CALENDAR YEAR 2024 TARGETED PROVIDER RATE INCREASES FREQUENTLY ASKED QUESTIONS

March 12, 2025

Background

1. ***What is the status of SPA 23-0035?***

   The Calendar Year (CY) 2024 targeted provider rate increases (TRI) were approved by Centers for Medicare & Medicaid Services (CMS) on December 19, 2023, through State Plan Amendment 23-0035.

2. ***What is the status of the 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. CMS formally approved the State of California's MCO Tax on December 15, 2023. In addition, 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 which are pending CMS approval.

3. ***Where will the rates be updated on DHCS' website?***

   The TRI rates have been published on both the provider manual website and the Medi-Cal Targeted Provider Rate Increases and Investments website.

4. ***How were the TRI increases determined?***

   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.

Procedure Code Eligibility

5. ***What procedure codes qualify for TRI? Why do certain codes that are non-benefits appear on the TRI Fee Schedule?***

   Only codes listed on the TRI fee schedule are eligible for TRI increases. These codes were selected based on their status as primary care, obstetric, and non-specialty mental health services. Non-benefit procedure codes are not published on the monthly rate file. The TRI Fee Schedule does not supersede FFS benefit and billing policies described in the California Medicaid State Plan, Medi-Cal Provider Manual, Medi-Cal Provider Bulletins, or Title 22, Division 3 of the California Code of Regulations (CCR) including, but not limited to Benefit Restrictions, and Multiple Procedure Payment Reductions. Certain codes marked with a "1" in the Benefits Restriction column on the 2024 TRI fee schedule may not be eligible for reimbursement without a Treatment Authorization Request (TAR). For additional information, please see the TAR and Non-Benefit section of the provider manual and the "Notes" tab in the 2024 TRI Fee Schedule located on the DHCS website. Due to the complexity of the provider manual and the nuance between the Fee-for-Service (FFS) and the Managed Care requirements, DHCS recommends that all entities refer to the TRI fee schedule (TRI Fee Schedule v1.06.01082024) posted to the Medi-Cal Targeted Provider Rate Increases and Investments website.

6. ***How are Alternative Conversion Factors taken into consideration?***

   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.

7. ***What about Rate Adjustments? Are they taken into consideration in the TRI fee schedule?***

   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. The 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	Damage of skin abscess	Primary/General Care	$109.05		1	1
10061	Draining of skin abscess	Primary/General Care	$195.14			1

8. ***Does DHCS have any specific guidance on place of service (POS) codes that are eligible for TRI?***

   Pursuant to the 2023 Budget Act and AB 118 (Chapter 42, Statutes of 2023), DHCS implemented the first phase of Targeted Rate Increases effective January 1, 2024. The target rate for OB and NSMH procedure codes are reimbursed at the TRI rate regardless of FI Claim Type (UB-04 and CMS-1500). For primary care

procedure codes, they are restricted to only FI Claim Type 05 (CMS-1500 form) and eligible provider types. There are no additional place of service restrictions.

9. ***What happened to the Proposition 56 Physician's Supplemental/Directed 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 Proposition 56 dental, Proposition 56 family planning, or Proposition 56 abortion services. Proposition 56 supplemental payments applicable to these services will not change effective January 1, 2024.

Provider Eligibility

10. ***Which providers are eligible?***

    Codes identified as primary/general care services on the TRI Fee Schedule and billed using Health Insurance Claim Form (CMS-1500) are eligible for TRI only when rendered by the following types of eligible providers: Physicians Physician Assistants, Nurse Practitioners, Podiatrists, Certified Nurse Midwife, Licensed Midwives, Doula Providers, Psychologists, Licensed Professional Clinical Counselors, Licensed Clinical Social Workers, and Marriage and Family Therapists. Codes identified as obstetric care services and non-specialty outpatient mental health services are eligible for TRI when billed or rendered by a provider who is otherwise eligible to bill the code.

11. ***Does provider specialty or taxonomy impact eligibility for TRI?***

    Provider taxonomy and specialty is not used to define eligibility for TRI. However, MCPs may utilize taxonomy, specialty, or other datapoints as resources to determine provider type. DHCS expects MCPs to work with Providers to identify whether they qualify for TRI increases based on the provider type list.

12. How does DHCS determine provider type in the FFS Delivery System?

In the FFS delivery system, providers enroll in Medi-Cal Fee-for-Service using the Provider Application and Validation for Enrollment System (PAVE). The PAVE application requires providers to include provider data including National Provider Identifier (NPI) and provider type. DHCS' Provider Enrollment Division (PED) publishes a list of provider types by business structure on the PAVE website from which providers may select from. Additionally, when a provider applies for a NPI through NPPES, they are required to include a taxonomy code (a unique 10-character code that designates provider classification and specialization). CMS updates the Medicare provider and supplier taxonomy crosswalk semiannually, which crosswalks taxonomy to a provider/supplier type description.

13. What if my provider type is not listed as eligible for TRI?

For codes identified as Primary/General Care, all other providers will continue to be reimbursed at the legacy Medi-Cal rate. For procedure codes identified as Obstetric and Non-Specialty Mental Health Services, all providers otherwise eligible to bill these codes will be reimbursed at the CY 2024 TRI Fee Schedule rate.

14. Do services (CPT codes) that are carved out of the managed care program fall under the FFS timeline or the managed care timeline?

If the service is being reimbursed by Medi-Cal FFS then it will be under the FFS timeline. If the service is being reimbursed in the Managed Care delivery system, then it will be under the managed care timeline.

15. Who can I contact about my reimbursement amounts?

In the FFS delivery system providers may reach out to CA-MMIS at 1-800-541-5555 for payment or billing questions. In the Managed Care delivery system providers may reach out their individual managed care plan for internal processing timelines and procedures.

16. What are the exact requirements in Managed Care?

The contractual requirements for Managed Care Plans are detailed in All Plan Letter 24-007.

17. How does TRI affect provider reimbursement in a per-service (FFS) arrangement from a Managed Care Plan?

In instances where the Network Provider is reimbursed on a per service basis, TRI requirements apply at the procedure code level.

18. How does TRI affect provider reimbursement in non-per service (capitated or other arrangement) relationship with an MCPs, their Subcontractors, or Downstream Subcontractors?

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 at least equal to, or projected to be at least equal to, the CY 2024 TRI Fee Schedule rates for applicable services at minimum. Therefore, MCPs are not required to adjust payment for capitated subcontracts that are already being reimbursed at levels at or above the new TRI rates. Examples of non-per service relationships include, but are not limited to, Health Maintenance Organization (HMO), capitation and full risk payment, payments with shared savings and recoupments, performance payments, etc.

For examples of payment requirements for per service and non-per service relationships see the July 17, 2024 Provider Webinar slides 23 and 24.

19. How do these reimbursement requirements affect MCPs and providers when there are multiple layers of contracting such as Independent Practice Associations?

In accordance with Exhibit A, Attachment III, Subsection 3.1.5 (Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements) of the MCP Contract and 22 CCR section 53250, each Network Provider Agreement and Subcontractor Agreement 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.

TRI-equivalent payment levels are evaluated at the Network Provider level. The Network Provider must be paid at a level that meets TRI requirements regardless of whether the contract is directly with the MCPs, their Subcontractors, or Downstream Subcontractors.

20. Are Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Indian Health Care Providers, or Cost-Based Reimbursement Clinics (CBRCs) eligible for TRI? Are there any parity requirements?

FQHC, RHC, Indian Health Care Provider, and CBRC services do not qualify for reimbursement under the TRI Fee Schedule in the FFS delivery system and thus are not qualifying services for the purposes of this directed payment arrangement. 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. MCPs must also comply with the requirements of Provision 3.3.7 of Exhibit A, Attachment III, of the MCP Contract specific to non-contracting FQHCs and RHCs.

21. How should MCPs treat Proposition 56 physician services supplemental payments until full compliance with APL 24-0007 is achieved?

Until such time that MCPs achieve full compliance with the requirements of APL 24-0007, DHCS anticipates MCPs will ensure that eligible Network Providers continue to receive the equivalent value of former Proposition 56 physician services supplemental payments.