State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 13, 2019

ALL PLAN LETTER 19-006
SUPERSEDES ALL PLAN LETTER 18-010

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

SUBJECT: PROPOSITION 56 PHYSICIANS DIRECTED PAYMENTS FOR SPECIFIED SERVICES FOR STATE FISCAL YEARS 2017-18 & 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information on directed payments for certain services funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for State Fiscal Year (SFY) 2017-18 and SFY 2018-19.

BACKGROUND:
Proposition 56 increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the Department of Health Care Services (DHCS). Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, and Senate Bill 840 (Mitchell, Chapter 29, Statutes of 2018), Section 2, Item 4260-101-3305, appropriate Proposition 56 funds for SFY 2017-18 and SFY 2018-19, respectively, including a portion to be used for directed payments for specified services in managed care according to the DHCS developed payment methodology outlined below.[2]

On February 21, 2018, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) pursuant to Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2), for this directed payment arrangement during SFY 2017-18.[3] On January 14, 2019, DHCS obtained federal approval from CMS pursuant to 42 CFR Section 438.6(c)(2), for this directed payment arrangement during SFY 2018-19. Note that the requirements of this APL may be subject to change if required for any further CMS approvals applicable to this directed payment arrangement.

POLICY:
Proposition 56 appropriated funds will result in directed payments by MCPs and their delegated entities and subcontractors (as applicable) to individual providers rendering

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] California Law Code is searchable at http://leginfo.legislature.ca.gov/faces/codes.xhtml.
[3] CFRs are searchable at: https://www.ecfr.gov/cgi-bin/ECFR?SID=d15b0ce81c0ea804f39e129fd7f11a5f&mc=true&page=browse.

specified services with the dates of service specified in Appendix A and B, as applicable. Consistent with 42 CFR Section 438.6(c), DHCS is requiring MCPs, and their delegated entities and subcontractors, to make directed payments for qualifying services (as defined below) in the amounts and for the Current Procedural Terminology (CPT) codes specified in Appendix A and B, as applicable. The directed payment shall be in addition to whatever other payments eligible Network Providers (as defined below) would normally receive from the MCP, or the MCP's delegated entities and subcontractors, as MCP Network Providers. The projected value of the directed payments will be accounted for in the MCP's actuarially certified risk-based capitation rates. For SFY 2018-19, the portion of capitation payments to the MCP attributable to this directed payment shall be subject to a minimum medical expenditure percentage as described in Appendix B.

Eligible Network Providers are "Network Providers" (as defined in the MCP contract and 42 CFR Section 438.2) who are the individual rendering providers qualified to provide and bill for the CPT codes specified in the table below. Federally Qualified Health Centers, Rural Health Clinics, and American Indian Health Programs (as defined in the MCP contract), as well as Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of the State Plan and California Welfare and Institutions Code Section 14105.24), are not eligible Network Providers for the purposes of this APL. A qualifying service is one provided by an eligible Network Provider where a specified service is provided to a member, enrolled in the MCP, who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). The MCP is responsible for ensuring qualifying services reported using the specified CPT codes are appropriate for the services being provided and reported to DHCS in encounter data pursuant to APL 14-019.[4]

Starting with the calendar quarter ending June 30, 2018, the MCP must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and subcontractors at the MCP's direction. Reports shall include all directed payments made covering dates of service between July 1, 2017 and June 30, 2019. MCPs must provide these reports in a format specified by DHCS, which at a minimum shall include Health Care Plan code, CPT code, service month, payor (i.e. MCP, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e. Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) contract manager.

Updated quarterly reports must be submitted in the same format as the initial submission and be a replacement of the initial submission. MCPs are responsible for

[4] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

submitting updated reports when the actual counts or total value of directed payments pursuant to this APL have changed since the MCP's previously submitted report, or MCPs shall submit an attestation if no updated information is available. When the MCP considers the report complete, an attestation shall be submitted to DHCS.

MCPs must continue to submit encounter data for the specified CPT codes as required by DHCS; however, there are no new encounter data submission requirements associated with Proposition 56 directed payments.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a Proposition 56 directed payment, as is already required by the MCP contract for other payments. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance. DHCS will publish a list of all MCPs' designated contacts on the DHCS website.

MCPs must have a process to communicate with providers about the payment process. The communication at a minimum must include: how payments will be processed, how to file a provider grievance, and how to determine who the payor will be.

If you have any questions regarding the requirements of this APL, please contact your MCOD contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

APPENDIX A

SFY 2017-18 (dates of service between July 1, 2017 and June 30, 2018)

For clean claims or accepted encounters with dates of service between July 1, 2017, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services. These timing requirements apply to payments made directly by the MCP, and by the MCP's delegated entities and subcontractors at the MCP's direction, and may be waived only if agreed to in writing between the MCP, or the MCP's delegated entities or subcontractors, and the rendering provider.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

APPENDIX B
SFY 2018-19 (dates of service between July 1, 2018 and June 30, 2019)

For clean claims or accepted encounters with dates of service between July 1, 2018, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying services received by the MCP more than one year after the date of service.[5] These timing requirements apply to payments made directly by the MCP, and by the MCP's delegated entities and subcontractors at the MCP's direction, and may be waived only if agreed to in writing between the MCP, or the MCP's delegated entities or subcontractors, and the rendering provider.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$18.00
99202	Office/Outpatient Visit New	$35.00
99203	Office/Outpatient Visit New	$43.00
99204	Office/Outpatient Visit New	$83.00
99205	Office/Outpatient Visit New	$107.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$23.00
99213	Office/Outpatient Visit Est	$44.00
99214	Office/Outpatient Visit Est	$62.00
99215	Office/Outpatient Visit Est	$76.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	$30.00

[5] If a claim received by the MCP within one year of the date of service was originally denied by the MCP, but the denial was later reversed and the claim approved, the MCP is required to make the payments described in this APL even if the denial was overturned more than one year after the date of service.

CPT	Description	Directed Payment
99391	Periodic comprehensive preventive med E&M (<1 year old)	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	$72.00
99395	Periodic comprehensive preventive med E&M (18-19 years old)	$27.00

The portion of capitation payments to MCPs attributable to this directed payment arrangement (Proposition 56 Physicians Directed Payment capitation) shall be subject to a minimum medical expenditure percentage (MEP), wherein each MCP shall achieve a minimum MEP of no less than 95 percent across all applicable categories of aid within each rating region where the MCP operates. MCPs shall be required to expend at least 95 percent of Proposition 56 Physicians Directed Payment capitation, for each rating region where the MCP operates, for payments required by this APL to eligible Network Providers. No sooner than July 1, 2020, DHCS will utilize each MCP's submitted encounters that have been accepted by DHCS, in accordance with its policies, to calculate the amount of directed payment expenditures issued by the MCP to its eligible Network Providers in accordance with this APL across all applicable categories of aid for the service period of July 1, 2018 through June 30, 2019, which will constitute the numerator of the minimum MEP. DHCS may, at DHCS's discretion, contact MCPs to discuss the preliminary results based on the encounters that have been accepted by DHCS. The denominator of the minimum MEP shall be the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's Proposition 56 Physicians Directed Payment capitation across all applicable categories of aid for SFY 2018-19, as calculated by DHCS. If the MCP's MEP, as defined, for any rating region is less than 95 percent for the rating period, as calculated by DHCS, the MCP shall remit to DHCS the full amount calculated by DHCS within 90 days of notice. In such cases, the remittance amount shall equal the difference between 95 percent of the medical portion of the Proposition 56 Physicians Directed Payment capitation to the MCP and the actual Proposition 56 directed payment expenditures, as calculated by DHCS based on accepted encounters for SFY 2018-19.