DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: July 25, 2023

ALL PLAN LETTER 23-019
SUPERSEDES ALL PLAN LETTER 19-015

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

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR PHYSICIAN SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified physician services.

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

Assembly Bill (AB) 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305; Senate Bill (SB) 840 (Mitchell, Chapter 29, Statutes of 2018), Section 2, Item 4260-101-3305; AB 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-101-3305; SB 74 (Mitchell, Chapter 6, Statutes of 2020), Section 2, Item 4260-101-3305; AB 128 (Ting, Chapter 21, Statutes of 2021), Section 1, Item 4260-101-3305; and SB 17 (Skinner, Chapter 43, Statutes of 2022), Section 1, Item 4260-101-3305 appropriated Proposition 56 funds to support physician services for Medi-Cal beneficiaries, which DHCS is completing in managed care in the form of a directed payment arrangement for specified services in accordance with DHCS' developed payment methodology outlined below.[2] Subject to future appropriation of funds by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to continue this directed payment initiative on an annual basis for the duration of the program.

In accordance with Title 42 of the Code of Federal Regulations (CFR) section 438.6(c),[3] the Centers for Medicare and Medicaid Services (CMS) has approved this directed

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] State legislation is searchable at: http://leginfo.legislature.ca.gov/faces/codes.xhtml.
[3] The CFR is searchable at the following link: https://www.ecfr.gov/.

payment arrangement for the following rating periods: State Fiscal Year (SFY) 2017-18; SFY 2018-19; July 1, 2019 to December 31, 2020 (i.e., the "Bridge Period"); calendar year (CY) 2021; and CY 2022. On December 30, 2022, DHCS requested approval from CMS to implement this directed payment arrangement for CY 2023 (i.e., January 1, 2023 through December 31, 2023). The CMS-approved preprints will be made available on DHCS Directed Payments Program website upon CMS approval.[4] The requirements of this APL may change if necessary to obtain CMS approvals applicable to this directed payment arrangement or to comport with future state legislation.

POLICY:
Subject to obtaining the necessary federal approvals and appropriation of funds by the California Legislature, MCPs, either directly or through their Subcontractors, must make uniform and fixed dollar add-on payments to eligible individual Providers rendering specified services with the dates of service specified in Table A below. MCPs must ensure these directed payments are received by the individual rendering Providers that are eligible Network Providers, as defined below. The directed payments must be in addition to whatever other payments eligible Network Providers would normally receive from the MCP or the MCP's Subcontractors.

Eligible Network Providers are Network Providers (as defined in the MCP Contract and 42 CFR section 438.2) that are the individual rendering Providers qualified to provide and bill for the Current Procedural Terminology (CPT) codes specified in Table A. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and American Indian Health Service Programs (as defined in the MCP Contract), as well as Cost-Based Reimbursement Clinics (pursuant to Supplement 5 to Attachment 4.19-B of the State Plan and California Welfare and Institutions Code (W&I) section 14105.24), are not eligible Network Providers for the purposes of this APL. A qualifying physician service is one provided by an eligible Network Provider where a specified service is provided to a Member enrolled in the MCP who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). The MCP must ensure qualifying physician services reported using the specified CPT codes are appropriate for the services being provided and reported to DHCS in Encounter Data pursuant to APL 14-019: Encounter Data Submission Requirements, and any subsequent iterations on this topic.[5] The uniform dollar add-on amounts of the directed payments vary by CPT code and apply to the specified dates of service.

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[4] DHCS' Directed Payments Program webpage is available at the following link: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[5] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

TABLE A

CPT Code	Description	Uniform Dollar Add-On Amount	Dates of Service
90791	Psychiatric Diagnostic Eval	$35.00	7/1/2017-Ongoing
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	7/1/2017-Ongoing
90863[6]	Pharmacologic Management	$5.00	7/1/2017-12/31/2020
99201	Office/Outpatient Visit New	$10.00	7/1/2017-6/30/2018
99201[7]	Office/Outpatient Visit New	$18.00	7/1/2018-12/31/2021
99202	Office/Outpatient Visit New	$15.00	7/1/2017-6/30/2018
99202	Office/Outpatient Visit New	$35.00	7/1/2018-Ongoing
99203	Office/Outpatient Visit New	$25.00	7/1/2017-6/30/2018
99203	Office/Outpatient Visit New	$43.00	7/1/2018-Ongoing
99204	Office/Outpatient Visit New	$25.00	7/1/2017-6/30/2018

[6] 90863 was terminated 12/31/2020 because it is no longer reimbursable after DOS 9/1/2020. https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30612.aspx
[7] 99201 was terminated as of 12/31/2021. https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

CPT Code	Description	Uniform Dollar Add-On Amount	Dates of Service
99204	Office/Outpatient Visit New	$83.00	7/1/2018-Ongoing
99205	Office/Outpatient Visit New	$50.00	7/1/2017-6/30/2018
99205	Office/Outpatient Visit New	$107.00	7/1/2018-Ongoing
99211	Office/Outpatient Visit Est	$10.00	7/1/2017-Ongoing
99212	Office/Outpatient Visit Est	$15.00	7/1/2017-6/30/2018
99212	Office/Outpatient Visit Est	$23.00	7/1/2018-Ongoing
99213	Office/Outpatient Visit Est	$15.00	7/1/2017-6/30/2018
99213	Office/Outpatient Visit Est	$44.00	7/1/2018-Ongoing
99214	Office/Outpatient Visit Est	$25.00	7/1/2017-6/30/2018
99214	Office/Outpatient Visit Est	$62.00	7/1/2018-Ongoing
99215	Office/Outpatient Visit Est	$25.00	7/1/2017-6/30/2018
99215	Office/Outpatient Visit Est	$76.00	7/1/2018-Ongoing
99381	Initial Comprehensive Preventive Med E&M (<1 Year Old)	$77.00	7/1/2018-Ongoing

CPT Code	Description	Uniform Dollar Add-On Amount	Dates of Service
99382	Initial Comprehensive Preventive Med E&M (1-4 Years Old)	$80.00	7/1/2018-Ongoing
99383	Initial Comprehensive Preventive Med E&M (5-11 Years Old)	$77.00	7/1/2018-Ongoing
99384	Initial Comprehensive Preventive Med E&M (12-17 Years Old)	$83.00	7/1/2018-Ongoing
99385	Initial Comprehensive Preventive Med E&M (18-39 Years Old)	$30.00	7/1/2018-Ongoing
99391	Periodic Comprehensive Preventive Med E&M (<1 Year Old)	$75.00	7/1/2018-Ongoing
99392	Periodic Comprehensive Preventive Med E&M (1-4 Years Old)	$79.00	7/1/2018-Ongoing
99393	Periodic Comprehensive Preventive Med E&M (5-11 Years Old)	$72.00	7/1/2018-Ongoing
99394	Periodic Comprehensive Preventive Med E&M (12-17 Years Old)	$72.00	7/1/2018-Ongoing
99395	Periodic Comprehensive Preventive Med E&M (18-39 Years Old)	$27.00	7/1/2018-Ongoing

Data Reporting

MCPs must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guidance" document available on the DHCS Directed Payments Program website, which is hereby incorporated herein by reference.[8]

Payment and Other Financial Provisions

[8] The "Prop 56 Directed Payments Expenditures File Technical Guidance" document is available at the following link: https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Proposition-56-Directed-Payments-Expenditures-File-Technical-Guidance.pdf

MCPs must ensure the payments required by this APL are made within the timely payment standards in the Contract for clean claims or accepted encounters that are received by the MCP or Subcontractor no later than one year after the date of service. [9] The Contract specifies the requirements pertaining to timely payment in Exhibit A, Attachment 8, Provision 5.[10]

MCPs have an obligation to communicate and provide clear policies and procedures to their Network Providers with respect to the MCP's claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, the MCP is not required to make payments for claims or submitted encounters submitted one year following the date of service. These timing requirements may be waived through an agreement in writing between the MCP (or the MCP's Subcontractors) and the Network Provider.

MCPs and their Subcontractors must not pay any amount for any services or items, other than Emergency Services, to Provider that is suspended, excluded, or terminated from the Medi-Cal program.[11] This prohibition must apply to non-emergency services furnished by a Provider at the medical direction or prescribed by a suspended, excluded, or terminated Provider when the Provider knew or had a reason to know of the suspension, exclusion, or termination, or by a suspended, excluded, or terminated Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

As required by the Contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgement, and resolution of Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying physician service, how payments will be processed, how to file a grievance, and how to identify the responsible payor. In addition, MCPs must include an itemization of payments made with each payment to the Network Provider in accordance with this APL. The itemization must include

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[9] A "clean claim" is defined in 42 CFR section 447.45(b). Additionally, MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP Contracts and amendments executed thereto.

[10] MCP boilerplate Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP Contracts and amendments executed thereto.

[11] See MCP Contract at Exhibit E, Attachment 2, Program Terms and Conditions.

sufficient information to uniquely identify the qualifying service for which payment was made, be provided upon the Network Provider's request unless the MCP has established a periodic dissemination schedule and be made available in electronic format when feasible.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in the MCP's actuarially certified, risk-based capitation rates. For SFY 2018-19, the portion of Capitation Payments to the MCP attributable to this directed payment arrangement shall be subject to a minimum medical expenditure percentage and for the rating periods of July 1, 2019, to December 31, 2020, and all subsequent years, the portion of Capitation Payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the applicable CMS-approved preprints, which will be made available on the DHCS' Directed Payments Program website upon CMS approval.[12] The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

If the requirements contained in this APL necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its MCOD contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an e-mail confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed, and that no changes are necessary. The e-mail confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their 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.[13] These requirements must be communicated by each MCP to all applicable Subcontractors and Network Providers. DHCS may impose corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

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[12] DHCS' Directed Payment Program website is located at the following link: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

[13] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

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

Sincerely,

Original Signed Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division