DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

September 16, 2026

Tyler Sadwith, State Medicaid Director
State of California, Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Tyler Sadwith:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving California's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on December 30, 2025. The proposal has a control name of CA_Fee_IPH.OPH.AMC.Oth_Renewal_20260101-20261231.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform increases established by the state for eligible Designated Public Hospital systems for the rating period covering January 1, 2026 through December 31, 2026, incorporated in the capitation rates through a separate payment term amount up to $3,865,000,000.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state

must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, the SDP proposal with the control name of CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20250101-20251231 likely qualified for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of $3,865,000,000 (as specified in item 4 of the applicable SDP preprint form) for the grandfathered SDP named CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20250101-20251231 submitted on December 11, 2024 cannot increase, and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.09.16 16:13:14 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

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, 2026 - December 31, 2026
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, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Mainstream Managed Care Plans (County Organized Health Systems, Geographic Managed Care, Regional Model, Two-Plan Model, and Single-Plan Model)
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $3,865,000,000
   a. Identify the estimated federal share of this state directed payment: 65%
   b. Identify the estimated non-federal share of this state directed payment: 35%

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

SFY 2017-18; SFY 2018-19; Bridge Period (July 1, 2019 - December 31, 2020); CY 2021; CY 2022; CY 2023; CY 2024; and CY 2025

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).

DESIGNATED PUBLIC HOSPITAL (DPH) ENHANCED PAYMENT PROGRAM (EPP) - PROGRAM YEAR (PY) 9. The State will direct Medi-Cal managed care health plans (MCPs) to enhance contracted payments for the applicable classes of DPH systems by either uniform percentage or dollar amount add-on increases adjusted for each DPH based on the amount of capitation payments or the acuity of FFS services provided, respectively. Total funding available for these enhanced contracted payments will be limited to a predetermined amount (pool). The pool funding and projected utilization will be assumed in the development of prospective, actuarially sound rates.

Upon determination of actual utilization or actual capitation payments, the State will direct MCPs to make enhanced payments for contracted services within specific classes of DPH systems, via All Plan Letter or similar instruction. The State may calculate directed payment amounts based on actual capitation payments or actual utilization, respectively, for two distinct time periods within PY 9 (CY 2026) and direct MCP payments accordingly. Following the issuance of all enhanced payments, the State will notify CMS of the updated actual per-member-per-month (PMPM) increment adjusted for actual utilization and actual capitation amounts paid by MCPs.

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 multiple subsequent amendments. The latest approval letters are linked below:

https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Eval-Design-Approval.pdf
https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-Approval-Letter-Revised-STCs.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. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

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

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

See Attachment 3 for the estimated uniform dollar amounts and percentages.

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).

A retroactive adjustment done as early as 15 months after the end of the calculation period.

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

See Question No. 21. This directed payment arrangement replaces pre-existing supplemental payment programs under Assembly Bill (AB) 85 (Welfare & Institutions Code (W&I) 14199.1 & 14199.2; Stats 2013, c. 24 (AB 85), 2, eff. June 27, 2013) and Senate Bill (SB) 208 (W&I 14182.15; Stats. 2010, c. 714 (SB 208), 20, eff. Oct. 19, 2010), which have been an integral part of California's managed care program since 2010. The directed payments will support DPH systems that provide critical services to Medi-Cal managed care members.

The payment levels for Program Year (PY) 9 will remain consistent with those approved in PY 8. There will be no increase in the total dollar amount relative to PY 8. This approach maintains the current aggregate Medicaid managed care payment levels for applicable services, which continue to support the goals of the SDP program.

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: Professional Services at non-AMCs.

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

Designated public hospitals as defined in CA Welfare & Institutions Code 14184.10(f).

Class A is composed of Santa Clara Valley Medical Center DPH system that holds a risk-based capitated contract with a Medi-Cal MCP that includes capitation for the provision of most services including inpatient hospital services.
Class B is composed of Los Angeles County DPH system that holds a risk-based capitated contract with a Medi-Cal MCP that includes capitation for the provision of most services including inpatient hospital services.
Class C is composed of other county-operated or -affiliated DPHs or DPH multi-hospital systems that are predominantly reimbursed by their MCPs on a FFS basis that does not include capitation for hospital inpatient services. These include Alameda Health System Hospitals, Arrowhead Regional Medical Center, Contra Costa Regional Medical Center, Kern Medical Center, Natividad Medical Center, Riverside University Health System Medical Center, San Joaquin General Hospital, San Mateo Medical Center, Ventura County Medical Center, and Zuckerberg San Francisco General.
Class D is composed of University of California (UC) hospital systems. These include UC Davis Medical Center, UC Irvine Medical Center, UC San Diego Medical Center, UC San Francisco Medical Center, and UCLA Medical Center, and affiliated government entity providers.

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.

The provider type is defined in State law, CA Welfare & Institutions Code § 14184.10(f).

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.

For each class of providers, the State will establish two pools from which the uniform increases to payments for that provider class will be made. For PY 9, the two pools will consist of total amounts for:
1) uniform percent increases to payments for capitated contractual arrangements for classes of DPHs that are reimbursed primarily on a capitated basis, and
2) uniform dollar amount payments for FFS contractual arrangements for all classes of DPHs, separately for: a) contracted inpatient hospital services including hospital-based long-term care services, and b) contracted non-inpatient services including outpatient hospital, emergency department, and non-facility professional services.

MCPs that have contracted with an eligible provider, within the designated classes, based on a capitated arrangement (1) will be directed to make uniform percent increases to their contracted capitated payments to these providers for payments associated with assigned Medi-Cal managed care members.

MCPs that have contracted with an eligible provider, within the designated classes, based on a FFS arrangement (2a and 2b), will be directed to make uniform dollar amount add-on payments for actual FFS utilization of contracted inpatient and non-inpatient services. For the contracted inpatient services sub-pool of the FFS pool (2a), MCPs will be directed to make uniform dollar amount add-on payments to eligible DPHs based on actual utilization of contracted inpatient and long-term care bed days for eligible Medi-Cal managed care members (as adjusted for the acuity of services provided). For the contracted non-inpatient services sub-pool of the FFS pool (2b), MCPs will be directed to make uniform dollar amount add-on payments to the eligible DPHs based on actual utilization of contracted non-inpatient services (as adjusted for the acuity of services provided).

For both the capitated and FFS pools identified above (sub-pools 1, 2a, and 2b), a weighted pro rata redistribution of a particular sub-pool shall be used to distribute each sub-pool's funding based on either the amount of actual capitation or all actual utilization of FFS services, as applicable. For example, if the number of actual FFS inpatient encounters exceed what is projected in the rate development, the state will ensure that all eligible encounters in the rate year are accounted for in a weighted pro rata portion of the sub-pool. For classes of providers that consist of one provider only (Class A and Class B), if the weighted pro rata redistribution would result in a uniform dollar amount or uniform percent increase payment that exceeds what is projected in the rate development, that payment shall be limited to what is projected in the rate development.

Uniform dollar amount or uniform percent increase payments will be subject to a tiered methodology based on cost accountability parameters. Each DPH will be placed into a designated payment tier, which will correspond to a specified percentage (ranging from 95% to 100%) of the uniform dollar add-on amounts or uniform percentage increases applicable to that class of providers. See Attachment 1 for more 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.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a.					
b.					
c.					
d.					
e.					
f.					
g.					

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: Average commercial rate

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.

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 2026 Medi-Cal managed care capitation rates, as well as class-specific unit share and unit cost differentials for each applicable service category. The class-specific unit share and unit cost differentials are as compared to the total units and average unit cost across all providers for each applicable category of service, and are based on a review of MCP-submitted supplemental data. The SDPs are converted to an add-on unit cost based on the sub-pool amounts and the estimated total applicable unit counts.

Percentages represent a comparison of projected CY 2026 Medi-Cal to a 2024 ACR for inpatient hospital, long-term care hospital, and outpatient hospital and emergency room, and a 2023 ACR for qualified practitioner services at an AMC, and primary care and specialty professional. The ACRs for Class D inpatient and outpatient/emergency room service categories are class-specific. The ACRs for all other class/service combinations are statewide service-specific.

The ACR unit cost benchmarks for the inpatient hospital, long-temr care hospital, and outpatient/emergency room service categories are California-specific (and class-specific for Class D), sourced from the California Department of Health Care Access and Information (HCAI) hospital financial and utilization data for CY 2024.

The ACR unit cost benchmarks for professional services leverage Commercial data sourced from the Merative™ MarketScan® Commercial Database for calendar year 2023 incurred dates of service, limited to professional services at acute care hospital systems in California. Unit Allocations are based on Medi-Cal managed care encounter data reported units for each respective provider class for January 1, 2024 through June 30, 2024 incurred dates. The commercial weighted unit cost for each provider class weights the 2023 statewide commercial unit cost by procedure code using the class-specific unit allocation.

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

As shown in Table 2.A, the total payment levels from MCPs to providers for each provider class and service type, after accounting for all SDPs and PTPs, fall below the ACR.

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 136

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

MCP Contract Exhibit B, 1.1.14

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. MCR-CA-COHS-GMC-REGIONAL-SINGLEPLAN-TWOPLAN-20260101-20261231-CERTIFICATION-20251219	12/24/2025	Yes	63-93
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

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.

The certification will provide the methodology that will be used by DHCS to allocate actual payments associated with this payment arrangement. The estimated impacts of this payment arrangement on a PMPM basis will be provided in a supporting exhibit, but the estimated PMPM add-ons will not be included in the final rate ranges. A separate payment term is necessary in order to calculate and pay on actual utilization or member assignment. The separate payment term was designed to meet the objectives outlined in the quality strategy to deliver effective, efficient, affordable care.

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:

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 the state needs more space, please use Addendum Table 4.A and check this box: ☒

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.

The State has yet to enter into any written agreements with potential funding entities relating to the non-federal share of this SDP. The State is not aware of any additional written agreements that may currently exist between healthcare providers and/or related entities to finance the non-federal share specific to this payment arrangement. If this SDP is approved, the State intends to enter into separate agreements with eligible funding entities regarding the voluntary provision of IGTs for this purpose, including a mechanism whereby the transferring entities will certify that the funds are eligible for federal financial participation pursuant to applicable federal regulations.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.dhcs.ca.gov/services/Documents/2025-Comprehensive-Quality-Strategy.pdf
- **b.** The effective date of quality strategy. January 1, 2025

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Engaging Members in their Care	Continue existing efforts to improve member experience and empower members to own their care and to inform Medi-Cal programs and policy through ongoing efforts.	62
b. Providing Early Interventions for Rising Risk	Help preserve health and quality of life for Medi-Cal members, thru critical programs that effectively manage chronic conditions and identify changes in health status as early as possible.	64
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.

The State will direct MCPs to make enhanced payments to DPH systems, based on actual capitation payments by MCPs to applicable DPH systems or their utilization of contracted services, as applicable. These directed payments are expected to enhance quality, including the patient care experience, by supporting core safety-net providers in California to deliver critical care, including primary, specialty, and inpatient (both tertiary and quaternary) care.

This SDP addresses children's preventive care, maternity care and birth equity, and behavioral health integration. These clinical areas address the foundations of health (i.e., preventive efforts that have long-lasting impact from infants to seniors). Addressing child and maternal health and behavioral health for all populations will reduce chronic diseases and serious illnesses in the decades to come.

Access to care is the first step in realizing quality, health, and improved outcomes. This program will support the critical goals of promoting access and increasing credibility and accuracy of encounter reporting by the DPHs, which deliver care to millions of Medi-Cal beneficiaries each year. In addition, this SDP creates a robust data monitoring and reporting mechanism with strong incentives for data, especially since this proposal links payments to actual reported encounters. This information will enable dependable data-driven analysis, issue spotting, and solution design to guide care management and care coordination needs.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See Table 8.A				
ii.				
iii.				
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.

See website link for prior years, PY 1, PY 2, PY 3, PY 4, PY 5 and PY 6 including evaluation findings and discussion of this payment arrangement's impact:

https://www.dhcs.ca.gov/services/Pages/DP-DPH-EPP.aspx

The PY 7 evaluation will be completed and submitted to CMS by June 30, 2026.

PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. 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 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A: Provider Payment Analyses

Column1	Provider Class(es)	Service(s)	Program	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)
a.	DPH Class A	Inpatient Hospital	Mainstream	50.2%	39.9%	9.2%	0.0%	99.2%
b.	DPH Class A	Long-Term Care Hospital	Mainstream	46.0%	12.6%	6.0%	0.0%	64.5%
c.	DPH Class A	Outpatient Hospital and Emergency Room	Mainstream	22.8%	21.6%	31.3%	0.0%	75.8%
d.	DPH Class A	Primary Care and Specialty Professional	Mainstream	28.4%	28.7%	4.1%	0.0%	61.2%
e.	DPH Class B	Inpatient Hospital	Mainstream	14.4%	24.9%	6.0%	0.0%	45.3%
f.	DPH Class B	Outpatient Hospital and Emergency Room	Mainstream	6.2%	11.8%	19.9%	0.0%	37.9%
g.	DPH Class B	Primary Care and Specialty Professional	Mainstream	13.8%	26.8%	4.0%	0.0%	44.7%
h.	DPH Class C	Inpatient Hospital	Mainstream	35.6%	23.1%	12.4%	0.0%	71.2%
i.	DPH Class C	Long-Term Care Hospital	Mainstream	33.6%	21.8%	11.7%	0.0%	67.2%
j.	DPH Class C	Outpatient Hospital and Emergency Room	Mainstream	13.5%	9.5%	50.0%	0.0%	73.1%
k.	DPH Class C	Primary Care and Specialty Professional	Mainstream	18.0%	12.7%	7.5%	0.0%	38.2%
l.	DPH Class D	Inpatient Hospital	Mainstream	36.5%	14.2%	2.9%	0.0%	53.5%
m.	DPH Class D	Outpatient Hospital and Emergency Room	Mainstream	37.4%	18.9%	36.1%	0.0%	92.4%
n.	DPH Class D	Qualified Practioner Services at an AMC	Mainstream	18.4%	9.3%	2.2%	0.0%	30.0%
o.								
p.								
q.								
r.								
s.								
t.								
u.								
v.								
w.								
x.								
y.								
z.								
aa.								
bb.								
cc.								
dd.								
ee.								
ff.								
gg.								
hh.								
ii.								
jj.								
kk.								
ll.								
mm.								
nn.								
oo.								
pp.								
qq.								
rr.								
ss.								
tt.								
uu.								
vv.								
ww.								
xx.								
yy.								
zz.								
aaa.								
bbb.								
ccc.								
ddd.								
eee.								
fff.								
ggg.								
hhh.								
iii.								
jjj.								
kkk.								
lll.								
mmm.								
nnn.								
ooo.								
ppp.								
qqq.								
rrr.								
sss.								
ttt.								
uuu.								
vvv.								
www.								
xxx.								
yyy.								
zzz.								

1. A meaningful comparison of payment rates between two different time periods requires considerations for the change in the price of services over time, or trend, from one period to the other. In the 2024 Final Rule preamble, CMS indicated that § 438.6(c)(2)(iii)(A) was intended to align with the rate development standards outlined in § 438.5. Rate development standards outlined in § 438.5 require that actuarially sound capitation rates include the application of cost trend factors. In the actuary's professional judgment, comparing commercial unit cost levels from a prior period to projected Medicaid unit cost levels in the rating period without the consideration for inflation and other unit cost changes in the interim, deviates from generally accepted actuarial principles and practices. Such a comparison is being performed by CMS request.

2. Percentages represent a comparison of projected CY 2026 Medi-Cal to a 2024 ACR for inpatient hospital, long-term care hospital, and outpatient hospital and emergency room, and a 2023 ACR for qualified practitioner services at an AMC, and primary care and specialty professional.

PREPRINT SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE
ADDENDUM TABLE 4.A. IGT TRANSFERRING ENTITIES
Directions

4. Use Table 4.A below to add IGT transferring agencies to Table 4. States may also use Table 4.A in lieu of completing Table 4 in the preprint. Provide the following (respond to each column for all entities transferring funds). Input data only in beige cells in columns B - H.
States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 4 in the preprint, please delete Tabs 1.A - 3.A and 5.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 4.A: IGT Transferring Entities

Column1	Name of Entity 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)	Notes
Data Format	Free text	Set values (select one)	Dollar ($x,xxx,xxx.00)	Set values (select one)	Free text	Set values (select one)	Free text
i	Alameda Health Systems	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	Special District
ii	City and County of San Francisco	Other (specify in "Notes" column)	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	City and County
iii	Contra Costa County	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
iv	County of Los Angeles	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
v	County of Riverside	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
vi	County of San Mateo	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
vii	Kern County Hospital Authority	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	Special District
viii	Monterey County	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
ix	UCLA Medical Center	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	University of California
x	San Bernardino County	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
xi	San Joaquin County	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
xii	Santa Clara Valley Medical Center	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	
xiii	UC Davis	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	University of California
xiv	UC Irvine	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	University of California
xv	UCSD Medical Center	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	University of California
xvi	UCSF Medical Center	Other (specify in "Notes" column)	TBD	No	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	University of California
xvii	Ventura County Medical Center	County	TBD	Yes	To the best of the State's knowledge, the entity has not received State appropriations specific to the PY 9 period at this time. The entity, or its county, does receive State allocated realignment funds. As stated above, the nonfederal share of this payment will consist of a voluntary IGT for which the transferring entity will certify that the transferred funds qualify for federal financial participation.	Yes	

PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 6.A EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS

Directions

8. Use Table 6.A below to add each measure the State intends to use in the evaluation of this payment arrangement, including (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. States may also use Table 6.A in lieu of completing Table 6 in the preprint. Input data only in base cells in columns B – F.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A – 6.A. For example, if the State only needs extra rows to complete Table 6 in the preprint, please delete Tabs 1.A – 7.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 6.A: Evaluation Measures, Baseline and Performance Targets

Column!	Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
Data Element	Enter text	Enter text	Decimal/text (99.9%)	Decimal/text (99.9%)	Free text. If the State will deviate from the measure specification, please describe here. If the State is using a state-specific measure, please define the numerator and denominator here. In addition, describe any planned data or measure stratifications (for example, age, race, as affected the State will use to evaluate the payment arrangement
Example:	Ex. Immunizations for Adults Area: All, Ad Hoc, Auto: NQF # 0419	CY 2010	54.0%	54.0%	
	Child and Adolescent Well Care Visits	CY 2021	48%	Increase MCAS measure by 3%	CMS Measure
1	Prenatal and Postnatal Care	CY 2021	Postpartum Care (61.39%) Prenatal Care (87.57%)	Increase MCAS measure by 3%	NCQA Measure
2	Depression Screening and Follow-Up for Adolescents and Adults	CY 2022	Depression Screening (3.74%) Follow-Up on Positive Screen (72.43%)	Increase MCAS measure by 3%	NCQA Measure
	See DVD, CY 2006 – Attachment 5 – CCD – Evaluation Plan				
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					
53					
54					
55					
56					
57					
58					
59					
60					
61					
62					
63					
64					
65					
66					
67					
68					
69					
70					
71					
72					
73					
74					
75					
76					
77					
78					
79					
80					
81					
82					
83					
84					
85					
86					
87					
88					
89					
90					
91					
92					
93					
94					
95					
96					
97					
98					
99					
100					
101					
102					
103					
104					
105					
106					
107					
108					
109					
110					
111					
112					
113					
114					
115					
116					
117					
118					
119					
120					
121					
122					
123					
124					
125					
126					
127					
128					
129					
130					
131					
132					
133					
134					
135					
136					
137					
138					
139					
140					
141					
142					
143					
144					
145					
146					
147					
148					
149					
150					
151					
152					
153					
154					
155					
156					
157					
158					
159					
160					
161					
162					
163					
164					
165					
166					
167					
168					
169					
170					
171					
172					
173					
174					
175					
176					
177					
178					
179					
180					
181					
182					
183					
184					
185					
186					
187					
188					
189					
190					
191					
192					
193					
194					
195					
196					
197					
198					
199					
200					
201					
202					
203					
204					
205					
206					
207					
208					
209					
210					
211					
212					
213					
214					
215					
216					
217					
218					
219					
220					
221					
222					
223					
224					
225					
226					
227					
228					
229					
230					
231					
232					
233					
234					
235					
236					
237					
238					
239					
240					
241					
242					
243					
244					
245					
246					
247					
248					
249					
250					
251					
252					
253					
254					
255					
256					
257					
258					
259					
260					
261					
262					
263					
264					
265					
266					
267					
268					
269					
270					
271					
272					
273					
274					
275					
276					
277					
278					
279					
280					
281					
282					
283					
284					
285					
286					
287					
288					
289					
290					
291					
292					
293					
294					
295					
296					
297					
298					
299					
300					