Calendar Year 2024 Medi-Cal Targeted Rate Increases Managed Care Provider Webinar

July 17, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Call-in Number

- In addition to the Webex webinar, members of the public may call in to **+1 415-655-0001**; meeting number **2660 559 5798 #**
- Please visit https://www.dhcs.ca.gov/TRI for meeting materials and information on how to join upcoming meetings.

Introductions

- Rafael Davtian, Deputy Director, Health Care Financing
- Alek Klimek, Assistant Deputy Director, Health Care Financing
- David Bishop, Division Chief, Capitated Rates Development Division
- Aditya Voleti, Division Chief, Fee-For-Service Rates Development Division
- Michelle Tamai, Branch Chief, Fee-For-Service Rates Development Division
- Nick Leach, Section Chief, Capitated Rates Development Division
- Eric Lichtenberger, Section Chief, Capitated Rates Development Division

Webinar Objectives

- Inform providers of changes in Medi-Cal Managed Care reimbursement due to the Calendar Year (CY) 2024 targeted provider rate increases (TRI) initiative.
- Inform providers of the eligibility criteria for provider increases.
- Discuss interactions between reimbursement changes, the legacy Medi-Cal Fee Schedule, and existing supplemental payment programs.
- Inform providers of the implications and requirements in Medi-Cal Managed Care for Managed Care Plans (MCPs), Subcontractors, and Downstream Subcontractors.
- Out-of-scope:
  - Targeted provider rate increases or investments for CY 2025 or beyond
  - Rates for services not specifically targeted in authorizing statute

Background

Managed Care Organization Tax

- Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) authorized a Managed Care Organization (MCO) tax effective April 1, 2023, through December 31, 2026.
- Revenues from the MCO tax will be used to support the Medi-Cal program including targeted provider rate increases and other investments that advance access, quality, and equity for Medi-Cal members and promote provider participation in the Medi-Cal program.
- The Centers for Medicare & Medicaid Services (CMS) formally approved the State of California's MCO Tax on December 15, 2023.
  - Senate Bill 136 (Chapter 6, Statutes of 2024) and AB 160 (Chapter 39, Statutes of 2024) authorized further modifications to the MCO tax effective January 1, 2024.

Medi-Cal Targeted Rate Increases

- Pursuant to AB 118 (Chapter 42, Statutes of 2023), Medi-Cal is implementing ongoing targeted provider rate increases for primary care, obstetric and doula, and non-specialty mental health services effective for dates of service on or after January 1, 2024.
- The CY 2024 targeted provider rate increases were approved by CMS on December 19, 2023, through State Plan Amendment 23-0035.

Medi-Cal Targeted Rate Increases (cont'd)

- DHCS published the CY 2024 TRI Fee Schedule at https://www.dhcs.ca.gov/TRI.
- DHCS published All Plan Letter (APL) 24-007 on June 20, 2024, outlining guidance for MCP implementation.

CY 2024 TRI Fee Schedule

CY 2024 TRI Fee Schedule Rates

- Pursuant to AB 118, the CY 2024 TRI Fee Schedule rate was calculated at the greater of:
  A. 87.5% of the lowest 2023 Medicare locality rate in California
  B. The existing basic rate on the legacy Medi-Cal fee schedule effective December 31, 2023, plus any applicable Proposition 56 Physician Services supplemental payment amount.
- DHCS calculated an equivalent targeted rate for services that do not have a rate established by Medicare.
- Codes on the CY 2024 TRI Fee Schedule will be exempt from the AB 97 provider payment reduction.

Provider Eligibility

- Procedure codes identified as Obstetric and Non-Specialty Mental Health Services will be reimbursed at the CY 2024 TRI Fee Schedule rate for all otherwise eligible providers.
- Procedure codes identified as Primary/General Care will be reimbursed at the CY 2024 TRI Fee Schedule rate if the service is billed using the Health Insurance Claim Form (CMS-1500) and provided by an otherwise eligible provider in the following provider type categories: Physicians, Physician Assistants, Nurse Practitioners, Podiatrists, Certified Nurse Midwife, Licensed Midwives, Doula Providers, Psychologists, Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist.
  - These providers are eligible without regard to specialty or taxonomy.
- Other providers will continue to be reimbursed at the existing Medi-Cal rate for procedure codes identified as Primary/General Care.

Proposition 56 Payments

- Effective for dates of service on or after January 1, 2024, the CY 2024 TRI Fee Schedule rates are inclusive of the former Proposition 56 Physician Services supplemental payments for applicable codes.
- Pursuant to AB 118, the CY 2024 TRI Fee Schedule does not include procedure codes related to dental, family planning, or abortion services. Proposition 56 supplemental payments applicable to these services will not change effective January 1, 2024.

Alternative Conversion Factors

- The legacy Medi-Cal Fee Schedule applies alternative conversion factors when calculating rates applicable to certain places of service, provider types, or member populations. Alternative conversations factors are not used to calculate CY 2024 TRI Fee Schedule rates which are uniform. For certain codes, legacy Medi-Cal fee schedule rates calculated using alternative conversion factors may exceed the CY 2024 TRI Fee Schedule rates.
- In the FFS delivery system, Medi-Cal will continue to reimburse services at no less than the net reimbursement amount, inclusive of any alternative conversion factors and supplemental payments, authorized pursuant to the California Medicaid State Plan in effect on December 31, 2023.
- In the Managed Care delivery system, DHCS is not directing MCPs to pay legacy rates calculated with alternative conversion factors in excess of the CY 2024 TRI Fee Schedule rate, except for qualifying SB 94 comprehensive family planning services.

Other Rate Adjustments

- The CY 2024 TRI Fee Schedule rate is subject to further adjustment for specified codes:
  - 39.7% payment augmentation for specified physicians' services provided to a Medi-Cal member eligible under the California Children's Services program.
  - 20% payment reduction for specified procedures performed in outpatient facilities.
- Applicable codes are identified on the TRI Fee Schedule. Please refer to the Notes tab for additional information.

Medi-Cal Targeted Rate Increase Fee Schedule effective dates of service January 1, 2024

Procedure Code	Description	Category	Targeted Provider Rate January 1, 2024	Benefit Restrictions	Cutback Indicator	CCS Authorized Physician Service
10040	Acne surgery	Primary/General Care	$108.61		1	1
10060	Drainage of skin abscess	Primary/General Care	$109.05		1	1
10061	Drainage of skin abscess	Primary/General Care	$195.14			1

Managed Care Delivery System

Policy

- For dates of service on or after January 1, 2024, MCPs must comply with a minimum fee schedule for each qualifying service provided by an eligible Network Provider and eligible for reimbursement at the TRI Fee Schedule rate pursuant to paragraph 3 of Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan.
- Furthermore, MCPs must comply with a minimum fee schedule for each qualifying service, described on page 3g of Attachment 4.19-B of the California Medicaid State Plan, provided by an eligible Network Provider and eligible for reimbursement at a State Plan rate exceeding the TRI Fee Schedule rate pursuant to paragraph 4 of Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan.

Policy (cont'd)

- In instances where the Network Provider is reimbursed on a per-service basis, this requirement applies at the procedure code level.
- In instances where a Network Provider is reimbursed on a capitated basis, MCPs must ensure the Network Provider receives reimbursement that provides payment that is equal to, or projected to be equal to, the CY 2024 TRI Fee Schedule rates for applicable services at minimum.
  - MCPs will be required to attest, and be able to demonstrate, that provider capitation rates meet this requirement.

Network Status

- MCPs are required to pay eligible Network Providers, as defined in APL 19-001, no less than the CY 2024 TRI Fee Schedule rate for specified codes and provider types.
- A provider is considered “In Network” if it meets all the criteria in APL 19-001 and there is an unbroken chain of contracts between the MCP and rendering provider.
- One-Time Agreements and Letters of Agreement in general do not meet the requirements to be considered “In Network.”
- In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, each Subcontractor Agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters.

FQHC/RHC Services

- Federally qualified health center (FQHC) and rural health clinic (RHC) services do not qualify for reimbursement under the CY 2024 TRI Fee Schedule in the FFS or Managed Care delivery systems.
- Pursuant to W&I section 14087.325(d), MCPs are required to reimburse contracted FQHCs and RHCs in a manner that is no less than the level and amount of payment that the MCP would make for the same scope of services if the services were furnished by another Provider type that is not an FQHC or RHC.

MCP Capitation Rate Increases

- Base MCP capitation rates were increased to reflect reimbursement of network providers, for applicable services, at the greater of the CY 2024 TRI Fee Schedule rate or the level historically paid by the MCP inclusive of any Proposition 56 Physician Services supplemental payments.
  - If the MCP's historical payment levels to providers exceed the CY 2024 TRI Fee Schedule, DHCS continued to fund the MCP to continue paying their historical contractual rates for applicable service codes (inclusive of Proposition 56 Physician Services supplemental funding).
  - If the MCP historically paid providers a set percentage of the legacy (non-TRI) Medi-Cal Fee Schedule, DHCS is neither directing nor funding the MCP to pay the same percentage of the CY 2024 TRI Fee Schedule effective January 1, 2024.
- In addition, and separate from TRI, base MCP capitation rates were increased to account for FQHC reimbursement parity requirements.

MCP Compliance

CY 2024 Timing in Managed Care

- MCPs, and their Subcontractors and Downstream Subcontractors as applicable, must achieve full compliance for payments associated with TRI. This includes retroactive payment adjustments where necessary for capitated and non-capitated arrangements by December 31, 2024.*
- DHCS anticipates MCPs will ensure eligible network providers continue receiving the equivalent value of the former Proposition 56 Physician Services per-service add-on amounts pending full compliance.

*Except for instances where payment would not otherwise be due by that date.

Fee-For-Service Arrangement Examples

- MCP is paying $75 for Code A. The CY 2024 TRI Fee Schedule rate for Code A is $100. No later than December 31, 2024, MCP must ensure that all Code A clean claims submitted will start receiving no less than the $100 rate. No later than December 31, 2024, MCP must retroactively provide an additional $25 per claim for Code A for applicable clean claims submitted for dates of service beginning on or after January 1, 2024, inclusive.*
- MCP is paying $125 for Code B. The CY 2024 TRI Fee Schedule rate for Code B is $110. MCP is already reimbursing above the CY 2024 TRI Fee Schedule rate and will not be required to adjust the level of payment.

*Except for instances where payment would not otherwise be due by that date.

Capitated Arrangement Examples

- MCP makes a per member per month (PMPM) capitated payment of $20 PMPM. This capitation rate is inclusive of TRI Code C. The CY 2024 TRI Fee Schedule rate is $120 for Code C. MCP will evaluate whether the $20 PMPM paid meets the TRI requirements.
  - If MCP's evaluation shows that the payment levels are high enough, the MCP does not need to adjust the $20 PMPM payment rate.
  - If MCP's evaluation shows that the payment levels are not high enough, the MCP will need to increase the $20 PMPM to a level that meets the TRI requirements.

MCP Attestation Requirement

- MCPs must ensure that eligible Network Providers receive no less than the applicable minimum fee schedule rates for qualifying services. MCPs must attest to compliance with this requirement in a form and manner specified by DHCS.
- MCPs must provide documentation of any methodologies and analyses that support their attestation to DHCS upon request and MCPs may require and rely upon similar attestations and supporting documentation by their Subcontractors and Downstream Subcontractors.
- TRI equivalent payment levels are evaluated at the Network Provider level. Therefore, the MCP's attestation must be specific to the level of payment received by the provider, not by a Subcontractor or Downstream Subcontractor.
- Additional guidance regarding the attestation and related documentation requirements will be forthcoming.

Upcoming DHCS Guidance

- Attestation Guidance and Frequently Asked Questions (FAQ) to be published in the coming weeks.

Medi-Cal Managed Care Health Plan Directory

- The Medi-Cal MCP Directory can be found on the DHCS website: https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx
- DHCS may collect and publish a TRI specific MCP directory on the TRI website.

Questions?

» Additional questions can be directed to: TargetedRateIncreases@dhcs.ca.gov