DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DATE: October 2, 2025

ALL PLAN LETTER 25-015

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: DATA SHARING AND QUALITY RATE PRODUCTION FOR DIRECTED PAYMENT INITIATIVES AND ALTERNATIVE PAYMENT METHODOLOGY PROGRAMS

PURPOSE:
The purpose of this All-Plan Letter (APL) is to provide details on Medi-Cal managed care plans' (MCPs') obligations surrounding data sharing and quality measures in Department of Health Care Services' (DHCS) Directed Payment Initiatives[1] or DHCS administered Alternative Payment Methodology (APM) programs as described in the following sections of the MCP Contract[2]: Exhibit A, Attachment III, Subsection 3.3.19; Exhibit B Subsection 1.1.14.B; and Exhibit B, Subsection 1.1.14.B.16. In these programs, payment to and/or participation of Providers are tied to specific quality measures.

BACKGROUND:
DHCS administers Directed Payment Initiatives and APM programs (collectively referred to as "programs") that focus on various types of Providers. These programs require MCPs to implement specific reimbursement rates or methodologies. Each program must be approved by the Centers for Medicare & Medicaid Services (CMS).

Historically, one of the largest DHCS directed payment programs has been the Quality Incentive Pool (QIP) for both Designated Public Hospitals (DPHs) and District & Municipal Public Hospitals (DMPHs). In QIP, eligible hospital Providers produce their own quality measure performance rates using data available to the hospital. This approach has resulted in the need to audit hospitals' data, develop QIP-specific measure specifications (which can be measured at the Provider level), multiple audit

[1]"Directed Payment Initiative" is defined in the MCP Contract, Exhibit A, Attachment I, Article 1.0 (Definitions). As used in this APL, "Directed Payment Initiatives" refers to DHCS' directed payment programs collectively. The DHCS Directed Payments landing website is located at https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx. Program specific policies and policy letters can be found at each program's website, which are linked from the landing website.
[2]The MCP boilerplate Contract is located at https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

processes (when measures are also reported in the Medi-Cal Managed Care Accountability Set, which have caused mismatches between rates produced by QIP hospitals and MCPs and increased administrative burden in QIP. For these reasons, DHCS designed new programs to require MCP reporting on behalf of Providers, rather than having Providers produce and report their own quality performance data. In parallel, DHCS has also worked with stakeholders on a process to transition QIP to a similar structure of MCP produced rates. MCP-produced quality performance rates offer numerous benefits including simplifying the reporting process, ensuring MCPs are central points of collection of Member data (which is a core managed care function), creating a scalable model with less administrative burden for future programs, pushing for more effective partnership between MCPs and Providers, and establishing a single source of truth for reporting quality measures.

To support the above approach and administration of programs broadly, Exhibit B Subsection 1.1.14.B and 1.1.14.B.16 of the MCP Contract outline each MCP's obligations to make payments to Providers and to supply Provider-level data to DHCS and Providers eligible for programs in a form and manner specified by DHCS through APLs and technical guidance. This APL serves to further describe MCPs' obligations under these sections of the MCP Contract. However, this APL is not intended to provide all requirements specific to every program. For specific requirements on each program, please refer to the program-specific APLs and/or policies. Where a program-specific requirement conflicts with this APL, that program-specific requirement supersedes this APL.

This APL specifically concerns the following programs and will govern additional programs approved or pending approval by CMS at a time post-dating the issuance of this APL:

- Children's Hospital Supplemental Payment
- Children and Youth Behavioral Health Initiative
- Community Clinic Directed Payment Program
- Directed Payments for Adverse Childhood Experiences
- Directed Payments for Developmental Screening Services
- District and Municipal Public Hospital Directed Payment Program
- Enhanced Payment Program
- Equity and Practice Transformation (EPT) Directed Payment Program
- Federally Qualified Health Center APM (to create capitated rates)
- Long Term Care Fee-For-Service-Equivalent Base Directed Payment
- Organ and Bone Marrow Transplants
- Private Hospital Directed Payment Program
- Proposition 56 Directed Payments for Family Planning Services
- QIP for DPHs

- QIP for DMPHs
- Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP)
- Targeted Rate Increases

This list of programs may be updated in future MCP Contracts and/or iterations of this or other APLs.[3]

POLICY:

Data Sharing and Quality Measure Rate Production

Programs require reporting to produce quality, utilization, value-related, and/or other measure rates by Providers or a designee (for example, an MCP), depending on the nature and operation of the program. Measures may require MCPs to either supply data to Providers or produce performance rates on behalf of Providers.[4]

Where the MCP must produce performance rates on behalf of Providers, the MCP must supply the Provider with the performance rates, the immediate components used to mathematically calculate that rate, and the time period for each component. Notwithstanding other sections of this document which may require sharing Member-level data, the MCP is not required to share Member-level data for each component; however, MCPs are encouraged to share Member-level data where relevant and useful to aid quality improvement and population health efforts. For example, for cervical cancer screening, the MCP must provide the rate, the numerator and denominator associated with the rate, and the time period used for numerator, denominator, and rate. As another example, if a measure rate is a utilization rate of visits per 1,000 Member months, then the MCP must provide the number of visits, number of Member months, and the time period for all components.

Where data must be supplied, data which may be required include but are not limited to the following: Enrollment files/rosters for Primary Care assignment, current and historical claims data, pharmacy data (which is provided to MCPs daily pursuant to APL 25-013: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX or any superseding APL), admission/discharge/transfer (ADT) feed data, and/or care management assignment and data.

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[3]APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. The current list of APLs associated with programs approved or pending approval by CMS at the time of the publication of this APL are: APL 21-015, APL 21-018, APL 23-008, APL 23-014, APL 23-015, APL 23-016, APL 23-017, APL 23-019, APL 24-003, APL 24-007, APL 24-009, APL 24-010, APL 24-011, and APL 25-002.

[4] All data sharing is subject to the applicable data sharing, privacy, and security provisions of the MCP Contract and related guidance.

In programs where Providers calculate their own performance, MCPs must supply Providers the necessary data to calculate performance on measures in programs. These data must be provided as outlined in the table below. If DHCS is the source for data and the MCP does not have access to these data (due to action or inaction on the part of DHCS), then the MCP is not compelled to provide data it does not have access to. For example, if the pharmacy data feed is unavailable, then the MCP is not compelled to provide the pharmacy data it does not have access to. MCPs are encouraged to regularly ingest and utilize outside data made available through DHCS. MCPs are required to access all sources of data that are available from DHCS in a timely manner. MCPs neglecting to utilize DHCS data sources run the risk of incomplete data sets and miscalculated rates, which can have a negative impact on Providers in the programs listed in this APL.

To the extent permissible by federal and state statutes and regulations and subject to the minimum necessary standard of the Health Insurance Portability and Accountability Act (HIPAA)[5], if a measure in a specific program has a denominator broader than Members assigned to the Provider for Primary Care, then MCPs must share data for Members beyond those assigned to the Provider for Primary Care. For example, if a Provider's performance is measured based on an Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence or Follow-Up After Emergency Department Visit for Mental Illness denominator, that denominator would include Member seen in the Provider's emergency department regardless of where the Member is assigned for Primary Care.

[5]Assembly Bill 133 (Statutes 2021, Chapter 143) added Welfare & Institutions Code Section 14184.102(j), which provides an exemption from state and local privacy laws to permit Medi-Cal partners to disclose protected health information and personally identifiable information to other Medi-Cal partners to the extent necessary to implement applicable California Advancing and Innovating Medi-Cal (CalAIM) components and the CalAIM Terms and Conditions, and to the extent consistent with federal law. With respect to the minimum necessary standard, 45 Code of Federal Regulations (CFR) 164.502(b) requires that "[w]hen using or disclosing protected health information or when requesting protected health information from another covered entity or business associate, a covered entity or business associate must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request." MCPs should consult with their legal counsel with respect to compliance with state and federal privacy law and data sharing practices.

Data Elements	**Minimum Frequency MCPs Must Provide Data** (request may be from Providers, DHCS contractor, and/or DHCS)	**Data Format**	**Required Turnaround from Date of Request*** (by Provider, DHCS contractor, and/or DHCS)	**Recommended**
ADT feed data	Real-time** to Providers	MCP must facilitate an interface with a California Health and Human Services Agency Data Exchange Framework (DxF) Qualified Health Information Organization (QHIO) and make data available to Providers through that QHIO.	Real-time notifications (if Provider has implemented an interface with a DxF QHIO)	N/A
Enrollment files and rosters***	Monthly on request	• Enrollment Files: 834 (when DHCS requests data) • Enrollment Rosters: machine-readable format	Within seven calendar days of request by Provider and up to a maximum of once monthly	Available in real-time via a portal
Gaps in care files (a list of Members meeting and not	Monthly on request	• FHIR or Electronic Data Interchange, OR Machine-	Within seven calendar days of request by	N/A

Data Elements	**Minimum Frequency MCPs Must Provide Data** (request may be from Providers, DHCS contractor, and/or DHCS)	**Data Format**	**Required Turnaround from Date of Request*** (by Provider, DHCS contractor, and/or DHCS)	**Recommended**
meeting numerator criteria for each quality measure)****		readable format	Provider and up to a maximum of once monthly	
Pharmacy claims/Encounter Data (inclusive of Behavioral Health medications)*****	Monthly on request	• 837 files • National Council for Prescription Drug Programs sent via FHIR	Within 14 calendar days of request by Provider and up to a maximum of once monthly	Pushed to Providers on monthly basis or provided through DxF QHIO
Professional and Facility Claims and Encounter Data (inclusive of 42 CFR Part 2 data where legally permissible)	Quarterly on request	• 837, OR • FHIR	Within 30 calendar days of request by Provider and up to a maximum of once quarterly	Pushed to Providers on monthly basis or provided through DxF QHIO
Quality measure performance rates on measures that MCP is responsible for calculating,	Quarterly on request	• Machine-readable format	Within 45 calendar days of request by Provider or DHCS and no more	Create and maintain portals, dashboards, or other data repositories that allow Provider

Data Elements	**Minimum Frequency MCPs Must Provide Data** (request may be from Providers, DHCS contractor, and/or DHCS)	**Data Format**	**Required Turnaround from Date of Request*** (by Provider, DHCS contractor, and/or DHCS)	**Recommended**
including immediate mathematical components used to calculate rates (performance rates must be rolling 12 months to allow trending over time)			than once quarterly	real-time and self-serve access to performance rates (while recommended in this APL, some specific programs might require one or more of these)

*The date of the request is the date where all the information needed for the MCP to act on the request is made available by the Provider, DHCS contractor, and/or DHCS (the "requestor". Where the requestor has not provided the MCP with all of the information needed to act on the request, the MCP must follow up with the requestor to ask for the missing information within 14 calendar days. Requests cannot be made for data needed in the future; however, requestors may make MCPs aware of future data needs to give the MCPs more time to prepare data. Additionally, where data are available on demand to a requestor (for example, through a portal) in the required format, the turnaround time is not relevant since data are already available to the requestor. Nothing in this APL modifies MCPs' obligations to provide data to DHCS or its contractors as outlined in other sections of the MCP Contract and/or other MCP requirements.

**Real-time data from MCPs is limited by what data are available to and can be reported by MCPs at any given time. For example, claims lag refers to the period between when a service is rendered and associated claims data is available for analysis or reporting. Claims lag can result in a delay in when data can be provided to Providers.

***If measures in a program involve Members assigned for Primary Care to the Provider, then the MCP must share Enrollment files and roster as indicated. Additionally, in some programs, DHCS may require MCPs to provide a total count of Members assigned for Primary Care to a Provider at a given point in time. MCPs must provide this as requested by DHCS or a designated contractor that administers programs.

****Gaps in care files provided to a Provider must include all measures against which that Provider is measured in program(s) and the MCP is responsible for producing rates in program(s). If there are multiple programs, then the gap in care file must include measures across all programs the Provider participates in. Gaps in care files are not required to be generated using the technical specifications listed in subsection Technical Specifications for Provider-Level Measurement, as the software MCPs use may not be able to create gaps in care files using those technical specifications. Gaps in care reports typically only cover prior months rather than the current month; for example, a gaps in care report run in December would cover November.

*****Pharmacy data are generally provided to MCPs by DHCS through Medi-Cal Rx pursuant to APL 25-013.

As of the date of this APL, only QIP and EPT have measures which are directly calculated by Providers; in EPT, the only measures Providers must calculate are those for which MCPs do not have data (for example, third next available appointment metrics). In all other programs, measures are calculated by MCPs or another party (including but not limited to DHCS and DHCS' contractors). For example, in SNF WQIP, a contractor of DHCS calculates performance rates on multiple measures using national data sets including the CMS Minimum Data System (MDS).

In some programs, a DHCS contractor administers the program and is a Business Associate of DHCS. In these cases, DHCS may instruct MCPs to share data with a contractor as necessary for the contractor to carry out the contractor's scope of work. If the data being transferred does not include any Personal Information[6] or Protected Health Information[7] and has been de-identified in accordance with the DHCS Data De-Identification Guidelines v2.2 (or current version)[8], then use and disclosure of such data is permissible under HIPAA and California Confidentiality of Medical Information Act. DHCS will provide, upon request of the MCP, confirmation that the contractor is a Business Associate of DHCS and whether the request is for de-identified data.

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[6] "Personal Information" is defined in Civ Code section 1798.3(a).
[7] "Protected Health Information" is defined in 45 CFR section 160.103.
[8] For more information see:
https://www.dhcs.ca.gov/dataandstats/Pages/PublicReportingGuidelines.aspx

MCPs are highly encouraged to accept all relevant supplemental data from Providers in programs in order to maximize potential performance on quality measures in these programs and improve data integrity as well as the MCP's overall performance on these measures. For example, where the National Committee on Quality Assurance (NCQA) and DHCS requirements on methodology allow, MCPs are highly encouraged to accept glycated hemoglobin (A1c) data (outside of claims data) as supplemental data for the measure Hemoglobin A1c Control for Patients with Diabetes.

Technical Specifications for Provider-Level Measurement

In programs, DHCS strives to use measure specifications that are as similar as possible to specifications from national measure stewards (for example, NCQA Healthcare Effectiveness Data and Information Set, CMS MDS, or similar specifications). However, for programmatic and strategic reasons, use of specifications from national stewards is not always possible. When MCPs are required to calculate performance rates on behalf of Providers, MCPs must follow the specification for the measure in the program. When implementing specifications, DHCS will consider the timeline required for MCPs to implement a new or changed measure specification.

DHCS has released the California Technical Specifications (CaTS) for measures in programs[9], which provides specific direction to MCPs on how to calculate Provider-level quality measure performance. In parallel to CaTS, DHCS may also release program-specific guidance for how to calculate Provider-level performance. For example, in SNF WQIP, the Technical Program Guide[10] describes how to calculate claims-based clinical measures. In some cases, DHCS may need to provide the MCP with a technical specification. DHCS' goal is to eventually include all MCP-calculated Provider-level measures in CaTS.

Dispute Process

MCPs must work with Providers to ensure measure rate production is accurate and complete. Various data elements shared throughout the year (for example, Enrollment rosters, quarterly quality measure performance rates, gaps in care, etc.) will help MCPs and Providers identify and address concerns as early as possible, thus minimizing the chance of disputes.

MCPs are required to have a dispute resolution process for Providers who disagree with the MCP data or rate production, and/or in cases where the MCP is not working with the Provider in a meaningful way to resolve data concerns or discrepancies. This dispute

[9] See https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx for a link to CaTS
[10] See https://www.dhcs.ca.gov/services/Documents/WQIP-PY-2-Technical-Program-Guide.pdf

process must follow the MCP Contract Exhibit B, Attachment III, Subsection 3.2.2. [11] Providers may submit a dispute to the MCP in accordance with Subsection 3.2.2. The dispute process should be no longer than 90 calendar days from the dispute being formally filed by the Provider and the final disposition of the dispute. If Providers request Member-level data to assist in validating data elements and measure rates, then the MCP must provide Member-level data. The MCP must determine what level of Member-level data is appropriate to provide given the nature of the dispute.

Note that the dispute process may not align with the payment timeline in a specific program, given the timeline between rate production and payments being made may be less than 90 calendar days in some programs. Whether any retroactive change to payments can occur in a program if the dispute process results in a change to data and/or a measure rate depends on the specifics of each program, including but not limited to CMS requirements.

MCP Communication

When Providers contact the MCP with questions or concerns about a program, the initial recipient of communication at each MCP must either address the issue or connect the Provider with a designated program-specific subject matter expert (SME). The program-specific SME may be a specific person or a shared inbox that is answered by SMEs. If a shared inbox is used, the inbox cannot be a general-purpose inbox for Providers; the shared inbox must be specific to the program.

MCPs must submit contact information for program-specific SMEs to the "Liaison Directory" section available on the Managed Care Operations Division (MCOD)-MCP Submission Portal. However, note that program-specific SMEs referenced in this APL are not formal liaisons of the MCPs; rather, program-specific SMEs serve to triage communications and connect Providers with the relevant MCP resources to address the issue.

Policies and Procedures

In order to handle any type of inquiry, MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to the MCOD-MCP Submission Portal[12] within 90

[11] The MCP-Provider dispute resolution process in Exhibit B, Attachment III, Subsection 3.2.2 governs, even though data quality and measure rate production is not currently listed as one of the areas subject to the provision in the MCP Contract. DHCS will amend the MCP Contract to expressly list data quality and measure rate production as a matter subject to Subsection 3.2.2.
[12] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.

calendar days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 calendar days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose enforcement actions, including corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in enforcement actions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,
Original signed by Bambi Cisneros
Bambi Cisneros
Acting Division Chief, Managed Care Quality and Monitoring Division
Assistant Deputy Director, Health Care Delivery Systems