

DATE: June 20, 2024

ALL PLAN LETTER 24-007

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: TARGETED PROVIDER RATE INCREASES

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on Network Provider payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024.

BACKGROUND:

Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) authorized a managed care organization provider tax effective April 1, 2023, through December 31, 2026.¹ Tax revenues will be used to support the Medi-Cal program including, but not limited to, new targeted Provider rate increases and other investments that advance access, quality, and equity for Medi-Cal members and promote Provider participation in the program.

Pursuant to the 2023 Budget Act and AB 118 (Chapter 42, Statutes of 2023),² which enacted Welfare and Institutions (W&I) Code section 14105.201, the Department of Health Care Services (DHCS) increased rates for targeted services, as applicable on a procedure code basis, to no less than 87.5% of the lowest California-specific Medicare locality rate as outlined in the TRI Fee Schedule, inclusive of eliminating applicable AB 97 (Chapter 3, Statutes of 2011) provider payment reductions and incorporating applicable Proposition 56 physician services supplemental payments into the fee schedule.³ For services that did not have a rate established by Medicare, DHCS calculated an equivalent rate benchmark and increase. The federal Centers for Medicare & Medicaid Services approved State Plan Amendment (SPA) 23-0035

¹ AB 119 is available at:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB119. State law is searchable at: <https://leginfo.legislature.ca.gov/>.

² AB 118 is available at:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB118.

³ AB 97 is available at:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB97.

implementing the TRI Fee Schedule for the Medi-Cal Fee-For-Service (FFS) delivery system.⁴

The TRI Fee Schedule is established in Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan.⁵ Procedure codes on the TRI Fee Schedule are categorized as Primary/General Care, Obstetric Care, and Non-Specialty Outpatient Mental Health Services.

The TRI Fee Schedule rate applies to procedure codes identified as Primary/General Care services billed using Health Insurance Claim Form (CMS-1500) and rendered by an otherwise eligible Provider in the following Provider type categories, without regard to the rendering Provider's specialty:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwives
- Licensed Midwives
- Doula Providers
- Psychologists
- Licensed Professional Clinical Counselor
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists

The TRI Fee Schedule rate applies to procedure codes identified as Obstetric and Non-Specialty Mental Health Services when billed or rendered by an otherwise eligible Provider without regard to claim type or the Provider's specialty.

The 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 (CCS) program.
- 20% payment reduction for specified procedures performed in outpatient facilities.

⁴ SPA 23-0035 is available at: <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-23-0035-Approval.pdf>.

⁵ The California Medicaid State Plan is available at: <https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx>.

The TRI Fee Schedule rate does not apply to services which receive a greater net reimbursement amount, inclusive of any supplemental payments, pursuant to the California Medicaid State Plan in effect on December 31, 2023.

The TRI Fee Schedule rate does not apply to services billed or rendered by Assistant Surgeons. The TRI Fee Schedule also does not apply to services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) (pursuant to the page 6 et seq. of Attachment 4.19-B of the State Plan), Indian Health Care Providers (pursuant to Supplement 6 of Attachment 4.19-B of the State Plan), and Cost-Based Reimbursement Clinics (pursuant to Supplement 5 to Attachment 4.19-B of the State Plan and W&I section 14105.24).

The TRI Fee Schedule does not supersede FFS benefit and billing policies described in the California Medicaid State Plan, Medi-Cal Provider Manual,⁶ Medi-Cal Provider Bulletins,⁷ or Title 22, Division 3 of the California Code of Regulations (CCR)⁸ including, but not limited to Benefit Restrictions, and Multiple Procedure Payment Reductions.

In accordance with W&I section 14105.201(b), and subject to receiving all necessary federal approvals, a directed payment arrangement in the Medi-Cal managed care delivery system is authorized pursuant to 42 Code of Federal Regulations (CFR) section 438.6(c)(2)(ii), as a minimum fee schedule for Network Providers that provide particular Covered Services using State Plan approved rates in accordance with 42 CFR section 438.6(c)(1)(iii)(A).⁹

POLICY:

For dates of service on or after January 1, 2024, MCPs must comply with a minimum fee schedule for each qualifying service provided by an eligible Network Provider¹⁰ and eligible for reimbursement at the TRI Fee Schedule rate pursuant to paragraph 3 of

⁶ Medi-Cal Provider Manuals are available at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual>.

⁷ Medi-Cal Provider Bulletins are available at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/bulletin>.

⁸ The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>.

⁹ The CFR is searchable at: <https://www.ecfr.gov/>.

¹⁰ For more information on evaluating Network Provider status, see APL 19-001, available at: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-001.pdf>.

Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan.¹¹ Furthermore, MCPs must comply with a minimum fee schedule for each qualifying service, described on page 3g of Attachment 4.19-B of the California Medicaid State Plan, provided by an eligible Network Provider and eligible for reimbursement at a State Plan rate exceeding the TRI Fee Schedule rate pursuant to paragraph 4 of Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan. Other services eligible for reimbursement at a State Plan rate exceeding the TRI Fee Schedule rate pursuant to paragraph 4 of Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan are not subject to the minimum fee schedule requirement established by this APL.

MCPs must ensure that eligible Network Providers receive no less than the applicable minimum fee schedule rates for qualifying services. In instances where the Network Provider is reimbursed on a per-service basis, this requirement applies at the procedure code level. In instances where the Network Provider is reimbursed on a capitated basis, MCPs must ensure the Network Provider receives reimbursement that provides payment that is equal to, or projected to be equal to, the TRI Fee Schedule rate for applicable services at minimum. MCPs must attest to compliance with this requirement in a form and manner specified by DHCS. MCPs must provide documentation of any methodologies and analyses that support their attestation to DHCS upon request. MCPs may require and rely upon similar attestations and supporting documentation by their Subcontractors and Downstream Subcontractors. Additional guidance regarding the attestation and related documentation requirements will be posted on the TRI website.¹²

FQHC and RHC 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.¹³

The reimbursement requirements of this APL pertain to reimbursement for or attributable to specified services. DHCS has developed capitation rates for MCPs accounting for these increases as specified in this APL. Nothing in this APL constitutes

¹¹ Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan is available at: <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement-39-to-Attachment-419-B.pdf>.

¹² The TRI website is available at: <https://www.dhcs.ca.gov/TRI>.

¹³ The MCP boilerplate Contract is available at: <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

a requirement for MCPs to maintain or increase total reimbursement across all services or assigned Members to an eligible Network Provider relative to historical total reimbursement to that Provider, except insofar as is necessary to ensure the eligible Network Provider receives no less than the TRI Fee Schedule rates for qualifying services. Total reimbursement may include services not covered by this APL and is affected by factors outside the scope of this APL, such as changes in the quantity of services rendered or Members assigned. Further, this APL does not obligate MCPs that historically paid eligible Network Providers for applicable services at a set percentage of the legacy Medi-Cal fee schedule rates to continue to pay the same percentage of the TRI Fee Schedule rates, and DHCS did not develop capitation rates for MCPs for such additional increases. For reference purposes, DHCS has retained legacy Medi-Cal fee schedule rates on the main Medi-Cal rates website.¹⁴ TRI rates are indicated by procedure type “X”, while legacy rates are indicated by all other procedure types.

Data Reporting

MCPs must ensure qualifying services are reported using the specified Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes, and are appropriate for the services being provided and reported to DHCS in Encounter Data pursuant to APL 14-019: Encounter Data Submission Requirements and any subsequent APLs on this topic.¹⁵

MCPs must follow the reporting requirements which will be available on the TRI website¹⁶ and the DHCS Directed Payments Program website¹⁷ and requested through a Supplemental Data Request (SDR).

No sooner than January 1, 2025, DHCS will leverage the SDR to collect data and verify full compliance in accordance with this APL for the Calendar Year 2024 dates of service.

Payment and Other Financial Provisions

MCPs, and their Subcontractors and Downstream Subcontractors as applicable, must achieve full compliance with this APL by December 31, 2024. Full compliance includes ensuring that eligible Network Providers receive payment in accordance with this APL,

¹⁴ The main Medi-Cal rates website is available at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates>.

¹⁵ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

¹⁶ The TRI website is available at: <https://www.dhcs.ca.gov/TRI>

¹⁷ DHCS' Directed Payments Program website is available at: <https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx>.

including retroactive payment adjustments where necessary, by the compliance date, except for instances where payment would not otherwise be due by that date.¹⁸

MCPs that fail to meet these compliance timelines may be subject to interest penalties, corrective action, and other remedies available under state law and the MCP Contract. Until such time that MCPs achieve full compliance with the requirements of this APL, DHCS anticipates MCPs will ensure that eligible Network Providers continue to receive the equivalent value of former Proposition 56 physician services supplemental payments. To protect Members' access to Covered Services, DHCS reserves the right to establish shorter compliance timelines for any MCP that fails to ensure eligible Network Providers continue to receive said reimbursement until the MCP achieves full compliance with the requirements of this APL.

MCPs must ensure that payments pursuant to this APL are made in accordance with the timely payment standards in the MCP Contract for clean claims¹⁹ or accepted Encounters that are received by the MCP, or the MCP's Subcontractors or Downstream Subcontractors, within one year of the date of service, outside of the compliance timelines specified above or unless otherwise specified by further DHCS guidance. The MCP Contract specifies the requirements pertaining to timely payment in Exhibit A, Attachment III, Subsection 3.3.5 (Claims Processing)²⁰ and APL 23-020: Requirements for Timely Payments of Claims.

MCPs must communicate and provide clear Policies and Procedures (P&Ps) 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 P&Ps, the MCP is not required to make payments for claims or Encounters submitted one year following the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's Subcontractors or Downstream Subcontractors) and the Network Provider.

¹⁸ Instances where payment would not otherwise be due by December 31, 2024, include instances where the MCP has not received a clean claim, where less than 30 days has elapsed since the MCP received the clean claim, or where the MCP and Network Provider have mutually agreed to an alternative payment schedule. For more information, see APL 23-020 available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-020.pdf>.

¹⁹ A "clean claim" is defined in 42 CFR section 447.45(b) and in the MCP Contract in Exhibit A, Attachment I, Article 1.0 (*Definitions*)

²⁰ MCPs are also advised to review their specific MCP Contract and amendments executed thereto.

As required by the MCP Contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of payments required by this APL. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility (DOFR) provisions as appropriate to ensure compliance with this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network 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 payor. In addition, for retroactive adjustments to per-service or capitated reimbursements made to a Network Provider in accordance with this APL, MCPs must make available to the Network Provider an itemization of the reimbursement adjustments in an electronic format. The itemization must include sufficient information for the Network Provider to uniquely identify the value of the adjustment for each claim for qualifying services or each assigned Member, as applicable, for which a retroactive payment adjustment was made.

The requirements contained in this APL necessitate a change in MCPs' contractually required P&Ps. MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCO) Contract Oversight SharePoint Submission Portal²¹ within 90 days of the release of this APL. MCPs must also review their Network Provider Agreements as applicable and determine whether updates are needed.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, MCP Contract requirements, and other DHCS guidance, including APLs and Policy Letters.²² These requirements must be communicated by each MCP to all Subcontractors, Downstream 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: Enforcement Actions: Administrative and Monetary Sanctions, and any subsequent APLs on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

²¹ The MCO Contract Oversight SharePoint Submission Portal is located at:

<https://cadhcs.sharepoint.com/sites/MCO-MCPSubmissionPortal/SitePages/Contract%20Oversight.aspx>.

²² For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and any subsequent APLs on this topic.

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If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

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