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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: December 24, 2019

ALL PLAN LETTER 19-015
SUPERSEDES ALL PLAN LETTER 19-006

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 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 840 (Mitchell, Chapter 29, Statutes of 2018), Section 2, Item 4260-101-3305; and AB 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-101-3305 appropriate Proposition 56 funds for State Fiscal Year (SFY) 2017-18, and SFY 2018-19, and SFY 2019-20, respectively, including a portion to be used for directed payments for specified services in managed care according to the DHCS-developed payment methodology outlined below.[2] Subject to future budgetary authorization and appropriation by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis for the duration of the program.

On February 21, 2018, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services (CMS) to implement this directed payment arrangement, in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2), for the period of SFY 2017-18.[3] On January 14, 2019, DHCS obtained federal approval

[1] This APL does not apply to Prepaid Ambulatory Health Plans and Rady Children's Hospital.
[2] California Law Code is searchable at http://leginfo.legislature.ca.gov/faces/codes.xhtml.
[3] CFRs are searchable at: https://www.ecfr.gov/cgi-bin/ECFR?SID=d15b0ce81c0ea804f39e129fd7f11a5f&mc=true&page=browse.

from CMS to implement this directed payment arrangement, in accordance with 42 CFR, Section 438.6(c)(2), for the period of SFY 2018-19. On June 30, 2019, DHCS requested approval from CMS to implement this directed payment arrangement, in accordance with 42 CFR, Section 438.6(c)(2), for the period of July 1, 2019, through December 31, 2020. The CMS-approved preprint will be made available on DHCS' Directed Payments Program website upon CMS approval.[4] Please note that the requirements of this APL may change based upon future budgetary authorization and appropriation by the California Legislature or the status of the required CMS approvals applicable to this directed payment arrangement.

POLICY:
Proposition 56 appropriated funds will result in directed payments by MCPs and their delegated entities and Subcontractors (as applicable) to individual providers rendering specified services with the dates of service specified in Appendices A, B, and C, as applicable. Consistent with 42 CFR, Section 438.6(c), DHCS is requiring MCPs, and their delegated entities and Subcontractors, to make directed payments for qualifying services (as defined below) in the amounts and for the Current Procedural Terminology (CPT) codes specified in Appendices A, B, and C, as applicable. MCPs are responsible for ensuring these directed payments are received by the individual rendering providers who are eligible Network Providers, as defined below. The directed payments shall be in addition to whatever other payments eligible Network Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors, as Network Providers.

Eligible Network Providers are Network Providers (as defined in the MCP contract and 42 CFR, Section 438.2) who are the individual rendering providers qualified to provide and bill for the CPT codes specified in the table below. Federally Qualified Health Centers, Rural Health Clinics, and American Indian Health Programs (as defined in the MCP contract), as well as Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of the State Plan and California Welfare and Institutions Code Section 14105.24), are not eligible Network Providers for the purposes of this APL. A qualifying 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 is responsible for ensuring qualifying 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*.[5]

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[4] DHCS' directed payments webpage is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[5] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Data Reporting

Starting with the calendar quarter ending June 30, 2018, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2017. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, CPT code, service month, payer (i.e. MCP, delegated entity, or Subcontractor), and rendering Network Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e. Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

MCPs must continue to submit encounter data for the specified CPT codes as required by DHCS; however, there are no new encounter data submission requirements associated with this APL.

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made within the timeframes specified in Appendices A, B, and C. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, 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 service, how payments will be processed, how to file a grievance, and how to determine who the payer will be.

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 shall be subject to a minimum medical expenditure percentage as described in Appendix B. Starting July 1, 2019, the portion of capitation payments to the MCP attributable to this directed payment shall be subject to a two-sided risk corridor as described in Appendix C.

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

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 by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

APPENDIX A

SFY 2017-18 (dates of service between July 1, 2017 and June 30, 2018)

For clean claims or accepted encounters received by the MCP with dates of service between July 1, 2017, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services. These timing requirements apply to payments made directly by the MCP, and by the MCP's delegated entities and Subcontractors at the MCP's direction, and may be waived only if agreed to in writing between the MCP, or the MCP's delegated entities or Subcontractors, and the rendering Network Provider.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

APPENDIX B
SFY 2018-19 (dates of service between July 1, 2018 and June 30, 2019)

For clean claims or accepted encounters received by the MCP with dates of service between July 1, 2018, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying services received by the MCP more than one year after the date of service.[6] These timing requirements apply to payments made directly by the MCP, and by the MCP's delegated entities and Subcontractors at the MCP's direction, and may be waived only if agreed to in writing between the MCP, or the MCP's delegated entities or Subcontractors, and the rendering Network Provider.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	$80.00

[6] If a claim received by the MCP within one year of the date of service was originally denied by the MCP, but the denial was later reversed and the claim approved, the MCP is required to make the payments described in this APL even if the denial was overturned more than one year after the date of service.

CPT	Description	Directed Payment
99383	Initial comprehensive preventive med E&M (5-11 years old)	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	$27.00

The portion of capitation payments to MCPs attributable to this directed payment arrangement (Proposition 56 Physicians Directed Payment capitation) shall be subject to a minimum medical expenditure percentage (MEP), wherein each MCP shall achieve a minimum MEP of no less than 95 percent across all applicable categories of aid within each rating region where the MCP operates. MCPs shall be required to expend at least 95 percent of Proposition 56 Physicians Directed Payment capitation, for each rating region where the MCP operates, for payments required by this APL to eligible Network Providers. No sooner than July 1, 2020, DHCS will utilize each MCP's submitted encounters that have been accepted by DHCS, in accordance with its policies, to calculate the amount of directed payment expenditures issued by the MCP to its eligible Network Providers in accordance with this APL across all applicable categories of aid for the service period of July 1, 2018 through June 30, 2019, which will constitute the numerator of the minimum MEP. DHCS may, at DHCS's discretion, contact MCPs to discuss the preliminary results based on the encounters that have been accepted by DHCS. The denominator of the minimum MEP shall be the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's Proposition 56 Physicians Directed Payment capitation across all applicable categories of aid for SFY 2018-19, as calculated by DHCS. If the MCP's MEP, as defined, for any rating region is less than 95 percent for the rating period, as calculated by DHCS, the MCP shall remit to DHCS the full amount calculated by DHCS within 90 days of notice. In such cases, the remittance amount shall equal the difference between 95 percent of the medical portion of the Proposition 56 Physicians Directed Payment capitation to the MCP and the actual Proposition 56 directed payment expenditures, as calculated by DHCS based on accepted encounters for SFY 2018-19.

APPENDIX C
Dates of service on or after July 1, 2019

Subject to obtaining the necessary federal approvals and budgetary authorization and appropriation by the California Legislature, DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to make directed payments to eligible Network Providers for qualifying services (as defined below) with dates of service beginning July 1, 2019, in accordance with the CMS-approved preprint, which will be made available on the DHCS' Directed Payments Program website upon CMS approval.

For clean claims or accepted encounters received by the MCP with dates of service on or after July 1, 2019, MCPs must ensure that payments required by this APL are made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying services received by the MCP more than one year after the date of service.[7] These timing requirements apply to payments made directly by the MCP, and by the MCP's delegated entities and Subcontractors at the MCP's direction, and may be waived only if agreed to in writing between the MCP, or the MCP's delegated entities or Subcontractors, and the rendering Network Provider.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00

[7] If a claim received by the MCP within one year of the date of service was originally denied by the MCP, but the denial was later reversed and the claim approved, the MCP is required to make the payments described in this APL even if the denial was overturned more than one year after the date of service.

CPT	Description	Directed Payment
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	$27.00

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