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

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DATE: May 13, 2020

ALL PLAN LETTER 20-013

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

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR FAMILY PLANNING SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services with dates of service on or after July 1, 2019.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the California Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill (AB) 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-101-3305 appropriates Proposition 56 funding to support family planning services for Medi-Cal beneficiaries, which DHCS is implementing in managed care in the form of a directed payment arrangement for specified family planning services in accordance with DHCS' developed payment methodology outlined below.[2] On June 30, 2019, DHCS requested approval from the federal Centers for Medicare & Medicaid Services (CMS) for this directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2).[3] CMS approval of this directed payment arrangement is still pending.

Subject to future budgetary authorization and appropriation by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis for the duration

[1] This APL does not apply to Prepaid Ambulatory Health Plans or Rady Children's Hospital.
[2] AB 74 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB74.
[3] Part 438 of the CFR can be accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=c131f365759360ca3555585f2b6a1b6e&mc=true&node=pt42.4.438&rgn=div5.

of the program. The requirements of this APL may change, if required, to obtain CMS approval for this directed payment arrangement or to comport with future State legislation.

This directed payment program is intended to enhance the quality of patient care by ensuring that Providers in California who offer family planning services receive enhanced payment for their delivery of effective, efficient, and affordable health care services. Timely access to vital family planning services is a critical component of beneficiary and population health. In particular, this program is focused on the following categories of family planning services:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

Under federal law,[4] "a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such [family planning] services under Section 1396d(a)(4)(C) of this title…."[5] Therefore, Members must be allowed freedom of choice of family planning Providers, and may receive such services from any qualified family planning Provider, including out-of-Network Providers, without the need to obtain prior authorization. DHCS managed care contracts specify the requirements pertaining to family planning services in Exhibit A, Attachment 9, Access and Availability.[6]

POLICY:
Subject to obtaining the necessary federal approvals and budgetary authorization and appropriation by the California Legislature, DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to pay qualified contracted and non-contracted Providers[7] a uniform and fixed dollar add-on amount for the specified

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[4] *See* Title 42 of the United States Code (U.S.C.), Section 1396a(a)(23)(B).
[5] "[F]amily planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies[.]" 42 U.S.C. Section 1396d(a)(4)(C).
[6] MCP boilerplate contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[7] A qualified Provider is a Provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish family planning

family planning services (listed below) provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D), with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website upon CMS approval.[8]

MCPs are responsible for ensuring that qualifying family planning services are reported to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes in the table below. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided. MCPs must include oversight in their utilization management processes, as appropriate. The uniform dollar add-on amounts of the directed payments vary by procedure code:

Procedure Code[9]	Description	Uniform Dollar Add-on Amount
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00
J3490U8	DEPO-PROVERA	$340.00
J7303	CONTRACEPTIVE VAGINAL RING	$301.00
J7304	CONTRACEPTIVE PATCH	$110.00

services to a member. *See* Title 22 California Code of Regulations (CCR), Section 51200. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

[8] The preprint will be available upon approval by CMS. DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

[9] Services billed for the following Current Procedural Terminology codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	$399.00
11981	INSERT DRUG IMPLANT DEVICE	$835.00
58300	INSERT INTRAUTERINE DEVICE	$673.00
58301	REMOVE INTRAUTERINE DEVICE	$195.00
81025	URINE PREGNANGY TEST	$6.00
55250	REMOVAL OF SPERM DUCT(S)	$521.00
58340	CATHETER FOR HYSTEROGRAPHY	$371.00
58555	HYSTEROSCOPY DX SEP PROC	$322.00
58565	HYSTEROSCOPY STERILIZATION	$1,476.00
58600	DIVISION OF FALLOPIAN TUBE	$1,515.00
58615	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	$978.00
58670	LAPAROSCOPY TUBAL CAUTERY	$843.00
58671	LAPAROSCOPY TUBAL BLOCK	$892.00
58700	REMOVAL OF FALLOPIAN TUBE	$1,216.00

The uniform dollar add-on amounts for these family planning services must be in addition to whatever other payments eligible Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs,[10] and Cost-Based Reimbursement Clinics[11] are not eligible to receive this uniform dollar add-on directed payment.

[10] MCP contract, Exhibit E, Attachment 1, Definitions.
[11] Cost-Based Reimbursement Clinics are defined in Welfare and Institutions Code Section 14105.24, which is located at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14105.24&lawCode=WIC, as well as Supplement 5 to Attachment 4.19-B of the State Plan, which is located at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement%205%20to%20Attachment%204.19-B.pdf.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs 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. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, procedure code, service month, payor (i.e., MCP, delegated entity, or Subcontractor), and the 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.

MCPs must submit updated reports each subsequent quarter in the same format as the initial submission until the MCP considers the report to be complete. Each updated report must replace any prior reports. 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 continue to submit encounter data for the specified procedure codes as required by DHCS; however, there are no new encounter data submission requirements associated with this APL.

Payment and Other Financial Provisions

For clean claims or accepted encounters with dates of service between July 1, 2019, 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[12] 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 applicable family planning services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the affected Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances

[12] A "clean claim" is defined in 42 CFR Section 447.45(b).

related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Providers. This communication must, at a minimum, include a description of how payments will be processed, how to file a grievance, and how to determine who the payor will be.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS' Directed Payments Program website upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

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

Subject to future budgetary authorization and appropriation by the California Legislature and CMS approval of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis in future years. Please note that the requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement or as required in future budgetary authorization and appropriation by the California Legislature.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division