DIRECTED PAYMENTS FOR PHYSICIAN SERVICES – PROGRAM YEAR 4 (PY 4), CALENDAR YEAR (CY) 2021

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):

CY 2021: January 1, 2021 through December 31, 2021

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

January 1, 2021

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

PY 1 (State Fiscal Year [SFY] 2017-18), PY 2 (SFY 2018-19), PY 3 (July 1, 2019 - December 31, 2020), PY 4 (CY 2021), and PY 5 (CY 2022), contingent on appropriation of funds by the California Legislature for this purpose. This preprint addresses the full PY 4; however, the program is in effect only during periods for which funds are appropriated by the California Legislature and may end in six months if additional funds are not appropriated by the California Legislature.

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 addressing this question based on the assumption that CMS is requiring an answer for Question 8 for uniform dollar increments under part 438.6(c)(1)(iii)(B).

This arrangement will direct Medi-Cal managed care health plans (MCPs) to pay uniform and fixed dollar amount add-on payments for specific services (see Question 12) to eligible network providers (see Question 11) based on the utilization and delivery of services for eligible enrollees (see Question 14.b) covered under the contract.

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 certain State expenditures, including existing health care programs administered by the DHCS. The Budget Act of 2020 allocated a specified portion of Proposition 56 revenue to DHCS for use as the nonfederal share of Medi-Cal expenditures in PY 4, including the directed payment arrangement for physician services described herein.

The specified services (see Question 12) were selected because of their focus in the outpatient setting and the high frequency of their use, specifically by primary care and specialty physicians.

Payments to MCPs under this arrangement shall be subject to a two-sided risk corridor, which will be calculated retrospectively by the State. Please see Attachment 1 for more details.

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

MCPs will be directed to pay to eligible network providers (see Question 11) a uniform and fixed dollar add-on payment for every adjudicated claim (contracted services only) for specific physician services (see Question 12). DHCS 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. Please see Attachment 1 for more details.

State may also provide an attachment).

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 individual rendering network providers qualified to provide the services specified in Question 12, 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).

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	Description	Uniform Dollar Amount
99201	Office/Outpatient Visit New	$18.00
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

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/formsandpubs/Documents/ManagedCareQSR062918.pdf

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

June 2018

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	Medi-Cal Managed Care Quality Strategy Report, Page 6

d. 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.

For PY 4, the State will direct MCPs to make directed payments to eligible network providers that utilize the specified procedure codes (see Question 12). 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 ensuring that physicians in California receive adequate payment to deliver effective, efficient, and 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 millions of Medi-Cal managed care beneficiaries each year.

This directed payment arrangement creates a robust data monitoring and reporting mechanism with strong incentives for quality 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.

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

Please see Attachment 2 for details.

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.

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.).

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.

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.

<u>Additional Questions for Value-Based Payment Arrangements</u>

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.

ATTACHMENT 1

438.6(c) Proposal – Uniform Dollar Increase for Physician Services
Risk Corridor
Program Year 4: January 1, 2021 – December 31, 2021

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,
- Proposition 56 Directed Payments for Developmental Screening Services, and
- Proposition 56 Directed Payments for Adverse Childhood Experiences 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 14.b), 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.

ATTACHMENT 2

438.6(c) Proposal – Uniform Dollar Increase for Physician Services
Evaluation Plan
Program Year 4: January 1, 2021 – December 31, 2021

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) Medi-Cal managed care health plans (MCPs) to network provider physicians for contracted outpatient services billed under Current Procedural Terminology (CPT) codes 99201-99205, 99211-99215, 90791-90792, 99381-99385, and 99391-99395, results 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)

Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do higher physician payments, via the proposed PY 4 directed payments, serve to maintain or improve the timeliness and completeness of encounter data reported for MCP members?

2. Do higher physician payments, via the proposed PY 4 directed payments, serve to maintain or increase utilization of outpatient physician services for MCP members?

Evaluation Design

Encounter Data:

The state will conduct encounter data quality assessments focusing on the timeliness and completeness of encounter data. All encounter data quality measures will have a baseline determined from data submitted in state fiscal year (SFY) 2017-18, July 1, 2017 – June 30, 2018. Each subsequent program year will be compared to the baseline to determine if any changes have occurred in the encounter data with the target of maintaining or increasing the baseline during the measurement year.

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

The target is to maintain the baseline (SFY 2017-18) or demonstrate timeliness in accordance with the lagtime categories below, whichever is higher.

File type	0-90 days	0-180 days	0-364 days
Professional	65%	80%	95%

- Completeness:
  - Completeness – This measure will be evaluated through the following Transformed Medicaid Statistical Information System (T-MSIS) related measures:
    - Professional Encounters will be evaluated to determine if the “Rendering Provider” field is populated with a Type 1 National Provider Identifier.

Outpatient Utilization:

Outpatient Visits per 1000 Member Months: From the MCP encounter data, DHCS staff will calculate the number of MCP Outpatient Visits per 1000 Member Months. Data for participating MCPs will be aggregated at a statewide level. A visit consists of a unique combination between provider, member, and date of service. The third measurement period will be PY 4 (January 1, 2021 – December 31, 2021). The baseline year will be SFY 2017-18 (July 1, 2017 – June 30, 2018). DHCS will compare the third measurement period (PY 4) to the second measurement period (PY 3) and the baseline year to identify any changes in utilization patterns, with the target of maintaining or increasing the baseline number of Outpatient Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by MCPs and providers, in response to the design of the directed payment program. The target is to maintain the baseline (SFY 2017-18) or demonstrate higher utilization as an indicator of improved encounter data completeness.

DHCS will stratify the measure by the following categories:

- Gender
- Age
- Ethnicity
- Eligible population groups: Duals[1], Medi-Cal Only Affordable Care Act (ACA)[2], Medi-Cal Only Optional Targeted Low Income Children (OTLIC)[3], Medi-Cal Only Seniors and Persons with Disabilities (SPD)[4], and Medi-Cal Only Other[5]

Data Collection Methods

[1] Dual population consists of any Medi-Cal eligible member who has active Medicare coverage. Active Medicare coverage means one or more of the following Medicare portions are active: Part A, B, or D. Dual members are not identified by an aid code.
[2] ACA population consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U.
[3] OTLIC population consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9.
[4] SPD population consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7.
[5] The Other population consists of all aid codes not categorized under ACA, OTLIC, or SPD.

All data necessary for encounter data quality measurement will be extracted from DHCS' Post-Adjudicated Claims and Encounters System (PACES) and Management Information System/Decision Support System (MIS/DSS).

To measure the number of Outpatient Visits per 1000 Member Months, DHCS will rely on encounter data submitted by MCPs. DHCS will conduct its analysis on 100% of the data received.

Timeline

All data necessary for encounter data quality measurement will be extracted after a sufficient lag period post-PY. The encounter data will be pulled no sooner than 12 months after the close of the measurement year to allow for sufficient lag period, with a report being completed within 6 months of the data pull.

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the State's directed payment website.