Policy:	FF.2011
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/08/2024*
Effective Date:	04/02/2020
Revised Date:	07/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which a Health Network shall administer the Directed Payments for Qualifying Services, and processes for the reimbursement of Directed Payments by CalOptima Health to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima Health shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, 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 Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

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

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy;

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy; and

8. A Health Network must not pay any amount for any services or items, other than Emergency Services, to an excluded Provider.

C. CalOptima Health shall include TRI codes' rates into the Health Networks' capitation effective January 1, 2024, and any Proposition 56 codes that are on the TRI fee schedule will no longer be subject to the reimbursement process.

D. A Health Network 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:

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 Ground Emergency Medical Transport (GEMT) Services.

E. A Health Network 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 CalOptima Health, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima Health.

F. A Health Network shall have a process to communicate the requirements of this Policy, 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. How to file a grievance with the Health Network and second level appeal with CalOptima Health;

4. Identify the payer of the Directed Payments. (i.e., Member's Health Network that is financially responsible for the specified Direct Payment.); and

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

G. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment

for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

H. Directed Payment Reimbursement

1. CalOptima Health shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima Health shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima Health for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima Health shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima Health shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima Health shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima Health's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima Health for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima Health and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Health Policy FF.1002: CalOptima Health Medi-Cal Fee Schedule and CalOptima Health shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima Health shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

I. On a monthly basis, CalOptima Health Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

J. A Health Network may file a complaint regarding a Directed Payment received from CalOptima Health in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

K. CalOptima Health shall ensure oversight of the Directed Payment programs in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

L. 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, a Health Network 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, a Health Network 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 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 (48 months).

    b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to 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. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to 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 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. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy is made 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 a Health Network 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). A Health Network 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, a Health Network 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 qualifying 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, a Health Network 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, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network 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. A Health Network is only required to make 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. With respect to an Eligible Contracted Provider, CalOptima Health shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to 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.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy is made available to CalOptima Health and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, a Health Network 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, a Health Network shall take appropriate action for cost avoidance or post-payment recovery, in accordance with its contractual obligations to CalOptima Health.

7. GEMT Services: A Health Network 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, a Health Network 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, a Health Network 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. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

d. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima Health.

e. 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: Health Networks must ensure the payments are made in accordance with CalOptima Health Policy HH.2015: Health Network Claims Processing and the timely payment standards in the contract for Clean Claims or accepted encounters that are received by the Health Network 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 should be denied due to untimely filing. The timing requirement may be waived through an agreement in writing between the Health Network and the Network Provider.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network 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.4. 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 a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network 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, a Health Network 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. Notice by CalOptima Health

a. CalOptima Health, Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima Health received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima Health on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. 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, Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

a. Upon receipt of written notice from CalOptima Health under Section III.B.3.c. of this Policy, a Health Network shall 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 the DHCS issues the final guidance.

b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the 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 the Health Network 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. Directed Payments Processing

1. On a monthly basis, CalOptima Health shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment report(s) in accordance with Section III.D. of this Policy.

   a. Excluding the VBP Program, the CalOptima Health Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

   b. For the VBP Program, on a monthly basis, CalOptima Health's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

      i. The report will include at minimum, a list of:

         a) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

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

         c) Directed Payment amounts.

      ii. CalOptima Health Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Health Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Health Accounting Department, in writing, of the reason for the overpayment. CalOptima Health shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Health Policy FF.1001: Capitation Payments.

   a. CalOptima Health shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

   b. If CalOptima Health adjusts or rejects the overpayment, CalOptima Health shall include the overpayment adjustment in the subsequent month's process.

   c. In the event CalOptima Health identifies that Directed Payments were made by a Health Network 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 Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima Health's secure File Transfer Protocol (sFTP) site. A Health Network shall submit such adjustment report(s) in accordance with CalOptima Health's requirements and using CalOptima Health's proprietary format and file naming convention, as set forth in CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting. CalOptima Health shall not reimburse a Health Network for any claim submitted in Directed Payment adjustment report(s) and received by CalOptima Health over thirteen (13) months from the month of service due to untimely submission.

2. CalOptima Health Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima Health may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima Health rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Health Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Health Accounting Department, CalOptima Health shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima Health's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima Health for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima Health shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima Health shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

    a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims;

    b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima Health shall base the Estimated Initial Month Payment on the expected monthly cost of those services; or

    c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Health Quality Analytics Department to CalOptima Health Accounting Department.

2. Thereafter, CalOptima Health shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Health Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima Health shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Health Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. For dates of service on or after July 1, 2019, a Health Network shall submit all data related to Directed Payments to the CalOptima Health Information Services Department through the CalOptima Health secure File Transport Protocol (sFTP) site in a format specified by CalOptima Health, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (*i.e.*, the Member's Health Network that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima Health may require additional data as deemed necessary.

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

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima Health shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

   a. 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.

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

   c. Each updated report 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 EE.1111: Health Network Encounter Reporting Requirements

B. CalOptima Health Policy FF.1001: Capitation Payments
C. CalOptima Health Policy FF.1002: CalOptima Health Medi-Cal Fee Schedule
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Health Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
G. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
H. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
I. CalOptima Health Policy IS.1600: Provider Access to In-House Provider Portal
J. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
K. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
L. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
M. Department of Health Care Services All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
N. Department of Health Care Services All Plan Letter (APL) 23-008: Proposition 56 Directed Payments for Family Planning Services (Supersedes APL 22-011)
O. Department of Health Care Services All Plan Letter (APL) 23-014: Proposition 56 Value-Based Payment Program Directed Payments (Supersedes APL 22-019)
P. Department of Health Care Services All Plan Letter (APL) 23-015: Proposition 56 Directed Payments For Private Services (Supersedes APL 19-013)
Q. Department of Health Care Services All Plan Letter (APL) 23-016: Directed Payments for Developmental Screening Services (Supersedes APL 19-016)
R. Department of Health Care Services All Plan Letter (APL) 23-017: Directed Payments for Adverse Childhood Experiences Screening Services (Supersedes APL 19-018)
S. Department of Health Care Services All Plan Letter (APL) 23-019: Proposition 56 Directed Payments for Physician Services (Supersedes APL 19-015)
T. Department of Health Care Services All Plan Letter (APL) 24-007: Targeted Provider Rate Increases
U. Department of Health Care Services (DHCS) State Plan Amendment (SPA) 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
V. Department of Health Care Services (DHCS) State Plan Amendment (SPA) 21-0017: One-Year Reimbursement Rate Add-on for Eligible Ground Emergency Medical Transport Services
W. Department of Health Care Services (DHCS) State Plan Amendment (SPA) 22-0015: Public Provider Ground Emergency Medical Transport Intergovernmental Transfer (PP-GEMT IGT)
X. Department of Health Care Services (DHCS) State Plan Amendment (SPA) 22-0040: Ground Emergency Medical Transportation (GEMT) Quality Assurance FEE (QAF)
Y. Proposition 56 Value-Based Payment Program Measure Valuation Summary
Z. 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
04/10/2020	Department of Health Care Services (DHCS)	File and Use
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

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	12/03/2020	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	05/05/2022	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	09/01/2022	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	11/01/2022	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	01/01/2023	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	09/01/2023	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	01/01/2024	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2024	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	07/01/2024	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are 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.
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 arrangements 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.
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
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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 time period: 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.
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.

Term	Definition
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.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network 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 a Health Network 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).
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
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)).
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, and Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned in that particular Health Network.

Term	Definition
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 1396d(r)(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 a Health Network at the time Qualifying Services are rendered.
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.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	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.
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.
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.