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

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ACTING DIRECTOR

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DATE: October 17, 2019

ALL PLAN LETTER 19-013

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

SUBJECT: PROPOSITION 56 HYDE REIMBURSEMENT REQUIREMENTS FOR SPECIFIED SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information on required payments funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for the provision of specified state-supported medical pregnancy termination services.

BACKGROUND:
Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the Department of Health Care Services (DHCS). Assembly Bill (AB) 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305 of Section 2.00 of the Budget Act of 2017; Senate Bill (SB) 856 (Committee on Budget and Fiscal Review, Chapter 30, Statutes of 2018), Section 44, Item 4260-101-3305 of Section 2.00 of the Budget Act of 2018; and AB 74 (Ting, Chapter 23, Statutes of 2019), Section 2.00, Item 4260-101-3305 appropriate Proposition 56 funds for State Fiscal Year (SFY) 2017-18, SFY 2018-19, and SFY 2019-20, respectively. A portion of these appropriations are used for rate increases for state-supported medical pregnancy termination services in the Medi-Cal managed care program to fund the reimbursement requirements outlined below.[2] Subject to future budgetary authorization and appropriation by the California Legislature, DHCS intends to renew this required payment arrangement on an annual basis in future years.

POLICY:
DHCS is requiring MCPs, either directly or through their delegated entities and subcontractors, to pay the individual rendering providers that are qualified to provide and bill for medical pregnancy termination services with dates of service on or after July 1, 2017, using Proposition 56 appropriated funds. Consistent with the enacted budgets, DHCS is requiring MCPs, or their delegated entities and subcontractors, to pay at least the rate for Current Procedural Terminology – 4th Edition (CPT-4) code 59840 in

[1] This APL does not apply to Prepaid Ambulatory Health Plans.
[2] California's Law Code is searchable at http://leginfo.legislature.ca.gov/faces/codes.xhtml.

the amount of $400 and CPT-4 code 59841 in the amount of $700. This payment obligation applies to contracted and non-contracted providers. This required reimbursement level will be accounted for in the MCP's capitation rates.

Timing of Payments

For clean claims[3] or accepted encounters with dates of service between July 1, 2017, and the date the MCP began receiving capitation payments from DHCS accounting for the projected value of the reimbursement obligations discussed in this APL, the MCP must distribute the payments required by this APL to the rendering provider(s) within 90 calendar days from the date the MCP begins receiving capitation payments from DHCS accounting for the projected value of the reimbursement obligations discussed in this APL.

For clean claims or accepted encounters timely submitted that have not already been reimbursed in accordance with this APL, MCPs must issue the payments required by this APL in a manner that does not require providers to resubmit claims or impose any reductions or denials for timeliness.

For clean claims or accepted encounters with dates of service on or after the date MCPs received payment from DHCS accounting for the projected value of the reimbursement obligations discussed in this APL, MCPs must distribute the payments required by this APL within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services.

These timing requirements apply to payments made directly by an MCP, or by the MCP's delegated entities or 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.

Administrative Obligations

MCPs are responsible for ensuring that the specified CPT-4 codes are appropriate for the services being provided and that this information is submitted to DHCS in encounter data that is complete, accurate, reasonable, and timely.[4] In instances where a member is

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[3] A "clean claim" is defined in Title 42 of the Code of Federal Regulations (CFR), Section 447.45(b). 42 CFR Part 447 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=605e8561a83bfced0a6ea61f9d7b4e20&mc=true&node=pt42.4.447&rgn=div5

[4] For more information, please see APL 14-019: Encounter Data Submission Requirements, or any future iteration of this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery.[5]

Each MCP must report to DHCS within 45 calendar days of the end of each calendar quarter all directed payments made either directly by the MCP or by the MCP's delegated entities and subcontractors at the MCP's direction pursuant to this APL. Reports must include all directed payments made covering dates of service on or after July 1, 2017. The first such report is due within 45 calendar days of December 31, 2019. MCPs must provide these reports in a format specified by DHCS, which at a minimum must include Health Care Plan (HCP) code,[6] CPT-4 code, service month, payer (i.e. the MCP, or the MCP's delegated entity or subcontractor), and rendering provider's National Provider Identifier (NPI).[7] DHCS may require additional data as deemed necessary. All reports must be submitted in a consumable file format (e.g., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) contract manager.

MCPs must submit 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. Updated quarterly reports must be submitted in the same format as the initial submission and be a replacement of the initial submission. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

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.[8] In addition, MCPs must communicate with providers about the payment process. The communication, at a minimum, must include the following:

- How to process payments;
- How to file a provider grievance; and
- How to determine the payer financially responsible when an MCP has delegated financial obligation for the service.

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[5] MCP Contract, Exhibit E, Attachment 2, Cost Avoidance and Post-Payment Recovery of Other Health Coverage Source (OHCS). MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[6] HCP codes are available on the Medi-Cal website at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpcodedir_z01.doc.
[7] The NPI database is available at: https://npiregistry.cms.hhs.gov/.
[8] MCP Contract, Exhibit A, Attachment 7, Provider Grievance.

Subject to future budgetary authorization and appropriation by the California Legislature, DHCS intends to renew this required payment arrangement on an annual basis in future years. Please note that the requirements of this APL may change based upon future budgetary authorization and appropriation by the California Legislature.

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

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division