State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 15, 2020

ALL PLAN LETTER 20-014

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-103-3305 appropriates Proposition 56 funds for State Fiscal Year (SFY) 2019-20, SFY 2020-21, and SFY 2021-22, pursuant to Welfare and Institutions Code (WIC) section 14188.1, including a portion to be used for directed payments in managed care according to the DHCS-developed payment methodology outlined below.[2]

Senate Bill 78 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) added Article 5.8 (commencing with section 14188) to WIC. In alignment with the Governor's Budget, this article requires DHCS to develop a value-based payment (VBP) program for the managed care delivery system to provide payments to Network Providers aimed at improving health care in the domains of prenatal and postpartum

[1] This APL does not apply to Prepaid Ambulatory Health Plans, Rady Children's Hospital, or SCAN Health Plan.
[2] California Law is searchable at http://leginfo.legislature.ca.gov/faces/codes.xhtml.

care, early childhood prevention, chronic disease management, and behavioral health care.[3]

On January 17, 2019, DHCS issued APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, which describes how DHCS evaluates Network Provider status and establishes requirements that must be satisfied in order for Network Providers to be eligible for directed payments.[4]

On June 21, 2019, DHCS released the VBP program specifications outlining the measures and payment triggers for each domain on the "Value Based Payment Program" webpage on the DHCS website.[5] The specifications provide an explanation for each VBP program measure, the source for each measure, and the appropriate procedure codes.[6] DHCS selected the measures in each domain in coordination with various professional and medical organizations and considered several factors, including but not limited to, stakeholder and advocate feedback, whether or not a measure aligns with DHCS' quality efforts, the number of impacted Members, and whether or not sufficient administrative support is available for the measure.

On June 30, 2019, DHCS requested approval from the Centers for Medicare and Medicaid Services (CMS) to implement this directed payment arrangement, in accordance with Title 42 of the Code of Federal Regulations (CFR) section 438.6(c)(2).[7] DHCS will make the CMS-approved preprint available on the "Directed Payments Program" webpage on the DHCS website upon CMS approval.[8]

POLICY:
Subject to obtaining the necessary federal approvals and consistent with 42 CFR section 438.6(c), MCPs, either directly or through their delegated entities and Subcontractors, must make directed payments for qualifying VBP program services (as defined below) for dates of service on or after July 1, 2019, in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments shall be in addition to whatever other payments eligible Network

---

[3] WIC sections 14188–14188.4.
[4] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[5] DHCS' Value Based Payment Program webpage is available at: https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx.
[6] The VBP program specifications are outlined in the *Value Based Payment Program Performance Measures* specifications, available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-05.07.20.pdf.
[7] The CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.
[8] DHCS' Directed Payments Program webpage is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Providers would normally receive from the MCP or the MCP's delegated entities and Subcontractors.

VBP Program Domains, Measures, and Qualifying Services

MCPs must make value-based directed payments to eligible Network Providers for specific qualifying services tied to performance across four domains, as set forth in the VBP program specifications and the valuation summary.[9] The domains and measures eligible for directed payments and the corresponding amounts for qualifying services are:

Domain	Measure	Add-On Amount for Non-At-Risk Members	Add-On Amount for At-Risk Members[10]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
	Prenatal Care Visit	$70.00	$105.00
	Postpartum Care Visits	$70.00	$105.00
	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
	All Childhood Vaccines for Two Year Olds	$25.00	$37.50

[9] The VBP valuation summary is outlined in the "Proposition 56 Value Based Payment Program Measure Valuation Summary," available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-VS.pdf.

[10] For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members.

	Blood Lead Screening	$25.00	$37.50
	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
	Diabetes Care	$80.00	$120.00
	Control of Persistent Asthma	$40.00	$60.00
	Tobacco Use Screening	$25.00	$37.50
	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
	Management of Depression Medication	$40.00	$60.00
	Screening for Unhealthy Alcohol Use	$50.00	$75.00

A qualifying service is a specific service, as set forth in the VBP program specifications, that is provided by an eligible Network Provider (see below) on or after July 1, 2019, to a Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). MCPs must ensure that qualifying services reported using the procedure codes indicated in the VBP program specifications are appropriate for the services being provided. Additionally, MCPs must report the qualifying services using the appropriate procedure codes in their encounter data submissions and provider network data submissions to DHCS.[11, 12] As MCPs are required to periodically report member-specific immunization information to an immunization registry, the California Immunization Registry (CAIR) will be used as a supplemental data source for the vaccine-related measures.[13, 14]

[11] For more information on encounter data, see APL 14-019: Encounter Data Submission Requirements, or any future iteration of that APL.
[12] For more information on provider network data, see APL 16-019: Managed Care Provider Data Reporting Requirements, or any future iteration of that APL.
[13] For more information on immunization requirements, see APL 18-004: Immunization Requirements or any future iteration of that APL.
[14] The CAIR website is available at: http://cairweb.org/

MCPs must make VBP directed payments for qualifying services provided by eligible Network Providers with dates of service on or after July 1, 2019, in accordance with the requirements outlined within the VBP program specifications. If applicable, for purposes of VBP directed payments, the "measurement year" for a given service is the calendar year in which that service was provided.

Network Providers Eligible for VBP Program Payments

Individual rendering Network Providers qualified to provide the VBP program services are eligible to receive VBP directed payments. In addition to the requirements outlined in APL 19-001, Network Providers must meet the following criteria to be eligible for the payments outlined above:

- Possess an individual (Type 1) National Provider Identifier (NPI); and
- Be practicing within their practice scope.

Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of California's Medicaid State Plan[15] and WIC section 14105.24) are not eligible Network Providers for the purposes of the VBP program. Services provided at or by these ineligible provider types are not eligible to receive VBP directed payments.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, VBP measure, service month, payer (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the

[15] Attachment 4.19-B of California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-B.aspx.

appropriate file format and include an attestation that the MCP considers the report complete.

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[16] or accepted encounter for a qualifying VBP program service, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying VBP program services received by the MCP more than one year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying service, how payments will be processed, how to file a grievance, and how to determine the responsible payer.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS "Directed Payments Program" webpage upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must communicate these requirements to all delegated entities and Subcontractors.

Please note that the requirements of this APL may change based upon future budgetary authorization and appropriation by the California Legislature or the status of the required CMS approvals applicable to this directed payment arrangement.

[16] A "clean claim" is defined in 42 CFR section 447.45(b).

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division