CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: August 19, 2025

ALL PLAN LETTER 25-012

SUPERSEDES ALL PLAN LETTERS 24-007,10-014 AND 10-003

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: TARGETED PROVIDER RATE INCREASES

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on eligible Network Provider[1,2] payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024. Provisions of this APL regarding augmented reimbursement rates for comprehensive family planning services enacted through Senate Bill (SB) 94 (Chapter 636, Statutes of 2007) supersede APLs 10-003 and 10-014 with retroactive effect for dates of service not included in TRI. Furthermore, provisions of this APL apply to out-of-Network providers outlined in Exhibit A, Attachment III, Subsection 3.3 (Provider Compensation Agreements) of the MCP Contract (including, but not limited to, family planning services, sexually transmitted diseases services, human immunodeficiency virus testing and counseling, and Minor Consent Services).

BACKGROUND:

Pursuant to the 2023 Budget Act and AB 118 (Chapter 42, Statutes of 2023),[3] which enacted Welfare and Institutions Code (W&I) section 14105.201, the Department of Health Care Services (DHCS) increased rates for targeted services, as applicable on a procedure code basis, to no less than 87.5% of the lowest California-specific Medicare locality rate as outlined in the TRI Fee Schedule, inclusive of eliminating applicable AB 97 (Chapter 3, Statutes of 2011) Provider payment reductions and incorporating applicable Proposition 56 physician services supplemental payments into the TRI Fee Schedule.[4] For services that did not have a rate established by Medicare, DHCS calculated an equivalent rate benchmark and increase. The federal Centers for

[1] For definition of Network Provider, see Sec 1.0 over MCP Contract available at: https://www.dhcs.ca.gov/provgovpart/Documents/2024-Managed-Care-Boilerplate-Contract.pdf
[2] One-time agreements, single-case agreements, and letters of agreement generally do not meet the requirements to be considered Network Provider Agreements.
[3] AB 118 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB118.
[4] AB 97 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB97.

Medicare & Medicaid Services (CMS) approved State Plan Amendment (SPA) 23-0035 implementing the TRI Fee Schedule for the Medi-Cal Fee-For-Service (FFS) delivery system.[5]

The TRI Fee Schedule is established in Supplement 40 to Attachment 4.19-B of the California Medicaid State Plan.[6] Procedure codes on the TRI Fee Schedule are categorized as Primary/General Care, Obstetric Care, and Non-Specialty Outpatient Mental Health Services.

The TRI Fee Schedule rates apply to procedure codes identified as Primary/General Care services billed using Health Insurance Claim Form (CMS-1500) and rendered by an otherwise eligible Network Provider in the following Provider type categories, without regard to the rendering Provider's specialty:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwives
- Licensed Midwives
- Doula Providers
- Psychologists
- Licensed Professional Clinical Counselor
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists

The TRI Fee Schedule rates apply to procedure codes identified as Obstetric and Non-Specialty Mental Health Services when billed or rendered by an otherwise eligible Network Provider without regard to claim type or the Provider's specialty.

The TRI Fee Schedule rates are subject to further adjustment for specified codes:

- 39.7% payment augmentation for specified physicians' services provided to a Medi-Cal member eligible under the California Children's Services program.
- 20% payment reduction for specified procedures performed in outpatient facilities.

The TRI Fee Schedule rates do not apply to services which receive a greater net reimbursement amount, inclusive of any supplemental payments, pursuant to the California Medicaid State Plan in effect on December 31, 2023 (referred to as the "Legacy Fee Schedule" rates).

---

[5] SPA 23-0035 is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-23-0035-Approval.pdf.

[6] Supplement was previously numbered 39 in error and has been updated to 40. The California Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx.

The TRI Fee Schedule rates do not apply to reimbursement for services billed or rendered by Assistant Surgeons.

The TRI Fee Schedule rates also do not apply to reimbursement for services billed or rendered by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) (pursuant to pages 6-11 of Attachment 4.19-B of the State Plan), Indian Health Care Providers (pursuant to Supplement 6 of Attachment 4.19-B of the State Plan), and Cost-Based Reimbursement Clinics (pursuant to Supplement 5 of Attachment 4.19-B of the State Plan and W&I section 14105.24).

The TRI Fee Schedule does not supersede FFS benefit and billing policies described in the California Medicaid State Plan, Medi-Cal Provider Manual[7], Medi-Cal Provider Bulletins[8], or Title 22, Division 3 of the California Code of Regulations (CCR)[9] including, but not limited to, Benefit Restrictions and Multiple Procedure Payment Reductions.

In accordance with W&I section 14105.201(b), and subject to receiving all necessary federal approvals, a directed payment arrangement in the Medi-Cal managed care delivery system is authorized pursuant to 42 Code of Federal Regulations (CFR) section 438.6(c)(2)(ii), as a minimum fee schedule for Network Providers that provide particular Covered Services using State Plan approved rates in accordance with 42 CFR section 438.6(c)(1)(iii)(A).[10]

SB 94 added W&I section 14105.181 requiring the Medi-Cal program to, effective January 1, 2008, increase rates for comprehensive clinical family planning services when specified evaluation and management office visits are billed in conjunction with specified family planning diagnosis codes. These rate increases are reflected in Attachment 4.19-B, page 3g, of the California Medicaid State Plan. Legacy Fee Schedule rates for comprehensive family planning services are published in the SB 94 Comprehensive Family Planning Services Fee Schedule located on the TRI website.[11,12]

---

[7] Medi-Cal Provider Manuals are available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual.
[8] Medi-Cal Provider Bulletins are available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/bulletin.
[9] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[10] The CFR is searchable at: https://www.ecfr.gov/.
[11] The TRI website is available at: https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx.
[12] Exhibit A, Attachment I, Article 1.0 (Definitions) of the MCP Contract defines “Medi-Cal FFS Rate” as “the rate that DHCS pays Providers on a per unit or per procedure billing code basis.” Because the State Plan’s payment requirements apply to specific procedural codes (99202, 99203, 99204 etc.), the “FFS rate” for these services accounts for the SB 94 rate augmentation, and the augmentation is not considered a supplemental payment.

POLICY:

For dates of service on or after January 1, 2024, MCPs[13] must comply with a minimum fee schedule for each qualifying service provided by an eligible Network Provider and eligible for reimbursement at the TRI Fee Schedule rates pursuant to paragraph 3 of Supplement 40 to Attachment 4.19-B of the California Medicaid State Plan.[14] Additionally, MCPs must comply with a minimum fee schedule for each qualifying comprehensive family planning service, as described on page 3g of Attachment 4.19-B of the California Medicaid State Plan, provided by an eligible Network Provider or out-of-Network Provider and eligible for reimbursement at a Legacy Fee Schedule rate exceeding the TRI Fee Schedule rate under paragraph 4 of Supplement 40 to Attachment 4.19-B of the California Medicaid State Plan. Other services eligible for reimbursement at a Legacy Fee Schedule rate exceeding the TRI Fee Schedule rate are not subject to the minimum fee schedule requirement established by this APL.

MCPs must ensure that eligible Network Providers receive no less than the applicable minimum fee schedule rates for qualifying services. In instances where the Network Provider is reimbursed on a per-service basis, this requirement applies at the procedure code level. In instances where the Network Provider is reimbursed on a capitated basis, MCPs must ensure the Network Provider receives reimbursement that provides payment that is equal to, or projected to be equal to, the TRI Fee Schedule rate for applicable services at minimum. MCPs must attest to compliance with this requirement in a form and manner specified by DHCS. MCPs must provide documentation of any methodologies and analyses that support their attestation to DHCS upon request. MCPs may require and rely upon similar attestations and supporting documentation by their Subcontractors and Downstream Subcontractors. Additional guidance regarding the attestation and related documentation requirements will be posted on the TRI website.

This APL does not apply to claims under the Children and Youth Behavioral Health Initiative (CYBHI) school-linked fee schedule which will be addressed in a forthcoming APL.

Additional Provider Payment Requirements

Exhibit A, Attachment III, Subsection 3.3 (Provider Compensation Agreements) of the MCP Contract requires MCPs to reimburse specified services billed or rendered by eligible out-of-Network Providers (including, but not limited to, family planning services, sexually transmitted diseases services, human immunodeficiency virus testing and counseling, and Minor Consent Services) at no less than the Medi-Cal FFS Rate. Exhibit A, Attachment I, Article 1.0 of the MCP Contract defines “Medi-Cal FFS Rate” as “the rate that DHCS pays Providers on a per unit or per procedure billing code basis. Therefore, for dates of service on or after January 1, 2024, MCPs must reimburse these

[13] See Section 3.1.5 of the MCP Contract regarding Subcontractor and Downstream Subcontractor Agreement Requirements.
[14] Supplement 40 to Attachment 4.19-B of the California Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement-39-to-Attachment-419-B.pdf.

specified out-of-Network services at the greater of the Legacy Fee Schedule rate or, if applicable, the TRI Fee Schedule rate. For dates of service prior to January 1, 2024, MCPs must reimburse these specified out-of-Network services at the Medi-Cal FFS rate effective for the date of service.

FQHC and RHC services do not qualify for payment under the TRI Fee Schedule in the FFS delivery system and thus are not qualifying services for the purposes of the minimum fee schedule directed payment arrangement established by this APL. Pursuant to W&I section 14087.325(d) and Social Security Act § 1903(m)(2)(A)(ix)., MCPs are required to pay contracted FQHCs and RHCs in a manner that is no less than the level and amount of payment that the MCP would make for the same services if the services were furnished by another Provider type that is not an FQHC or RHC (the "FQHC/RHC Payment Parity Requirement"). For dates of service on or after January 1, 2024, the FQHC/RHC Payment Parity Requirement includes the TRI minimum fee schedule requirements established by this APL for applicable services furnished by eligible Network Providers that are not FQHCs or RHCs. MCPs must document the methodology by which the MCP determines the level and amount of payment required under the FQHC/RHC Payment Parity Requirement and must make this methodology available to DHCS and contracted FQHCs and RHCs upon request. MCPs must also comply with the requirements of Exhibit A, Attachment III, Subsection 3.3.7 (Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider) of the MCP Contract specific to non-contracting FQHCs and RHCs.

The payment requirements of this APL pertain to payments for or attributable to specified services. DHCS has developed capitation rates for MCPs accounting for these increases as specified in this APL. In instances where MCP historical payment levels to providers exceed the TRI Fee Schedule, DHCS funded MCPs assuming that MCPs would continue to pay the greater of the TRI Fee Schedule rate or the historical contractual rates for applicable service codes, inclusive of Proposition 56 Physician Services supplemental funding.

Nothing in this APL constitutes a requirement for MCPs to maintain or increase total payments across all services or assigned Members to an eligible Network Provider relative to historical total payment levels to that Provider, except insofar as is necessary to ensure the eligible Network Provider receives no less than the TRI Fee Schedule rates for qualifying services. Total payments may include services not covered by this APL and is affected by factors outside the scope of this APL, such as changes in the quantity of services rendered or Members assigned. Further, this APL does not obligate MCPs that historically paid eligible Network Providers for applicable services at a set percentage of the Legacy Fee Schedule rates to continue to pay the same percentage of the TRI Fee Schedule rates, and DHCS did not develop capitation rates for MCPs for such additional increases. For reference purposes, DHCS has retained the Legacy Fee Schedule rates on the main Medi-Cal rates website.[15] TRI Fee Schedule rates are

[15] The main Medi-Cal rates website is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates.

indicated by procedure type “X”, while Legacy Fee Schedule rates are indicated by all other procedure types.

Data Reporting

MCPs must ensure qualifying services are reported using the specified Healthcare Common Procedure Coding System and Current Procedural Terminology codes and 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 APLs on this topic.[16]

MCPs must follow the reporting requirements which will be available on the TRI website and the DHCS Directed Payments Program website[17] and requested through a Supplemental Data Request (SDR).

No sooner than January 1, 2025, DHCS will leverage the SDR to collect data and verify full compliance in accordance with this APL for the calendar year 2024 dates of service.

Payment and Other Financial Provisions

MCPs, and their Subcontractors and Downstream Subcontractors as applicable, must achieve full compliance with this APL by December 31, 2024. Full compliance includes ensuring that eligible Network Providers receive payment in accordance with this APL, including retroactive adjustments where necessary, by the compliance date, except for instances where payment would not otherwise be due by that date.[18]

Pursuant to Supplement 40 to Attachment 4.19-B of the California Medicaid State Plan, DHCS may make technical revisions and corrections to the TRI Fee Schedule as necessary, such as to account for changes to coding and billing definitions. MCPs are not subject to compliance with technical revisions and corrections to the TRI Fee Schedule until so directed.

MCPs that fail to meet these compliance timelines may be subject to interest penalties, corrective action, and other remedies available under state law and the MCP Contract. Until such time that MCPs achieve full compliance with the requirements of this APL, DHCS anticipates MCPs will ensure that eligible Network Providers continue to receive the equivalent value of former Proposition 56 physician services supplemental

---

[16] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[17] DHCS’ Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[18] Such instances (where payment would not otherwise be due by December 31, 2024) include where the MCP has not received a Clean Claim, where less than 30 days has elapsed since the MCP received the Clean Claim, or where the MCP and Network Provider have mutually agreed to an alternative payment schedule. For more information, see APL 23-020: Requirements for Timely Payment of Claims, available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-020.pdf.

payments.[19] To protect Members' access to Covered Services, DHCS reserves the right to establish shorter compliance timelines for any MCP that fails to ensure eligible Network Providers continue to receive said payment until the MCP achieves full compliance with the requirements of this APL.

MCPs must ensure that payments pursuant to this APL are made in accordance with the timely payment standards for Clean Claims[20] in the MCP Contract or accepted Encounters that are received by the MCP, or the MCP's Subcontractors or Downstream Subcontractors, within one year of the date of service, notwithstanding the compliance timelines specified above, if inapplicable, or unless otherwise specified by further DHCS guidance. Requirements pertaining to timely payment are specified in the MCP Contract, Exhibit A, Attachment III, Subsection 3.3.5 (Claims Processing)[21] and in APL 23-020: Requirements for Timely Payments of Claims.

MCPs must communicate and provide clear Policies and Procedures (P&Ps) to their Network Providers with respect to the MCPs' 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 P&Ps, the MCP is not required to make payments for claims or Encounters submitted one year following the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's Subcontractors or Downstream Subcontractors) and the Network Provider.

MCPs and their Subcontractors, and Downstream Subcontractors, must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider, as defined in Exhibit A, Attachment I, Article 1.0 (Definitions) of the MCP Contract, or to any suspended and/or ineligible Providers. This prohibition must apply to non-emergent services furnished by a Provider at the medical direction of or prescribed by an Excluded Provider, or a suspended and/or ineligible Provider, when the Provider knew or had a reason to know of the exclusion, suspension, and/or ineligibility, or furnished by a restricted Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

As required by the MCP Contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of payments required by this APL. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility (DOFR) provisions as appropriate, to ensure compliance with this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a

---

[19] Requirements for all other Proposition 56 Directed Payments remain specified in their respective APLs or any superseding APLs. See APL 23-008, APL 23-015, APL 23-016, APL 23-017, and APL 23-019.
[20] A "Clean Claim" is defined in 42 CFR section 447.45(b) and in the MCP Contract in Exhibit A, Attachment I, Article 1.0 (Definitions).
[21] MCPs are also advised to review their specific MCP Contract and amendments executed thereto.

minimum, include a description of the minimum requirements for a qualifying service, how payments will be processed, how to file a grievance, and how to identify the responsible payor. In addition, for retroactive adjustments to per-service or capitated payments made to an eligible Network Provider in accordance with this APL, MCPs must make available to the Provider an itemization of the payment adjustments in an electronic format. The itemization must include sufficient information for the Provider to uniquely identify the value of the adjustment for each claim for qualifying services or each assigned Member, as applicable, for which a retroactive payment adjustment was made.

The requirements contained in this APL may necessitate a change in MCPs' contractually required P&Ps. MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCOD) Contract Oversight SharePoint Submission Portal[22] within 90 days of the release of this APL. MCPs must also review their Network Provider Agreements as applicable and determine whether updates are needed.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, MCP 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 Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. 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 a CAP and subsequent sanctions.

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

Sincerely,

Original signed by Rafael Davtian

Rafael Davtian

Acting Division Chief, Capitated Rates Development Division and

Deputy Director, Health Care Financing

[22] The MCOD Contract Oversight SharePoint Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Contract%20Oversight.aspx.