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



EDMUND G. BROWN JR.
GOVERNOR

DATE: May 1, 2018

ALL PLAN LETTER 18-010

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS¹

SUBJECT: PROPOSITION 56 DIRECTED PAYMENT EXPENDITURES FOR SPECIFIED SERVICES FOR STATE FISCAL YEAR 2017-18

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.

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, appropriates Proposition 56 funds for SFY 2017-18, including a portion to be used for directed payments for specified services in managed care according to the DHCS developed payment methodology outlined below.

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), § 438.6(c)(2), for this directed payment arrangement during SFY 2017-18. 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 specified services with dates of service between July 1, 2017 and June 30, 2018. Consistent with 42 CFR § 438.6(c), DHCS is requiring MCPs, and their delegated entities and subcontractors, to make directed payments for qualifying services (as defined below) for the 13 Current Procedural Terminology (CPT) codes specified in the table below. The amounts of the directed payments vary by CPT code. The directed payment shall be in addition to whatever other payments eligible network providers (as

¹ This APL does not apply to Prepaid Ambulatory Health Plans.

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 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 may be waived only if agreed to in writing between the MCP, or the MCP's delegated entities or subcontractors, and the rendering provider.

Eligible network providers are "network providers" (as defined in the MCP contract and 42 CFR § 438.2) who are 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 14-019².

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

² APLs can be accessed at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

CPT	Description	Directed Payment
90791	Psychiatric Diagnostic Eval	\$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	\$35.00
90863	Pharmacologic Management	\$5.00

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, 2018. MCPs must provide these reports in a format to be 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 (MCP’s MCO) 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 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; 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 shall 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 shall have a process to communicate with providers about the payment process. The communication at a minimum shall 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 MCO contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division