DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 27, 2023

ALL PLAN LETTER 23-008 *(REVISED)*
SUPERSEDES ALL PLAN LETTER 22-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR FAMILY PLANNING SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services. Revised text is found in *italics*.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the California Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-101-3305 and Senate Bill 74 (Mitchell, Chapter 6, Statutes of 2020), Section 2, Item 4260-101-3305 appropriated Proposition 56 funds to support family planning services for Medi-Cal beneficiaries, which DHCS is implementing in managed care in the form of a directed payment arrangement for specified family planning services in accordance with DHCS' developed payment methodology outlined below.[2] The Centers for Medicare & Medicaid Services (CMS) has approved this directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c),[3] for the rating

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] Bills are searchable at: https://leginfo.legislature.ca.gov/faces/home/xhtml. Assembly Bill 74 (Statutes of 2019) is available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB74. Senate Bill 74 (Statutes of 2020) is available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB74.
[3] The CFR is searchable at: https://www.ecfr.gov/.

periods of July 1, 2019 to December 31, 2020, and calendar year (CY) 2021.[4] DHCS has also requested approval from CMS for this directed payment arrangement for CY 2022 and CY 2023.

Subject to future appropriation of funds by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to continue this directed payment arrangement on an annual basis for the duration of the program. The requirements of this APL may change if necessary to obtain CMS approvals applicable to this directed payment arrangement or to comport with future state legislation.

This directed payment program is intended to enhance the quality of patient care by ensuring that Providers in California who offer family planning services receive enhanced payment for their delivery of family planning services. Timely access to vital family planning services is a critical component of Member and population health. In particular, this program is focused on the following categories of family planning services:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

Under federal law,[5] "a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive [family planning] services under Section 1396d (a)(4)(C) of this title…"…" (with limited exceptions).[6] Therefore, Members must be allowed freedom of choice of family planning Providers, and may receive such services from any qualified family planning Provider, including Out-of-Network Providers, without the need to obtain prior authorization. The

[4] Preprint approvals are published on DHCS' Directed Payments Program website, which is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.
[5] See Title 42 of the United States Code (U.S.C.), Section 1396a (a)(23)(B). The U.S.C. is searchable at: https://uscode.house.gov/search/criteria.shtml.
[6] See 42 U.S.C. Section 1396d (a)(4)(C).

DHCS managed care contract (Contract) specifies the requirements pertaining to family planning services in Exhibit A, Attachment 9, Access and Availability.[7]

POLICY:
Subject to obtaining the necessary federal approvals and appropriation of funds by the California Legislature, MCPs, either directly or through their Subcontractors, must pay eligible contracted and non-contracted Providers[8] a uniform and fixed dollar add-on amount for specified family planning services (listed below) provided 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) with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website[9] upon CMS approval.

MCPs are responsible for ensuring that qualifying family planning services are reported to DHCS in Encounter Data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes in the table below. Both professional and facility claims are eligible for reimbursement for payment under the program, but not both for the same service. MCPs are responsible for ensuring that the Encounter Data reported to DHCS is appropriate for the services being provided. MCPs must include oversight in their utilization management processes, as appropriate. The uniform dollar add-on amounts of the directed payments vary by procedure code:

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[7] MCP boilerplate Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP contracts and amendments executed thereto.
[8] An eligible Provider is 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 a member. See Title 22 California Code of Regulations (CCR), Section 51200. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[9] The preprint will be available upon approval by CMS. DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Procedure Code[10]	Description	Uniform Dollar Add-on Amount	Dates of Service[11]
J7294	CONTRACEPTIVE VAGINAL RING: SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	$301.00	1/1/2022 – Ongoing
J7295	CONTRACEPTIVE VAGINAL RING: ETHINYL ESTRADIOL AND ETONOGESTREL	$301.00	1/1/2022 – Ongoing
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00	7/1/2019 – Ongoing
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00	7/1/2019 – Ongoing
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00	7/1/2019 – Ongoing
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00	7/1/2019 – Ongoing
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00	7/1/2019 – Ongoing
J7303	CONTRACEPTIVE VAGINAL RING	$301.00	7/1/2019 – 12/31/2021
J7304	CONTRACEPTIVE PATCH	$110.00	7/1/2019 – 12/31/2021

[10] Services billed for the following Current Procedural Terminology codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 55250, 58300, 58301, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.
[11] "Ongoing" means the directed payment is in effect, subject to CMS approval and future appropriation of funds by the California Legislature, until discontinued by DHCS via an amendment to this APL.

Procedure Code[10]	Description	Uniform Dollar Add-on Amount	Dates of Service[11]
J7304U1	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	$110.00	1/1/2022 – Ongoing
J7304U2	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	$110.00	1/1/2022 – Ongoing
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00	7/1/2019 – Ongoing
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00	7/1/2019 – Ongoing
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00	7/1/2019 – Ongoing
J3490U8	DEPO-PROVERA	$340.00	7/1/2019 – Ongoing
11976[10]	REMOVE CONTRACEPTIVE CAPSULE	$399.00	7/1/2019 – Ongoing
11981[10]	INSERT DRUG IMPLANT DEVICE	$835.00	7/1/2019 – Ongoing
55250[10]	REMOVAL OF SPERM DUCT(S)	$521.00	7/1/2019 – Ongoing
58300[10]	INSERT INTRAUTERINE DEVICE	$673.00	7/1/2019 – Ongoing
58301[10]	REMOVE INTRAUTERINE DEVICEDEVICE	$195.00	7/1/2019 – Ongoing

Procedure Code[10]	Description	Uniform Dollar Add-on Amount	Dates of Service[11]
58340[10]	CATHETER FOR HYSTEROGRAPHY	$371.00	7/1/2019 – Ongoing
58555[10]	HYSTEROSCOPY DX SEP PROC	$322.00	7/1/2019 – 12/31/2019
58565[10]	HYSTEROSCOPY STERILIZATION	$1,476.00	7/1/2019 – 12/31/2019
58600[10]	DIVISION OF FALLOPIAN TUBE	$1,515.00	7/1/2019 – Ongoing
58615[10]	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00	7/1/2019 – Ongoing
58661[10]	LAPAROSCOPY REMOVE ADNEXA	$978.00	7/1/2019 – Ongoing
58670[10]	LAPARASCOPY TUBAL CAUTERY	$843.00	7/1/2019 – Ongoing
58671[10]	LAPARASCOPY TUBAL BLOCK	$892.00	7/1/2019 – Ongoing
58700[10]	REMOVAL OF FALLOPIAN TUBE	$1,216.00	7/1/2019 – Ongoing
81025	URINE PREGNANCY TEST	$6.00	7/1/2019 - Ongoing

The directed payments must be in addition to whatever other payments eligible Providers would normally receive from the MCP or the MCP's Subcontractors. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), American Indian Health

Service Programs (AIHSP),[12] and Cost-Based Reimbursement Clinics[13] are not eligible to receive this uniform dollar add-on directed payment.

Data Reporting

MCPs must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guidance document available on the DHCS Directed Payment - Proposition 56 website, which is hereby incorporated herein by reference. [14]

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made in accordance with the timely payment standards in the Contract for clean claims or accepted encounters that are received by the MCP or Subcontractor no later than one year after the date of service. [15] The Contract specifies the requirements pertaining to timely payment in Exhibit A, Attachment 8, Provision 5.[16]

MCPs have an obligation to communicate and provide clear policies and procedures to their Network Providers with respect to the MCP's claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, the MCP is not required to make payments for claims or submitted encounters submitted one year following the date of service. These timing requirements may be waived through an agreement in writing between the MCP (or the MCP's Subcontractors) and the Network Provider.

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[12] See "definitions" section of the Contract for definitions of FQHC, RHC, and AIHSP.
[13] Cost-Based Reimbursement Clinics are defined in Welfare and Institutions Code Section 14105.24, which is located at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14105.24&lawCode=WIC, as well as Supplement 5 to Attachment 4.19-B of the State Plan, which is located at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement%205%20to%20Attachment%204.19-B.pdf.
[14] Prop 56 Directed Payments Expenditures File Technical Guidance is available at: https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Proposition-56-Directed-Payments-Expenditures-File-Technical-Guidance.pdf
[15] A "clean claim" is defined in 42 CFR section 447.45(b). 42 CFR Part 447 is available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447.
[16] MCP boilerplate Contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP contracts and amendments executed thereto.

MCPs and their Subcontractors must not pay any amount for any services or items, other than Emergency Services, to an excluded Provider as defined in the "Definitions" section of the Contract. This prohibition must apply to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

As required by the Contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgement, and resolution of Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying service, how payments will be processed, how to file a grievance, and how to identify the responsible payer. In addition, MCPs must make available to a Provider an itemization of payments made to the Provider in accordance with this APL. The itemization must include sufficient information to uniquely identify the qualifying service for which payment was made, be provided upon the Provider's request unless the MCP has established a periodic dissemination schedule and be made available in electronic format when feasible.

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

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[17] These requirements must be communicated by each MCP to all applicable Subcontractors and Network Providers. DHCS may impose corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a Corrective Action Plan and subsequent sanctions.

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

Sincerely,

Original signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[17]For more information on Subcontractors and Network Providers, including definitions and applicable requirements, see the Contract, APL 19-001, and any subsequent APLs on this topic.