Targeted Rate Increase (TRI)

10/31/2024

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Agenda

1. Background
2. Program overview
3. Eligibility criteria
4. Payment process
5. Resources

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Background

- Assembly Bill (AB) 119: Authorized a managed care organization (MCO) provider tax (April 1, 2023 - December 31, 2026).
- Purpose: Support Medi-Cal program, enhance access, quality, equity, and provider participation.
- Legislation: AB 118 and AB 97.
- Managed Care Organization Tax:
  - Revenues support Medi-Cal programs, including targeted rate increases and investments to enhance access, quality, and equity.
  - CMS formally approved the MCO Tax on December 15, 2023.

Program Overview

Targeted Rate Increases (TRI):

- Effective January 1, 2024.

Scope:

- Applies to specific procedure codes for various provider types (e.g., Physicians, Nurse Practitioners, Psychologists).

TRI Fee Schedule:

- Published by DHCS and includes rates calculated at the greater of 87.5% of the lowest 2023 Medicare locality rate in California or the existing Medi-Cal rate plus Proposition 56 payments.

Goals:

- Increase provider rates to at least 87.5% of the lowest California-specific Medicare locality rate.
- Eliminate AB 97 payment reductions.
- Incorporate Proposition 56 supplemental payments.

Proposition 56 Payments:

- Effective for dates of service on or after January 1, 2024, the CY 2024 TRI Fee Schedule rates are inclusive of the former Proposition 56 Physician Services supplemental payments for applicable codes.
- The CY 2024 TRI Fee Schedule does not include procedure codes related to Proposition 56 dental, Proposition 56 family planning, or Proposition 56 abortion services. Proposition 56 supplemental payments applicable to these services will not change effective January 1, 2024.

Expectations from Managed Care Plans (MCPs)

Compliance

- Ensure eligible providers receive no less than TRI Fee Schedule rates.

Documentation

- Attest to compliance and provide supporting documentation.

Use specified HCPCS and CPT codes

- Ensure codes match the services provided.
- Report claim/encounters data to DHCS.

Communication

- Inform providers about requirements, payment processes, and grievance procedures.

Timeline

- Achieve full compliance, including retroactive adjustments, by December 31, 2024
  - Payment Exceptions: Payment may not be due by December 31, 2024, if:
    - MCP has not received a clean claim.
    - Less than 30 days have passed since receiving the clean claim.
    - MCP and Network Provider have agreed to an alternative payment schedule.

Attestation

- MCPs must attest to compliance and provide supporting documentation upon request.

Subcontractor requirements

Ensure clean claims are submitted timely following Molina Healthcare Plan of California, Inc. (MCA) guidelines.

Eligibility criteria

Codes identified as primary/general care services on the TRI Fee Schedule and billed using Health Insurance Claim Form (CMS-1500) are eligible for TRI only when rendered by the following types of eligible providers:

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

Codes identified as obstetric care (OB) services and non-specialty outpatient mental health (NSMH) services are eligible for TRI when billed or rendered by a provider who is otherwise eligible to bill the code.

Contracted network providers

Exclusions:

- Assistant Surgeons
- If a claim line is billed with a modifier that affects payment, the claim line is not eligible for TRI e.g. TC,26.
- Services by FQHCs, RHCs, Indian Health Care Providers, and Cost-Based Reimbursement Clinics.

Other Rate Adjustments:

- 20% payment reduction for specified procedures performed in outpatient facilities.

Additional details

- **FQHC/RHC Services:**
  - Do not qualify for TRI Fee Schedule rates.
  - MCPs must reimburse contracted FQHCs and RHCs at levels comparable to other provider types.
- **Network Status:**
  - Providers must meet criteria in APL 19-001 to be considered "In Network."
  - One-Time Agreements and Letters of Agreement generally do not qualify.

Payment process and timeline

FFS

Retrospective:

- Jan-Nov 2024 DOS received clean claims, FFS payments processed through claims adjustment.
- Previously paid claims priced at TRI rates.
- Adjustments paid out following normal claims adjustment process.
- Payment adjustment process continues until MCA system is configured for prospective payments.
- Complete retroactive payment adjustments where necessary by Dec 31st, 2024 , except for instances where payment would not otherwise be due by that date.

Prospective:

- After MHC system is configured to apply TRI pricing, FFS payments will be made following normal claims payment process.

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Payment Scenario

Fee-For-Service (FFS) Basis: MCPs must ensure FFS payments for qualifying services meet TRI Fee Schedule rates at the procedure code level.

Example: For a given TRI eligible service code

MCP pays $75 including Prop 56 payments

TRI Rate is $100

Retrospective: MCA will retroactively adjust payments to meet the $100 rate by December 31, 2024.

Prospective: The fee schedule will be compared against TRI rate and provider will receive the greater of (a minimum of $100)

Resources

- **TRI Website**: https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx
- **APLs :**
  - APL 24-007: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-007.pdf
  - APL 19-001: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-001.pdf
- **MCA TRI Provider Bulletins:** https://www.molinahealthcare.com/providers/ca/medicaid/comm/bulletin.aspx
- **MCA Medi-Cal Provider Manual:** MCA 2024 Medi-Cal Provider Manual

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