Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/08/2024*
Effective Date:	06/04/2020
Revised Date:	07/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima Health shall administer Directed Payments for Qualifying Services rendered to CalOptima Health Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima Health is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima Health shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima Health claims and utilization management policies, including but not limited to CalOptima Health Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct Administrative Members, CalOptima Health Community Network Members, or Members Enrolled in a Shared Risk Group, subject to future budgetary authorization and appropriation by the California Legislature and Centers for Medicare & Medicaid (CMS) approval of the directed payment arrangements. DHCS intends to renew this directed payment arrangement on an annual basis in future years.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Health Direct or a Shared Risk Group on the date of service.

3. The Designated Provider was eligible to receive the Directed Payment.

4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

5. CalOptima Health shall follow all guidelines related to claims determination as outlined in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima Health is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima Health shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

   a. Subject to federal approval, the projected value of Directed Payments will be accounted for in CalOptima Health's actuarially certified capitation rates.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima Health shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima Health shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima Health shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Health Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima Health is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Health Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. Make available to a Provider an itemization of payments made to provider, in accordance with CalOptima Health Policy IS.1600: Provider Access to In-House Provider Portal.

5. For CalOptima Health Direct, how to file a grievance and second level appeal with CalOptima Health. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima Health.

H. CalOptima Health Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima Health, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct-Administrative Members, CalOptima Health Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

J. DHCS may impose Corrective Action Plans (CAPs) as well as administrative and/or monetary sanctions for non-compliance with any of the following outlined procedures in this Policy.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service July 1, 2017, through December 31, 2023, CalOptima Health shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member. Effective January 1, 2024, a Health Network shall reimburse eligible providers at a targeted rate increase (TRI) as specified in Attachment B of this Policy for the applicable procedure codes.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), cost-based reimbursement clinics, American Indian Health Services Programs, and Indian Health Care Providers (IHCP) including Indian Health Services Memorandum of Agreement (IHS-MOA) clinics, FQHCs, Tribal FQHCs, and Community clinics, are not eligible to receive this Add-On Payment for Physician Services. Effective January 1, 2024, these providers are eligible for TRI and a Health Network shall make reimbursement as specified in Attachment B of this Policy for the applicable procedure codes.

    b. Effective January 1, 2024, services eligible for TRI will no longer qualify for proposition 56 supplemental payment. Services that are not eligible for TRI will continue to receive proposition 56 supplemental payment(s) if the provider is eligible.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, CalOptima Health shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            a) On or before the first birthday (twelve (12) months);

b) After the first birthday and before or on the second birthday (twenty-four (24) months); or

c) After the second birthday and on or before the third birthday (thirty-six (36) months).

ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

a) Routine screenings conducted after the third birthday (thirty-six (36) months) are not eligible for an Add-On Payment.

b) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (forty-eight (48) months).

b. Development Screening Services are not subject to any Prior Authorization requirements.

c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family;

v. Any appropriate actions taken;

vi. Completion of the developmental screening with CPT code 96110 without the modifier KX; and

vii. Any additional developmental screenings done when Medically Necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima Health and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima Health shall make a uniform and fixed dollar Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). CalOptima Health may pay for professional, or facility claims that are eligible for reimbursement for payment under the program, but not both, for the same service.

    a. Categories of Family Planning Services:

        i. Long-acting contraceptives

        ii. Other contraceptives (other than oral contraceptives) when provided as a medical benefit

        iii. Emergency contraceptives when provided as a medical benefit

        iv. Pregnancy testing

        v. Sterilization procedures (for females and males)

    b. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this uniform and fixed dollar Add-On Payment for Family Planning Services.

    c. Family Planning Services are not subject to any Prior Authorization requirements including Non-Contracted Providers.

4. VBP Program Services: For dates of services on or after July 1, 2019 to June 30, 2022, CalOptima Health shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

    a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

        i. Possess an individual (Type 1) National Provider Identifier (NPI); and

        ii. Are practicing within their practice scope.

    b. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

    c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima Health shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima Health shall make Add-On Payment

amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

d. CalOptima Health's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima Health shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. CalOptima Health shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima Health and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima Health shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

   a. In instances where a Member is found to have other sources of health coverage, CalOptima Health shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Health Policy FF.2003: Coordination of Benefits.

7. GEMT Services: CalOptima Health shall provide an add-on reimbursement rate to the Medi-Cal fee-for-service (FFS) fee schedule rates for eligible GEMT services to all qualified Medi-Cal GEMTs.

   a. For dates of service on or after July 1, 2018, to June 30, 2024, CalOptima Health shall reimburse non-contracted Quality Assurance Fee GEMT (QAF-GEMT) Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing QAF-GEMT Services to a Member.

   b. For dates of service on or after January 1, 2023, to December 31, 2024, CalOptima Health shall reimburse non-contracted eligible Public Provider GEMT (PP-GEMT), at the FFS rate, including the add on increase for PP-GEMT services and will no longer be eligible to participate on the GEMT QAF program, as specified in Attachment A of this policy for the applicable CPT code, for providing PP-GEMT Services to the Member.

   c. CalOptima Health shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Health Policy FF.2003: Coordination of Benefits.

   b. In instances where a Member is found to have other sources of health coverage, CalOptima Health shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Health Policy FF.2003: Coordination of Benefits.

   c. Providers are eligible to participate in the program if they meet all the following criteria:

      i. Provide GEMT services to Medi-Cal beneficiaries;

      ii. Are enrolled as a Medi-Cal provider for the period being claimed; and

      iii. Are owned or operated by the state, a city, county, city and county, fire protection, special, community services, or health care district, or a federally recognized Indian tribe.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: CalOptima Health must ensure the payments made in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible and the timely payment standards in the contract for Clean Claims or accepted encounters that are received by CalOptima no later than one (1) year after the date of service. Claims received over twelve (12) months from date of service with no valid delay reason code will be denied due to Timely Filing Period Exceeded. The timing requirement may be waived through an agreement in writing between CalOptima Health and the Network Provider. CalOptima Health has no agreement to waive the timing requirements.

    a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima Health to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

    b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima Health receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima Health and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima Health shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima Health shall ensure that Directed Payments required by this Policy are made:

    a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

    b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Health Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health shall:

    a. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

    b. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima Health is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima Health to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima Health identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima Health shall recover from the Provider, in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct-Administrative Members, CalOptima Health Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. For dates of service on or after July 1, 2019, CalOptima Health shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Health Policy FF.2011: Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report in an Excel or Comma Separated Values file format. Reports shall include CalOptima Health's Health Care Plan Code, as well as CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (e.g., CalOptima Health or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

    a. CalOptima Health shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima Health must submit an attestation to DHCS stating that no updated information is available.

    b. If updated information is available for the quarterly report, CalOptima Health must submit the updated data report to DHCS within forty-five (45) days of the end of applicable reporting quarter.

i. Reports must be submitted to DHCS in an Excel or Comma Separated Values file format and include attestation that CalOptima Health considers the report complete.

ii. CalOptima Health must submit updated reports each subsequent quarter in the same format as the initial submission until considered to be complete.

iii. Each updated report submitted by CalOptima Health must replace any prior reports.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes
B. CY 2024 Medi-Cal TRI Fee Schedule

V. REFERENCE(S)

A. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
B. CalOptima Health Policy FF.2003: Coordination of Benefits
C. CalOptima Health Policy FF.2011: Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
D. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
E. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
F. CalOptima Health Policy IS.1600: Provider Access to In-House Provider Portal
G. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
I. State Plan Amendment (SPA) 21-0017: One-Year Reimbursement Rate Add-on for Eligible Ground Emergency Medical Transport Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-008: Proposition 56 Directed Payments for Family Planning Services (Supersedes APL 22-011)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-014: Proposition 56 Value- Based Payment Program Directed Payments (Supersedes APL 22-019)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-015: Proposition 56 Directed Payments For Private Services (Supersedes APL 19-013)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-016: Directed Payments for Developmental Screening Services (Supersedes APL 19-016)
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-017: Directed Payments for Adverse Childhood Experiences Screening Services (Supersedes APL 19-018)
T. All Plan Letter (APL) 23-019: Proposition 56 Directed Payments for Physician Services (Supersedes APL 19-015)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-007: Targeted

Provider Rate Increases

V. Department of Health Care Services State Plan Letter (SPA) 22-0015: Public Provider Ground Emergency Medical Transport Intergovernmental Transfer (PP-GEMT IGT)
W. Department of Health Care Services State Plan Letter (SPA) 22-0040: Ground Emergency Medical Transportation (GEMT) Quality Assurance FEE (QAF)
X. Proposition 56 Value-Based Payment Program Measure Valuation Summary Department of Health Care Services State Plan Letter (SPA) 23-0035: Targeted Provider Reimbursement Methodology for Primary/General Care, Obstetric Care, Doula, And Non-Specialty Outpatient Mental Health Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
04/21/2023	Department of Health Care Services (DHCS)	File and Use
10/17/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
12/03/2020	Regular Meeting of CalOptima Board of Directors
05/05/2022	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	12/03/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	05/05/2022	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	09/01/2022	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2022	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	01/01/2023	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	09/01/2023	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	05/01/2024	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	07/01/2024	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members When CalOptima Health is Financially Responsible for the Qualifying Services	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima Health.
Adverse Childhood Experiences (ACE) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312;

Term	Definition
	9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.

Term	Definition
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima Health to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Health Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima Health does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).

Term	Definition
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health Medi-Cal program and assigned to CalOptima Health Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.

Term	Definition
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.